



Changunarayan Municipality

Age-Friendly City (AFC) Baseline Assessment - 2024



Changunarayan Municipality, Bhaktapur District

Technical and financial support



Age-Friendly City Assessment Report – 2024

Changunarayan Municipality, Bhaktapur District

Project: Shared Action for Healthy, Active and Respectful Aging (SAHARA)

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Dr. Madhab Adhikari
Team Leader

List of Acronyms

AFC	Age-friendly City
BCS	Brahman/Chhetri/Sanyasi
BEP	Benign Enlargement of the Prostate
CBOs	Community Based Organizations
CCA	Climate Change Adaptations
CEA	Community Engagement Accountability
COPD	Chronic Obstructive Pulmonary Disease
CSR	Corporate Social Responsibility
DC	District Chapter
DRR	Disaster Risk Reduction
FGD	Focus Group Discussion
HR	Human Resources
ICOPE	Integrated Care for Older People
KII	Key Informant Interviews
MDGP	Medical Doctorate in General Practice
MoU	Memorandum of Understanding
NCDs	Non-communicable Diseases
NGOs	Non-governmental Organizations
NRCS	Nepal Red Cross Society
NSCEH	National Environment and Health Study Center
PGI	Performance Grading Index
SAHARA	Shared Action for Healthy, Active and Respectful Aging
SDGs	Sustainable Development Goals
SEE	Secondary Education Examination
SOPs	Standard Operating Procedures
SPSS	Statistical Packages for Social Science
TOR	Term of Reference
WHO	World Health Organization

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Executive Summary

The older peoples of Nepal is increasing both in terms of absolute number and as a proportion of the total population, as socioeconomic growth and improved health indicators have elevated life expectancy among Nepali citizens. The population is aging at such a speed that the existing healthcare system and economy might fail to mitigate the challenges of aging. In this light, a paradigm shift is expected in the pattern of diseases within this population. In this regard, in achieving the Sustainable Development Goals (SDGs), a proactive concern is needed to address the rapid population aging. Nepal Red Cross Society (NRCS), as a supporting hand of the government, has been addressing humanitarian needs and implementing healthy aging initiatives as part of its health strategy in collaboration with municipalities and community stakeholders over the past three years. In this context, a MoU has been signed between the partners to implement the healthy aging project, referred to as the SAHARA project, from 2024 to 2026 where Municipality is committed to becoming an age-friendly city based on WHO's parameters.

This assessment aims to describe the existing situation of the older people based on the WHO's age friendly city (AFC) parameters in Changunarayan Municipality through a comprehensive AFC assessment. The assessment was conducted in July 2024 to assess the situation of older people in the nine wards of Changunarayan Municipality using the age friendly city parameters of the WHO, the assessment aims to establish the baseline of Changunarayan municipality project. The assessment has also recognized the perception of government service providers and family members towards older people, access to municipal services, proper care and support, specific needs of older people, and meaningful engagement of older people. The baseline data will influence the municipality's plans and policies, adjusting project interventions to develop an effective and sustainable community support system for older people.

WHO designated methodology for AFC assessment has been used in the study. Both qualitative and quantitative approaches were used to analyze the data. Qualitative data was gathered by transcribing audio recorded Key Informant Interviews (KIIs) with representatives of key stakeholder organizations and transcribing audio recorded Focus Group Discussions (FGDs) with representatives of older people's clubs¹.

With an older people population of 7,975 and a utilized sample of 373, the assessment was done in Changunarayan Municipality, revealing a higher female population and a majority of them belonging to the Brahmin Chhetri Sannyasi (BCS) group. Most of the old aged population live with

¹ Audio recording of FGD and KII will be submitted as per requirement

their family and over half with their spouse. Older peoples are encouraged to participate in municipal activities and benefit from programs like "Healthy Elderly."

Despite efforts to make public spaces old aged-friendly, significant challenges remain, including inaccessible ward offices and insufficient senior-friendly facilities in health posts and public buildings. Health services are strengthened with plans for doorstep nursing services, free health insurance, and geriatric care programs, although there is a shortage of geriatric professionals. Education and housing data show that over one-fifth of seniors are literate, with most of them living in RCC-constructed houses. Older people cards are held by more than two-fifths, but many are unaware of their benefits. Transportation issues include distance bus stops and inadequate seating, with over two-thirds facing these challenges. While a majority receive support from public transport staff, discounts on fares are less common. Respect within the community is reported by almost two-thirds, though a smaller proportion experience abuse, primarily psychological. Overall findings emphasize for improved infrastructure facilities, awareness on benefits and dedicated support to promote the quality of life of older peoples. The assessment shows a mix of positive and challenging aspects for the old aged population in then Changunarayan Municipality.

In order to improve the infrastructure facilities, it is recommended for upgrading traditional resting platforms (Falcha), pathways to ward offices. Renovation is needed in existing resting places (*pratixyalaya, ghumti*) to improve older peoples' accessibility and comfort. It is necessary to include provisions for senior-friendly buildings in the building code guideline ensuring that new buildings are senior, disabled, and child-friendly within the municipality, necessitating for new housing plans to include senior-friendly amenities, including at least one toilet with a commode per house. It is recommended for improving road facilities with timely maintenance, better placement of bus station, stricter enforcement of reserved seating policies, and the establishment of more accessible waiting areas and bus stops. As older people face difficulties reaching Changunarayan hospital (the designated first point of contact for insurance) due to poor transportation, doctors from Changunarayan hospital should visit the health post at least once a week as a satellite clinic.

The municipality should capitalize the skills and knowledge of older peoples. This can be achieved by creating leisure activities where seniors could engage in traditional arts and cultural activities. Organizing programs for skill and experience transfer can create conducive environment for gatherings in every community. Although direct abuse is found to be rare, older peoples faced financial abuse, and few experienced physical violence. Some cases of psychological abuse also have occurred. Adhering this, it is recommended to run the advocacy program between the related stakeholders.

Majority of older peoples were found generally not active in social sectors such as in politics, member of consumer committees and community development work at their communities, even the president of the older peoples' club was often absent during the FGD. Awareness and advocacy are needed to empower older people's club members as they might play crucial role for the older people to understand their duties and rights such as sharing their ideas and experiences. Forming older peoples' clubs in each neighborhood and providing home visit services for those unable to walk to health facilities were also emphasized. It is recommended for availing physiotherapy services and a contact point for addressing issues. Establishment of a religious library might be helpful for older peoples gathering, sharing their ideas and interacting. Organizing traditional musical festivals and cultural programs might be helpful to enhance well-being.

Section I: Introduction

1.1 Background and Context

Following the global trend, the old-age population of Nepal is increasing both in terms of absolute number and as a proportion of the total population, as socioeconomic growth and improved health indicators have elevated life expectancy among Nepali citizens. The population is aging at such a speed that the existing healthcare system and economy might fail to mitigate the challenges of aging. In this regard, a paradigm shift is expected in the pattern of diseases within this population. In achieving the Sustainable Development Goals (SDGs), a proactive concern is needed to address the rapid population aging.

Nepal Red Cross Society (NRCS), as a supporting hand of the government, has been addressing humanitarian needs and implementing healthy aging initiatives as part of its health strategy in collaboration with municipalities and community stakeholders over the past three years. In this context, an MoU has been signed between the NRCS Bhaktapur District Chapter and Changunarayan Municipality to implement the healthy aging project, referred to as the SAHARA project, from 2024 to 2026 where Municipality is committed to becoming an age-friendly city based on WHO's parameters. Currently, their focus areas include establishing older people clubs in each Ward, ensuring effective distribution of social security allowances, providing free health insurance, organizing health camps, supporting assistive devices, and facilitating recreational and spiritual activities. To effectively plan interventions and align priorities with WHO's age-friendly city parameters, this baseline survey is carried out.

In recent years, NRCS has been implementing healthy aging² initiatives as part of its healthy strategy. Similarly, Changunarayan Municipality also provides health and non-health services to older people. As healthy aging is a priority for both partners, it was agreed to initiate a community-based healthy aging program with shared resources between Changunarayan Municipality and NRCS Bhaktapur District Chapter. A Memorandum of Understanding (MoU) has been signed between the partners to implement the Healthy Aging Project, called the SAHARA Project, from 2024 to 2026 AD. The project aligns with the WHO's parameters for an age-friendly city, with a focus on establishing older people clubs, ensuring social security allowances, providing health insurance, organizing health camps, supporting assistive devices, and promoting

² Healthy Aging is the process of developing and maintaining the functional ability (i.e. capabilities that enable people to be and do what they have reason to value) that enables well-being in older age (UN Decade of Healthy Ageing: Plan of Action, 2021-2030).

recreational and spiritual activities. The project benefits 20,000 people out of the municipality's population of 85,000.

The SAHARA project aims to improve the quality of life, independence, and dignity of vulnerable older individuals in Changunarayan Municipality. This is achieved through a comprehensive strategy that encompasses policy advocacy, upgraded healthcare services, a focus on social and environmental initiatives, and the active engagement of seniors, their families, and communities.

1.2 Scope and Objective of the Study

Using the age friendly city parameters of the WHO, the assessment aims to establish the baseline of Changunarayan municipality project. The baseline data will influence the municipality's plans and policies, adjusting project interventions to develop an effective and sustainable community support system for older people. The assessment provides appropriate implementation strategies, interventions, inputs, and processes at the operational level to address gaps with regard to AFC parameters. Required needs will be provided based on the assessment findings. While doing the baseline assessment protection, gender, and inclusion information were taken into account.

The assessment reflects the perception of government service providers and family members towards older people, access to municipal services, proper care and support, specific needs of older people, and meaningful engagement of older people. Additionally, it evaluates the existing capacities of partners in various areas to respond to healthy aging.

Based on the assessment, comprehensive recommendations on strategic and programmatic priorities and considerations for the age-friendly city (AFC) framework (inclusive of healthy aging) in the context of the project municipality are provided.

1.3 Major topics and areas of the baseline assessment

The major topics and areas of the baseline assessment are structured according to the WHO's Age-Friendly Cities (AFC) eight domains, which include:

- Outdoor spaces and buildings,
- Transportation,
- Housing,
- Social participation,
- Respect and social inclusion,
- Civic participation and employment,
- Communication and information,
- Community support and health services

Section II: Methodology

2.1 Approach

The baseline study was conducted through qualitative and quantitative techniques. The qualitative data were collected through the KII with elected bodies and officials of the Changunarayan Municipality, line agencies and stakeholders. FGD was done with community people and older people's groups of all nine wards of the municipality. For quantitative data, information was gathered through structure questionnaire with the older peoples having age more than 60 years.

For the baseline assessment within Changunarayan Municipality, we considered a sample size of 373 individuals aged 60 or above. The sample size was equally distributed across all 9 wards, with respondents selected using simple random sampling. Ethnicity balance among respondents was maintained during the survey.

Before the baseline assessment, the 9 wards of the municipality were divided into 3 clusters:

- **Cluster 1:** Wards 1, 2, and 3
- **Cluster 2:** Wards 4, 5, and 6
- **Cluster 3:** Wards 7, 8, and 9

Enumerators were deployed on a cluster-wise basis. Additionally, the respondents' age groups were considered, categorizing them into two groups: 60-70 years and above 70 years. The gender ratio aimed for at least equal representation of males and females wherever possible.

2.2 Data Collection Tool

Quantitative data were collected through a survey of aging individuals using the KOBO Toolbox. Similarly, qualitative information was gathered through FGD and KII, with recordings made with participants' consent.

Quantitative information was obtained through structured and semi-structured questionnaires based on the WHO's AFC domains. The tools were finalized after a series of consultations with officials from the Changunarayan Municipality, Nepal Red Cross Society's health service department and the Swiss Red Cross. For qualitative information, the FGD guidelines and KII checklists were developed by the research agency and finalized in close consultation with the same officials.

Sample size is calculated by applying formula below for 95% confidence level and 5% of marginal error.

$$\text{Sample size (n)} = \frac{\chi^2 * N * (1-P)}{ME^2(N-1) + (\chi^2 * P * (1-P))}$$

Where

n = required sample size

P= probability of success

χ^2 = Chi square for the specified confidence level at 1 degree of freedom

N = Population size

ME = Desired Marginal error (expressed as a proportion.)

Total sample required at least 366

In the baseline assessment, 373 older peoples participated as respondents. Additionally, 98 older people members and 21 community members under 60 years old participated in the FGD across all 9 wards of the municipality. Moreover, 11 elected, government, and non-government officials participated in the KII. Both qualitative and quantitative information were triangulated during data analysis.

2.3 Biases and Mitigation Strategies

To address potential linguistic barriers, particularly within the Newar community in Changunarayan Municipality, we included local enumerators in our survey team. The assessment questionnaires were translated into Nepali to ensure comprehensibility. Additionally, we recruited two highly experienced field researchers from the Newar community and four others from various ethnic backgrounds. The team comprised three female and three male enumerators.

The enumerators participated in a two-days training session to enhance their ability to build rapport and understand the social and cultural values pertinent to the Newar and other communities. The training covered linguistic proficiency, cultural sensitivity, and strategies for effective communication with the target demographics. This training helped to minimize language barriers and ensured accurate data collection.

2.4 Limitations and Challenges

The survey faced challenges due to heavy rainfall. Data collection was stopped for one day due to heavy rainfall. Despite this, the survey ran smoothly as per the plan. Six qualified and experienced field researchers were hired for data collection. The recruitment process involved reviewing the curriculum vitae (CV) of potential candidates from the roster, focusing on criteria such as at least a Bachelor's degree in public health or social science, experience in similar

research, and knowledge of local languages (especially Newari). Candidates were individually interviewed to assess their suitability based on their experience, field knowledge, and language proficiency. Special emphasis was placed on forming a gender and ethnically inclusive team.

The training was conducted in consultation with the Municipality and NRCS and followed a structured two-day session plan. In the first day discussion was carried out to enlighten the project's background and context, survey objectives, methodology, and familiarization with the questionnaires and on the second day training was done about use of Kobo Toolbox, practicing questionnaire completion, and addressing any difficulties or clarifications.

By equipping the researchers with these skills and knowledge, we managed to minimize biases and ensure the reliability and accuracy of data collected from the targeted study area.

Section III: Result/findings

3.1 Demographic Information

- The findings indicate that 52% of the respondents were female, and 48% percent of the respondents were male.
- Survey data indicates that 58.9% of respondents identified as Brahmin, Chhetri, or Sannyasi (BCS), followed by 22.8% Newar, 12.9% Tamang, 2.7% Janajati, and the remaining belonging to other ethnicities.
- 92% of the respondents were found to be living with their family members. Among them, 50.4% reported living with their spouse, 44.8% with other relatives, and the remaining with other living arrangements.
- 37.5% respondents can read and write while significant proportion of respondents i.e., 62.5% cannot.
- 78% of respondents' houses are primarily constructed with Reinforced Cement Concrete (RCC), followed by 9.9% with brick and mortar, 7.8% with mud mortar, and the remaining with other materials.
- 44.8% of older people live on the ground floor of their homes, 31.1% on the first floor, 19.6% on the second floor, and 4.6% on the third floor or above.
- 62.2% of older people's family members live abroad. The main source of income for older people is from other sources (62.2%), with only 26.6% receiving a pension.
- 46.6% of older people reported having an Identity Card (ID Card) issued by the municipality office, and among them, 78.2% have benefited from it. Among the 53.4% who do not have an ID card, the reasons include 59.8% being unaware of its existence, 21.1% citing other reasons, and 19.1% not needed.
- 51.5% respondents reported that they are receiving the social security allowances.

(Detail demographic information has provided in Annex 1)

3.2 Domain 1: Outdoor spaces and buildings

- Survey data reveal that 63.8% of older people feel their neighborhood is suitable for walking, while 36.2% do not feel safe. Among those who do not feel safe walking around the community, 84.4% cited uneven and unsafe pathways as the reason, with the remaining due to other reasons.
- 63.8% of older people feel that public spaces and buildings in their community, such as parks and ward offices, are accessible.
- However, 80.2% of older people face difficulties accessing public buildings and parks. Among them, 43.2% have issues with steps, 18.9% with a lack of seats to rest or wait, 8.1% with a lack of railings, 2.7% with a lack of ramps, 4.1% with difficulties related to doors, and the remaining face other issues.

(Detail information has provided in Annex 1)

3.3 Domain 2: Transportation

- Survey data reveal that 80.5% of older people do not face problems with transportation, while 19.5% experience difficulties in accessing appropriate transport. Among those facing transportation issues, 68.1% reported that the bus stop is too far from their home, 25% noted that the nearest bus stop lacks seating or benches, 12.5% cannot afford transportation costs, 8.3% do not have family or friends to drive them, 1.4% cannot access a wheelchair, and the remaining face other problems.
- 42.1% of older peoples have obtained reserved seat during their travel in public transport.
- 57.9% of older people have not obtained a discount on public transport during their travel, meanwhile, 42.1% of older peoples have obtained a discount during their travel.
- 52.8% older people have obtained a support or priority from public vehicle drivers or helpers during travel.

(Detail information has provided in Annex 1)

3.4 Domain 3: Housing

- 80.4% of older people feel safe in their home. 19.6% feel unsafe due to the following issues: 11.5% poor layout of home, 6.4% fare from services and only 1.1 % neighbors and are make them unsafe.

- 56% of respondents' houses are adapted or can be adapted older facilities at home. Among them, 78.5% reported that adaptations are possible in the kitchen, 73.2% in the toilets, 39.2% in the doors, 35.4% in the stairs, 30.6% in the floors, and 5.3% in the ramps.

(Detail information has provided in Annex 1)

3.5 Domain 4: Civic participation and employment

- 92.5% respondent stated that they are not engaged in any volunteer activities in the last month.
- 92.2% of respondents stated that they had not got working opportunity as a paid employment.
- 82% of respondents are not interested in paid employment. However, few numbers of older people are interested in small home-based income-generating activities incense burner (*dhup batti*), leaf bowls (*duna tapari*) making etc.

(Detail information has provided in Annex 1)

3.6 Domain 5: Respect and social inclusion

- 60.9% of older people have received respect in their community. Among them, 97.7% reported receiving respect from family members, 96.4% from neighbors, 94.1% from service and retail staff, 93.7% from civil servants, and 94.1% from the general public.
- 93.8% of older people had not experienced abuse or violence in their family or community, while 6.2% reported having faced such issues. Among those who experienced abuse or violence, 55.6% were abused by family members, 11.1% by friends, and 33.3% by others in their community.
- The types of misbehavior or abuse faced include: 50% reported psychological abuse, 40% reported neglect, 20% reported social abuse, 10% reported financial abuse, 10% reported physical abuse, and the remaining faced other types

(Detail information has provided in Annex 1)

3.7 Domain 6: Social participation

- The data reveal that 72.4% of respondents stated that they had not participated in socio-cultural activities in their community, while 27.6% reported participating in such activities in the past week.

- Among those who did not participate, 43.3% cited poor health as the reason. This was followed by a lack of interest in attending local events (36.7%), not having timely information (21.5%), the venue being too far from their home (8.5%), physical limitations (7.8%), and financial constraints. Additionally, a few respondents (6.7%) reported other reasons for their inability to participate in socio-cultural activities in the past week.
- Among those who participated, 58.3% reported attending religious functions, 45.6% participated in religious tours, 25.2% attended birthday, marriage, and other similar functions, 8.7% engaged in community development work, and the remaining participated in other activities.
- 41.6% of older people stated that they are engaged in community organizations within their community. Among them, 83.9% are involved in cooperatives, 12.3% in Guthi, and in various other community organizations.
- 91.4% of older people are not involved in decision-making activities in their community, while only 8.6% are involved. Among those who are involved in decision-making, 56.3% participated as members, 25% with a minor role, and 18.8% with a major role.
- 48.8% of older people participate in physical activities such as yoga, playing games, gardening, hiking/walking, farm work, and other activities.
- 3.5% of older people are enrolled in educational learning programs, including agriculture training, vegetable farming, environment and climate change adaptation trainings, old education classes, and other programs.

