UNIVERSITY FOR DEVELOPMENT STUDIES

THE IMPACT OF DEMOGRAPHIC TRANSITION ON THE SOCIO-ECONOMIC WELL BEING OF THE ELDERLY IN THE ADA EAST DISTRICT, GHANA

JUSTICE KANOR TETTEH

2018

UNIVERSITY FOR DEVELOPMENT STUDIES

ASSESSING THE IMPACT OF DEMOGRAPHIC TRANSITION ON THE SOCIO-ECONOMIC WELL BEING OF THE ELDERLY IN THE ADA EAST DISTRICT, GHANA

BY

JUSTICE KANOR TETTEH (B.A. Population & Health)

UDS/CHD/0109/12

A DISSERTATION SUBMITTED TO THE DEPARTMENT OF PUBLIC HEALTH, SCHOOL OF ALLIED HEALTH SCIENCES, UNIVERSITY FOR DEVELOPMENT STUDIES IN PARTIAL FULILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF PHILOSOPHY IN COMMUNITY HEALTH AND DEVELOPMENT

2018

DECLARATION

I hereby declare that this submission is my own work towards the Master of Philosophy and that, to the best of my knowledge it contains no materials previously published by another person nor material which has been presented for the award of any degree of the University, except where due acknowledgement has been made in the text.

Candidate's Signature …… Date:……..…..……

Name: Justice Kanor Tetteh

Supervisors'

I hereby declare that the preparation and presentation of the dissertation was supervised in accordance with the guidelines on supervision of dissertation laid down by the University for Development Studies.

Supervisor's Signature …..…… ……..……

Date

Name: Dr. Abdulai Abubakari (Ph.D)

ABSTRACT

The study was conducted to examine the impact of demographic transition on the socio-economic wellbeing of the elderly in the Ada East District, Ghana. The study employed descriptive cross sectional study design using simple random sampling technique to select the respondents. A sample of 250 respondents was used to gather data for the study. Primary data collection was basically through administered questionnaire and in-depth interviews and was analyzed using basically descriptive and inferential statistics involving mainly frequency distributions and cross tabulations. . From the results, respondents who were educated (at least had primary education) were 5 times more likely to have one form of coping strategy to improve their wellbeing as compared to those who were not educated. It was also established that there was relationship between marital status of respondents and frequency of visitors at respondents home at the study area (P >0.000). Findings again revealed that respondents had ever suffered one form of abuse or the other. The study recommends that intensive public education on the psychological effects of abuse, neglect or social isolation on the elderly should be intensified at the study area.

ACKNOWLEDGEMENT

My sincere gratitude goes to my very able supervisor Dr Abdulai Abubakari for the patience, love, time and above all guidance during the period of the thesis. The completion of this thesis would not have been possible without his corrections and assistance. I am also grateful to the Dean of School of Allied Health Sciences for all the support. I also want to appreciate the co-operation of all the elders visited in the Ada East District most especially in the communities where they were contacted during the research period. Special thanks go to the household heads and the Assembly men for their role in making this study a success by locating houses where the elderly were found. I would like also to express my sincere and special thanks to my family for the financial and moral support.

Above all, I thank the Almighty Father for the gift of life and protection during the production of this thesis. May God bless all those who contributed in diverse ways to make this thesis a reality.

DEDICATION

This thesis is dedicated to the Almighty God, my wife Naomi Quainoo and the rest of my family including my supervisor and all those who contributed in diverse ways to make this thesis a reality. And also those who would find the material useful one day

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

AED	Ada East District
ADL	Activities of Daily Living
DT	Demographic transition
EU	European Union
GSS	Ghana Statistical Service
PHC	Population and Housing Census
NHIS	National Health Insurance Scheme
SES	Socioeconomic Status
SSA	Sub Saharan Africa
TCG	Traditional care givers
UN	United Nations
WHO	World Health Organization

CHAPTER ONE

1.1 Introduction

Ageing is profound, and has major consequences and implications for all facets of human life. A total of 1,643,381 persons aged 60 years and above were enumerated in the 2010 Population and Housing Census in Ghana, constituting 6.7 percent of the total population and also representing an increase of more than 2 percent of Ghana's population from the year 2000 (GSS, 2010). This chapter contains the background of the study, problem statement, objective of the study, research questions, justification of the study, scope of the study and organization of the study.

1.2 Background of study

Old age is the last period of life, associated with the decline of mental and physical capacities. The term is also used to refer to the population group known as the elderly (Poterba, 2014). The precise onset of old age varies culturally and historically, as it is a social construct rather than a biological stage (Ogunbodede, 2013). Most developed countries have accepted the chronological age of 65 and above as a definition of an 'elderly' or older person. While this definition is somewhat arbitrary, it is often associated with the age at which one can begin to receive pension benefits (UN, 2011).

This cut-off age for the elderlymay not adapt well to the situation in Africa, where life expectancy levels are comparatively lower and pension systems do not

currently cover a large share of the elderly (Wongboonsin & Kua, 2014). The cut-off referred to in the, Madrid International Plan of Action on Ageing (UN, 2012) as well as recent UN publications and statistics on the elderly (UN, 2011) is 60 years. This study adopts the same age cut-off, which also corresponds to the age used in the analysis of the 2010Ghana Population and Housing Census (PHC).

During the past decades, there has been a surge of interest in the living arrangements of older persons. The concern has been part of the demography and sociology of the family, but only as an outcome subordinate to the broader issue of household and family organization (Mba, 2010). It has received new impetus owing to two interrelated factors: First, the rapidity and demographic inevitability of ageing in the world and even more accelerated pace in countries that have experienced recent demographic transitions.

Secondly, an upsurge of research in the economics of intergenerational transfers, an area that for a long time has been inextricably linked to the explanation of fertility changes but that now, paradoxically, experiences a revival in order to understand the consequences, rather than the causes, of demographic transition on the economic status of the elderly (Ogunbodede, 2013; Marmot, 2013; Martin, 2012).

From the outset, research has seen the transition as a by-product of a larger process of social and economic change on the elderly people especially in rural communities. Several researchers have stated that fertility change has an impact on the consequence of social and economic change of the elderly in developing countries (Marmot, 2013; Martin, 2012).

Even though the results of these efforts were not conclusive and have led to often contradictory explanations of fertility change and economic wellbeing of the elderly, the effort to explain fertility change as the result of social change continues to be the subject of myriad publications in the field of historical demography (Kannisto & Vaino, 2014; Gruber and Wise, 2014).

It is only natural that researchers of the demographic transition would want to see it as part of the larger process of economic and social modernization, with demographic change largely guided by social and economic change. The demographic transition will be considered as a largely autonomous process that ended up having profound social, economic, and even psychological or ideational implications for the elderly (Galor, 2010; Dyson, 2010).The preponderance of large family sizes is not in doubt however, the incidence of single living and living with grandchildren is noticeable.

The demographic profile of Ghana projection results indicated that Ghana's rural population would rise from 10.6 million in 2000 to 22.1 million by 2050 (GSS, 2010), while the proportion of the elderly people would increase from 7.9 percent to 15.7 percent (that is from 838,000 to 3,461,000) over the same period (Dyson, 2010). Majority of the aged would be in the age range 60-69 years, and by 2050 Ghana's rural population would be an old population (Cowgill, 2013).

Rural life is generally characterized by poverty and underdevelopment. These are reflected in the poor and inadequate housing structures, poor nutrition, low life expectancy, safe drinking water challenges, low income levels, poor transport and communication facilities (Asante, 2012). What has been said about the rural

elderly people can also be said concerning the urban older population (Ayernor, 2012). The economic and social environment is ill-equipped to manage the rapid demographic change occurring in Ghana, characterized by high levels of poverty, low pension coverage, inadequate social protection, and deteriorating traditional family support structures (Barrett, 2013).What is not known is the preparedness of the country for significant changes in its age structure in response to demographic transition.

1.3 Problem statement

Social and economic changes taking place in Ghanaian traditional society have resulted in the gradual erosion and substantial break down of the traditional familial support for the elderly (Mba, 2010). There is fragmentation of families stemming from increasing economic hardship, stagnation and weakening of family organization and kinship networks in Ghana and many parts of the African continent, due to, among other factors, rapid urbanization and industrialization and poor economic conditions portend difficult years ahead for the Ghanaian elderly (Martin, 2012).

Modern education is seen to foster individualism, straining old community ties of interdependence (Mba, 2010). Women, the traditional care givers to the elderly are increasingly joining the labor force and modernization has also created institutions that have assumed the functions, tasks and duties previously fulfilled by children (Poterba, 2014). In addition to this, social transformation, economic constraints and high level of unemployment and under employment have

diminished the traditional expectation that the younger generation will take care of the old, in time of need. Older persons, therefore, can no longer rely on the traditional family support for survival (Asante, 2012).

This implies older persons in Ghana are likely to experience loneliness, poverty, and neglect which could lead to deteriorating health conditions and deteriorating health care due to abandonment. What is more worrying, it is estimated that about 60-80 per cent of the working population in Ghana are engaged in subsistence farming and other informal work and often has no pension savings or any other form of reliable social security to live on (Asante, 2012).This situation is not different in the Ada East District of Ghana. Today, over 7301 persons aged 60 years and above live in the district (GSS, 2010).

It is estimated that more than 85% of the population in the district are subsistence farmers or are engaged in other agricultural related occupations such as fishing and also salt mining and often has no pension savings or investment towards the future. This implies that more than 85% of the people of Ada East age into poverty with no pension cover or any means of income security. With the youth constantly drifting away from agriculture and migrating to urban towns in search of jobs, it is increasingly becoming difficult for them to perform their traditional role of taking care of the elderly.

The researcher observed that most elderly in the district were living alone and the absence of youth and adults were clearly visible in households. Informal interviews and interactions with some of the elderly and key informants such as the Assembly man and a worker at the district Assembly attested to these

findings. Some of the elderly especially the frail or old-old (80 years and above), weak and disable complained bitterly about the impact of demographic transition on their lives and the struggle they go through every day to survive on their own.

In the Ada East district, little information is available about the impact of demographic transition on the lives of the elderly. Such knowledge, however, is important because the elderly are weak and cannot do anything on their own. This has necessitated this empirical study to assess the impact of demographic transition on the socioeconomic wellbeing of the elderly in the study area.

1.4 Objective of the study

1.4.1 General objective

The main objective of the study is to assess the impact of demographic transition on the socio-economic well being of the elderly in the Ada East District.

1.4.2 Specific objectives

1. To determine the socio-economic wellbeing of the elderly.
2. To examine the changing situation of the elderly in the context of demographic transition.
3. To assess the coping mechanisms used by the elderly to improve their economic wellbeing
4. To determine the socio-economic wellbeing and perceived health (self reported health) of the elderly.

1.5 Research questions

1. What is the socio-economic wellbeing of the elderly?
2. What is the changing situation of the elderly in the context of demographic transition?
3. What are the coping mechanisms used by the elderly to improve their economic wellbeing?
4. What is the relationship between socio-economic wellbeing and perceived health status of the elderly?

1.6 Justification of the study

Findings from the study would be useful for designing interventions and formulating policies that would aim at improving the socio-economic wellbeing of the Ghanaian elderly especially in the Ada East district. The findings of this study would serve as a reference material for other researchers and would be of benefit to the Ministry of Gender and Social Protection and Non-Governmental Organizations who would like to roll out measures to improve the wellbeing of the elderly. The findings of this study when published would serve as resource material for future research works.

1.7 Scope of the study

The study was limited in scope to only elderly aged 60 years and above in the Ada East district. The delimitation of the study was done to manage the data collection considering.

1.8 Definition of terms

- **Elderly:** This refers to people who are 60 years old and above
- **Remittance:** This refers to the transfer of money by migrant children and grandchildren to their elderly parents or grandparents back home.
- **Wellbeing:** This refers to how an elderly feels about himself/herself. Only social wellbeing, economic wellbeing, emotional wellbeing and health of respondents were considered and carefully reviewed and presented in this research work.
- **Demographic transition:** This refers to the process where countries experience a shift from the period of high birth and death rates to low birth and death rates as the country develops from a pre-industrial to an industrialized economic system.
- **Traditional care givers:** This refers to women, children and grandchildren who as a societal and cultural norm are traditionally obligated or expected to take care of the elderly by providing both physical and material support.
- **Social wellbeing:** This refers to the ability of the elderly to interact successfully within a community.
- **Economic wellbeing:** This refers to the ability to meet personal requirements for food, clothing, shelter, medical care and other reasonable expenses with or without any support.

1.9 Organization of the study

The thesis is structured into six chapters. Chapter two tackles related reviews of publications on demographic transition and socio-economic status of the elderly. Chapter three consists of the research design, profile of study area, target population, sample size and sampling procedure, research instruments, validity and reliability of the research, data collection procedure, data analysis and ethical considerations. Chapter four presents data analysis and interpretation whiles chapter five looks at the discussions of the research findings. Chapter six also deals with the summary of the study findings, conclusion and recommendations.

CHAPTER TWO

Literature review

2.1 Introduction

This chapter examines the review of literature related to the impact of demographic transition on the socio-economic well being of the elderly in the world. The review of this literature looks at the concept of the elderly particularly as they are handled globally, in Africa and specifically in Ghana.

From that premise, literature pertaining to the socio-economic wellbeing of the elderly is reviewed, followed by the changing situation of the elderly in the context of demographic transition. Additionally, coping mechanisms used by the elderly to improve their economic wellbeing in the phase of demographic transition is also tackled. Brief concepts on the Demographic Transition Model is also included in this chapter. The chapter concludes with the summary of the literature review.

2.2 Concept of the elderly

Although there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. The common use of a calendar age to mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous. As far back as 1875, in Britain, the Friendly Societies Act, enacted the definition of old age as, "any age after 50", yet pension schemes mostly used age 60 or 65 years for eligibility (Bryant, 2013).

The traditional African definitions of an elder or 'elderly' person correlate with the chronological ages of 50 to 65 years, depending on the setting, the region and the country (Hermalin, Albert, and Mary, 2013; Kuria, 2012). Adding to the difficulty of establishing a definition, actual birth dates are quite often unknown because many individuals in Africa do not have an official record of their birth date. In addition, chronological or "official" definitions of ageing can differ widely from traditional or community definitions of when a person is older (Hermalin, Albert, and Mary, 2013; Kuria, 2012).

Empirical evidence shows that most nations will face population ageing to some degree over the next decade and poor planning now will mean serious developmental implications in the future (Martin and Kevin, 2014; Kuria, 2012).Between 2012 and 2050, the population of the aged is expected to increase by about 26% in East, Middle, Northern, and Western Africa and about 15% in Southern Africa (Ogunbodede, 2013). A total of 1,643,381 persons aged 60 years and above were enumerated in the 2010 census, constituting 6.7 percent of the total population representing an increase of more than 2 percent of Ghana's population from the year 2000 (GSS, 2010).

Most of these elderly persons reside in rural areas and an overwhelming majority of the older population has no formal education (Asante, 2012).The age structure of Ghana's population, according to Asante (2012) is the result of the three basic population processes, namely; fertility, mortality, and migration. When these processes are constant for many years, a stable age structure emerges.

2.3 Socio-economic wellbeing of the elderly

The beginning of research on ageing in Africa can be traced to the early 1970s, when the United Nations social development section, aware of the dearth of information on older people in developing countries, sponsored nine developing-nation pilot surveys on the socio-economic conditions of the aged. The survey came out with interesting findings indicating that the aged in Africa including Ghana were in a very periled state and with empirical evidence indicating the rapid growth of this population due to significant reductions in fertility and mortality rate coupled with improved public health care and nutrition with increasing life expectancies (Ayernor, 2012; Ogunbodede, 2013).

Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible (Caldwell, Reddy and Caldwell, 2012). Declining health, loneliness, financial insecurity and security of life and property have been found to be the respective problems of the elderly globally (Ayernor, 2012).

In a cross sectional survey conducted by Ogunbodede (2013) using simple random sampling technique concerning the socio-economic status of the elderly in Northern Nigeria, it was realized that, most of the elderly conditions of lives was very deplorable as most of them indicated they could not get proper food to eat.

Similarly, a study conducted by Coale (2013) using a descriptive cross sectional survey design concerning how people cared for the aged in Tanzania, the findings indicated that most of the people were not having time for the elderly and most of

the family members have even moved to the cities leaving the aged at the rural areas. In a related survey conducted in Ghana, on the elderly, findings revealed that, most children of the aged hardly visited them and did not even cared to provide them food in the village (Ayernor, 2012).

In Sub Saharan Africa (SSA), the situation is not different, older people's lives in the region are characterized by growing inadequacies in customary family support systems, vulnerability to poverty and exclusions from health services (Bhat & Mari, 2012; Mba, 2010). For example in Tanzania the free NHIS registration for the aged did not cover people aged 60 – 69 years meanwhile the pension age in the country is pegged at 60 years (Asante, 2012).

In a cross-sectional survey conducted to assess the socio-economic status of the elderly aged 60 years and above in Zambia using purposive sampling technique, it was revealed that, the elderly who were considered as poor mostly women were particularly disadvantaged in terms of social and economic support and status in many contexts because they lacked control over their children because most of them were leaving in the cities and urban towns leaving the aged in the rural communities (Hermalin, Albert and Mary, 2013).

In a descriptive cross sectional survey carried out using simple random sampling method to assess the economic status of the aged in South Africa, it was revealed that most of them had cattle, lands, houses for rents and few had taxies which were generating income for them (Oppong, 2014). In a similar study conducted to assess the social conditions of old soldiers in Uganda using a purposive sampling technique involving 120 study participants, it was discovered that most of them

used their pension benefits to built houses which were used as rent for people which served as a source of monthly income for them. Most of the old soldiers who were contacted had animals which they could sell while few had nothing at all but depended on their children who took up the same career (Ogunbodede, 2013).