(Detail information has provided in Annex 1)

3.8 Domain 7: Communication and information

- 65.1% older people know whom to call if they need information about health concerns and relevant services in their community.
- 82.3% older people receiving the information on older people activities of municipality by family and neighbors. Similarly, they get information by phone through ward members (33%), from the local radio-FM (16,6%), the internet and social media (9,1%), and from newspapers (11,5%).
- 71.6% of older people had access to the internet at their home however 75.6% do not know how to use.

- 19.6% older peoples are interested in learning basic digital literacy with the support of club volunteers, while almost twenty percent are interested in learning basic digital literacy with the support of club volunteers.

(Detail information has provided in Annex 1)

3.9 Domain 8: Community support and health services

- 39.1% older people need the personal care or assistance in their home or community. Among them, 91.1% older people having personal care or assistance facilities from family members (86.5%), from personal source (31.6%), from local government (4.4%) and from local community (1.5%).
- 72.9% older people are suffering from noncommunicable disease such as hypertension, asthma, diabetes, COPD, BEP, kidney diseases, cancer and Alzheimer and others.
- 82% of older people reported being assisted by family members to visit health institutions for check-ups when sick, while 14.7% visited on their own. The remaining were facilitated by close friends, relatives, and others.
- Regarding municipality services more than half of the older peoples (51.5%) were moderately satisfied. 26.8% stated the service as good and 17.7% as poor. More than half (59.8%) of the older people had health insurance. The majority (94,9%) of older peoples stated that staff from health facilities did not visit them periodically to check on their health condition, while few said that staff did visit them periodically.
- 59.8% respondents have health insurance.
- 94.9% of respondents reported that staff from health facilities did not visit them periodically to check on their health conditions.

(Detail information has provided in Annex 1)

3.10 Focus Group Discussions (FGDs)

3.10.1 Focus Group Discussion with Older People (age 60 and above)

Domain 1: Outdoor Spaces and Buildings

Many respondents reported significant challenges with outdoor spaces for older peoples. Issues included inaccessible ward offices and chamber rooms due to steps, absence of resting areas within ward office premises, and inadequate seating at places like temples. Health posts lacked ramps and older people-friendly toilets. Public buildings also lacked necessary facilities like

commode-type toilets and fixed handles. Traditional resting platforms (Falcha) needed upgrading, and pathways to ward offices and other areas were often narrow and uneven, with stairs lacking railings or ramps. Temples similarly lacked accessibility features such as railings and ramps. Respondents suggested renovating existing resting places like Pati, Pauwa, and Chautaro, and constructing new ones on public lands to improve older peoples' accessibility and comfort.

Domain 2: Transportation

Older peoples faced numerous challenges with public transportation due to poor road conditions and inadequate infrastructure. Many roads were in disrepair, making travel difficult. Bus parks were often located far from accessible areas, complicating seniors' ability to catch buses. Within buses, reserved seats for seniors were often occupied by others, and conductors did not enforce priority seating rules. There was also inconsistency in bus schedules and the implementation of older people cards. Moreover, bus stops were insufficient, and waiting areas were lacking, further adding to the difficulties faced by older peoples. Addressing these issues required improved road maintenance, better placement of bus parks, stricter enforcement of reserved seating policies, and the establishment of more accessible waiting areas and bus stops.

Domain 3: Housing

Many homes lacked older people-friendly features such as toilets with commodes and adequate railings on stairs. Existing houses needed modifications to become more accommodating for seniors. New ward office buildings should have been designed to be accessible for seniors and disabled individuals. Building codes needed to include guidelines ensuring that new buildings were senior, disabled, and child-friendly within the municipality and ward. In ward 8, most houses did not meet senior-friendly standards, necessitating retrofits for older homes and strict standards for new housing plans to include senior-friendly amenities, including at least one toilet with a commode per house.

Domain 4: Civic Participation and Employment

The municipality has provided an opportunity for older people to visit the temple once a year through bus reservation. Some older residents in the ward reported a desire to transfer and exchange skills, knowledge, and experience between generations. The municipality did not utilize the skills and knowledge of senior citizens. Not all older people have identity cards. There are no significant employment opportunities for civic participation and skills utilization. The participation of females is limited in activities related to traditional arts and culture. The skills and knowledge of older people are not being transferred to younger generations. However, some older residents mentioned that the municipality and the ward have not demonstrated

harmonization and coordination in operating programs related to older people. They also stated that they were not effectively involved in ward programs.

Domain 5: Respect and Social Inclusion

Although direct abuse is rare, few of older peoples face financial abuse. Some cases of psychological abuse occur, but no neglect has been found. Most seniors are treated respectfully by family and neighbors, but bank and other sector employees sometimes don't prioritize them. Misbehavior for economic reasons is noted, especially from sons and daughters-in-law in one of the wards. In some areas, there are no reported cases of economic, psychological, physical, sexual, social abuse, or neglect of older peoples.

Domain 6: Social Participation

Older peoples were generally not active in social sectors, and even the president of the older peoples' club was often absent. They did participate in religious festivals, and the municipality organized yearly religious tours for them. A few were active in politics and cultural sectors, but many-faced issues like weak economic conditions, difficulty walking, and trouble expressing thoughts. In some areas, wards organized religious pilgrimages, election campaign participation, and various festivals and events for seniors, who were more engaged in worship, religious functions, and devotional songs compared to politics.

Domain 7: Communication and information

The municipality struggled to effectively communicate with every household. In Ward 1, social mobilizers used social networks for information dissemination. Older peoples in some wards relied on elected ward members and notices posted in public places for information. Ward 4 faced challenges due to geographical barriers that hindered information flow. In Ward 7, information primarily reached residents through mobile phones and neighbors. To improve community-wide communication, information needed to be posted widely and distributed via mobile phones to ensure older peoples were well-informed.

Domain 8: Community Support and Health

FGD members reported difficulties reaching Changunarayan hospital, the designated first point of contact for insurance, due to poor transportation. Bhaktapur and Madhyapur Thimi hospitals were easier to access. Doctors from Changunarayan Hospital visited the health post weekly, but seniors and helpless citizens struggled to reach it due to steep roads and lack of transport. No ambulance services were available for all seniors, and obtaining older people cards at the municipality took an entire day. Lab test services like blood sugar and urine dipstick were needed at the health post. Some wards and municipalities provided ambulance, blood, and financial

support to ill seniors. Changunarayan municipal hospital offered home services for bedridden seniors in a few wards, but no public transport connected the ward to the hospital.

Suggestions:

FGD members in ward two suggested health service programs for older peoples, including regular health awareness and interaction sessions. They recommended organizing programs for skill and experience transfer and building small huts for gatherings in every community. Forming older peoples' clubs in each neighborhood and providing home visit services for those unable to walk to health facilities were also emphasized. Physiotherapy services and a contact point for addressing issues were proposed. In ward three, older peoples requested a religious library. Ward five highlighted the need for senior-friendly buildings, safe roads and pathways, and public toilets. Ward seven emphasized installing railings on stairs, building rest areas with traditional musical instruments and religious books and organizing cultural programs to enhance well-being. Ensuring medical treatment and support for economically weak older peoples was also stressed.

In ward eight, providing free ambulance services for economically weak, disabled, and single older peoples was deemed crucial. Ward nine focused on restoring old patios and pavements and recording disappearing cultures and histories to educate younger generations. These measures aimed to improve the quality of life and accessibility for older peoples across various domains.

3.10.2 Focus Group Discussion with community people (age <60)

Domain 1: Outdoor Spaces and Buildings

There were no older people-friendly outdoor spaces or buildings. Roads and sidewalks were not senior-friendly, and streetlights were lacking throughout the ward. Existing patios and pavements were deteriorated and needed restoration. Unsafe pathways and the absence of streetlights led to potential wildlife attacks. The health post building was disabled-friendly with ramp facilities, but there was no ramp at the police station. There was no public park, and buildings for older peoples needed to be arranged.

Domain 2: Transportation

There was no public transportation facility, and there was no waiting room/space at the bus station.

Domain 3: Housing

There were no older people-friendly homes. Most houses had a pan in the outhouse but no commode. The mud walls were fragile. The municipality needed to ensure that newly built

houses had at least one commode and were senior-friendly. Mud walls were to be modified to make adobe.

Domain 4: Civic Participation and Employment

The municipality should have better utilized the skills and knowledge of older peoples. It was important to ensure that all seniors had older people cards for access to benefits. At that time, there were limited opportunities for seniors to participate civically and utilize their skills, particularly among women.

Domain 5: Respect and Social Inclusion

Misbehavior towards older peoples was noticed due to economic reasons. Mental stress was observed in a few individuals, and physical abuse was occasionally reported.

Domain 6: Social Participation

Older peoples were active in social activities. It was essential to carry out activities for knowledge transfer and building friendships.

Domain 7: Communication and information

To improve community-wide communication, information needed to be posted widely and distributed via mobile phones to ensure older peoples were well-informed.

Domain 8: Community Support and Health Services

The insurance program had not been successfully implemented. There was a need to manage an ambulance service from the ward.

Suggestions

Older people buildings, patios, pavements, rest areas, and parks needed to be constructed in each neighborhood. Roads and pathways required safety improvements. Older people-friendly public toilets should have been built in public places and along roads.

3.11 Key Informant Interviews (KII)

3.11.1 KII with Municipal Chairperson (Mayor)

Domain 4: Civic participation and employment

The mayor of the municipality, Mr. Jeevan Khatri, stated that older peoples are encouraged to participate in activities organized by the municipality, attend meetings, and provide suggestions.

Programs like Healthy Ageing, in coordination with the Nepal Red Cross Society, utilize the experience and skills of seniors for the municipality's prosperity. Efforts are made to document historical statements and transfer knowledge to future generations through collaboration with intellectuals and historians. Seniors are involved in developing five-year plans for the municipality.

Older peoples' Forums (Jestha Nagarik Chautari) and religious entertainment groups (bhajan) are established in each ward based on municipal needs. Various organizations collaborate with the federal government and older peoples to support the Healthy Elderly Program due to limited budgets. These forums conduct awareness programs, and open events like religious songs and cultural events are organized. An action plan is in place for implementing the Older Peoples' Forums. The municipality provides free blood, distributes free medicines, offers hearing aids, conducts eye health camps, and provides free home health care for seniors.

3.11.2 KII with Section chief of Social Development Section

Domain 1: Outdoor Spaces and Buildings

The section chief of social development section of municipality stated that efforts were made to ensure newly constructed public buildings, parks, roads, and temples were senior-friendly by adding ramps and basic seating. However, the Changunarayan-Nagarkot road had not been handed over by the Road Department, preventing the use of footpaths, unlike roads built by other municipalities. Temple interiors had been senior-friendly, and paths to outer temples were being constructed, with plans to add ramps to the Changunarayan temple complex. Although not all outdoor spaces and buildings were senior-friendly, community awareness programs were conducted, and plans were in place to ensure future constructions would be senior-friendly.

Domain 4: Civic Participation and Employment

Annual intergenerational skill transfer programs were planned to be publicly organized in schools and communities through the older peoples' forum. While there was no policy for the employment of older peoples, the municipality adopted a policy to purchase locally produced goods made by seniors. Depending on their condition, individuals over sixty could be engaged in service-oriented work. Older peoples' skills, such as making pickles and handicrafts, were collected and promoted at local fairs, with assistance provided for labeling. The mindset of needing to earn quickly remained a challenge. Various entrepreneurship programs, capacity-building initiatives, and skill development training were provided, with plans to continue in the future.

Domain 5: Respect and Social Inclusion

Older people abuse was observed two years ago, but no complaints were filed recently. However, there were few older people complaints about children misusing older peoples' allowances. Plans were in place to provide doorstep nursing services to those over eighty. Free health insurance, blood, oxygen, and ambulance services for disabled older peoples were provided.

Domain 7: Communication and Information

Information was disseminated through the ward office, Tol Bikash Samiti, Women's Cooperative, and Jesth Nagarik Milan Chautari.

3.11.3 KII with Urban Planner at municipality Level (Physical Infrastructure Section)

Domain 1: Outdoor Spaces and Buildings

The Physical Infrastructure Section chief, Basanta Bahadur KC, stated that public places and buildings were made senior-friendly by adding railings, ramps, and commode-equipped public toilets. The construction of senior-friendly parks had also started in ward one.

Domain 2: Transportation

Rough roads were being organized and paved. Roads with footpaths on both sides were constructed, such as at the ward number one office in Jhaukhel. Plans were in place to construct buildings in all wards targeting older peoples. Rest areas were built in ward three, and the reconstruction of older rest areas was ongoing. There were also plans to construct waiting areas along the roads.

Domain 3: Housing

Most of the existing houses were not older people-friendly. New houses were designed to be senior-friendly during the approval of their plans. It was necessary to include provisions for senior-friendly buildings in the building code guidelines.

3.11.4 KII with ward chairperson

Domain 6: Social Participation

In ward four, the ward chairperson stated that few older peoples were involved in politics, but they actively participated in social work and cultural activities, especially at the Changunarayan temple. The ward collaborated with Budhyauli Sahitya Samaj to organize programs and annual religious pilgrimages for seniors and single women. Despite its large size and challenging geography, efforts were made to form a volunteer squad for disasters, and plans included forming a team of retired army and police personnel and a committee of former teachers and professionals to share expertise.

In ward seven, older peoples actively participated in election campaigns, social events like weddings and Bratabandha ceremonies, and cultural activities such as religious pilgrimages and festivals like Biska Jatra and Gai Jatra. They guided younger committee members and provided training on traditional musical instruments. In ward eight, older peoples were moderately active politically and socially, contributing to temple renovations and participating in festivals. The ward established a platform for senior gatherings and planned future initiatives like skill transfer programs, health checkups, and mobile health camps, though geographical remoteness posed challenges.

3.11.5 KII with Health Coordinator at municipal level

Domain 8: Community Support and Health Services

Health Coordination Section chief at the municipality reported that last year, health workers conducted door-to-door check-ups for 3,285 older peoples, revealing that most had various ailments. Seniors over seventy received free insurance, blood, and services from eleven government health institutions across nine wards. Free medicines for non-communicable diseases were provided, and Changuarayan Municipal Hospital offered 24-hour services, including emergency care and specialist treatments.

The municipality spent ten million rupees on the health insurance program last year and continued it this year for financially deprived individuals. Health workers conducted ward-wise health camps and planned to use an electric vehicle for better coverage. Labs for essential tests were started in six out of eleven health institutions, and health posts could consult with Changuarayan hospital for further care. The municipality aimed to improve access to transportation and ensure comprehensive care for older peoples.

3.11.6 KII with Senior Programme Officer at the Nursing and Social Security Division under MoHP

Existing policy: Senior Programme Officer at the Nursing and Social Security Division, stated that the older people operation guidelines required hospitals with more than fifty beds, including Bhaktapur Hospital, to run geriatric care programs. These guidelines mandated at least one geriatrician or a trained MDGP or geriatric nurse. Due to a shortage of geriatric professionals in Nepal, the Geriatric-Based ICOPE training was provided to medical officers, paramedics, and nurses. Hospitals were allocated budgets based on older people patients, with decisions on discounts or free services made by hospital management.

In Lumbini Province, the provincial health and social development ministry planned various geriatric-focused programs, including increased training and screening for issues like mental

health and mobility. The Nursing and Geriatric Division also conducted orientation for nearly retired civil servants in Kathmandu to prepare them to share their knowledge and skills with their communities. Starting this fiscal year, sensitization and awareness programs for geriatric services were implemented to inform the community about available services and social service units in hospitals for older peoples. A small fund was allocated for geriatric and gender-based violence management in some municipalities. Paramedics will be trained across municipal, provincial, and federal health facilities, and a budget was arranged for ICOPE screening in Madhesh, Sudurpaschim, and Karnali Provinces. The plan included expanding older people services to more government hospitals beyond the initial sixty-one.

3.11.7 KII with Programme officer from the Ministry of Women, Children, and Older peoples

She expressed the existing policy from the Ministry of Women, Children, and Older peoples such as Older peoples Act, 2063 BS³ (First Amendment, 2079 BS), Older peoples Regulations, 2081 BS, Criteria for Nomination of Central Older peoples Committee Members, 2075 BS, and National Action Plan for Older peoples, 2081 BS were in place. These measures aimed to protect and promote the health and well-being of older peoples at federal, provincial, and local levels.

3.11.8 KII with NRCS

Existing Policies

Nepal Red Cross Society General Secretary stated that they made many provisions for older peoples regarding health and other fundamental rights. Various programs are being conducted to support these provisions and to assist the government's policies, plans, and program. Its own development plan is in place and has started new initiatives for the physically, mentally, and socially vulnerable, including the order and the disabled. The Nepal Red Cross Society prepared a healthy aging guideline in 2022. Programs addressing national and international contexts related to international principles are being conducted.

In Changunarayan Municipality, efforts are being made to address the social and family problems of older peoples, protect their lives, ensure their health, create a healthy environment, advocate for laws and regulations benefiting them, and raise awareness about the laws and regulations enacted by the state and local governments. Creating an environment for older peoples to live comfortably, such as establishing older people centers to engage them in religious and recreational activities, conducting health check-ups, informing them about government services, raising awareness about respecting and honoring older peoples, and helping create a respectful environment for their social life. Similarly, assisting in improving the living standards of older

³ Bikram Sambat (Nepal follows this calendar which is around 57 years ahead of AD)

peoples and helping those under seventy years without any income sources to generate income. Conducting disaster preparedness programs.

Regarding future plan Nepal Red Cross Society will be support plan made by the government. Making available services and facilities to the older people friendly. Designing disaster and health programs of the Nepal Red Cross Society with a focus on older peoples. Prioritizing older people programs. Conducting awareness programs about non-communicable diseases. Considering older peoples in plans for all three phases of disaster (pre, during, and post).

3.11.9 KII with Swiss Red Cross

The Swiss Red Cross Country Coordinator has emphasized that municipalities play a crucial role in promoting healthy ageing. Therefore, it is essential that municipal policies and guidelines are age-friendly and inclusive. These guidelines often address public infrastructure and the needs of residents, increasingly incorporating more Age-Friendly City (AFC) areas into municipal policies, programs, and periodic plans to sustainably address the issues and well-being of older people. The SAHARA project has focused on three main areas: policy, service, and community empowerment concerning healthy ageing, which are closely linked to promoting sustainable age-friendly policies and programs within municipalities.

Looking ahead, healthy ageing remains a priority for the Swiss Red Cross. The organization encourages all National Societies to focus on healthy ageing, as demographic changes are a global phenomenon, not confined to individual countries. Addressing the challenges of ageing requires continuous global efforts, and it is also a key priority for Nepal. The NRCS and municipalities have been collaborating by sharing resources and technical expertise to enhance this approach. To expand the Age-Friendly City model nationwide, further collaboration between municipalities and the NRCS is necessary. The Swiss Red Cross can continue to support these efforts by providing technical assistance. It is recommended that municipalities invest in making older people clubs functional and engage other partners to diversify their partnerships.

Section IV: Discussion and Conclusions

Of total, 64% of older peoples find their neighborhood suitable for walking, however of remaining who do not feel their neighborhood suitable to walk, 84% reported that their pathways are uneven and unsafe, bringing problems for mobility within their community. 64% of the older people felt accessible to public spaces and buildings, such as parks and ward offices. Focus Group Discussion (FGD) with older peoples in Wards also reveal that older peoples face significant challenges in several areas. Outdoor spaces and public buildings lack accessibility features, such as ramps and adequate seating, while transportation issues include poor road conditions, distant bus parks, and inadequate seating enforcement. Many homes and new buildings need retrofitting and design improvements to be more senior-friendly. Seniors' skills are underutilized, with limited opportunities for civic participation and employment. Communication methods are inconsistent, and access to healthcare is hampered by poor transportation and long wait times. Despite generally respectful treatment, some seniors face financial abuse and occasional violence. Enhancing infrastructure, healthcare access, and community support are crucial for improving their quality of life. The Focus Group Discussion with community members under 60 in Ward No. 5 highlights significant gaps in infrastructure and services for older peoples. Outdoor spaces and buildings lack senior-friendly features, including safe pathways, street lights, and accessible facilities, while housing is inadequate with no commodes and fragile mud walls.