According to a cross-sectional study conducted in Duduza Township in South Africa, the needs of the elderly poor aged 60 years and above included lack of access to quality health care, inadequate knowledge of nutrition, inadequate financial resources to meet their basic needs, few clothing and poor shelter. It was also observed that most of the elderly aged 60 years and above could not afford transportation cost to health centers (Coale, 2013). According to a cross-sectional study carried out by Bryant (2013), it was observed in that study that poverty in old age increases as the elderly spent more years on earth.

Abuse and disrespect particularly among the elderly have been found to be common in many demographic researches. Studies have shown that the elderly poor do face some forms of abuse and disrespect due to their poverty (Bledsoe, 2013).

According to a cross sectional study conducted by Bloom and Canning (2014) concerning abuse and disrespect among the elderly in South Africa, it was found that 53% of older people interviewed had personal experiences of abuse and disrespect. Bloom and Canning (2014) went further to report that, forty percent respondents stated they have personally been abused by their own children who

beat them up while 6% respondents mentioned that they have ever been abused in the hospital by hospital staff.

Poverty among the elderly can therefore be said to predispose the aged to all forms of abuse. More worrying is the fact that poverty experienced by the majority of older people, particularly in Africa has been largely ignored (Bledsoe, 2013). By contrast, researches on pre-capitalist, as well as contemporary agrarian, societies in Asia and Africa testify to the significance of family networks to secure on old age (Mba, 2010). Indeed, in the absence of alternative institutional arrangements, family members, and children in particular have been the primary form of social support for old age (Mba, 2010).

Confucianism in East Asia (Hermalin and Albert, 2012) and Judaeo-Christian religions which dominated in other parts of the world all upheld the privileged of the elderly, in such societies, children who failed to care for their elderly parents faced social disapproval and ostracism and, in some cultures, also formal sanctions in the form of fines or incarceration (Hermalin and Albert, 2012).

According to a research by Ayernor (2012) population ageing is profound, and has major consequences and implications for all facets of human life. In the economic sphere, population ageing will have an impact on economic growth, savings investment, consumption, labor markets, pensions, taxation, and intergenerational transfers. In the social sphere, population ageing will influence family composition and living arrangements, housing demand, and migration trends. In health, population ageing will affect epidemiology and the need for special healthcare services.

As Seike and Atsushi (2013) suggested, aid and direction for the elderly most especially those around the ages of 70 to 80 years were welcomed from wider kin and community rather than necessarily from family members. Other accounts point out that an explicit retirement contract was a common way among those with property of assuring their needs in old age till death (Wongboonsin and Kua, 2014).

In fact, these contracts themselves did not have to be with children or even akin, although children might have been preferred. For those without property to secure such intergenerational contracts, the prospect of old age was grim and in England, a pattern of life cycle poverty produced regular disparity in the economic status of an elderly parent and their progeny were frequently reported by researchers (Martin, 2012).

The effect of modernization and urbanization have affected the traditional solidarity family network, particularly the extended family system, which is disintegrating, leaving the elderly population aged 60 years and above with little or no means of support and care which as a result is leading Ghana's rapidly increasing number of older citizens in a precarious situation that is likely to perpetuate poverty (Cowgill, 2012).

The precarious and poor living conditions of the elderly aged 60 years and above most especially those leaving in the rural communities is further worsened by the rural-urban migration and international migration of the working population (Chen, 2013; Chayovan, John, and Siriwan, 2013).

In that finding, older women were found to be leaving in extreme poverty than older men. In most developing countries, poverty increases with age and is particularly prevalent among elderly women principally those who are living without their spouses in rural communities in Africa (Caselli, Graziella, and Jacques, 2014).

2.4 Changing situation of the elderly in the context of demographic transition

This demographic trend together with socio economic changes has several implications and one such implication is the challenge of youth-parents-grandparents intergenerational relationship. While older adults may have more opportunities to share knowledge and resources with younger generations, they are also more likely to depend on the support of younger generations for longer periods of time (Boersch-Supan and Ludwig, 2010).

But however, with growing unemployment disproportionately affecting youth, young people may need to depend on their parents or grandparents for material support or housing provision longer than before (Bryant, 2013)

The importance of intergenerational transfers for the well-being of the ageing population in Africa has been the concern of a growing body of research in recent years. Intergenerational contract is essentially an inherent way of living in Africa where intergenerational transfers and family relationships are of paramount importance for the health and well-being of individuals especially the elderly (Cowgill, 2013).

However, with the current demographic transitions in Africa's population coupled with changes in the socio economic environment, it remains unclear how the flow of material resources is fairing and not forgetting that most elderly in Africa depend entirely on that for survival (Chen, 2013; Dyson, 2010).

More specifically, ageing is linked to a higher propensity for long-term physical and mental health conditions that will likely increase the needs for personal care (Bryant, 2013). However, average spending on health among the elderly aged 60 years and above is low and health care systems in most African countries are weak (Robert, and House, 2000).

Traditionally in Sub-Saharan Africa, the main source of support for the elderly has been the household and family (Bryant, 2013). With the exceptions of Botswana, Mauritius, Namibia and South Africa, formal pensions or other social welfare schemes are virtually non-existent (Galor, 2010).

When they do exist, schemes tend to pay minimal benefits and cover only a small fraction of the elderly population (Cowgill, 2013). Moreover, the prevalence of poverty, particularly among households headed by elderly persons, is a key emerging policy challenge across most African countries. The limited access to formal pensions is also prevalent in Rwanda (Galor, 2010). According to Hermalin and Albert (2012), only around 7% of people over 65 years of age have access to a pension scheme (Coale, 2013).

In a cross sectional study to examine the economic condition of the elderly in Ghana, Gruber and Wise (2014) looked into the elderly living arrangements, their self-reported problems and their activity status and also tried to assess the

availability of care provider and fulfillment of expectations by their children. The sample consisted of 280 male and female elderly in the age group of sixty years and above. The elderly were further classified into three groups, that is, young old (60-69), middle old (70-79) and old (80 and above). The snow-balling technique was applied to locate the elderly sample. It was found that though children provided care to their ageing parents but the satisfaction level was found to be lower than expected.

The economic and social implications of rural-to-urban and inter-regional migration have probably been just as important as those of international migration. As a result of this internal migration, societies urbanized and the labor force was positioned where it was most needed economically.

The risks, and possibly the rewards, of internal migration may have been lower than those of international migration for the elderly especially those in rural communities (Hermalin, Albert and Mary, 2013), although the net effect on both sending and receiving areas was similar. The movement in favor of increased educational attainment of children has been a hallmark of developed societies for over a century and is increasingly becoming a goal for governments and families in the developing world as well.

This phenomenon has contributed negatively to the upkeep of the elderly in Africa as most children hardly even got time to visit their aged parents at home or even send them money for their needs (Kannisto and Vaino, 2014).The widespread transformation of the role of women in society is perhaps the most important social change of the past half century. There is every indication that

these processes are underway in the developing world as societies increasingly adopt the "developmental idealism" of the highly industrialized countries (Galor, 2010; Kuria, 2012). Beyond the strictly economic implications of increased longevity, the increased duration of life and the ever-greater chances of living to old age have had a profound effect on the way people think, the way life-course strategies are formulated, and the way life is lived (Cowgill, 2013).

This effect, only partially reflected in the framework presented here, is perhaps the most pervasive of all of the effects of the demographic transition and one of the hallmarks of modern life. While increasing reproductive efficiency also contributes to this effect, the primacy here of longevity is unquestionable.

It is impossible to forecast the way this transition will take place in sub-Saharan Africa, where the transition is in its initial stages. The gradual declines in vital rates visible so far, however, suggest that in this region the demographic transition, when it does take place, will have different characteristics from those of other developing countries and may well last considerably longer (Kuria, 2012).

It has been suggested that declining fertility is the dominant contributor to population aging in the world today. More specifically, it is the large decline in the total fertility rate over the last half century that is primarily responsible for the population aging that is taking place in the world's most developed countries (Kannisto and Vaino, 2014). Because many developing countries are going through faster fertility transitions, they will experience even faster population aging than the currently developed countries in the future (Kannisto and Vaino,

2014). Issues pertaining to socio-economic and demographic profiles, living arrangements, problems and services to the elderly have received focus (Martin, 2012).

The problems of the vulnerable elderly like widowed females, poor and middle class urban elderly, disabled, fragile older persons and those from the unorganized sector need to receive specific attention (Martin, 2012). Several studies have also explored health issues of the elderly.

Many of these studies have been done on the quality of life, well-being and life satisfaction of the elderly have been conducted all over the world and a few have been done at the micro level in India. However, it is necessary to devote further research on the mental health of the elderly to ensure a quality life for them. Many of the studies have viewed the elderly to be on the receiving end (Manuh, 2013).

However, few studies such as a study done by Mba (2010) have recognized their active role either in the social or economic setting. There is a need to develop further studies taking them as resources and include them in the development process.

According to a survey carried out by Martin and Kevin (2014) concerning the elderly health, well-being and aging, it was discovered that at least 20 percent of the population aged 60 years or over had limitations that affected the basic activities of daily living, such as bathing and dressing without assistance. It was revealed that two thirds of the older adults reported having one or more of the major chronic conditions, including hypertension, diabetes, heart disease, cerebro-vascular disease, joint problems and chronic obstructive pulmonary disease.

In a survey conducted in Thailand, more than a third of older persons reported having at least one functional limitation (Ogunbodede, 2013). These surveys also found that individuals over the age of 70 were much more likely than those in their sixties to be disabled, and that older women more frequently reported problems and poor health status than did older men (Oppong, 2014).Within the family, women provided most of the day-to-day care for older persons who needed assistance in both developing and developed countries (Oppong, 2014). According to a survey conducted by Poterba (2014), the results found that the typical caregiver of an elderly person was a woman over the age of 50, and that caregivers experienced high levels of stress. Sixty per cent of caregivers reported that they could not do more than they were already doing, and more than 80 per cent reported having difficulty meeting expenses.

Older persons still face a number of major challenges, but the outlook for the ageing population is positive in many respects. Ageist stereotypes persist, and low levels of literacy and educational attainment have hindered the full participation of older persons in society (Olson, 2014). However, the older generation is gradually coming into its own (Seike & Atsushi, 2013).

Within the next few decades, as the better educated younger population ages, education and literacy rates will increase significantly. Even now, as the number of older persons increases, there is a growing awareness of the importance of active ageing (Kuria, 2012).

Older individuals are gradually being recognized for their considerable contributions to intergenerational care giving and for their ongoing involvement

in community life (Olson, 2014). They are becoming a powerful and ever-expanding political force, especially in developed countries, and organizations of older persons are helping to ensure that the ageing population has a greater voice in decision-making processes (Kuria, 2012).

A remarkable feature of the modern era is the increase in the "quality" as well as quantity of people (Olson, 2014). In economics, quality or human capital has been taken to be synonymous with education but people should think of the quality of people in a broader sense (Stock and Wise, 2013).

Over the last 100 years researchers have seen substantial increases in the physical and cognitive development of elderly, as evidence by gains in adult heights (Kuria, 2012) and intelligence quotient scores (Olson, 2014), even in the component not associated with education.

These gains have been due to improvements in nutrition and health in the first few years of life (Wongboonsin and Kua, 2014). The mortality transition that sets off the demographic transition is also usually a health transition that is associated with better nutrition and a lower burden of disease. In addition, the onset of disability and physical and cognitive decline in old age is occurring later in life the compression of morbidity (Olson, 2014).

These improvements in physical and cognitive ability, in the quality of people, have played a large role in economic and social development of some elderly persons aged 60 years in developing countries. Researchers have argued that including measures of these improvements in population quality, in addition to

population quantity, in demography provides a richer basis for thinking about the link between population and development.

Several researchers' views on the issue are that the economic and social effect of these quality changes on the lives of the elderly has been fundamental in promoting economic growth of them most especially the disadvantaged in rural communities (Zimmer, Zachary and Pattama, 2014).

By definition, the demographic transition led to important increases in reproductive efficiency. People's reproductive goals were met with less childbirth and fewer childhood deaths (Kuria, 2012). At first the potentially transformational effects of this change were hidden by increasing population growth rates (Zimmer, Zachary and Pattama, 2014). Eventually, at a more advanced stage of the demographic transition, the original goal of maintaining net family size in the light of improving childhood health became one of reducing net family size (Williams, et al., 2014).

As childhood mortality became very low and more or less predictable, reproductive decision-making could be made with very small margins for error (Kuria, 2012). These changes and their implications are visible only gradually over time, though on a historical time scale everything takes place rather quickly. These changes had multiple and layered effects on family life and eventually on fundamental aspects of social organization (Williams, et al., 2014).

Before the demographic transition when childhood mortality was high, the death of a child meant that all familial investment in that child was lost (Kuria, 2012). At the outset of life, this parental investment corresponded mainly to mothers and

can be best measured in terms of parental time. As mortality declined, the importance of these wasted investments also declined (Williams, et al., 2014). This effect was enhanced by the fact that the number of childbirths also diminished, and so mothers went from a situation in which they invested widely and perhaps superficially in many children with low levels of return on their time, to one in which investments were concentrated on fewer children and tended to last longer (Wachter et al. 2013).

Since the relative density of very young infants in families also declined, women were progressively liberated from the type of intense dedication that infants demand (Wachter et al. 2013). Once net family size began to decline some years after the start of the fertility transition, the reduction of the number of very young children in the household ended up leading to increase family living standards being poor and a more efficient use of women time in the working field (Wachter et al. 2013)

An underlying purpose of the Princeton European Fertility Project was to see fertility change as the consequence of social and economic change (Stock and Wise, 2013). Even though the results of these efforts were not conclusive and have led to often contradictory explanations of fertility change, the effort to explain fertility change as the result of social change continues to be the subject of myriad publications in the field of historical demography (Olson, 2014).

The desire to do this was and is wholly understandable given the fact that at the same time the demographic transition was taking place, Europe was undergoing a massive process of social and economic transformation (Stock and Wise, 2013).

2.5 Coping mechanisms used by the elderly to improve their economic wellbeing

Coping is seen to be related to human personality trait and a time changing process in accordance with the situation an individual finds himself or herself (Poterba, 2014). A study by Seike and Atsushi (2013) classified a number of these coping strategies adopted by individuals into two distinctive groups but interrelated with the other classifications mentioned earlier.

The study showed that, old people prefer to use adaptive and active strategies in coping with their age related changes and the adaptive coping strategies used were observed to be acceptance, hope, change in perception, re-definition of self, avoidance attitude, dropping of responsibilities, prayer, less fear for life and death while active coping strategies were moderate exercise, education, social interaction, getting busy, having adequate rest, therapy, medications and good standard of living (Seike and Atsushi, 2013).

According to Ogunbodede (2013), Kung San elders in Botswana use complaining as a way to "mark their continued presence in the world" and to remind their children: "I am still alive". Meanwhile, further studies from South Africa have reported that such complaints fail to clarify to whom they are directed thereby leaving aged in abject poverty (Mba, 2010).

In a cross sectional study in rural communities in Ghana, Asante (2012) found that the Ghanaian elderly perception on using complains as a coping mechanism is almost the same as that of the Dutch elderly. He explained further that 'not

complaining' may be seen as a response to cultural ideal in Ghana: the "òpanyin", meaning the respected elder, which stresses that complaining, certainly to the young, does not befit an elderly. This implies that using complaining as a coping strategies could be influenced by demographic, social and cultural factors.

The elderly poor are normally left on their own to care and feed by themselves. In a study in London and New York, researchers found out that in contrast to the wealthy elderly persons, whose possessions, capital and power allowed them to be in a better position to secure a better-off old age, the aging poor strived to procure their daily sustenance and cared for themselves (Agyei-Mensah and Anase, 2014). Globally some rural poor elderly are involved in the common use of utensils, tools and provisions and are usually included in the keeping of domestic animals such as goats, sheep, rabbits and fowls at home, both for consumption and to bring up for sale, and sometimes pay rent with the produce as a way of coping with the economic situation (Barrett, 2013)

In Nigeria, a cross sectional study on poverty among elderly widow aged 60 years and above shown that the various coping strategies adopted in the phase of changing socio economic environment included; petty trading, farming, selling of personal property, and alms begging (Kuria, 2012). Several researchers in Nigeria also established that informal networks of support and social networks were also a common coping strategy employed by the elderly for dealing with poverty and these social networks also assisted some of the elderly in obtaining formal health services that ordinarily, would not have been able to obtain by themselves (Barrett, 2013)

The elderly are increasingly perceived as an obstacle to development and progress and youth is increasingly becoming what Kuria describes as “courted quality” (Kuria, 2012). Migration is seen as another factor which has contributed to the break-up of older patterns of family solidarity and the values on which they were based.

Motivations for, and expectations of, migration are varied, but many of these studies emphasis the impatience of the young with the older traditions on their return, or on visits, to their rural homelands, despite the existence of remittances, the personal interaction between generations is reduced and therefore the role of the elderly can be seen to be undermined (Basu, 2013).

Migration and urbanization have both separately and jointly undermined the traditional social structure and have in turn contributed to the destabilization of the values which in traditional times sustained and involved the elderly in a closely knit age integrated society (Bauer, 2011).

As family-based production systems declined, often in the context of urbanization, and education became the basis of economic mobility, the younger patriarch displaced the ageing and dependent father as family breadwinner and decision-maker, concentrating their effort to the improvements in the situation of their immediate family. This nucleation of families in turn induced reductions in the traditional support available to the elderly beyond just the physical implications of fewer caregivers (Ayernor, 2012).