Of total, 80% of the older peoples do not face any problems while finding appropriate transportation. 20% of the remaining people's major problem was the distance from home to the bus stops. 42% of the older people obtained reserved seats without any fail and 34% of the older people find the reserved seats sometimes while using public transportation. Furthermore, 58% of the older people have not received any discount on public transport. 53% older peoples have received support or priority from public vehicle drivers or helpers during their travels. Only 54% of the older people have obtained card from the municipality while, of people who have not obtained card, 60% of the population do not know the reality of the card. FGD revealed that there is no public transportation or waiting area. The KII done with the Mayor of Changunarayan Municipality reveals significant efforts to support older peoples in the municipality. Mayor mentioned, although not all outdoor spaces and buildings are fully senior-friendly, efforts are underway to improve accessibility, with future constructions planned to be more accommodating

80% of older people feel safe in their homes. 56% of older people have homes that are adapted or can be adapted to meet their needs. They felt that possible adaptation can be in kitchens, toilets, doors, lighting, furniture, stairs, and floors. Only 5% mentioned the possibility of adding ramps in their houses. The KII done with the Urban Planner highlights ongoing efforts to improve senior-friendly infrastructure within the municipality. Public spaces and buildings are being

enhanced with railings, ramps, and commode-equipped toilets, with senior-friendly parks under construction in Ward 1. Transportation improvements include paving rough roads, constructing footpaths, and planning rest and waiting areas in various wards. Although existing housing is not generally senior-friendly, new housing plans are required to adhere to senior-friendly design standards. Overall, these initiatives aim to better accommodate older peoples through thoughtful infrastructure planning and development.

Almost 93% of older people are not engaged in volunteer activities in the past month, and a large proportion have not had paid employment opportunities. Almost 20% said that they needed paid employment. Older peoples expressed interest in various types of work, including agriculture, livestock, labor, age-friendly work, small home-based income-generating activities, and simple physical tasks. The KII done with the Mayor of Changunarayan Municipality reveals significant efforts to support older peoples in the municipality. Civic participation is encouraged through programs like Healthy Elderly, where seniors contribute their skills and knowledge to municipal development, and through forums and cultural events organized in each ward.

61% of older people have received respect in their community. They report similar levels of respect from neighbors, the general public, service and retail staff, and civil servants. Most have not experienced abuse or violence within their family or community, although a smaller proportion have reported being victims of such issues. The KII done with the Mayor of Changunarayan Municipality revealed that respect and social inclusion are addressed with measures like doorstep nursing services and free health provisions.

Almost 73% of older people don't participate in socio cultural activities. The major reasons behind not participating in those activities are poor health, lack of information, lack of interest, proximity. Older age population in decision-making is very low as only 8% of older age people are in decisions making role. Educational or training enrollment is minimal, with less than 5% involved in learning programs. The KII done with the Ward Chairperson of ward no 4 reveals diverse and active engagement of older peoples in social and cultural activities across different wards. In Ward 4, seniors are involved in social work and cultural events, with collaboration on religious pilgrimages and disaster response planning. In Ward 7, they participate in election campaigns, social events, and cultural festivals, while also contributing to traditional music and guiding younger members. Ward 8 sees moderate political and social activity from seniors, with involvement in temple renovations and festivals. Each ward is working to enhance senior participation through gatherings, skill transfer programs, and health services, although geographical challenges impact some initiatives

Almost 35% older people donot know whom to contact for information about health concerns and community services. They primarily receive information from family, neighbors, phone calls,

local radio, the internet, social media, and newspapers. While 72% have access to the internet, nearly 24% of them do not know how to use internet. The Focus Group Discussion with community members under 60 in Ward No. 5 highlights significant gaps in Communication, requiring better dissemination of information through various channels. The KII done with the Mayor of Changunarayan Municipality revealed that, communication is managed through various community channels, while respect and social inclusion are addressed with measures like doorstep nursing services and free health provisions.

61% older people have not obtained personal care or assistance needs at home or in the community. Of total, 73% suffer from chronic diseases such as hypertension, asthma, diabetes, COPD, BEP, kidney diseases, and Alzheimer's, with most receiving help from family. Emergency training or drills addressing their needs are largely unavailable. Satisfaction with municipal services is moderate, and over half have health insurance. However, most older peoples do not receive regular health check-ups from facility staff. Quality of life ratings vary, with over two-fifths describing it as moderate. Interest in basic digital literacy training is low, with more than three-fourths not interested, though around twenty percent are open to learning with volunteer support.

The KII done with the Senior Programme Officer at the Nursing and Social Security Division under MoHP outlines ongoing efforts to enhance geriatric care in Nepal. Existing guidelines require hospitals with over fifty beds, like Bhaktapur Hospital, to offer geriatric care, staffed by geriatrician or trained personnel. Due to a shortage of specialized professionals, Geriatric-Based ICOPE training is provided to medical staff. Regional initiatives in Lumbini Province include increased training, mental health and mobility screenings, and orientation programs for near-retirement civil servants to share their expertise. Sensitization and awareness programs are also being implemented, with small funds allocated for geriatric and gender-based violence management. Plans include expanding geriatric services to more hospitals and training paramedics across various levels. The Focus Group Discussion with community members under 60 in Ward No. 5 stated that insurance program is ineffective, and there is a critical need for improved ambulance services. Addressing these issues will significantly enhance the quality of life for older peoples in the ward.

The KII done with the Health Coordinator at the municipal level reveals substantial efforts to support older peoples' health. Last year, health workers conducted door-to-door check-ups for 3,285 seniors, identifying various health issues. Free insurance, blood services, and medications for non-communicable diseases were provided, and 24-hour care was available at Changunarayan Municipal Hospital. Despite these efforts, challenges remain, including providing immediate care for seniors without family support and limited public transportation. The municipality invested ten million rupees in the health insurance program, conducted ward-wise

health camps, and is working on improving transportation and lab services to enhance access to comprehensive care for seniors.

The KII done with the Programme Officer from the Ministry of Women, Children, and Older peoples highlights several key policies aimed at supporting older peoples. The Older peoples Act, 2063 (First Amendment, 2079), Older peoples Regulations, 2081, and the Criteria for Nomination of Central Older peoples Committee Members, 2075, along with the National Action Plan for Older peoples, 2081, collectively focus on protecting and enhancing the health and well-being of seniors across federal, provincial, and local levels. These frameworks are designed to ensure comprehensive care and support for older peoples throughout Nepal.

The Nepal Red Cross Society (NRCS) with the support of the Swiss Red Cross are actively enhancing support for older peoples through programs and initiatives. NRCS has introduced guidelines for healthy aging and is addressing the physical, mental, and social needs of seniors, including establishing older people centers, conducting health check-ups, and improving living standards. Future plans involve supporting government initiatives and integrating older people-focused disaster and health programs. The Swiss Red Cross emphasizes policy integration, senior-friendly infrastructure, and community empowerment, advocating for global efforts in healthy aging and supporting the expansion of age-friendly cities. Both organizations stress the importance of functional older people clubs, diversified partnerships, and resource sharing to advance these goals.

Section V: Recommendations:

Domain 1: Outdoor spaces and buildings

For Municipality

- Adopt the policy and building code adhering the requirement of older people including ramps available at public buildings and spaces, commode at the public toilets, safety signs at the roads, improved pathways, railings, seats to rest, accessibility to the wards chair person's rooms and hospitals.
- Renovating existing resting places like Pati, Pauwa, and Chautaro.
- Construct new public gathering places within the community to share their experiences and interest.
- Manage the existing street lamps and install the new ones within the wards those have not previously.

For NRCS

- Support to prepare policies and plans for the healthy ageing programs.
- Deploy the volunteers and technical supports for the need assessment and prioritization.

Domain 2: Transportation

For Municipality

- Maintain the regularity schedule of public transport within the wards including new routes should be established in those wards where the public transportation facility is not available.
- Coordinate and monitor the implementation of reserved seat, implement to discount services to all eligible older people in public transport with the coordination to the traffic police.
- Ensure that older people know about their rights for ID card and its benefits.
- Establish the bus stops within the municipality and build waiting place (pratikshyalaya/ghumti) for the older people.

For NRCS

- Support to identify the bus stops accessible to the older people.
- Deploy the volunteers and technical supports.
- Use older people's groups to promote older people's rights.

Domain 3: Housing

For Municipality

- Review the existing building code and policy guideline and incorporate the provision of at least one commode toilet within the house for older people.
- Joint program for the implementation of older people friendly toilets, floors of building (for e.g., using non-slippery mat), handles in toilets, railing in stairs.

For NRCS

- Support to develop policy guideline and need assessment towards the older people safety measures at their homes.

Domain 4: Civic participation and employment

For Municipality

- On the basis of database, identify the expertise and create the suitable employment opportunities for older people.
- Identify the area for volunteer services i.e., religious and cultural functions, etc. to the older people.
- Engage older people focusing female, to transfer their inherent skills such as making *duna/tapari*, *bateko dhup*, *batti katne*, etc to the younger generations in coordination of different schools.

For NRCS

- Provide necessary materials and facilitate or organize the events.
- Supporting older people become Red Cross volunteers.

Domain 5: Respect and social inclusion

For Municipality

- Organize program for the interaction between older and younger people.
- Facilitate to organize awareness campaigns or sessions within the community, schools and other public places.
- Organize traditional tournaments (chess, baghchal etc.) to increase the harmony and respect between older and younger people.
- Celebrate the day of older people on the 1st of October and,
- Inform older people about their rights and where they can find support when there is abuse.

For NRCS

- Provide necessary materials and facilitate or organize the events.

Domain 6: Social Participation

For Municipality

- Strengthen and empower older people clubs (Jestha Nagarik Milan Chautari) ensuring more active and functioning by providing musical instruments, establishing religious library, skill transfer programs, spaces for yoga etc.
- Enroll at public concerns/activity within the municipality.
- Prepare database based on the expertise of older people and use their expertise in municipal activity.

- Empowering older people to participate in the decision-making process. Information campaigns, forums, actively inviting representatives of older people groups to participate in discussions, especially when it concerns their issues.

For NRCS

- Provide training/orientation and deploy volunteers to strengthen and empower older people clubs.
- Increase older people clubs and groups and visit lonely older people at home.

Domain 7: Communication and information

For Municipality

- In order to disseminate the information to the older people, via cellphone/phone, collect the phone number of older people and disseminate using the WhatsApp group or any other familiar social media.
- Organize the trainings or sessions for digital literacy programs for the familiarization and access of digital media.

For NRCS

- Organize/facilitate the training programs for the digital literacy to older people.

Domain 8: Community support and health services

For Municipality

- Organize health awareness activities on non-communicable diseases, anti-tobacco campaigns within the community.
- Satellite clinic from municipal hospital to health post to address the insurance issues to older people.
- Regularity of medicines for term diseases, routine health checkups, free ambulance services for deprived citizens, education and awareness to family members on old aged care, no stock out of medicine regarding non-communicable disease at health posts and municipal hospital.
- At least one ambulance should be provided in each ward.
- Regular monitoring of the municipal hospital and health posts by the municipality.

For NRCS

- Organize or provide support for the awareness programs.
- Deploy volunteers to collect the data to develop the database of older people.
- Provide visiting services to older people done by older people groups or by volunteers.

Annex

Annex 1: Detail findings and results

1. Demographic Information

1.1 Gender distribution of respondent

Figure 1 presents data regarding the gender distribution of the respondents. The findings indicate that more than half (52%) of the respondents were female, while less than half (48%) were male.

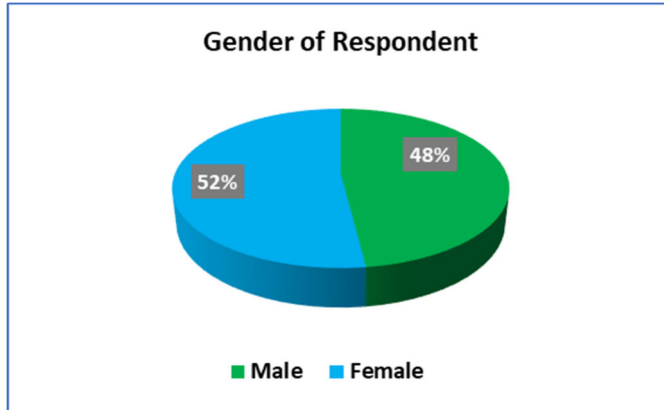


Figure 1: Gender distribution of respondent

1.2 Marital status of respondent

Figure 2 presents data regarding the marital status of the respondents. The findings indicate that almost all respondents (99%) were married, among married more than one fourth (28.4%) were widowed very few (0.3%) were separated and divorced respectively while a small minority (1.1%) were unmarried.

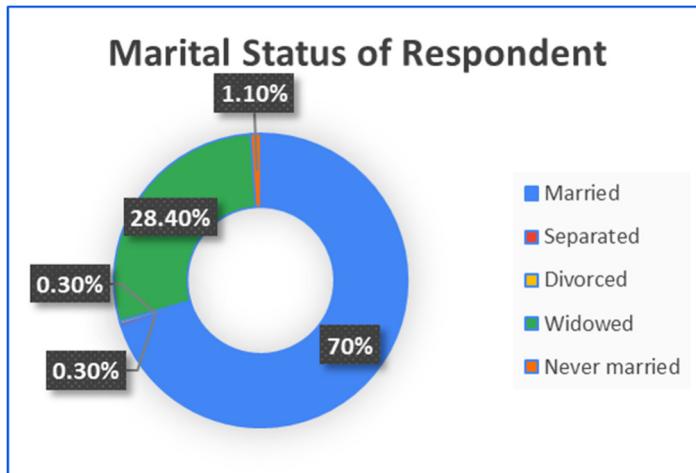


Figure 2: Marital status of respondent

1.3 Cast/ethnicity of respondents

Figure 3 provides information on the caste/ethnicity of the respondents. The data illustrates that the majority (59.8%) of the respondents identified as Bramhin Chhetri Sannyasi (BCS), followed by Newar (22.8%), Tamang (12.9%), Janajati (2.7%) and others (1.9%) respectively.

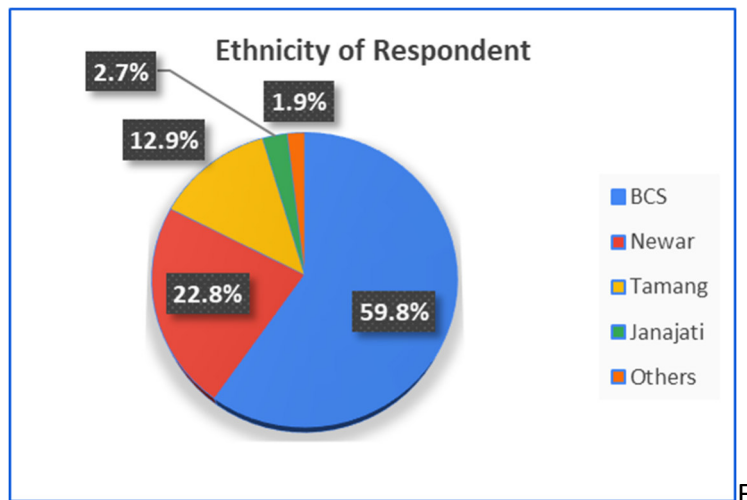


Figure 3: Ethnicity of respondent

1.4 Living with family member

The figure provides information on the living with their family members of the respondents. The data revealed that the majority (92%) of the respondents reported they are living with their family members, whereas a few (8%) of respondents reported not having their family members.

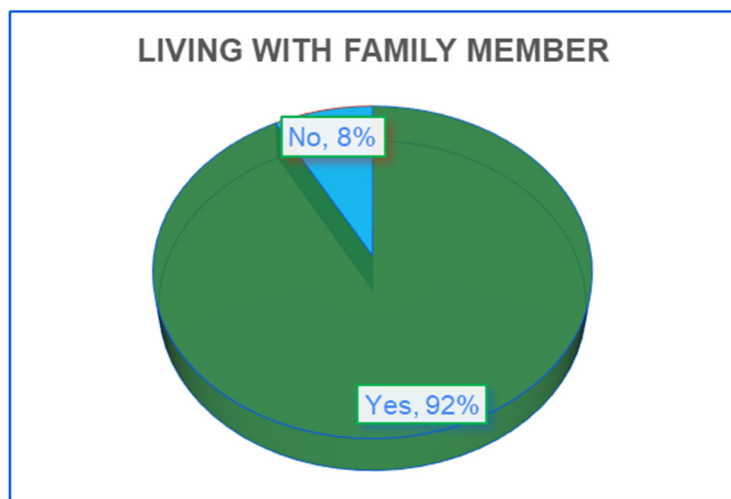


Figure 4: Living with family member

The 5 figure provides information on the living arrangements of the respondents. The data revealed that more than half (50.4%) of the respondents reported they are living with spouse, followed by others relative (44.8%) whereas a few (4.6%) of respondents reported they are living with their family members and very few reported they are living with other (0.3%) relative.

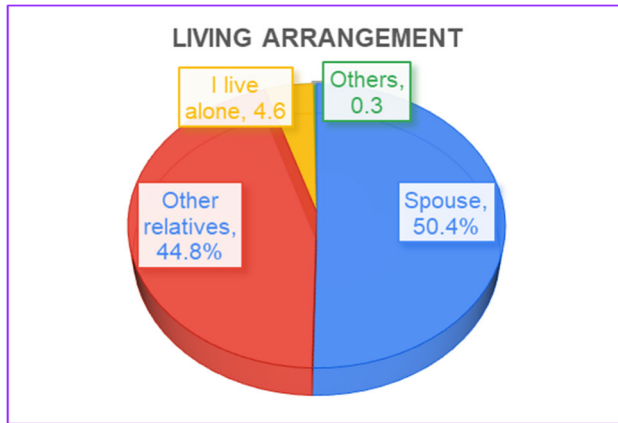


Figure 5: Living arrangement

1.5 Educational status

Figure 6 provides information on the highest educational of the respondents. The data reveal that more than one fifth (23.3%) of the respondents' found literate followed by completion of high school graduate or SEE or equivalent (7.5%), attainment of informal education (4.8%), higher education beyond School Leaving Certificate plus 2 (1.3%), attainment of bachelor degree or above (0.3%), attainment of master degree and above (0.3%), while a more than half (62.5%) were reported as can't read and write.

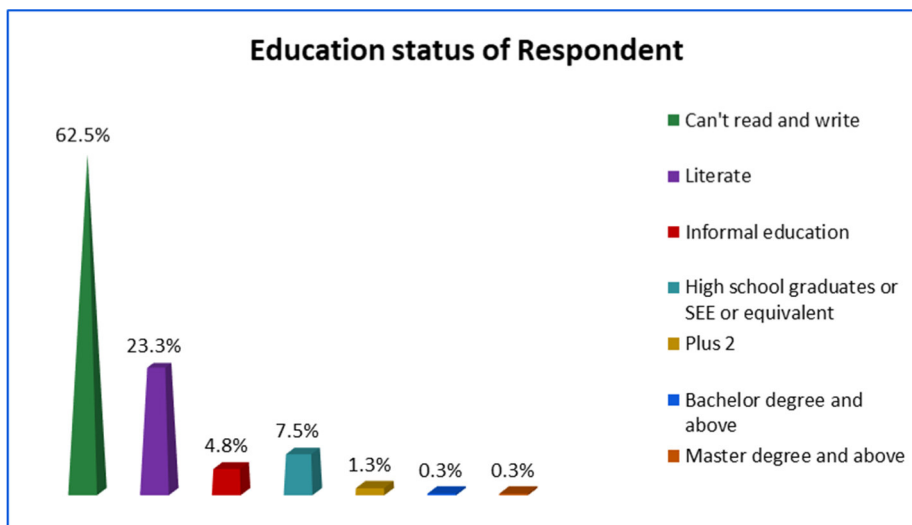


Figure 6: Education status of respondent

1.6 Household information

The figure 7 provides information on the construction material of the housing unit for the respondents. The data show that more than three fourth (78%) of the respondents reported they had RCC as the primary construction material of the housing unit, followed by brick mortar (9.9%), mud mortar (7.8%) while a few (4.3%) of the household construction materials had others, respectively.