Other studies on ageing which draw on the modernization paradigm, perhaps less explicitly, to explain demographic transition have also highlighted the role of

changing values and their largely negative implications for the modern, urbanized societies in the post-colonial era is believed to have induced a reversal in the fortunes of the elderly in ways that undermined the very basis of their citizens and social status (Basu, 2012). Caldwell conceptualized demographic transition in terms of the changing structure and functioning of the family and more specifically, the shift in the direction of net inter-generational wealth flows:

From the young to the old (children to parents) in pre-transition societies and from the old to the young (parents to children) in societies undergoing transition in stated by Basu's explanation of the reasons for the shift focuses on changing values and beliefs (Basu, 2012).

As Bledsoe (2013) pointed out, it is strongly influenced by 'modernization' theory suggesting that the shift occurred with the 'westernization' of beliefs and attitudes towards the family including attitudes towards children as a result of the spread of mass education. The 'emotional nucleation' of the family, what occurred as a result of these changing ideas, was associated with gradual concentration of parental emotions and resources on children rather than on extended kinship network (Bledsoe, 2013).

The demographic transition opens a window of opportunity for economic and social change. It is a period in which demographic change can work in favor of economic and social change, rather than against it as was often the case in earlier periods. It becomes, so to speak, a fellow traveler of change and progress (Bhat and Mari, 2012). Just how beneficial its effects will be and how long they will last is related to the 'size' of this window.

These benefits are constrained by three factors: (1) the speed of demographic change; (2) the population growth rates that are reached during the key period following initial mortality declines; and (3) the mechanisms available for population regulation. On all of these points, the earlier demographic transitions appear to have been much better situated than the more recent ones to take full advantage of the implications of demographic change (Bauer, 2011).

Rather less attention has been given to the demographic transition specifically as a cause rather than as a consequence of this process of change (Bhat and Mari, 2012). Ultimately, historians and social scientists tend to prefer to conceptualize demographic realities as determined by economic forces rather than the other way around.

The gap between the earlier and the more recent transitions is indeed being narrowed, but only at the expense of an important reduction in the time available to the newcomers for growth and consolidation (Bhat and Mari, 2012). The implications of this are difficult to forecast, but it is likely that the best educated from these emerging societies will continue to be attracted by the higher wages of the more developed societies and will follow in the steps of earlier emigrants.

The extent to which this solves the problems of either the sending or the receiving countries remains to be seen. The most likely scenario everywhere is and will become potentially very negative (Bledsoe, 2013).These results reveal sex differences in longevity, with larger numbers of women than men aged 50 and over, despite their poorer health outcomes.

The mean household size of 10 observed for households containing older people in several studies is broadly reflective of socio-cultural practices in rural areas of most countries in sub-Saharan Africa, where older people tend to live in extended family households rather than independently (Bledsoe, 2013).

Several studies have shown socio-economic status to be associated with older people's health status, quality of life and well-being (Kuria, 2012). However, the current studies also detected an association between household socio-economic status and quality of life, but not between wealth (Boersch-Supan and Ludwig, 2010).

There is broad agreement based on consultations around the world with older persons, their families and the professionals who work with them about the types of housing and community amenities that help older persons live comfortably and remain active and engaged in the wider society (Boersch-Supan and Ludwig, 2010).

These include, but are not limited to, dwellings that can accommodate those with limited mobility and strength, a clean and safe environment inside and outside the home, transportation that is affordable and accessible, walkways in urban areas that are in good repair and free of obstacles, traffic signals that allow enough time for older persons to cross streets safely, places to rest outdoors, and public buildings that are accessible to those with limited mobility (Bryant, 2013).

There are numerous examples of good practices and of ageing-friendly innovations in housing design, assistive devices, transportation and community services (Bryant, 2013). A growing number of national and local Governments

have adopted policies to make housing and the urban environment more accessible for older persons (Bryant, 2013). For instance, many cities offer reduced fares for older persons using public transit and special transportation arrangements for those with limited mobility, and building codes have been revised at the local and national levels to ensure the incorporation of age-friendly features in new construction (Bryant, 2013).

Governments and civil society organizations have sometimes made significant investments in this regard, often introducing modifications to existing housing and public facilities. Most such programs are found in the more developed countries, but cities such as Bangkok, Beijing, New Delhi and Singapore are also adopting similar measures, in some cases on a pilot basis (Bloom and Canning, 2014).

Although progress is being made on many levels, the fact remains that members of the ageing population frequently live in older housing that is not adapted to their needs and encounter obstacles in moving about their communities (Caldwell, Reddy and Caldwell, 2012).

Many building in cities and certain neighborhoods are perceived as unsafe by older persons. A study carried out in the European Union (EU) found that older persons and women are significantly more likely than other groups to fear walking in their area at night (Bloom and Canning, 2014). In the developing world, settlements often emerge and expand without planning and can lack basic amenities (Caselli, Graziella and Jacques, 2014).

The United Nations Centre for Human Settlements (Habitat) estimates that one third of the developing world's urban population lives in slum conditions, characterized by a lack of access to improved water, adequate sanitation, durable housing materials, sufficient living area, and security of tenure (Barrett, 2003).

In sub-Saharan Africa over 60 per cent and in Southern Asia over 40 per cent of urban dwellers lived in slums in 2005 (Chayovan, John and Siriwan, 2013). Access to adequate housing and basic services is usually much more limited in rural than in urban areas (Chayovan, John, and Siriwan, 2013). Statistics indicate that in many Latin American countries, older persons are more likely than younger adults to live in dwellings constructed from low-quality materials, though they are also more likely to own their home and in most countries are less likely to be living in poor neighborhoods (often shanty towns settled by recent migrants from the countryside).

In some countries in the region, older persons are also more likely to live in dwellings that lack basic services including safe water and sanitation (Chayovan and John, 2013). In Europe, older persons tend to live in less crowded housing conditions than do younger adults, and in most European countries older persons are more likely to own their home (Bhat and Mari, 2012).

In some countries, however, primarily those in Southern Europe and the newer EU member States, older persons are more prone than others to report housing deficiencies such as rotting woodwork and the lack of an indoor flush toilet, or to report that home heating is unaffordable (Bledsoe, 2013).

Older persons in Bulgaria, Estonia, Greece, Hungary, Latvia, Lithuania, Poland, Portugal and Romania are often homeowners, but many cannot afford to repair, maintain or modernize their property (Galor, 2010).In recent decades, some developed countries have witnessed an expansion in housing designed specifically for older persons, including facilities offering assisted-living services (Basu, 2012).

However, unless subsidized by the public sector or charitable institutions, such housing is unaffordable for many of those who might benefit from it (Barrett, 2013). In addition, because of high construction costs, these facilities are often built in peripheral areas far from other services and the residents' old neighborhoods, family and friends (Galor, 2010).

Nursing homes and similar institutions offer an alternative for older persons who require assistance and/or specialized medical services (Bauer, 2011). The quality and availability of institutional long term care vary enormously, however, and high-quality institutional care tends to be expensive (Basu, 2012).

Around 2006, the proportion of persons aged 65 years or over living in long-term care institutions ranged from 5 to 8 per cent in Australia, New Zealand, and some Northern and Western European countries; levels were considerably lower in Eastern and Southern Europe and in developing countries (Ayernor, 2012). Most of the residents of such institutions were women over 75 years of age.

Many developed countries have been restructuring long-term care services to enable more of those needing assistance to remain at home, and rates of institutionalization have declined in the 1990s and 2000s in some countries

(Bloom and Canning, 2014). Older persons who wish to continue living at home can now arrange for personal care, meals, housekeeping, home maintenance, care management, and treatment for health problems (Bhat and Mari, 2012).

Services and facilities in the community may include day care, congregate meals, and social centers. In many cases formal in-home care serves as a supplement to informal care provided by family and friends in big towns and cities to the elderly most especially the weak and some programs include respite services for unpaid careers, who are often under great stress (Chayovan, John, and Siriwan, 2013).

2.6 Relationship between socio-economic wellbeing and perceived health (self-reported health) of the elderly

In virtually all cross-sectional studies of the probability of the aged living alone (or co-residing with children or kin) there is mention of the role of the health status of the elderly (Chayovan, John and Siriwan, 2013). The conjecture is simple. Since the needs of elderly persons who are disabled or ill are greater, co-residence should be more likely (keeping everything else constant).

In yet others, the effects are as expected for some elderly (married) but not for others (unmarried) (Chayovan, John and Siriwan, 2013). In public health and social policy, it is important to pay attention to people's perceptions of their own health, partly because of the interactions between social relationships, physical and mental health (Basu, 2013).

Self-reported health status has been widely used globally in censuses, surveys, and observational studies as a measure that may encompass subjective concepts

such as mental, physical and social well being (Basu, 2013). It is widely recognized as an important client-based health outcome indicator and has also further been recommended as a disease risk screening tool (Bauer, 2011).

Bryant (2013) further explained that, self-reported health reflects people's overall perception of their own health, including both physical and psychological dimensions. In view of the conjecture posed earlier about the possible increase in disability and chronic illnesses among the elderly in Latin America, one would expect that the trend towards solitary living promoted by other factors would be counter balanced by the expected deterioration of health status but the story is still the same.

Reducing severe disability from disease and health conditions is one key to holding down health and social costs (Chayovan and John, 2013). The health and economic burden of disability also can be reinforced or alleviated by environmental characteristics that can determine whether an older person can remain independent despite physical limitations or not especially in rural communities in Africa (Bryant, 2013).

The longer people can remain mobile and care for themselves, the lower are the costs for long-term care to families and society (Coale, 2013). In the meantime, generations of children and young adults who grew up in poverty and ill health in developing countries will be entering old age in coming decades, potentially increasing the health burden of older populations in those countries (Coale, 2013). Studies have shown that self-reported health is a good predictor of future health care use, hospitalization, disability and mortality (Cowgill, 2013).It is very

important to note that people's assessments of their health is subjective and can be affected by cultural factors and also there are variations in the question and answer categories used to measure self reported health across surveys/countries as such extreme caution is required in making cross-country comparisons (Kuria, 2012). Previous studies normally ask the question "How is your health in general?" and an ordinal scale of responses are provided for respondents to determine whether it is very good, good, fair, poor or very poor.

Socioeconomic status (SES) is a primary predictor of an individual's health (Chen, 2013). It has also been identified as a major factor that shapes the multiple trends of life course including family, work, education, and health (Chen, 2013). Older adults with higher socioeconomic status tend to live in smaller households and are more likely to be alone or with fewer children (Cowgill, 2013).

SES has also been found to greatly influence one's decision for a particular living arrangement. Meanwhile, Cowgill (2013) have come out to say that living alone disadvantages the elderly aged 60 years and above on a range of health measures. Consistently, social epidemiological findings have shown an inverse relationship between SES and health status of the elderly (Agyei-Mensah and Anase, 2014). Bhat and Mari (2012) have all reported that lower SES is associated with higher incidence and prevalence of morbidity and mortality. Elderly aged 60 years and above with higher levels of socioeconomic status (SES) report better self-rated health than their counterparts (Basu, 2013). This also suggests that an elderly aged 60 years and above with higher SES is likely to have and report better self-rated health as compared to an elderly with a lower socioeconomic status.

Behavior and exposure to health risks during an elderly person aged 60 years and above life also influence health status in older age (Bhat and Mari, 2012). Exposure to toxic substances at work or at home, arduous physical work, smoking, alcohol consumption, diet, and physical activity may have long-term health implications on the elderly aged 60 years and above. Many of the oldest-old lose their ability to live independently because of limited mobility, frailty, or other declines in physical or cognitive functioning (Bhat and Mari, 2012).

Many require some form of long term care, which can include home nursing, community care and assisted living, residential costs associated with providing this support may need to be borne by families and society which in African countries have not gain much recognition (Chen, 2013).

In less developed countries that do not have an established and affordable long-term care infrastructure, this cost may take the form of other family members withdrawing from employment or school to care for older relatives which in these days has become very rare to see (Bauer, 2011). And, as more developing country children of the elderly aged 60 years and above seek jobs in cities or other areas, their older relatives back home will have less access to informal family care (Bryant, 2013).

A large proportion of health care costs associated with advancing age are incurred in the year or so before death (Chen, 2013). As more people survive to increasingly older ages, the high cost of prolonging life is shifted to ever-older ages (Bryant, 2013). In many societies, the nature and extent of medical treatment at very old ages is a contentious issue (Bryant, 2013).

However, data from the United States suggest that health care spending at the end of life is not increasing any more rapidly than health care spending in general (Bryant, 2013). At the same time, governments and international organizations are stressing the need for cost-of-illness studies on age-related diseases, in part to anticipate the likely burden of increasingly prevalent and expensive particular (Caldwell, Reddy and Caldwell, 2012).

Also needed are studies of comparative performance or comparative effectiveness in low-income countries of various treatments and interventions for the aged (Bryant, 2013). Caldwell, Reddy and Caldwell, (2012) applied logistic regression analysis to estimate the correlates of good health of elderly population in Assam. The main findings were that health conditions of rural area were poorer than urban area, significant gender difference in mobility outside the state, joint pain, cough, eye and health compared to health at age 50, longevity of women to men, education and spousal intimacy were important factors for good health. The great opportunity for public concern is to keep older people healthy longer, delaying or avoiding disability and dependence (Caldwell, Reddy and Caldwell, 2012).

Biological ageing is accompanied by a process of loss of physical and often also mental abilities, resulting in health problems that affect everyday life (Caldwell, Reddy and Caldwell, 2012). Overall, 100,657 persons aged 60 or older declared that they were living with a disability, out of which around 60% were women and 40% men (Bryant, 2013). Similar to the general distribution of the elderly population across areas of residence, most disabled elderly people live in rural areas (Caldwell, Reddy and Caldwell, 2012).

The percentage of elderly people living with a disability is considerably higher than among the younger population (Chayovan and John, 2013). One in five persons aged 60 or older are disabled (20%) compared to fewer than one in 20 among younger persons (Bryant, 2013). The most common disability type affecting elderly persons is difficulties walking/climbing, regardless of sex or place of residence. Sight-related disabilities are the second most common disability, but affect only 3% of elderly people in Rwanda. The most common cause of disabilities among the elderly was diseases or illnesses (Chayovan, and John, 2013).

Given the prevalence of illnesses and disability among the elderly, health insurance coverage is an important prerequisite for accessing health care (Bryant, 20130. Eighty seven percent of elderly people were covered by medical insurance in Uganda, the same percentage as for the population 0–59 (Chayovan, and John, 2013). There was some variation depending on the place of residence. Elderly people in urban areas and in the Southern Province are less likely to be insured than elderly people living in other parts of the country (Chayovan, and John, 2013; Bryant, 2013).

Household headship is more common among the elderly than among the younger population. Elderly women who were often left without a husband were considerably more likely to head their own household than younger females (Bryant, 2013).

Elderly household heads were more likely to own the housing unit they live in compared to younger heads of household (Kuria, 2012). There is only a very

small difference between households headed by the elderly and households headed by persons below the age of 60 in terms of access to an improved water source (Bryant, 2013).

Households headed by elderly persons were, however, disadvantaged regarding their access to electricity, and kerosene lamps as well as firewood remain more common in households headed by an elderly person than among households headed by a younger person (Kuria, 2012). Older persons also suffer from dementia. The cause of most dementia is unknown, but the final stages of the diseases usually means a loss of memory, reasoning, speech, and other cognitive functions (Galor, 2010).

The risk of dementia increases sharply with age and, unless new strategies for prevention and management are developed, this syndrome is expected to place growing demands on health and long term care providers as the world's population ages (Galor, 2010). Dementia prevalence estimates vary considerably internationally, in part because diagnoses and reporting systems are not standardized.

The disease is not easy to diagnose, especially in its early stages (Galor, 2010). The memory problems, misunderstandings, and behavior common in the early and intermediate stages are often attributed to normal effects of aging, accepted as personality traits, or simply ignored. Many cases remain undiagnosed even in the intermediate, more serious stages (Dyson, 2010).

The projected costs of caring for the growing numbers of people with dementia are daunting (Bryant, 2013). The complexity of the disease and the wide variety

of living arrangement can be difficult for people and families dealing with dementia, and countries must cope with the mounting financial and social impact (Hermalin, and Albert, 2012).

The challenge is even greater in the less developed world, where an estimated two-thirds or more of dementia sufferers live but where few coping resources are available (Hermalin and Albert, 2012).Population aging is likely to influence patterns of health care spending in both developed and developing countries in the decades to come.

In developed countries, where acute care and institutional long-term care services are widely available, the use of medical care services by adults rises with age, and per capita expenditures on health care are relatively high among older age groups (Hermalin, Albert and Mary, 2013).

Accordingly, the rising proportion of older people is placing upward pressure on overall health care spending in the developed world, although other factors such as income growth and advances in the technological capabilities of medicine generally play a much larger role (Hermalin and Albert, 2012). A large proportion of health care costs associated with advancing age are incurred in the year or so before death.

As more people survive to increasingly older ages, the high cost of prolonging life is shifted to ever-older ages. In many societies, the nature and extent of medical treatment at very old ages is a contentious issue (Hermalin, Albert and Mary, 2013). At the same time, governments and international organizations are stressing the need for cost-of-illness studies on age-related diseases, in part to

anticipate the likely burden of increasingly prevalent and expensive and chronic conditions (Bryant, 2013).

People living in developing countries not only have lower life expectancies than those in developed countries, but also live a greater proportion of their lives in poor health. For all age groups, levels of moderate and severe impairment are higher in low and middle-income countries than in high-income countries, and they are higher in Africa than in other low- and middle-income countries (Cowgill, 2013).