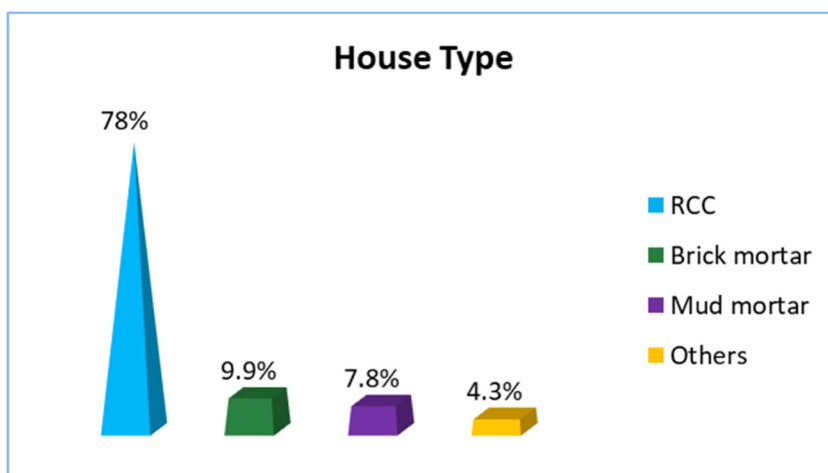


Figure 7: House type of respondent

1.7 Numbers of floor in dwelling

The table 1 provides information on the floor of this dwelling for the respondents. The data reveal that more than two fifth (43.7%) of the respondents reported they had two floors in their house, followed by three and one floor in their house (27.1%), few (1.3%) had four floors, while a very few (0.5%) had five floors, respectively.

Table 1: Numbers of floor in dwelling

No. of floor	Total	
	N	%
0	1	0.3
1	101	27.1
2	163	43.7
3	101	27.1
4	5	1.3
5	2	0.5
Total	373	100

1.8 Living floor of the dwelling

The figure 8 provides information on the living floor of this dwelling for the respondents. The data reveal that more than two fifth (44.8%) of the respondents reported they had living in ground floor in their house, followed by first floor (31.1%), second floor (19.6%) while a very few (4.6%) had living in third floor and above, respectively.

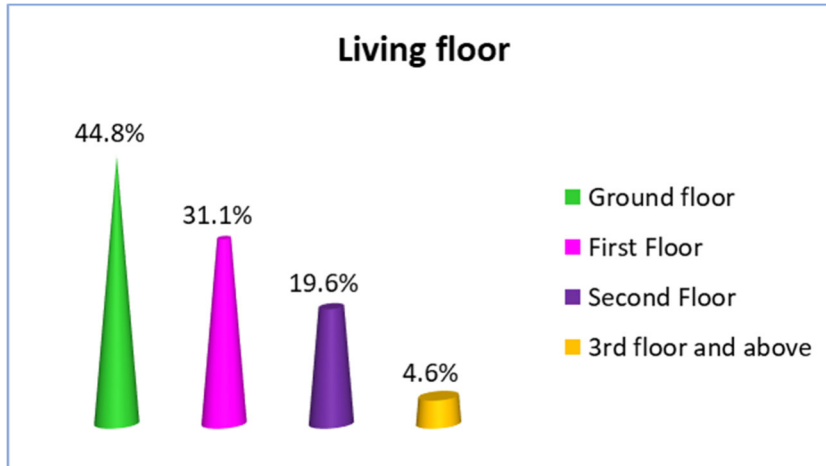


Figure 8 Living floor

1.9 Household Dwelling Ownership

The figure 9 provides information on the household of this dwelling for the respondents. The data reveal that the majority (95.4%) of the respondents reported owning their own home, followed by (4%) rented, whereas a few (0.5%) of respondents reported others having their own house.

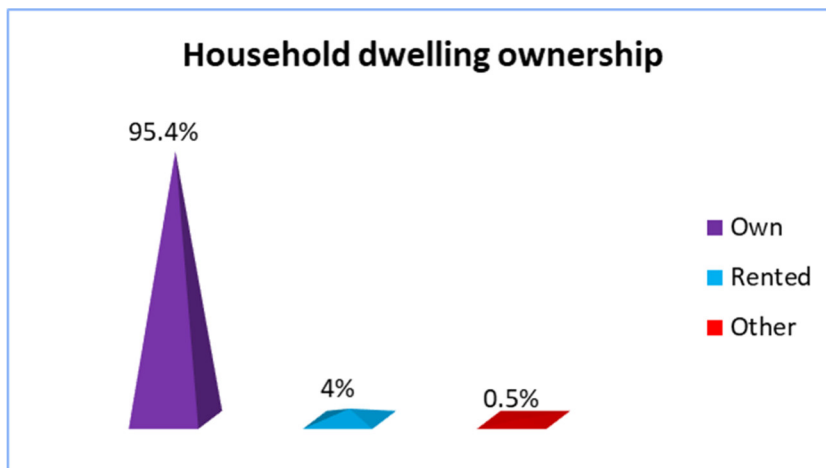


Figure 9 Household dwelling ownership

1.10 Family member living in abroad

The figure 10 provides information on family members living in abroad for the respondents. The data reveal that more than three fifth (62.5%) of the respondents reported their family members living together, whereas more than one third (37.5%) of respondents reported their family members living in abroad.

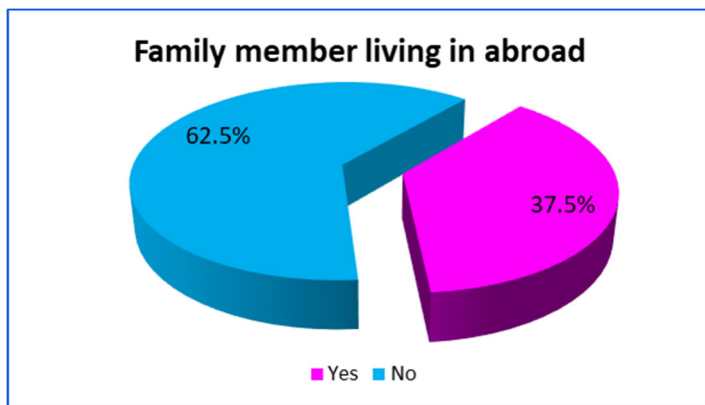


Figure 10: Family member living in abroad

1.11 Receiving Social Security Allowance from the Government

The figure 11 provides information on receiving social security allowance provided by government. The data revealed that more than half (51.5%) of the respondents reported they were receiving the social security allowance, whereas less than half (48.5%) of respondents reported not received the social security allowances. Regarding the reason, not receiving the social security allowance due to not eligible, pension holders, had not citizenship card and till government job.

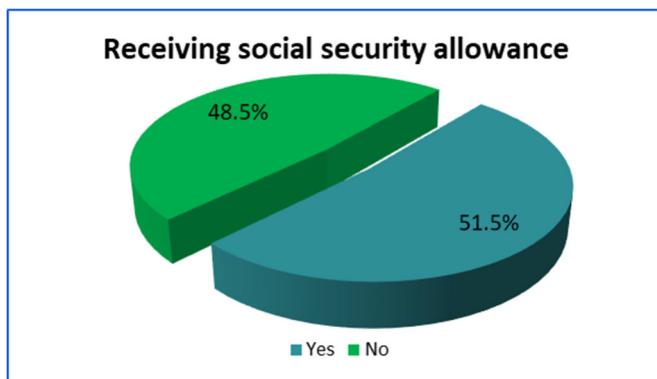


Figure 11: Receiving social security allowance

1.12 Main source of income

The figure 12 provides information on the main source of income of the respondents. The data reveal that more than one-fourth (26.3%) of the respondents identified pension as the main source of income, followed by remittances from abroad (8.3%), salary (3.2%), while a more than three-fifth (62.2%) identified other source as their main source of income, respectively.

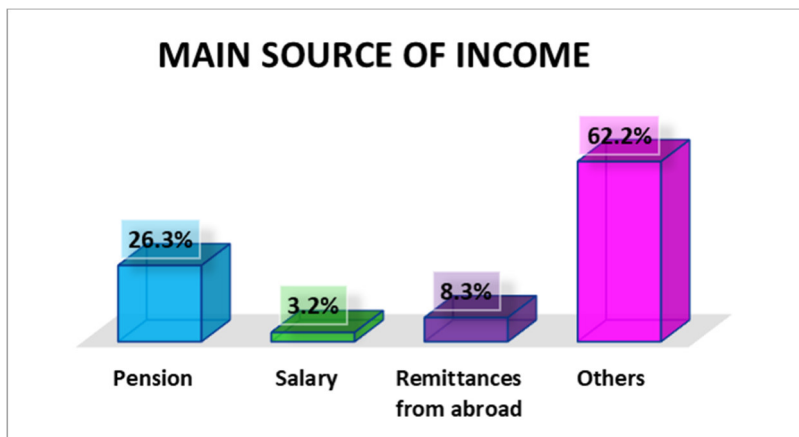


Figure 12: Main source of income

1.13 Status of personal total monthly income

The figure 13 provides information on the total monthly income of the respondents. The data reveal that less than one-third (32.4%) of the respondents identified less than 6000 monthly incomes, followed by 6000-15000 (27.1%), 15000-25000(23.6%),25000-50000(13.9%) while a few (2.9%) identified more than 50000 as their monthly income, respectively

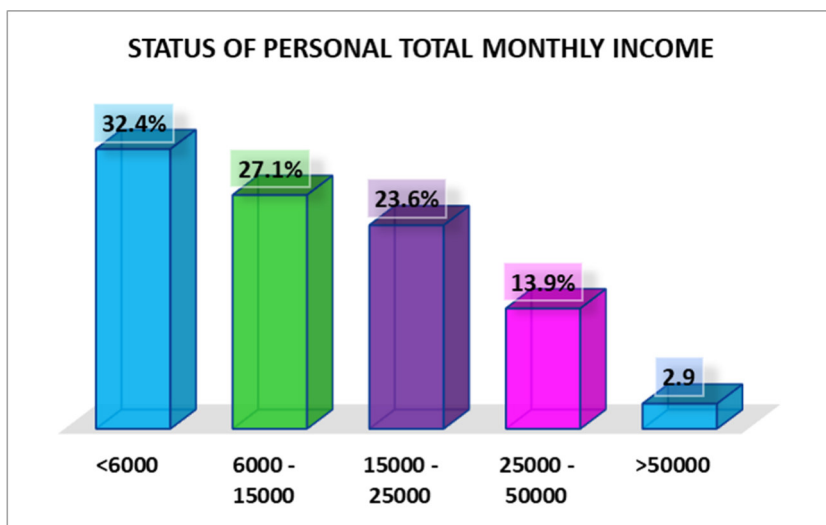


Figure 13: Status of personal total monthly income

1.14 Status of older people card received from the municipality office

The table provides information on the older people card received from the municipality office for the respondents having access to card. The data show that more than two-fifth (46.6%) of the respondents reported having older people card received from the municipality office, while more than half (53.4%) respondents reported not having the older people card.

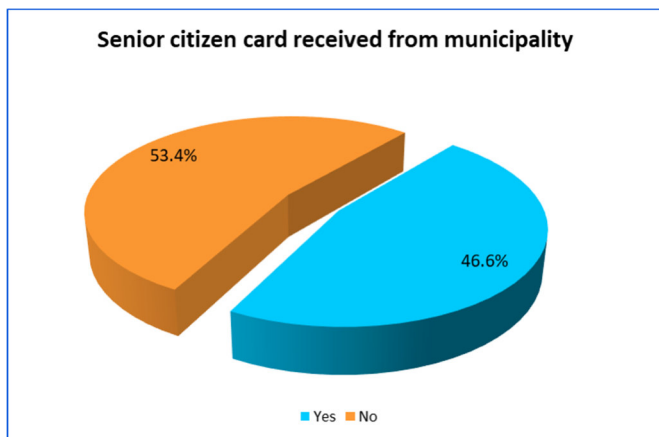


Figure 14: Older people card received from municipality

1.15 Status of benefit from older people card

The figure 15 provides information on the benefit from the older people card received from the municipality office for the respondents. The data show that more than three-fifth (78.2%) of the respondents reported benefited having older people card received from the municipality office, while less than one-fourth (21.8%) respondents reported not benefited from the older people card.

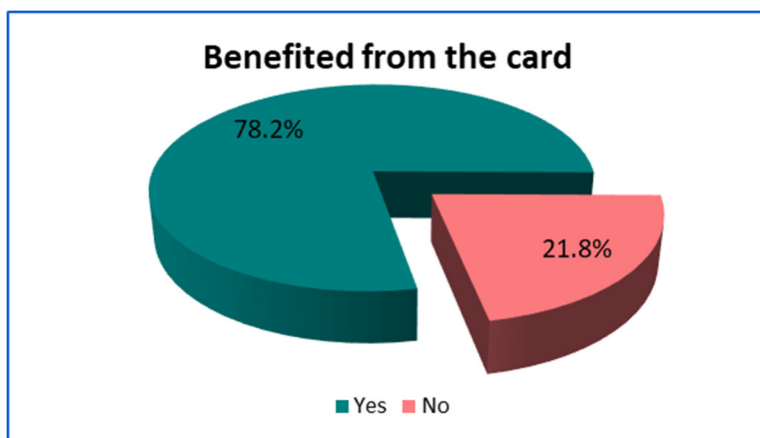


Figure 15: Benefited from the older people card

1.16 Reason of not receiving the older people card

The figure 16 provides information on the reason not receiving the older people card from the municipality office for the respondents. The data reveal that almost three-fifth (59.8%) of the respondents reported they weren't known about the reality of the older people card, followed by not needed (19.1%), while more than one-fifth (21.1%) respondents reported due to other reasons not receiving the older people card.

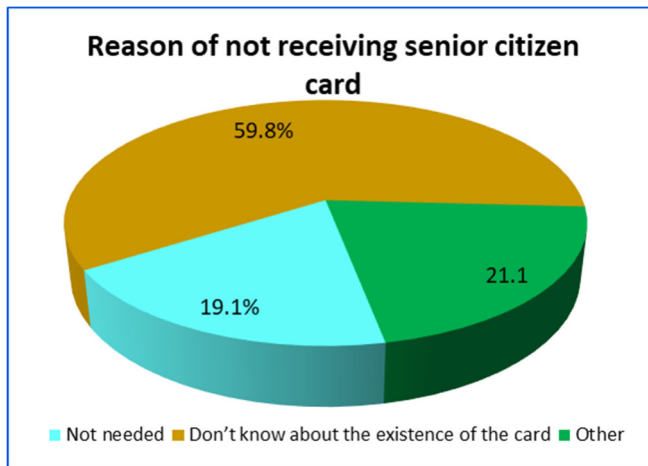


Figure 16: Reason of not receiving older people card

2. Domain 1: Outdoor spaces and buildings

2.1 Suitability of neighborhood for walking

The figure 17 provides information on the suitability of neighborhoods for walking, as reported by respondents. The data reveal that more than three-fifths (63.8%) of the respondents felt their neighborhood was suitable for walking, while less than two-fifths (36.2%) felt their neighborhood was not suitable for walking.



Figure 17: Suitability of neighborhood for walking

2.2 Status of neighborhood for walking

The figure 18 provides information on status of neighborhoods for walking to older peoples, as reported by respondents. The data reveal that the majority (84.4%) of respondents felt their neighborhood had uneven, unsafe pathways, and they had problems walking around their community, village, or town. This was followed by issues with too long distances (20%), general safety concerns (7.4%), poor street lighting (4.4%) and not enough public seating (3%). A very few respondents (0.7%) felt their neighborhood was not suitable for older peoples.

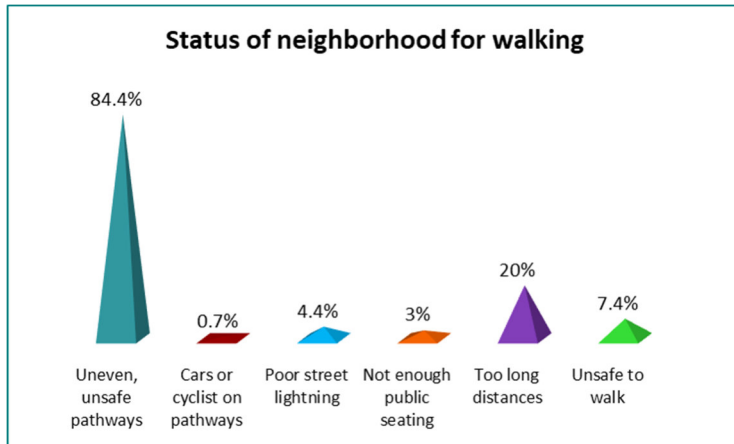


Figure 18: Status of neighborhood for walking

2.3 Accessibility to public spaces and buildings

The figure 19 provides information on the accessibility to existing public spaces and buildings as reported by respondents. The data reveal that more than three-fifth (63.8%) of respondents felt accessible to public spaces and buildings around their community, park, ward office. While more than one third (36.2%) felt not accessible to existing public buildings in their community offices, park, ward office.

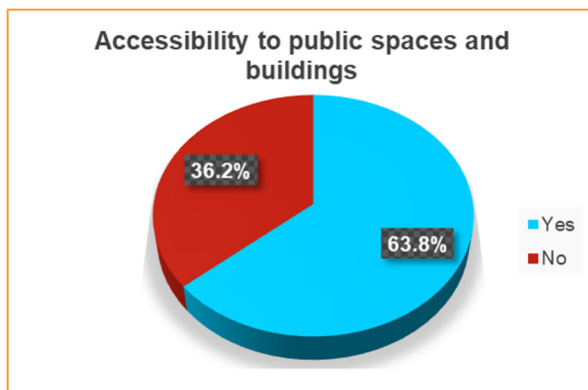


Figure 19: Accessibility to public spaces and buildings

2.4 Accessibility to public buildings and park

The survey data reveal that majority (80.2%) of respondents face the problems to public buildings around their community, park, ward office. While less than one fifth (19.8%) respondents not facing to public buildings in their community offices, park, ward office.

The table 2 provides information on the problem facing to public buildings community offices, park temple and ward offices as reported by respondents. The data show that more than two-fifth (43.2%) of respondents facing difficulties with steps to public spaces and buildings around their community, park, ward office, followed by lack of seats to rest or waiting (18.9%), lack of railings (8.1%), lack of doors (4.1%), lack of ramps (2.7%), while more than one third (37.8%) respondents facing with others to public buildings and park.

Table 2: Problems facing to public buildings and park

Problems	Total	
	N	%
Difficulty with doors	3	4.1
Difficulty with steps	32	43.2
Lack of railings	6	8.1
Lack of ramps	2	2.7
Lack of seats to rest or wait	14	18.9
Other	28	37.8

3. Domain 2: Transportation

3.1 Problem facing on public transportation

The figure 20 provides information on the problems of transportation as reported by respondents. The data reveal that majority (80.5%) of the respondents not facing the problems to getting appropriate transport, while less than one-fifths (19.5%) of the respondents facing the problems to getting the appropriate transportation.

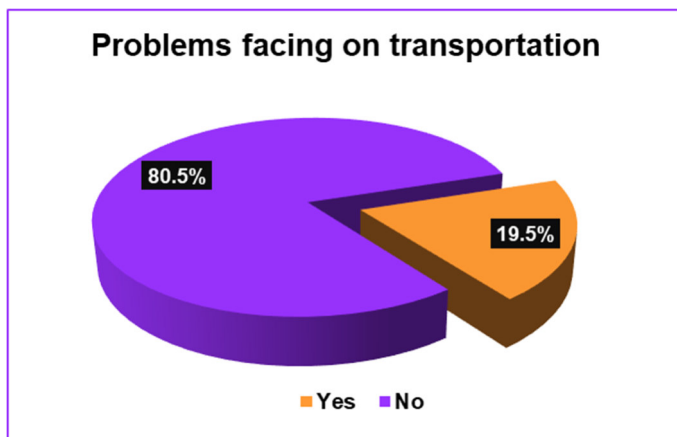


Figure 20: Problems facing on transportation

The table 3 provides information on the problems with public transportation as reported by respondents. The data illustrate that more than two-thirds (68.1%) of the respondents reported facing the problem of bus stops being too far from their home for public transportation. This is followed by the nearest bus stop not having a seat or benches (25%), being unable to afford transportation costs (12.5%), not having a family member or friend who could take them (1.4%), and being unable to access public transportation with a wheelchair (1.4%). Additionally, almost one-tenth (11.1%) of the respondents reported facing other problems with public transportation.

Table 3: Problems with public transportation

Problems with public transportation	Total	
	N	%
I don't have family or friends who can take me/ drive me	6	8.3
I cannot afford transportation costs	9	12.5
The bus stop is too far from my home to walk to	49	68.1
My nearest bus stop does not have a seat/ a bench	18	25
Can't access with wheel chair	1	1.4
Other	8	11.1

3.2 Access to reserved seat for older people and PWD in public transport

The figure 21 provides information on reserved seats for older peoples and people with disabilities during travel, as reported by respondents. The data reveal that more than two-fifths (42.1%) of respondents reported having obtained a reserved seat during travel. This is followed by sometimes (33.5%), while almost one-quarter (24.4%) of respondents reported being unable to obtain a reserved seat during their travel.

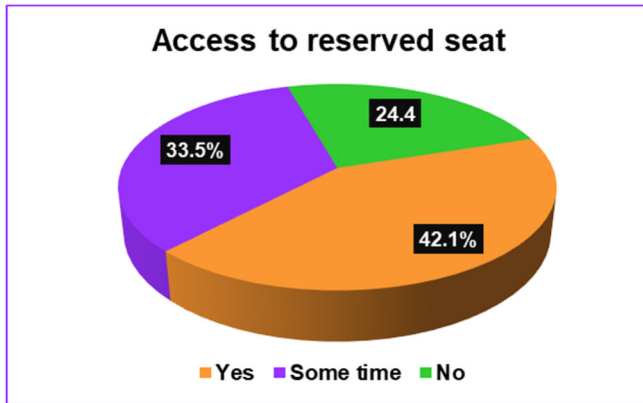


Figure 21: Access to reserved seat

3.3 Status of getting discount on public transport

The figure 22 provides information on discounts on public transport for older peoples and people with disabilities during travel, as reported by respondents. The data show that more than half (57.9%) of respondents reported not having obtained a discount on public transport during their travel. Meanwhile, almost two-fifths (42.1%) of respondents reported being able to obtain a discount during their travel.

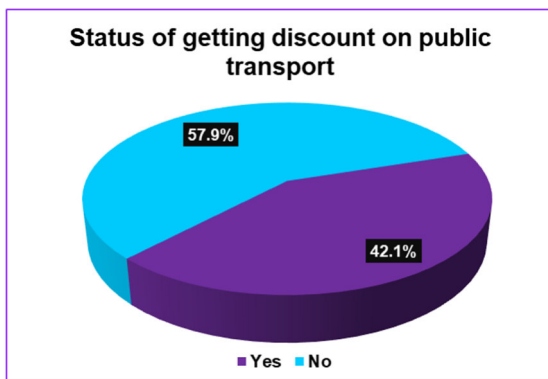


Figure 22: Status of getting discount on public transport

3.4 Status of getting the support or priority from public vehicle drivers or helpers

The figure 23 provides information on vehicle driver or helpers getting the support or priority for older peoples and people with disabilities during travel, as reported by respondents. The data illustrate that more than half (52.8%) of respondents reported having obtained a support or priority from public vehicle drivers or helpers during travel. Meanwhile less than half (47.2%) of respondents reported being unable to obtain a support or priority from public vehicle drivers or helpers during their travel.

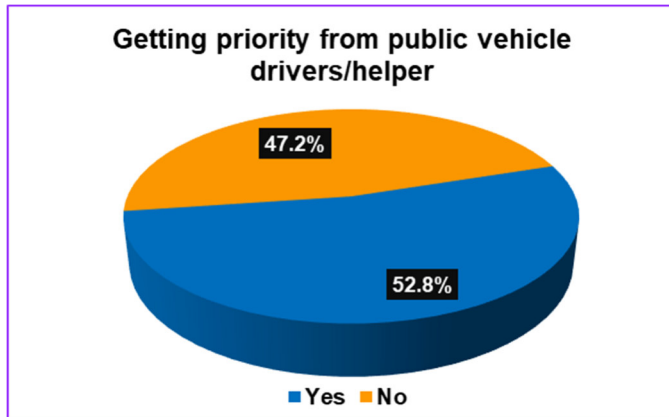


Figure 23: Getting priority from public vehicle drivers/helpers

3.5 Accessibility of public bus stop

The figure 24 provides information on the accessibility of public bus stops for older peoples and people with disabilities during travel, as reported by respondents. The data reveal that more than two-thirds (68.4%) of respondents reported that public bus stops were accessible during their travel. Meanwhile, less than one-third (31.6%) of respondents reported being unable to access public bus stops during their travel.

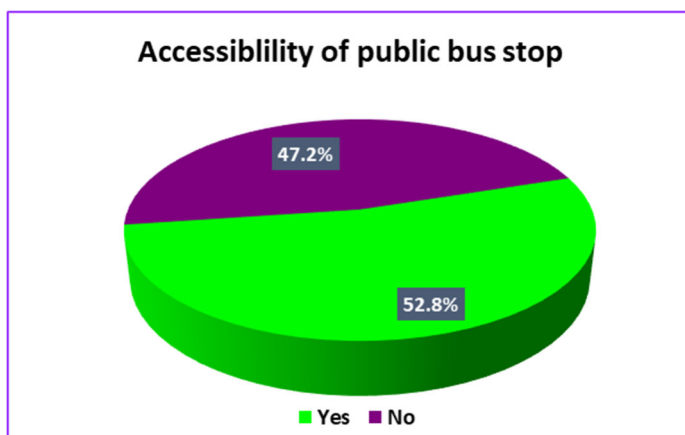


Figure 24: Accessibility to public bus stop

4. Domain 3: Housing

4.1 Reason of feeling home unsafe

The table 4 provides information on the reasons why respondents felt unsafe in their home, as reported by respondents. The data reveal that the majority (80.4%) of respondents did not feel unsafe in their home. The remaining respondents felt unsafe due to poor layout of their homes (11.5%), being far from service centers (6.4%), and feeling unsafe in their neighborhood area (1.1%).

Table 4: Reason of feeling home unsafe

Reasons	Total	
	N	%
Poor layout of your home	43	11.5
Far from services	24	6.4
Neighbors/area make me feel unsafe	4	1.1
I don't feel unsafe	300	80.4
Other	2	0.5
Total	373	100

The survey data reveal that more than half (56%) of respondent's house adapted, or can it be adapted, to meet older people needs to facilitate at home. Meanwhile more than two-fifth (44%) of respondents not adapted, or could not be adapted, to meet older people needs to facilitate at home.

The table 5 provides information on possible housing units to adopt the aging facility within the house, as reported by respondents. The data reveal that more than three fourth (78.5%) of respondents mentioned their kitchen would have possible adaption to meet the requirements. This is followed by toilets (73.2%), doors (39.2%), lighting (36.8%), furniture (35.9%), stairs (35.4%), floor (30.6%), while ramps a few (5.3%) possible adaptations of house to meet the requirements of the older peoples.

Table 5: Housing units to adopt aging facility

Housing units	Total	
	N	%
Kitchen	164	78.5
Floor	64	30.6
Stairs	74	35.4
Toilets	153	73.2
Doors	82	39.2
Ramps	11	5.3

Furniture	75	35.9
Lighting	77	36.8
Others	1	0.5

5. Domain 4: Civic participation and employment

5.1 Status of engagement in volunteer activity

The figure 26 provides information on respondents' engagement in volunteer activities, as reported by respondents. The data reveal that a majority (92.5%) of respondents stated that they had not engaged in any volunteer activities in the last month. Meanwhile, a small proportion (7.5%) of respondents reported that they had engaged in volunteer activities in the last month.



Figure 25: Engagement in volunteer activity

5.2 Status of getting working opportunities as a paid employment

The figure 26 provides information on working opportunities as a paid employment, as reported by respondents. The data reveal that a majority (92.2%) of respondents stated that they had not got working an opportunity as a paid employment. Meanwhile, a small proportion (7.8%) of respondents reported that they had got an opportunity as a paid employment

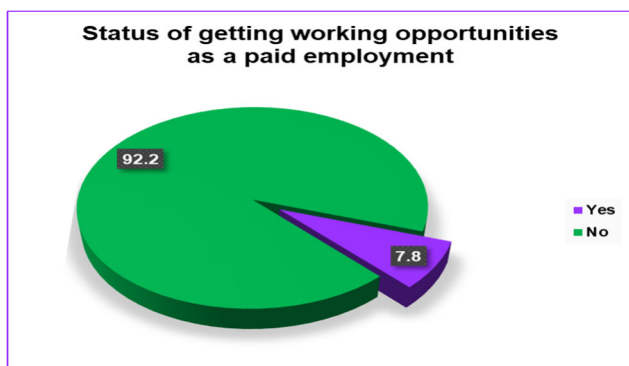


Figure 26: Status of getting working opportunities as a paid employment

The survey data reveal that a majority (82.8%) of respondents stated that they had not need as a paid employment. Meanwhile, a small proportion (17.2%) of respondents reported that they had need as a paid employment.

The older peoples are interested in various types of age friendly work, such as agriculture, animal raring, livestock, labor, age-friendly physical work, small home-based income-generating activities, handicrafts, gardening, and simple or easy physical tasks.

6. Domain 5: Respect and social inclusion

6.1 Received respect in community

The survey data reveal that almost two-thirds (60.9%) of respondents stated that they had received respect in their community, while almost two-fifths (39.1%) reported that they had not received respect in their community.

The figure 27 provides information on the respect received from different places in their community, as reported by respondents. The data show that almost all (97.7%) of the respondents stated that they had received respect from family members. This is followed by respect from neighbors (96.4%), the general public, service and retail staff (94.1%), and civil servants (93.7%).

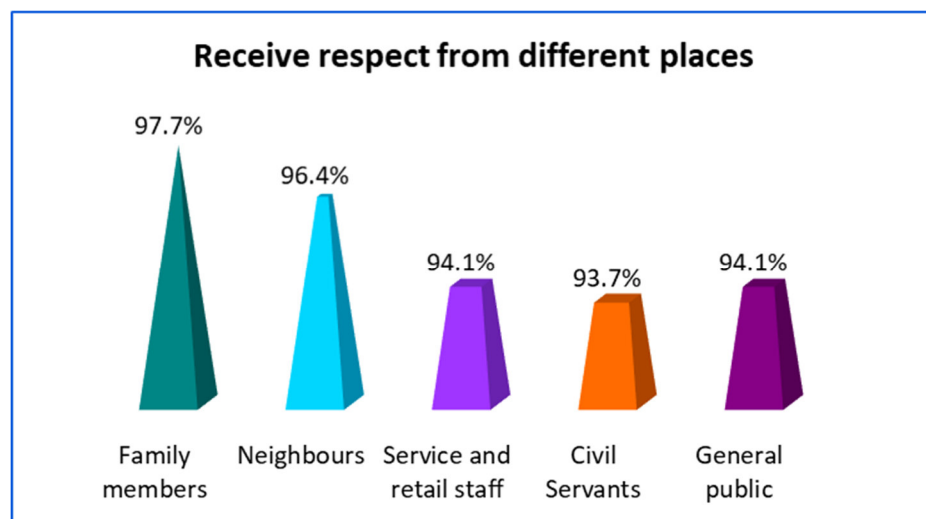


Figure 27: Receive respect from different places

6.2 Status of victim of abuse and violence

The survey data illustrate that the majority (93.8%) of respondents stated that they had not been victims of abuse and violence in their family or community, while a smaller percentage (6.2%) reported having been victims of abuse and violence in their community.

Out of 6.2 % victimized older peoples, more than half (55.6%) of the respondents stated that they had been victimized by their family members, while 11.1% reported being victimized by friends. Additionally, one-third (33.3%) reported being victims of abuse by others in their community.

6.3 Status of faced misbehavior in their community

The data reveal that all most all (97.3%) of respondents stated that they had not been faced misbehavior in their family or community, while a very few (2.7%) reported having been faced misbehavior in their community.

The table 6 provides information on the types of misbehavior faced in their family or community, as reported by respondents. The data show that out of fourteen respondents, half (50%) reported experiencing psychological misbehavior, such as being threatened, intimidated, or humiliated. This is followed by neglect, with (40%) of respondents reporting denial of basic needs such as food, medical care, and shelter. Additionally, (20%) reported being prevented from having social contact with family or friends. Meanwhile, a few respondents (10%) reported experiencing financial misbehavior and other types of abuse in their family or community.

Table 6: Area of misbehavior

Area of misbehavior	Total	
	N	%
Financial: your money	1	10
Psychological: you have been threatened, intimidated or humiliated	5	50
Physical: you have been physically hit, restrained, or overmedicated	1	10
Sexual: you have been made to feel sexually uncomfortable through inappropriate touching or other behavior	0	0
Social: you have been stopped from having social contact with family or friends	2	20
Neglect: you have been denied your basic needs (food, medical care, shelter, etc.)	4	40
Other	1	10

7. Domain 6: Social participation

7.1 Status of participation in socio-cultural activities at their own discretion

The figure 28 provides information on the participation in socio-cultural activities at their own discretion at least once in the last week, as reported by respondents. The data reveal that almost

three –fourth (72.4%) of respondents stated that they had not been participated in socio cultural activities in their community, while more than quarter (27.6%) reported that they had been participated in socio-cultural activities in the last week in their community.

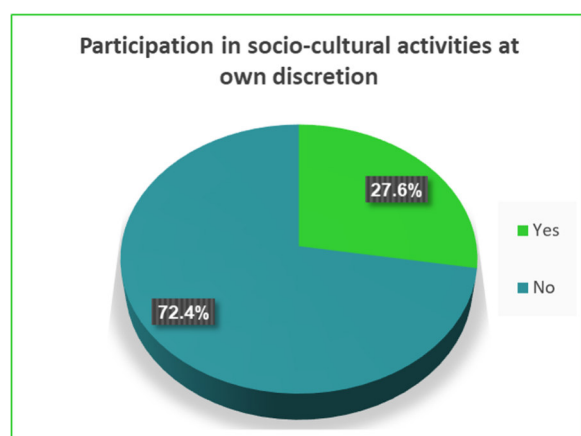


Figure 28: Participation in socio-cultural activities at own discretion

7.2 Reason of not participating socio-cultural activities

The table 7 provides information on the reason of not participating in socio-cultural activities at their own discretion at least once in the last week, as reported by respondents. The data reveal that almost two fifth (43.3%) of respondents stated that they had not been participated due to the poor health. This is followed by due to not interested in attending local events (36.7%), did not have timely information (21.5%), venue was too far from their house (8.5%), due to physical limitation (7.8%) and cannot afford. While a few (6.7%) reported due to the other reason the unable to participate in socio cultural activities in the last week in their community.

Table 7: Reason of not participating socio-cultural activities

Reason of not participating socio-cultural activities	Total	
	N	%
Poor health	117	43.3
Physical limitation	21	7.8
Cannot afford the events	12	4.4
The venue is too far from my house	23	8.5
I don't have timely information about the events	58	21.5
I am not interested in attending local events	99	36.7
Other	18	6.7

7.3 Participation on social activities

The table 8 provides information on participation on social activities, as reported by respondents. The data reveal that more than half (58.3%) of respondents stated that they had been participated in religious functions, followed by religious tour (45.6%), birthday and wedding ceremony function (25.2%), community development work (8.7%).while a few (5.8%) reported they had been participating on social activities in their community.

Table 8: Participation on social activities

Types of social activities	Total	
	N	%
Religious tour	47	45.6
Community development work	9	8.7
Attending birthday, marriage, etc. function	26	25.2
Attending religious function (Saptaha, Puran, Prabachan, etc.)	60	58.3
Participating Yoga organized by community	6	5.8
Others	1	1

7.4 Membership on community organizations

The table 9 presents the information on members of community organizations, as reported by the respondents. The majority (83.9%) of respondents are involved in a cooperative, making it the most common type of community organization. This is followed by Guthi, with 12.3% participation, and Aama Samuha (mothers' group), with 7.1% involvement. Additionally, 5.2% of respondents are part of a local bhajan group, 3.9% are members of a older people club, and 2.6% each are involved in a political organization, consumer group, and the Red Cross. Furthermore, 1.9% of respondents participate in a farmers group, 1.3% are involved in a forest user group, and 2.6% are members of other unspecified groups. This data highlights the predominant role of cooperatives among community organizations in the respondents' lives.

Table 9: Membership on community organizations

Types of organizations	Total	
	N	%
Political organization	4	2.6
Guthi	19	12.3
Aama Samuha	11	7.1
Forest user group	2	1.3
Farmers group	3	1.9

Consumer group	4	2.6
Local bhajan group	8	5.2
Older people club	6	3.9
Red Cross	4	2.6
Cooperative	130	83.9
Others	4	2.6

7.5 Status of involvement in decision making

The survey data reveals that majority (91.4%) of respondents were not involving in decision making activities in their community, where only (8.6%) of respondents were involving in decision making activities in their community.

Out of the 8.6% of respondents involved in decision making, more than half (56.3%) of respondents involving only members as a decision-making, one-fourth (25%) had a minor role in decision-making, and nearly one-fifth (18.8%) had a major role in decision-making.

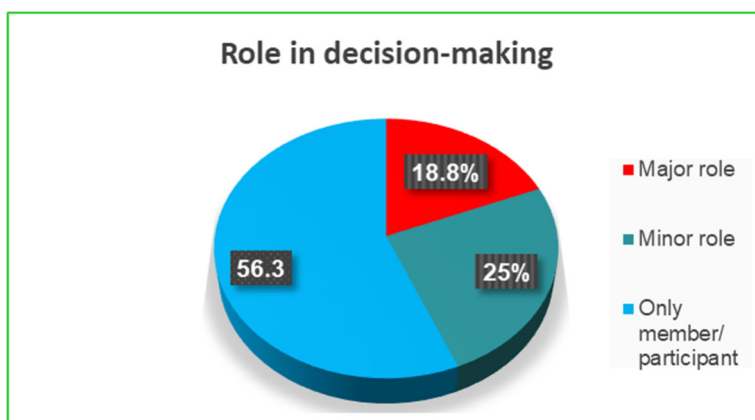


Figure 29: Role of older people in decision making

7.6 Participation in group physical activities

Survey data shows that more than half (51.2%) of respondents have not participated in group physical activities during leisure time, while less than half (48.8%) have participated in such activities.

The figure 30 provides on participation on physical activities as reported by the respondents. Two-third (66.5%) of respondents participated in hiking or walking in leisure time. This is followed by farm-related work (51.6%), Yoga(14.8%) , gardening (7.1%), playing game (1.6%) respectively and only (2.7%) who participated in other activities.