The average global prevalence of moderate and severe impairment is about three times higher among persons aged 60 years or over than among those aged 15-59 years. Studies in both developed and developing countries show that women's advantage in life expectancy is accompanied by a greater burden of chronic disease and impairment in old age (Coale, 2013).

Women can expect to live longer than men and to spend a greater total number of years in good health; however, women spend a greater proportion of their older years in poor health. Hearing loss, vision problems and mental disorders are the most common causes of impairment overall (Cowgill, 2013). Persistent conditions such as dementias, chronic obstructive pulmonary disease and cerebro-vascular disease are especially common at higher ages (Coale, 2013).

Hearing loss is extremely prevalent and increases with age; WHO estimates that more than 27 per cent of men and 24 per cent of women aged 45 years or over have some degree of hearing loss (Bryant, 2013). Low-income populations tend to have high rates of impairment attributable to preventable causes such as injuries,

and those living in poorer countries often lack access to basic interventions such as eyeglasses, cataract surgery, hearing aids or assistive devices that can keep functional limitations from becoming disabling (Hermalin, Albert and Mary, 2013). Several of these long-term physical, mental, intellectual or sensory impairments, in interaction with various barriers, may constitute a disability and interfere with the full and effective participation of older persons in society. Life expectancy, especially at older ages, has improved significantly in most countries over the past several decades (Kannisto & Vaino, 2014).

The extent to which the increased survivorship of older persons has been accompanied by good health remains unclear. Presently, the health conditions of greatest concern for older persons include vision and hearing loss, cardiovascular diseases, dementia, and obesity (Kannisto & Vaino, 2014).

In most countries, members of the older population do not have sufficient access to health services, and training in geriatric medicine is lagging behind the demand for this type of care (Idler, Ellen and Yael, 2014). Worldwide, there is a growing need for long-term care services, which have traditionally been provided by family members but are increasingly being carried out by paid caregivers (Idler, Ellen and Yael, 2014).

Significant levels of elder abuse and neglect have been reported in both developed and developing countries, cutting across all economic and social strata (Idler, Ellen and Yael, 2014).

2.7 Brief concept of Demographic Transition Model

The demographic transition model has been a very important model worldwide since the end of the nineteenth century. The unprecedented increase in population growth during the Post-Malthusian regime has been ultimately reversed, bringing about significant reductions in fertility rates and population growth in various regions of the world (Idler, Ellen and Yael, 2014).

The demographic transition model refers to the transition from high birth and death rates to low birth and death rates as a nation develops from a pre-industrial to an industrialized economy (Idler, Ellen and Yael, 2014).

The theory was developed in 1919 by the American demographer Warren Thompson. Thompson explained that there are four main stages in demographic transition; in stage one which is the pre-industrial society, death rates and birth rates are high and roughly in balance.

All human populations are believed to have had this balance until the late 18th century when this balance ended in Western Europe (Idler, Ellen and Yael, 2014). In stage two, the death rate drops rapidly due to improvements in food supply and sanitation which increases life spans and reduces the incidence of diseases.

In stage three, birth rates fall due to access to contraception, increases in wages, urbanization, a reduction in subsistence agriculture, an increase in the status and education of women, a reduction in the value of children's work, an increase in parental investments in the education of children and other social changes.

Thompson emphasized that most developing countries including Ghana are in stage three but some exceptional countries notably, Pakistan, Afghanistan and sub-Saharan Africa are still in stage two (Hermalin and Albert, 2012). During stage four there are both low birth rates and low death rates (Idler, Ellen and Yael, 2014).

Birth rates may drop to well below replacement level as has happened in most developed countries such as Italy and Germany.

Notably, the demographic transition is accompanied with industrialization, modernization, individualism and urbanization which has or is eroding traditional and cultural practices that care for the aged in most Sub-Saharan African countries with Ghana as no exception. The theory also explains that due to decrease in mortality and improvement in nutrition and health care, life expectancy is expected to rise (Hermalin and Albert, 2012).

Ghana has over the years made significant progress towards urbanization and industrialization. This development according to this framework is associated with significant increase in the ageing population which has been evidenced in the past few years (Kannisto and Vaino, 2014). It is therefore very important to understand the challenges facing the Ghanaian elderly today in order to provide sustainable solutions to guard against the future.

With the notable exception of the African continent, the populations in most countries of the world are ageing rapidly (Knodel, John and Mary, 2013). Commonly used indicators of ageing are the fraction of the population attaining

age 60 or 65 and indices, such as the dependency ratio, comparing the size of the elderly to the younger population.

Convergence of indicators of ageing is not just the result of the smoothing effects embedded in the persistence of a demographic regime, but also an outcome of more rapid ageing in countries with late demographic transitions (Knodel, John, and Mary, 2013).

Fertility behavior in sub-Saharan Africa, like other parts of the world, is determined by biological and social factors. Several factors have contributed to sustain relatively high levels of fertility in most of sub-Saharan Africa. These factors include high levels of infant and child mortality, early and universal marriage, early child bearing as well as child bearing within much of the reproductive life span, low use of contraception and high social value placed on child bearing (Knodel, John, and Chanpen, 2014).

In the face of perceived high infant and child mortality, the fear of extinction encouraged high procreation with the hope that some of the births would survive to carry on the lineage. Populations attaining age 60 or 65 now and in the near future belong to cohorts whose wage-earning history is fragile. These are cohorts whose levels of education are far lower than they are among the elderly in developed countries.

With a few exceptions, in Latin American countries, not less than 30 per cent of those attaining age 60 are illiterate (Knodel, John and Chanpen, 2014). Massive literacy campaigns did not begin in earnest until the late 1950s so their effects cannot be felt until after 2025. Even then, the composition of the elderly by levels

of education will be lopsided towards incomplete primary and secondary levels, far from assuring access to sources of income derived from accumulated assets and savings.

Because of modernization and urbanization, the traditional solidarity network, particularly the extended family system, is disintegrating, leaving the elderly population with little or no means of support and care. As a result, Ghana's rapidly increasing numbers of older citizens are in a precarious situation that is likely to perpetuate poverty (Knodel, John and Chanpen, 2014).

2.8 Brief concept of John Caldwell's Wealth Flow Model

The study also employed John Caldwell's wealth flow model and try to use it to explain how urbanization, industrialization and modernization is eroding the traditional system where flow of resources and care which used to be upward from children to parents, is now shifting from parents to children and also encouraging individualism. John Caldwell's wealth flow theory proposes a direct link between family structure and fertility (Knodel, John and Chanpen, 2014).

According to the theory, there are only two major forms of family structure, differing principally in the direction of wealth flows among generations. In 'primitive' and 'traditional' societies, net wealth flows are primarily upward from younger to older generations, and individual interests were subjugated to corporate interests.

In developed nations, family structure is organized in terms of downward wealth flows where parents are expected to provide for children's economic well-being.

The theory proposes that fertility decisions in all societies are economically rational responses to familial wealth flows (Knodel, John and Chanpen, 2014).

In societies with net upward wealth flows, the economically rational decision is to have as many surviving children as possible (within the constraints imposed by biology), because each additional child adds positively to a parent's wealth, security in old age, and social and political well-being (Martin, 2012). In societies with net downward wealth flows, the economically rational decision is to have no children or the minimum number allowed by a psychological disposition that derives pleasure from children and parenting.

This change in family structure is due to the spread of new values that places a premium on individual satisfaction and achievement (Martin, 2012). Those values emanated from the educated, middle-class in the west and are now being exported to the developing world such as Ghana through mass formal education.

2.9 Demographic transition

Both the developed and developing countries are experiencing substantial changes in their age structures with potentially important implications for economic growth (Marmot, 2013). The timing of the changes varies, but essentially every country in the world has experienced or will experience a substantial rise in the share of their population concentrated in the working ages (Martin and Kevin, 2014).

On its face, this development has a direct, favorable effect on per capita income. Given fixed output per worker, labor force participation rates, and unemployment rates, a rise in the share of the working-age population will lead, as a matter of simple algebra, to an increase in output per capita the first demographic dividend (Oppong, 2014).

As population ageing begins to dominate demographic trends, the share of the population in the working ages will decline (Poterba, 2014). The first dividend will turn negative as population growth outstrips growth in the labor force. Eventually, the share of the population in the working ages may be no greater than before the dividend period began. The same demographic forces that produce an end to the first dividend, however, may lead to a second demographic dividend (Williams et al., 2014). A key economic challenge for ageing populations is to provide for old-age consumption for older persons who typically have substantially reduced labor income.

Some societies are trying to meet this challenge by relying on transfer systems either public programs or familial support systems. Other societies are responding by increasing their saving rates and accumulating greater physical wealth or capital (Zimmer, Zachary and Pattama, 2014). It is in this latter response that prospects for more rapid economic growth are enhanced.