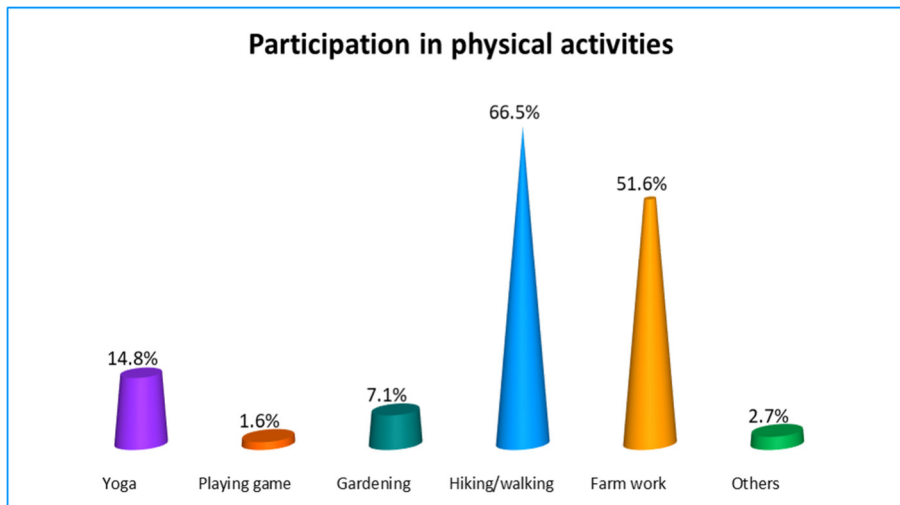


Figure 30: Participation in physical activities

7.7 Enrollment in any educational learning programs

The figure 31 provides information on enrollment in educational learning programs, as reported by the respondents. Majority (96.5%) of respondents were not enrolled in education or training, while very few (3.5%) of respondents were enrolled in educational learning programs.



Figure 31: Enrollment in any educational learning programs

7.8 Enrolment of education and training

The table 10 provides information on enrolment of education and training, as reported by the respondents. More than half (53.8%) of respondents were enrolled in the agriculture related training. This is followed by vegetable farming (30.8%), involved in environment and climate change adaptation training (23.1%), enrolled in older education classes (15.4%), enrolled in income-generating training, (7.7%), meanwhile (30.8%) enrolled in other training.

Table 10: Enrollment in education and training programs

Education and trainings	Total	
	N	%
Older education class	2	15.4
Agriculture training	7	53.8
Vegetable farming	4	30.8
Income generating training	1	7.7
Environment and climate change adaptation training	3	23.1
Others	4	30.8
Total	18	

7.9 Status of having social security card

The figure 32 provides information on social security card, as reported by the respondents. Almost two-third (64.1%) of respondents having their social security card, while more than one-third (35.9%) did not have a social security card.

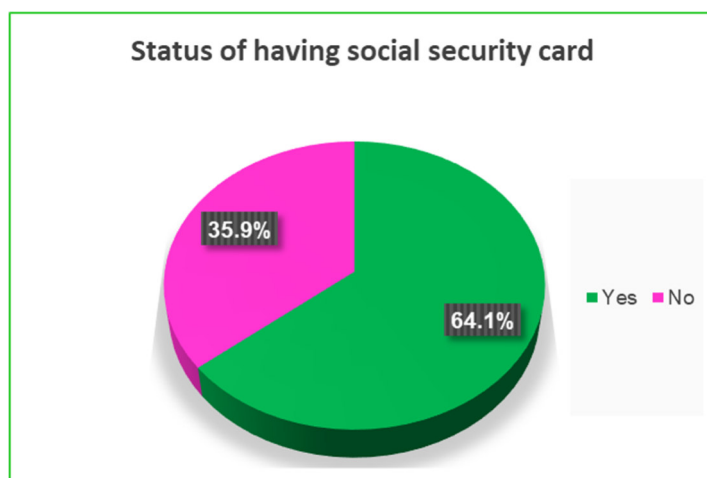


Figure 32: Status of having social security card

8. Domain 7: Communication and information

8.1 Knowledge on call for health concern

The figure 33 provides the information on knowledge on calls for their health concern, as reported by the respondents. Almost two-thirds (65.1%) of respondents know whom to call if they need information about health concerns and relevant services in their community, whereas one third (34.9%) do not know whom to call for this information.

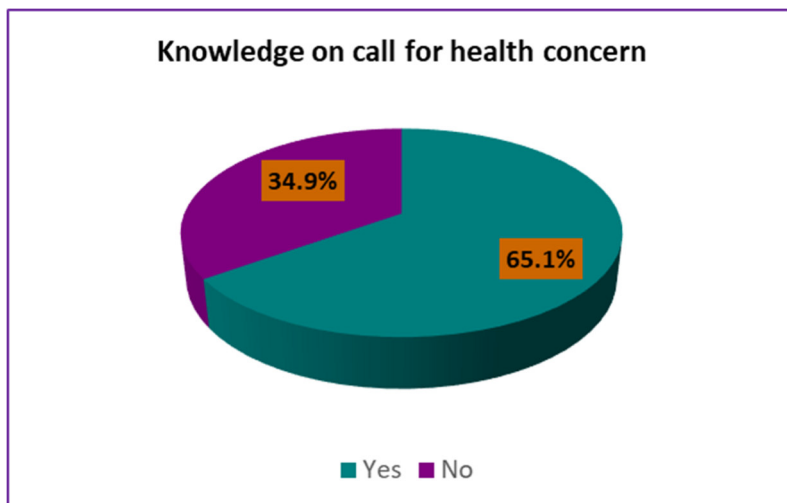


Figure 33: Knowledge on call for health concerns

8.2 Way of getting information

The figure 34 provides information on way of getting information, as reported by the respondents. Majority (82.3%) of respondents getting information from their family and neighbors, followed by phone (33%), from the local radio-FM (16.6%), from the internet and social media (9.1%), from newspapers (4.8%), and (11.5%) way of getting information from other sources.

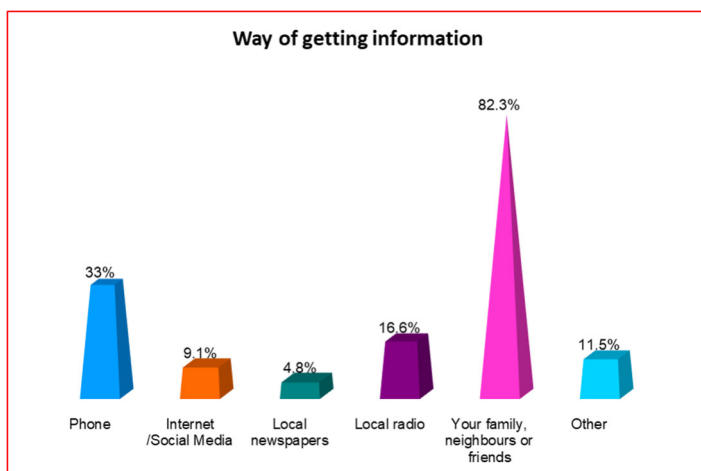


Figure 34: Way of getting information

8.3 Access and knowledge on use of internet

According to the survey data, more than two-thirds (71.6%) of the respondents had access to the internet, while only 28.4% of the respondents did not have internet access.

Furthermore, almost three-fourths (75.6%) of the respondents reported not knowing how to use the internet, while one-fourth (24.4%) reported knowing how to use it.

8.4 Interest on improving or learning basic digital literacy

The figure 35 provides information on improving or learning basic digital literacy, as reported by the respondents. Data reveal that more than three-fourths (80.4%) of respondents are not interested in learning basic digital literacy with the support of club volunteers, while only (19.6%) are interested in learning basic digital literacy with the support of club volunteers.

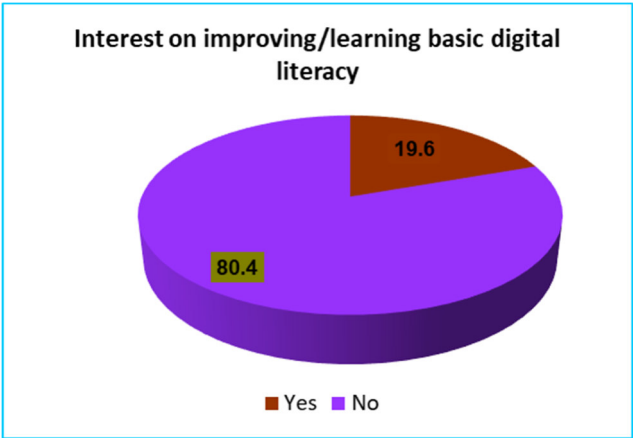


Figure 35: Interest on improving or learning basic digital literacy

9. Domain 8: Community support and health services

9.1 Status of personal care or personal assistance

According to the data, more than half (60.9%) of the respondents did not have their personal care or assistance needs met in their home or community, while slightly less than two-fifths (39.1%) had their personal care or assistance needs met.

Out of 60.9% , the majority (91.1%) of the respondents reported having personal care or assistance facilities, while less than 8.9% reported not having these facilities.

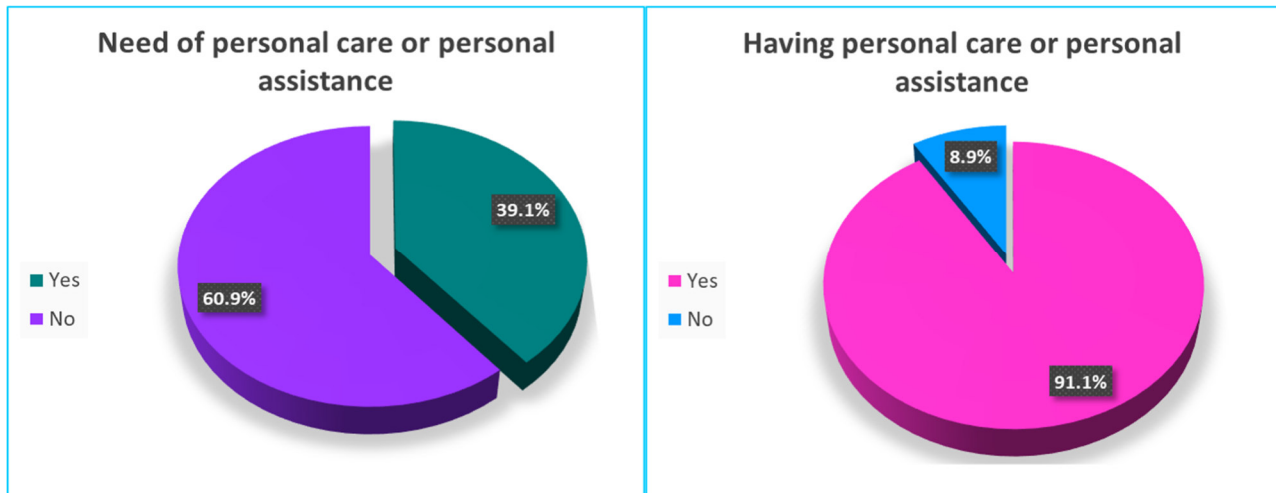


Figure 36: Status of personal care or personal assistance

The figure 37 provides information on the sources of personal care or assistance facilities as reported by the respondents. According to the data, the majority (86.5%) of the respondents reported that family members were involved in providing their personal care or assistance. This was followed by personal assistance (31.6%) and local government support (4.4%), while only a few (1.5%) respondents reported receiving these facilities from the local community.

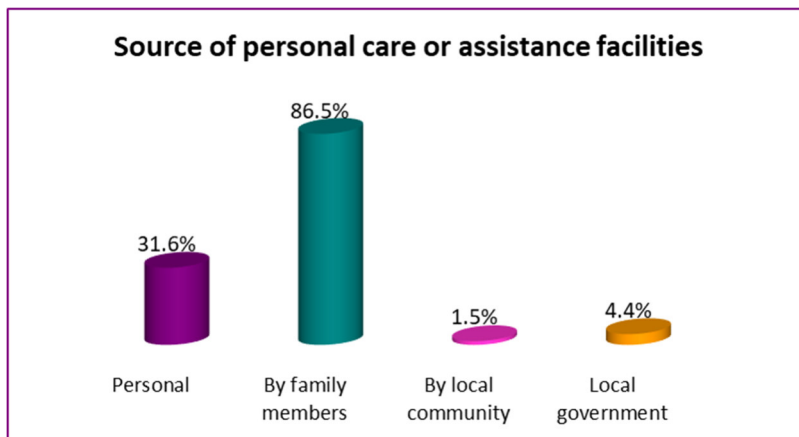


Figure 37: Source of personal care or assistance facilities

9.2 Status of term diseases

The survey data reveals that, more than two-third (72.9%) of the respondents reported they had suffering from term diseases, while less than one third (27.1%) of respondents reported they had not term disease.

The figure 38 shows the information on the types of diseases reported by respondents. According to the data, more than one-third (37.1%) of respondents were suffering from hypertension. This was followed by Asthma (25.7%), Diabetes (21.7%), and COPD and BEP (2.6%). Additionally, a small percentage (1.5%) of respondents were suffering from kidney diseases and Alzheimer's. Furthermore, a large proportion (54%) of respondents reported suffering from other types of diseases

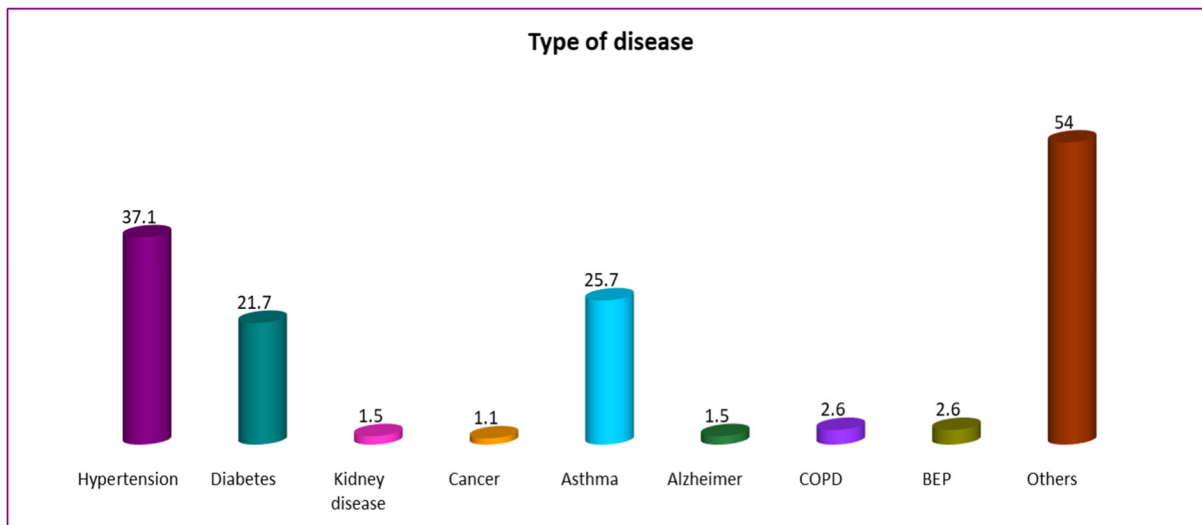


Figure 38: Types of disease

9.3 Facilitator to visit health institutions for health checkups during sick

The table 11 provides information about facilitators to visit health institutions for health checkups during sick. Data indicates that the majority (82%) of respondents were getting help from their family members. This was followed by those who visited the hospital by themselves (14.7%), those receiving help from relatives (2.3%), and a few (0.5%) of respondents were getting help from close friends and others during sick respectively.

Table 11: Facilitator to visit health institutions for health checkups during sick

Types of facilitators	Total	
	N	%
No-one, myself	55	14.7
My family member	306	82
With close friends	2	0.5
With relatives	8	2.3
Others	2	0.5
Total	373	100

9.4 Status of community organized an emergency response training or drill

The figure 39 provides information on community-organized emergency response training or drills, as reported by the respondents. The majority (93.3%) of respondents did not have the opportunity to receive emergency training or drills in the past year that addressed their needs, while only 6.7% had the opportunity to receive such training.

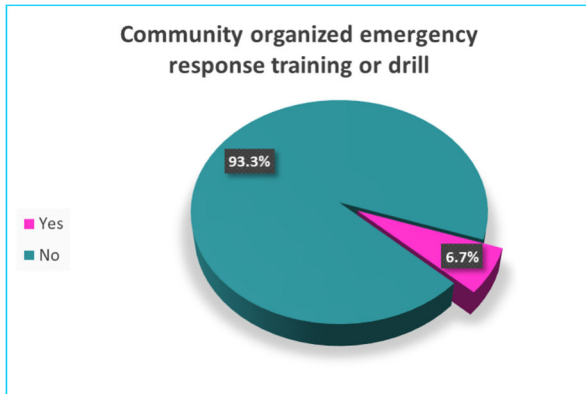


Figure 39: Status of community organized an emergency response training or drill

9.5 Satisfaction on services provided by the Municipality

The figure 40 provides information on the respondents' satisfaction with the services provided by the municipality. Almost half (51.5%) of the respondents were moderately satisfied with the services. This was followed by 26.8% who rated the services as good, 17.7% who were poorly satisfied, 3.2% who were very poorly satisfied, and a few (0.8%) who rated the services as very good.

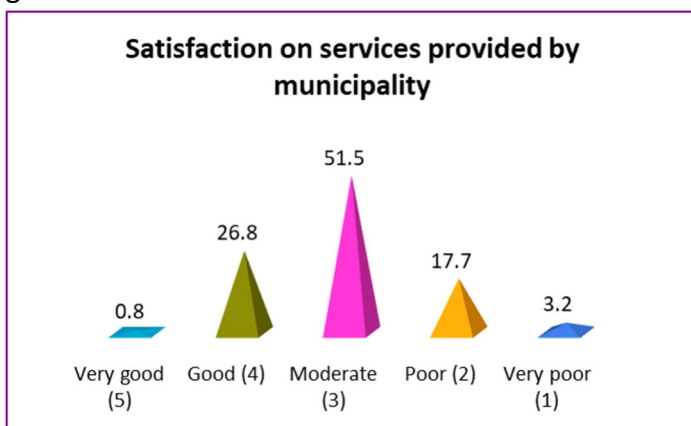


Figure 40: Satisfaction on services provided by the Municipality

9.6 Status of health insurance

The figure 41 provides information on the status of health insurance, as reported by the respondents. More than half (59.8%) of the respondents had health insurance, whereas two-fifths (40.2%) of the respondents did not have health insurance.

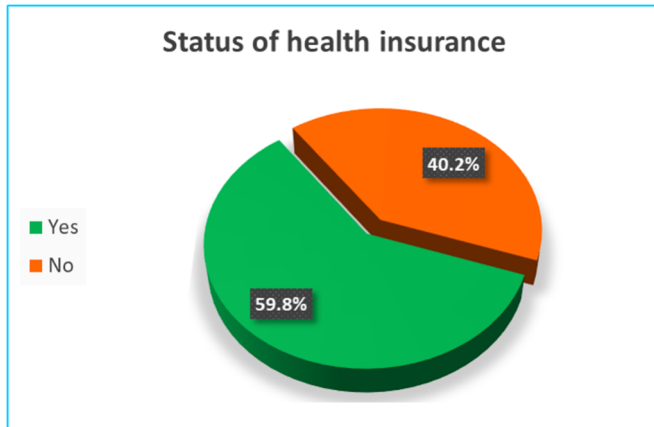


Figure 41: Status of health insurance

9.7 Status of the health facilities visited periodically to check the health condition

The figure 42 provides information on health facilities visiting respondents periodically to check their health condition. The majority (94.9%) of respondents reported that staff from health facilities did not visit them periodically to check on their health condition, while only 5.1% of respondents said that staff did visit them periodically.

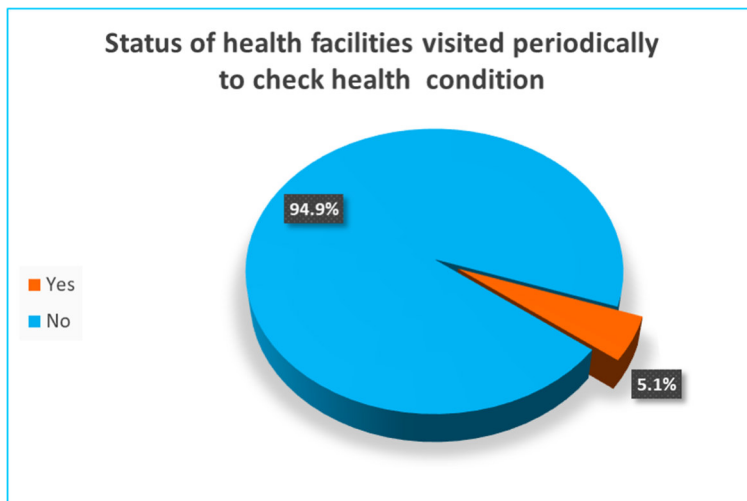


Figure 42: Status of health facilities visited periodically to check health condition

9.8 Available, affordable, accessible and desirable services in the community

Available services in the community

The table 12 provides information on the availability of service, as reported by the respondents. According to the data, almost three-fourths (75.3%) of respondents received primary health care, followed by those who did not need it (16.1%) and those who did not receive it (8.6%). Similarly, almost half (48.8%) of respondents did not receive home care services, followed by those who did not need it (48.3%), and only (2.9%) who said they needed the service. Additionally, almost two-fifths (42.4%) of respondents said they did not need the service of household assistance, followed by those who needed the service (30.8%), and (26.8%) who did not receive the household assistance service.

Table 12: Available services in the community

Services	Status	Total	
		N	%
Primary health care/ medical doctor	Yes	281	75.3
	No	32	8.6
	But needed	60	16.1
	Total	373	100
Home care / visiting nurse	Yes	11	2.9
	No	182	48.8
	But needed	180	48.3
	Total	373	100
Household assistance (cleaning, cooking, shopping)	Yes	115	30.8
	No	100	26.8
	But needed	158	42.4
	Total	373	100

Affordable of services in the community

The table 13 provides information on the affordability of services, as reported by the respondents. The majority (87.9%) of respondents received primary health care, followed by 12.1% who did not. Additionally, all (100%) respondents received home care services. Furthermore, almost all (98.3%) respondents received household assistance, whereas a few (1.7%) did not.

Table 13: Affordable of services in the community

Services	Status	Total	
		N	%
Primary health care/ medical doctor	Yes	247	87.9
	No	34	12.1
	Total	281	100
Home care / visiting nurse	Yes	11	100
	No		
	Total	11	100
Household assistance (cleaning, cooking, shopping)	Yes	113	98.3
	No	2	1.7
	Total	115	100

Accessible of services in the community

The table 14 provides information on the accessible of services, as reported by the respondents. According to the data, 87.9% of respondents received primary health care, followed by 12.1% who did not. All (100%) respondents received home care services. Additionally, 97.4% of respondents received household assistance, whereas a few (2.6%) did not.

Table 14: Accessible of services in the community

Services	Status	Total	
		N	%
Primary health care/ medical doctor	Yes	247	87.9
	No	34	12.1
	Total	281	100
Home care / visiting nurse	Yes	11	100
	No		
	Total	11	100
Household assistance (cleaning, cooking, shopping)	Yes	112	97.4
	No	3	2.6
	Total	115	100

Desirable services in the community

The table 15 provides information on the desirability of services, as reported by the respondents. Data reveal that almost two-thirds (68.8%) of respondents did not receive primary health care,

followed by 31.3% who did receive health care. Additionally, 54.9% of respondents received home care services, whereas 45.1% did not. Furthermore, 82% of respondents did not receive household assistance, while only 18% did receive household assistance.

Table 15: Desirable services in the community

Services	Status	Total	
		N	%
Primary health care/ medical doctor	Yes	10	31.3
	No	22	68.8
	Total	32	100
Home care / visiting nurse	Yes	100	54.9
	No	82	45.1
	Total	182	100
Household assistance (cleaning, cooking, shopping)	Yes	18	18
	No	82	82
	Total	100	100

9.9 Status of income sufficiency for personal care or assistant

The figure 43 provides information on sufficiency of their income for personal care or assistant, as reported by the respondents. According to the data almost two-third (64.3%) of respondent's income had been sufficient to cover personal care or assistant, while (35.7%) of respondent's income had not been sufficient.

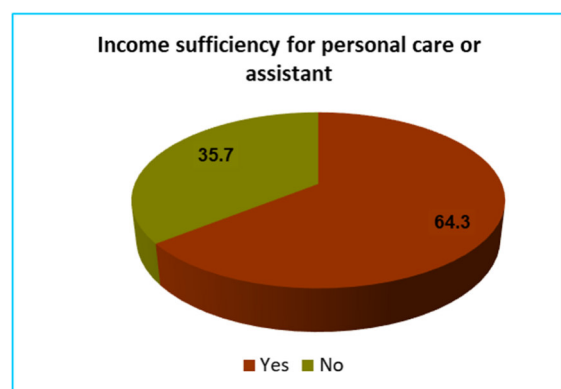


Figure 43: Income sufficiency for personal care or assistant

9.10 Rating of personal quality of life

The figure 44 provides information on the rating of personal quality of life, as reported by the respondents. According to the data, more than two-fifths (46.6%) of respondents rated their quality of life as moderate, followed by 40.8% who rated it as good, 9.4% as poor, 2.1% as very good, and a few (1.1%) who rated it as very poor.

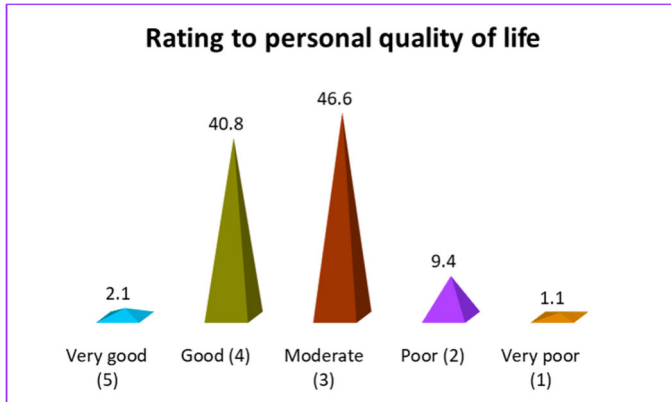


Figure 44: Rating to personal quality of life

9.11 Open Questions

Regarding an open question about knowing what to do and whom to call in emergency situations such as health and other emergencies, the majority of respondents said a family member is the first contact point for such situations, followed by hospital ambulances, general ambulances, hospital doctors, health post staff, and neighbors. However, a large proportion of respondents replied that they did not know.

Annex 2: Terms of Reference (TOR)

1. Background information:

Globally, the demographic transition is unprecedented and will impact almost all aspects of society. By 2050, one in five people will be 60 years or older globally. Similarly, the older population of Nepal is increasing both in terms of absolute number and as a proportion of the total population, as socioeconomic growth and improved health indicators have elevated life expectancy among Nepali citizens.

2 million people living in Nepal are aged over 60, which is almost 9% of the country's total population. The proportion of individuals aged 60 and above is expected to rise to 11% by 2030 and 18.6% in 2050, with 36 million people. There are many challenges in Nepal for healthy aging. The population is aging at such a speed that the existing healthcare system and economy might fail to mitigate the challenges of aging. In this light, a paradigm shift is expected in the pattern of diseases within this population. If we are to achieve Sustainable Development Goals, we will, therefore, need to consider the rapid population aging that is occurring in almost every country.

NRCS, as an auxiliary to the government, has been addressing humanitarian needs and implementing healthy aging initiatives as part of its health strategy. This collaboration with municipalities and community stakeholders has been ongoing for the past 3 years. The political landscape in Nepal has empowered municipalities to tackle local development and humanitarian needs, making them as resourceful as local governments in addressing these issues. Given that healthy aging is a priority for both agencies, it has been agreed upon that a community-based healthy aging program will continue, with shared resources between Changuarayan Municipality and Bhaktapur district chapter. An MoU has been signed between the partners to implement the healthy aging project, referred to as the SAHARA project, from 2024 to 2026. According to the MoU, the Municipality is committed to becoming an age-friendly city based on WHO's parameters. Feasible elements will be integrated into the Municipality's development plan, along with actions promoting healthy aging. Currently, their focus areas include establishing older people clubs in each Ward, ensuring effective distribution of social security allowances, providing free health insurance, organizing health camps, supporting assistive devices, and facilitating recreational and spiritual activities. To effectively plan interventions and align priorities with WHO's age-friendly city parameters, an assessment is necessary to establish a baseline and plan long-term interventions.

2. Outcomes of the project

The impact and outcomes planned for the SAHARA project are the following:

Impact: Contribute to the improved health and wellbeing of older people of Changunarayan Municipality

Outcome 1: Age-friendly environment is strengthened,

Outcome: 2 Service access for older people is improved,

Outcome: 3 Community behavior and actions towards older people are improved.

3. Scope and objective of the study

- This assessment aims to establish the baseline of the Changunarayan municipality project using the age-friendly city parameters of the WHO. The assessment data will influence the municipality's plans and policies, adjusting project interventions to develop an effective and sustainable community support system for older people.
- Provide suggestions for appropriate implementation strategies, interventions, inputs, and processes at the operational level to address gaps and needs will be provided based on the assessment findings. Protection, gender, and inclusion information were considered during the data collection process.
- It will assess the perception of government service providers and family members towards older people, access to municipal services, proper care and support, specific needs of older people, and meaningful engagement of older people. Additionally, it will evaluate the existing capacities of partners in various areas to respond to healthy aging.
- Comprehensive recommendations on strategic and programmatic priorities and considerations for the age-friendly city (AFC) framework (inclusive of healthy aging) in the context of the project municipality will be provided based on the assessment.

4. Specific tasks of consultant/firm:

- a) Examine relevant policies and guidance on DRR-CCA inclusive aging provisions at the municipal, NRCS and strategic levels.
- b) Conduct a desk review and study of the SAHARA project document, result matrix, and relevant studies/research that pertain to the AFC framework and project components, such as NSD, Healthy Aging, and DRR-CCA.
- c) Develop an understanding of the Municipality and NRCS, including their networks, principles, and areas of engagement.
- d) Adapt and design methodologies and tools, and finalize them in consultation with the project team, based on WHO'S AFC framework. These methodologies and tools should be tested.

- e) Identify and assess existing formal and informal groups, stakeholders, and organizations working on aging, health, and DRR-CCA in the project area, and involve them in the assessment.
- f) Engage experienced assessors to conduct AFC assessments together with local stakeholders.
- g) Monitor and supervise the assessors during the study to ensure the quality of data and information collected.
- h) Coordinate with respective authorities to obtain permission and support for field work in collaboration with NRCS.
- i) Compile, enter, and clean the assessment data, with disaggregation at the ward level.
- j) Assess the status of health facilities and municipal services, as well as their physical structures, from an aging-friendly perspective.
- k) Share biweekly updates on the critical progress of the assessment with the Municipality and NRCS team.
- l) Prepare the AFC assessment report, including data and data analyses, following a standard format. The report should include disaggregated data at the ward level and disaggregation by sex, socioeconomic status, and age. Submit the report within the stipulated time in both hard and soft copies.

5. Methodology

The consultant/firm will primarily use the WHO-designated methodology for the AFC assessment. Additionally, the consulting firm may apply other methods as necessary due to the inclusion of qualitative and quantitative variables specific to the local context.

This will involve sampling and adapting/developing assessment tools such as questionnaires, checklists/rating scales for focus group discussions, observations, and key informant interviews. The consultant will oversee trained/skilled assessors who will conduct the fieldwork for the study. The possibility of utilizing the capacity of existing Municipality community workers will be discussed, if applicable. If feasible, the consultant will receive ongoing support from experts from the Swiss Red Cross and Nepal Red Cross, as well as experts from WHO. The consulting firm will engage a statistical expert to analyze data and present the report using frequency, percentage, and cross-tabulation, as well as graphical representation as appropriate. Additionally, a participatory approach must be maintained when designing and finalizing the study methodology. The AFC framework tools should be considered at all times. Furthermore, the consultant should adhere to the principles of do no harm, informed consent, and confidentiality throughout the assessment.

The assessment will primarily be based on the WHO's age-friendly city framework and the indicators proposed for the project LFA at various levels of results.

6. Deliverables

- a. A final report (hardcopy and softcopy) and PowerPoint presentation highlighting (mainly focusing on the AFC framework Indicators and project Log frame) the results (assessment status) and recommendations.
- b. Templates/tools used for digital data collection.
- c. Hard copies of collected data (filled questionnaires, etc.), if any.
- d. An electronic copy of raw and final data is used for statistical inferences and tabulation.

7. Compliance of consultant/firm

The consultant must abide by the Red Cross Code of Conduct (CoC). The consultant will adhere to the rules and regulations of the Red Cross and Municipality, treat all information and data collected during the mission confidentially, and maintain confidentiality at all times. The consultant will propose an appropriate number of experienced human resources-both men and women as required for the study.

8. Qualification and experience of team members/firm

- Have a minimum of 7 years of experience conducting similar types of assessment, baseline, end-line evaluation/case study/research, and project evaluation in Nepal, preferably in health and community development. The assessment team should include experienced members who understand the core subject of the study and have a link with Healthy Aging and age-friendly city framework.
- Lead Consultant Master's Degree in a relevant field, preferably Public Health. Experience in healthy aging is preferred.
- Familiar with Nepal's aging-related services, including DRR CCA and Municipal services.
- Proven experience in qualitative and quantitative research; a clear understanding of research methodology and experience in using different social research tools, techniques, and project evaluations.
- Experience in data analysis and management.
- Have an excellent report-writing and analytical skills in the English language.

9. NRCS, Municipality, and partner's input:

- Provide necessary and relevant document
- Input into the finalization of tools
- Letters/correspondences from the Municipality to assist data collection during fieldwork

- Feedback on data analysis and draft report

10. Proposal requirement:

A detailed technical and financial proposal based on this ToR is expected. The technical proposal should contain a detailed methodology, a detailed action plan for fieldwork, specific roles and responsibilities of the lead consultant and team members, updated CVs, and a schedule of activities.

The consultant should submit a financial proposal for the required services in a separate sealed envelope.

The following documents should be included in the proposal

- VAT/PAN registration certification
- Tax clearance certificate (Recent)
- Company registration certificate
- CV of team members
- Sample report of similar works in the past
- Organizational profile
- Self-declaration
- Any other relevant document

11. Administrative matters:

Upon discussion with the project partners, the consultant may engage the existing community workers of the Municipality as assessors, provided that they meet the eligibility requirements. This expectation is based on the understanding that the assessment process can enhance the workers' knowledge of the issues addressed in healthy aging projects or age-friendly approaches. The consultant assumes overall responsibility for the administrative aspects of the study and provides necessary training, orientation, and briefings to the assessor and other study team members. Additionally, the consultant is accountable for various administrative matters associated with the study team.

12. Proposed report structure

The final product of the study shall be written in English and structured as follows (not exceeding 35 pages, excluding annexes).

Executive Summary (3 pages maximum)

- Overview of the project

- Scope of the assessment and purpose/targeted audience
- Methodology
- The most important findings and conclusions,
- Main recommendations

Introduction/background (2 pages maximum)

- Background of the project
- Scope and purpose of the assessment
- Major question/areas/topic to be explored

Summary Study methodology (2 pages maximum)

- Methodology, design,
- Data collection tool, type of respondent, and sample size/
- Any biases and how they were mitigated, Limitations/challenges

Result/findings (20 pages maximum)

Discussion (scientific analysis) and conclusions (4 pages maximum)

Recommendations (4 pages maximum)

Annexes

- Terms of Reference of the assessment
- Detailed study methodology (data collection tools, sample design worksheet, area population statistics, etc.)
- List of persons/organizations/facilities consulted
- Reference of literature and documentation reviewed
- Geographical map of the area studied
- Other technical annexes where relevant (e.g., statistical analyses, ethical approval)

Annex 3: Detailed study methodology

1. Approach

The baseline study will be conducted through a mixed approach both qualitative and quantitative. The qualitative data will be collected through the KII with local government authorities, ward chairpersons, community-based NGOs, CBOs, project staff and other relevant stakeholders and FGD with community people, older peoples groups etc. For quantitative data, surveys will be conducted to the older peoples having age equal or more than 60 years.

Also, the data collected from the field study i.e., survey, KII, FGD and observation will be the primary data and other information collected from the review of project documents, log frame and other literature similar to the assignment will be the secondary data.

2. Study Area

The study area for age-friendly city (AFC) baseline assessment will be Changuarayan Municipality of Bhaktapur District.

2.3 Sampling Method

Survey

Population distribution by age group by gender above 60-year older peoples of Changu Narayan Municipality:

Ward No.	Age group		Sample Size	Cluster (Each ward 3 cluster)	Female/ward (50%)	Male/Ward (50%)
	60-70	>=70				
1	30	11	41	13	20	21
2	30	11	41	14	21	20
3	30	11	41	14	20	21
4	30	11	41	14	21	20
5	30	12	42	14	21	21
6	30	12	42	14	21	21
7	30	12	42	14	21	21
8	30	12	42	14	21	21
9	30	11	41	13	20	21
Total	270	103	373	124	186	187

Key Informant Interviews (KII) and Focus Group Discussion (FGD)

Respondents/Source of Information	Tools for Data Collection	Number of Workshop
Municipal Chairperson	KII	1
Section chief of Women, Children and Older people Section	KII	1
Ward Chairperson	KII	3
Focal person of geriatric division under health ministry	KII	1
Older people coordination unit under mahila balbalika and jasthanagarik mantralaya	KII	1
Health workers at Palika Level	KII	1
Urban Planner at Palika Level	KII	1
NRCS, head quarter	KII	1
Swiss Red Cross, Country Coordinator	KII	1
Community people (local organizations, service providers, local businesses, housing associations, neighbourhood groups, voluntary organisations, care groups and older residents)	FGD	2
Older peoples group	FGD	9

Annex 4: List of persons/organizations/facilities consulted

1. Name list of participants of FGD with Older People

S.N.	Name of Participants	Age	Gender	Mobile No.	Ward No
1	Madhab Prasad Neupane	65	Male	9841298026	1
2	Maiya Khadka	63	Female		1
3	Maiya Karki	74	Female		1
4	Dolnath Dahal	60	Male	9841575969	1
5	Janardan Khadka	60	Male	9844065744	1
6	Mitthu Khadka	82	Female		1
7	Arjun Neupane	81	Male	15090755	1
8	Tulbahadur Karki	73	Male	9849827064	1
9	Apsara Khadka	67	Female		1
10	Gokul Roka	73	Male		1
11	Tej Prasad Pokharel	64	Male	9843199114	2
12	Amar Khadka	60	Male	9861237322	2
13	Padam Prasad Adhikari	61	Male	9841692160	2
14	Prakash Aale	78	Male	9841487413	2
15	Chandra Prasad Adhikari	65	Male	9851078703	2
16	Ishwari Prasad Neupane	60	Male	9841142289	2
17	Hari Prasad Adhikari	74	Male	9767645466	2
18	Surya Narayan Budhathoki	68	Male	9841299824	2
20	Maiya Karki	76	Female		2
21	Sita Khatri	65	Female	9818944470	2
22	Ram Bahadur Basnet	60	Male	9841805799	2
23	Maiya Thakuri	70	Female		3
24	Krishna Kumari Thapa	74	Female		3
25	Hari Prasad Dahal	77	Male	9841179761	3
26	Kanchhi Khadka	71	Female		3
27	Sita Khatri	76	Female		3
28	Ganga Banadur Fuyal	72	Male	9841111526	3
29	Muchhe Bhakta	79	Male		3
30	Yognath Dahal	78	Male	9843519748	3
31	Tikanath Dahal	76	Male	9843169226	3
32	Anar Thapa	70	Female		3
33	Krishna Bahadur Thapa	77	Male		3
34	Saraswoti Thapa	75	Female		3
35	Savitree Shrestha	65	Female	9860162244	4
36	Mina Bhandel	66	Female		4
37	Anantalal Bhandel	68	Male	9813756774	4
38	Rampyari Bhandel	66	Female		4

39	Sonak Man Bhandel	56	Male		4
40	Mohan Maya Tamang	80	Female		4
41	Bhagwan Thapa	71	Male	9841535690	4
42	Ambika Kunwar	60	Female		4
43	Gyan Maya Gurung	60	Female		4
44	Saili Tamang	60	Female		4
45	Niroj Kumar Bhandari	58	Male		5
46	Kedar Giri	62	Male		5
47	Shiva Ram Puri	61	Male		5
48	Shyam Bahadur Bhandari	75	Male		5
49	Ramsharan Thapa	65	Male		5
50	Shalikram Lamichhane	60	Male		5
51	Toyanath Dhungana	61	Male	9841670442	5
52	Ram Bahadur Wata	63	Male	9841676866	5
53	Bishnumaya Wata	72	Female		5
54	Tirtha Lal Wata	79	Male		5
55	Hirakaji Wata	64	Male		5
56	Man Bahadur Tamang	66	Male	9761002750	6
57	Bishnu Bahadur Tamang	70	Male	9848941466	6
58	Kanchhi Maya Shah	78	Female		6
59	Thuli Devi Tamang	74	Female		6
60	Hem Bahadur Bhujel	83	Male		6
61	Maya Tamang	71	Female		6
62	Chini Maya Tamang	74	Female		6
63	Jasman Tamang	81	Male		6
64	Bishnumaya Tamang	76	Female		6
65	Kanchha Shrestha	82	Male		7
66	Bhimsen Bharati	72	Male		7
67	Narayan Nyafu	67	Male		7
68	Krishna Prasad Lamichhane	69	Male		7
69	Purna Bahadur Nayaju	69	Male		7
70	Shambhu Prasad Giri	78	Male		7
71	Rukmani Lamichhane	73	Female		7
72	Sanubhai Khatri	60	Male		7
73	Ganesh Bahadur Moktan	61	Male		7
74	Ram Sin Moktan	64	Male		7
75	Saili Tamang	60	Female		7
76	Sitaram Lamichhane	61	Male		7
77	Arjun Prasad Kafle	61	Male		7
78	Aashakaji Hyangol	81	Male		8
79	Nabaraj Baniya	67	Male		8
80	Uday Baniya	68	Male		8
81	Gopal Pandit Kshetri	69	Male		8

82	Kamala Karki	66	Female		8
83	Thuli Karki	90	Female		8
84	Tirtha Bahadur Raya	74	Male		8
85	Sitaram Karki	81	Male		8
86	Sanobhai Karki	69	Male		8
87	Ganga Karki	60	Female		8
88	Chanamati Baniya	70	Female		8
89	Indra Baniya	69	Female		8
90	Shiva Khatri	78	Male		9
91	Sitvaram Khadka	71	Male	9841119636	9
92	Shyam Raut	66	Male	9843499117	9
93	Junu Darji	68	Male		9
94	Sanu Shrestha	70	Female		9
95	Baikuntha Khatri	69	Male		9
96	Mukunda Basnet	60	Male	9861871737	9
97	Sharada Khatri	61	Female		9
98	Keshar Bahadur Khadka	78	Male	9861135208	9

2. Name list of participants of FGD with community people <60

S.N.	Name of Participants	Age	Gender	Mobile No.	Ward No
1	Nirojkumar Khadki	58	Male		5
2	Rita Poudel	27	Female	9841163401	5
3	Laxhmi Shrestha	48	Female		5
4	Urmila Karki	56	Female		5
5	Sarita Shrestha	36	Female		5
6	Sumanda Bishnu	50	Female		5
7	Rajkumar Lamichhane	40	Male		5
8	Rampyari Adhikari	55	Female		5
9	Laxhmi Tamang	30	Female	9869388684	6
10	Urmila Tamang	38	Female	9813572047	6
11	Shanta Tamang	27	Female	9803055798	6
12	Jyoti Tamang	35	Female	9860921392	6
13	Shanta Thapa Magar	38	Female	9869011042	6
14	Rupa Shah	28	Female		6
15	Sirjana Syangbo	25	Female	9860677736	6
16	Ramita Tamang	30	Female	9841667780	6
17	Marich Man Tamang	32	Male	9860558129	6
18	Shanta Parajuli	42	Female		9
20	Narayan Kumar Rout	58	Male	9823403952	9
21	Ganesh Tyat	49	Male	9851078002	9

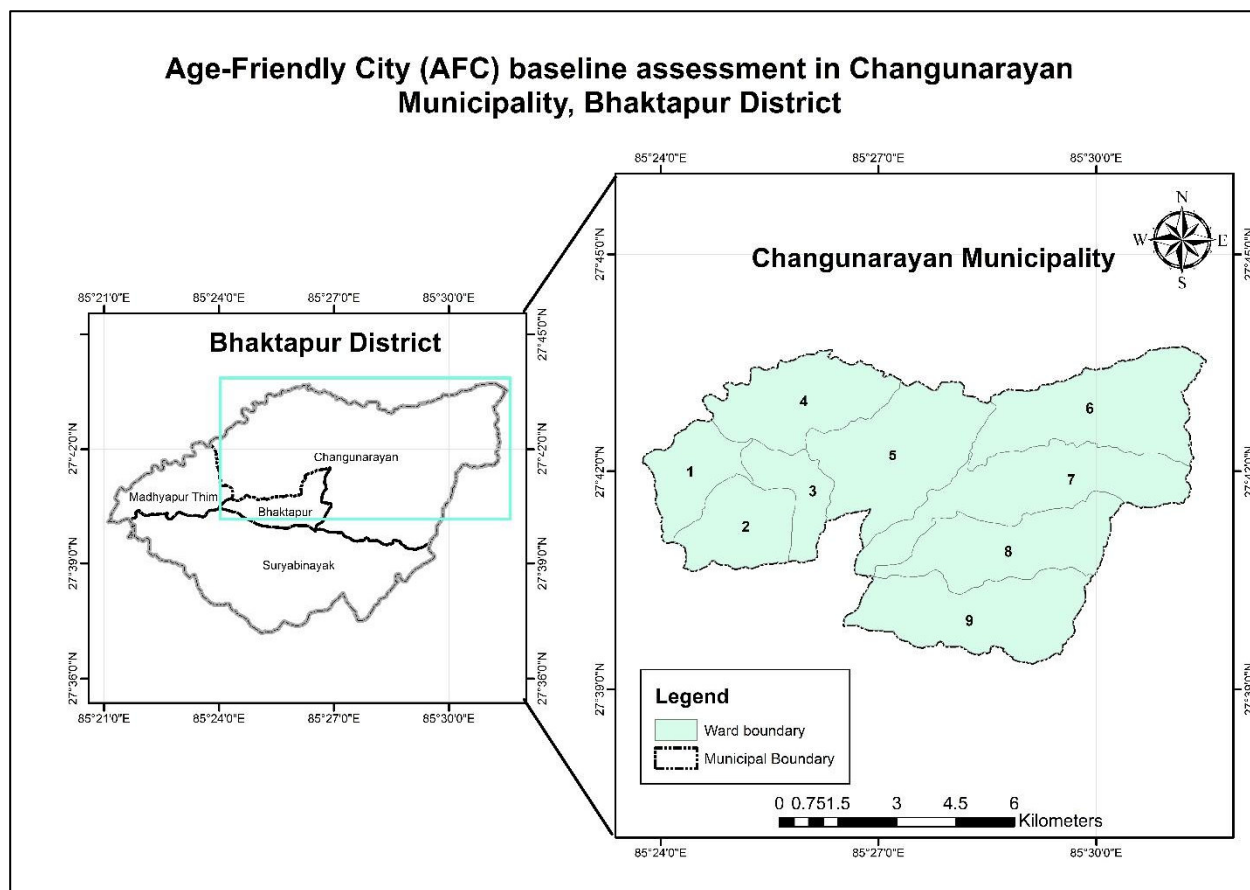
3. Name list of participants of Key Informant Interview (KII)

S.N.	Name	Office	Position
1	Jeevan Khatri	Changunarayan Municipality	Mayor
2	Nila Kumari Ghimire	Social Development Section, Changunarayan Municipality	Senior Women Development Officer
3	Basanta Bahadur KC	Physical Infrastructure Section, Changunarayan Municipality	Section Officer
4	Balram Timilsina	Health Coordination Section, Changunarayan Municipality	Section Officer
5	Roj Bahadur Tamang	Ward Office-4, Changunarayan Municipality	Ward Chairperson
6	Janak Khatri	Ward Office-8, Changunarayan Municipality	Ward Chairperson
7	Bandhana Bhatta	DoHS Nursing and Social Security Division, Geriatric and Gender-Voilence Management Section	Senior Public Health Officer
8	Nirmala Karki	Ministry of Women, Children and Older people, Older people Section	Chief Women Development Officer
9	Sandhya Kumari Yadav	Ministry of Women, Children and Older people, Older people Section	Women Development Officer
10	Bhupati Lal Shrestha	General Secretary	Nepal Red Cross Society, Headquarter
11	Kamal Baral	Country Coordinator	Swiss Red Cross, NRCS headquarter

Annex 5: Reference of literature and documentation reviewed

1. Global Age-friendly Cities: A Guide, WHO
2. Healthy Ageing: A Basic Concept, Hom Nath Chalise, PHD
<https://doi.org/10.3126/ajps.v2i1.51096>
3. Healthy Aging Guidelines, 2022, NRCS
4. MOU between NRCS and Changuarayan Municipality
5. SAHARA project document, NRCS and Changuarayan Municipality
6. SAHARA Project log-frame
7. SAHARA Project operation plan
8. SAHARA Project budget document, January 2024-December 2026
9. UN Decade of Healthy Ageing: Plan of Action, 2021-2030

Annex 6: Geographical map of the area studied



Annex 7: Focus Group Discussion (FGD) with Older peoples in Ward wise

Domain 1: Outdoor Spaces and Buildings
Ward 1: The ward office was not senior-friendly, with steps and no ground-floor service. There were few resting places and insufficient seating in temples.
Ward 2: Needed senior rest areas, railings at Faido Ganesh Temple, ramps at the health post, senior-friendly public toilets, better waiting areas, and electricity at bus stops and parks.
Ward 3: Required construction and upgrades of older peoples resting areas and traditional platforms (Falcha).
Ward 4: The ward office was accessible with benches, but visiting Changunarayan Temple was difficult due to its height.
Ward 5: Lacked senior-friendly outdoor spaces, buildings, and street lights. Needed restoration of patios and pavements, and senior-designated buildings.
Ward 6: Roads and pathways were not senior-friendly and lacked street lights and rest areas. Needed senior-friendly infrastructure improvements.

Ward 7: Pathways and stairs lacked railings and ramps. Recommended a yoga site, older peoples book related library, better street lighting, and senior rest platforms.
Ward 8: Public toilets were not senior-friendly. Needed seating areas, shelters, and benches at various temples and street lights in multiple locations.
Ward 9: Lacked roads and had unsafe existing roads. Needed drinking water facilities, improved street lighting, sufficient seating, and senior-friendly public buildings and toilets.
Domain 2: Transportation
Ward 1: Roads were in poor condition, making travel difficult. Needed road upgrades and a transportation service from Ratnapark to the ward office. Public buses required monitoring to ensure reserved seats for seniors were respected. Unsafe roads needed retaining walls.
Ward 2: The bus park was not suitable, and bus services were irregular, leading to reliance on expensive tempos. Public buses needed monitoring to enforce reserved seats for seniors. Awareness programs and parental guidance were suggested.
Ward 3: Public transportation was inconvenient, relying on tempos. Older people cards needed effective implementation. Reserved seats on buses required enforcement and drivers needed to assist seniors.
Ward 4: Public buses needed monitoring to enforce reserved seats for seniors, needed road upgrades. The 50% discount for seniors was not properly applied.
Ward 5: Faced public transportation difficulties. The 50% discount for seniors was only partially applied, and there was no waiting room at the bus station.
Ward 6: Reserved seats for seniors in public transport were not effectively implemented. The municipality needed to coordinate with traffic authorities for better monitoring and awareness. The 50% discount for seniors was not properly applied, and buses often did not stop for them.
Ward 7: Lacked public transportation and waiting areas at the bus park. Reserved seating for seniors was not effectively enforced.
Ward 8: Thalitar Road and Nepalgaau Road were risky. Not all buses had reserved seats for seniors, and effective implementation was lacking. Needed bus stops and waiting areas.
Ward 9: Reserved seats for seniors in public transport were not effectively implemented. Required coordination with traffic police and the ward office for monitoring and awareness. Seniors without a card should be allowed to use their citizenship certificate for public transportation.
Domain 3: Housing
Ward 1: Not all houses were older people-friendly. Building code guidelines needed provisions for senior-friendly features, and the municipality should ensure new house plans included these.

Ward 2: Each house needed a toilet with a commode and an attached bathroom for seniors. Ramps should be installed on stairs.
Ward 3: Every house required a toilet with at least one commode, non-slippery floors, railings on stairs, and kitchens on the ground floor.
Ward 4: Houses lacked full senior-friendly features. Each new house needed at least one room and a toilet with a commode for seniors.
Ward 5: No senior-friendly homes existed. Most houses had pans instead of commodes, and mud walls were fragile. The municipality needed to ensure at least one commode in newly built houses and make them senior-friendly.
Ward 6: Not all homes were senior-friendly, lacking commodes and having slippery floors. Old houses needed modifications, and new houses should be built to be senior-friendly.
Ward 7: Many houses lacked necessary railings and ramps. Existing homes needed modifications for seniors. The new ward office building should be accessible for seniors and disabled individuals. Building codes should include guidelines for senior, disabled, and child-friendly features.
Ward 8: Most houses were not senior-friendly. Old houses needed retrofitting to meet senior-friendly standards. New housing plans required standards ensuring senior-friendly features, including at least one toilet with a commode in each house. Slippery floors and courtyards needed improvement, and old houses needed modifications.
Domain 4: Civic Participation and Employment
Ward 1: The municipality did not utilize the skills and knowledge of older peoples. Job opportunities should have been created for them to participate in traditional arts, cultural activities, and skill transfer to younger generations. Schools with older people clubs could have organized religious, moral education, and experience-sharing sessions weekly.
Ward 2: Skills of older peoples needed identification, and community older people buildings should have been arranged. The ward provided participation opportunities, but not all older peoples had cards, and significant employment opportunities were lacking.
Ward 3: Female older peoples participated less. Skills and knowledge were not transferred to younger generations. The municipality offered an annual religious tour to the temple for older peoples.
Ward 4: Older peoples wanted to transfer and exchange skills, knowledge, and experiences between generations.
Ward 5: There was a lack of harmonization and coordination between the municipality and the ward in older people programs.
Ward 6: Older peoples were involved in activities, but their skills, knowledge, and experiences were not transferred to younger generations.

Ward 7: Efforts were needed to engage older peoples in skill transfer activities to leverage their experience and knowledge.
Ward 8: Opportunities for the transfer and exchange of skills, knowledge, and experiences between generations were lacking.
Ward 9: Older peoples were not effectively involved in ward programs. Activities should have been conducted to transfer their skills, knowledge, and experiences to younger generations.
Domain 5: Respect and Social Inclusion
Ward 1: Few older peoples faced financial abuse, some experienced psychological abuse, and very few experienced physical violence. No neglect cases were found. Most were treated respectfully by family members and neighbors, but some bank and sector employees did not prioritize them.
Ward 2: Financial abuse occurred in some cases, and occasional physical abuse was reported. Most older peoples were treated respectfully.
Ward 3: Some faced financial abuse, often from their sons. Older peoples' advice was ignored in community functions. Awareness on respecting seniors was needed.
Ward 4: Misbehavior towards older peoples for economic reasons was observed, often by sons and daughters-in-law.
Ward 5: Misbehavior due to economic reasons was noticed. Some experienced mental stress, and occasional physical abuse was reported.
Ward 6: Economic reasons led to neglect and mistreatment, including physical violence.
Ward 7: No reported cases of economic, psychological, physical, sexual, social abuse, or neglect. Moral education for youth was suggested to foster respect and inclusion.
Ward 8: Some older peoples suffered physical and mental violence due to economic reasons, highlighting the need to address these issues for their well-being and dignity.
Ward 9: No significant details provided in the summary.
Domain 6: Social Participation
Ward 1: Older peoples were not very active in social sectors, with even the president of the older peoples' club often absent. They did participate in social and cultural activities like religious festivals, and the municipality organized annual religious tours for them.
Ward 2: Awareness programs must be conducted for older peoples; older peoples has least participation in political matters.
Ward 3: Only one or two older peoples were active in politics and cultural sectors. They faced economic difficulties, mobility issues, and challenges in expressing their thoughts.
Ward 4: The ward initiated religious tours for older peoples.
Ward 5: Older peoples were active in social activities.

Ward 6: Awareness programs and workshops were needed for youths about their responsibilities toward older peoples.
Ward 7: The ward organized religious pilgrimages and encouraged older peoples' participation in election campaigns, festivals, fairs, and religious events.
Ward 8: Older peoples had limited participation in politics but actively engaged in worship, religious functions, and devotional songs.
Ward 9: There were no reported cases of abuse towards older peoples.
Domain 7: Communication and information
Ward 1: The municipality did not deliver information to every household. Social mobilizers used social networks to disseminate information in.
Ward 2: They had access to communication.
Ward 3: Elected members conveyed information to older peoples and displayed notices in various places.
Ward 4: There was no effective flow of information due to geographical difficulties.
Ward 5: Information was disseminated via cell phone.
Ward 6: Information was posted and shared via phone.
Ward 7: Information was received through mobile phones and neighbors. Improving accessibility and reach of information was needed.
Ward 8: Information was posted in various places and disseminated via mobile phones.
Ward 9: Information was posted in neighborhoods and shared via phone calls to ensure everyone was informed.
Domain 8: Community Support and Health Services
Ward 1: Reaching Changunarayan hospital was difficult for the people and older peoples of ward 1. They needed easier transportation to the hospital. Although Changunarayan Hospital was the first point of contact for insurance purposes, Bhaktapur Hospital or Madhyapur Thimi Hospital were more accessible. Weekly visits from Changunarayan hospital doctors to the ward health post and providing insurance recommendations from the health post would have benefited older peoples.
Ward 2: Seniors struggled to reach the health post when sick due to steep roads and no transportation. An ambulance service was necessary.
Ward 3: Ambulance, blood, and financial support were provided to older peoples. Older people cards took a whole day to get, so issuing them from the ward was suggested. Lab test services like blood sugar and urine dipstick were needed at the health post.
Ward 4: Older people allowances needed to be accessible at home.
Ward 5: Insurance implementation was unsuccessful. Ambulance services were needed within the ward.
Ward 6: Expensive medicines were not covered by the insurance program.

Ward 7: Public transportation needed to be arranged for access to Changunarayan Hospital.
Ward 8: Changunarayan Municipal Hospital provided home services for bedridden older peoples but lacked public transportation to the hospital. Extended services at the ward health post and 100,000 rupees for older peoples' treatment were provided.
Ward 9: No significant details provided in the summary.
Suggestions:
Ward 1: Information was poorly disseminated, and their skills were underused. More local services and educational programs were needed.
Ward 2: health service programs for older peoples were anticipated. Regular health awareness sessions and skill transfer programs were needed. Small gathering huts and clubs were requested to foster interaction. Home visits for those unable to walk were recommended, with a contact point to address issues.
Ward 3: sought the establishment of religious libraries for studying religious texts. Physiotherapy services were deemed helpful for musculoskeletal issues. Small huts for older peoples' gatherings were requested.
Ward 4: Older people allowances should be home-accessible. Information flow was hindered by geography. New houses required at least one room and a commode-equipped toilet.
Ward 5: there was a need for older people buildings, rest areas, and parks in each neighborhood. Roads, pathways, and public toilets should be made safer and more senior-friendly.
Ward 6: Youth needed awareness on older people care. Economic reasons caused neglect and physical abuse. Insurance didn't cover expensive medicines. Senior skills and experiences weren't transferred to youth.
Ward 7: emphasized installing railings on stairs for safety. It recommended constructing rest areas with traditional instruments, religious books, and senior-friendly toilets. Cultural programs and medical treatment arrangements were also suggested.
Ward 8: Highlighted the need for free ambulance services for economically weak, disabled, and single older peoples to improve accessibility and quality of life.
Ward 9: Suggested restoring old patios and pavements and preserving cultural records to educate younger generations.

Annex 8: Ward-wise quantitative data



Ward wise full
table.docx

Annex 9: Data collection tools



Survey Questionnaire_English.pdf



Survey Questionnaire_Nepali.pdf



Checklists for KII and FGD- Nepali.pdf



Checklists for KII and FGD- English.pdf