Moreover, the second dividend is not transitory in nature. Population ageing may produce a “permanent” increase in capital and thus on per capita income (Zimmer, Zachary and Pattama, 2014).The increased population growth that surged during the demographic transition proved to be a powerful stimulant for

migration. Everywhere the key period for the transition of vital rates was also a key period for migration.

Much of this was overseas migration, but some of it was also interregional and rural to urban migration (Zimmer, Zachary and Pattama, 2014). The role of the population pressure created by higher population growth rates is an unmistakable push factor for this process. Had it not existed, massive migration would probably never have taken place, at least not on the scale that it did during the period 1850-1930 and then again during the second half of the twentieth century (Seike and Atsushi, 2013).

The social and economic implications of migration are enormous for societies both in origin and destination (Seike and Atsushi, 2013).

Migration is a more or less efficient form of redistribution of labor. During the early decades of the twentieth century it took place basically among countries that were already immersed in their own demographic transitions, with the difference being that the sending countries were crowded and the receiving ones had an abundance of space and opportunities that required additional population (Poterba, 2014).

In more recent times, the direction of flows has been from underdeveloped regions of the world with overcrowded labor markets towards the rich nations of the world who need the inputs for their own depleted labor markets (Poterba, 2014).

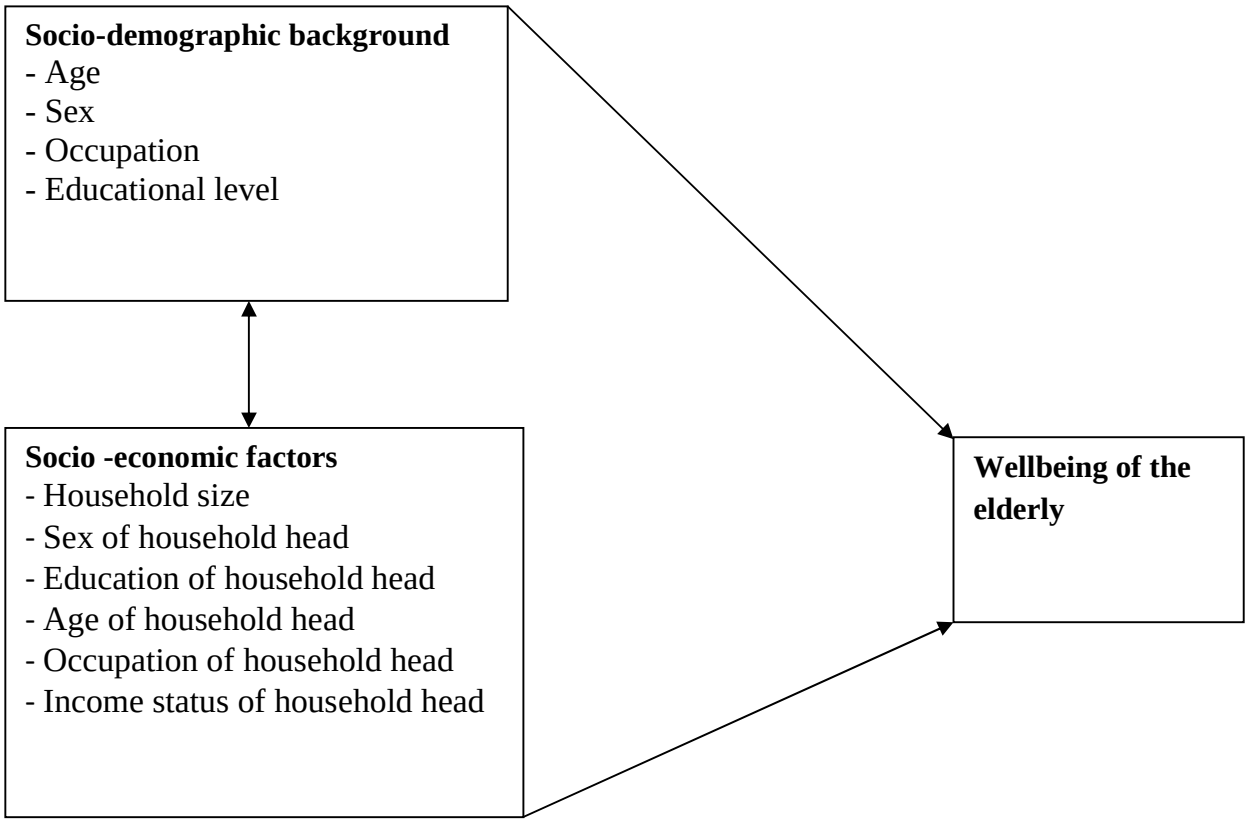
In both cases, population pressure in the sending countries has played a major role in conditioning the hypothetical supply of migrants and in the more recent flows

the demographically induced labor shortages in the host nations themselves linked indirectly to the demographic transition-have also played an important role in the process (Poterba, 2014).

Conceptual framework

The conceptual framework below shows the relationship between the demographic characteristics of respondents and the household characteristics and how these influence the well being of the elderly.

Figure 2.1: Conceptual framework



Source: Adopted from Bryant, 2013

The conceptual framework establishes the relationship between household characteristics, the socio-demographic background of elderly and the wellbeing of the elderly. The wellbeing of the Ghanaian elderly are presumed to be influenced by the household characteristics of the elderly which is further influenced by the accessibility, social and economic factors and support from family and children. From Figure 2.1, it is assumed that a smaller household size say nuclear family would provide the needed support to the elderly who is assumed to always be with them as compare to a larger family where children and family members may be occupied with their own social and personal activities at the expense of caring for the elderly.

From the Figure also, it is assumed that the occupational status of the household head could also influence the wellbeing of the elderly. A household head that is a salaried worker or engaged in any form of work will normally support the upkeep of the elderly as compare to a household head who is not working.

2.10 Summary of literature review

Aging is taking place alongside other broad social trends that will affect the lives of older people. Economies are globalizing, people are more likely to live in cities, and technology is evolving rapidly. Demographic and family changes mean there will be fewer older people with families to care for them. People today have fewer children, are less likely to be married, and are less likely to live with older generations. With declining support from families, society will need better

information and tools to ensure the well-being of the world's growing number of older citizens.

Defined as persons aged 60 years and over (Poterba, 2014), the world's elderly population is expected to rise from 606 million in 2000 to almost 2 billion by 2050, representing an increase of about 230 percent over the period. As a result of gains in life expectancy and declines in fertility, the older population in most countries is growing faster than the population as a whole (Mba, 2010).

What is more, if the envisaged reductions in mortality and fertility occur as currently projected, population ageing will inevitably become a universal phenomenon in Africa and all the other regions of the world in the coming decades (UN, 2011).

Partly because they constitute the smallest size in the age structure of Africa's youthful populations, and partly because they most usually live with their extended families throughout the older years, elderly persons have long been a neglected area of demographic and sociological enquiry.

With the anticipated rapid increases in the population of the elderly and the consequent greater potential need for food security and comprehensive social welfare services, it is necessary and urgent to gain a firm understanding of the demographic, social, and economic characteristics as well as the implications for poverty alleviation among the elderly persons in Ghana, with particular emphasis on rural areas where the phenomenon of population ageing is predominant.

CHAPTER THREE

Methodology

3.1 Introduction

This chapter presents the methodology that was employed to conduct the study. The subsections include profile of the study area, the research design, sampling design, sampling technique, data collection instrument, sources of data collection, data analysis technique, and ethical considerations among others.

3.2 Brief profile of study area

The research was conducted in the AED in the Greater Accra Region of Ghana. Ada East District is located in the eastern part of Greater Accra Region. The district covers a surface area of 909km² with its capital as Ada Foah. The district is located at the beach and estuary where the Volta Lake flows into the sea. One main important feature in the district is the fact that the district is located on the main road connecting Ghana with Lome.

Dangme also called Adandgme – a Guan language is the common language spoken in the district. The Ghana Statistical Service (2010) reported that about 82% of the population of the AED live in rural areas with more than 85% of its population also engaged in agriculture and often has no form of pension savings towards the future and with the youth constantly leaving the district to urban towns in search of non-existing jobs.

The district health directorate in their 2011 annual report has also indicated that financial and geographical health care accessibility is a major problem to most of the aged in AED. The report further explained that most of the aged do not have the financial means and the physical ability to travel to the NHIS registration centers to get registered and even when they do, the means to travel to see the doctor also becomes another challenge (AED, 2012).

The District Assembly Report (2012) mentioned that significant number of people migrate from the district to other urban towns such as Accra and Tema due to inadequate job opportunities in the District leading to the eroding and the eventual breakdown of familial ties, the long cherished extended family system and the expectation that the youth will take care of the elderly a norm which is also embedded in their culture.

The district like any other district in Ghana celebrates traditional and modern religious activities. In the District people do celebrate Christmas, Easter, Good Friday, Islam festivities (AED, 2012). The biggest event in the district is the annual Asafotufiam festival. The major religions in the district are Islam, Christianity and Traditional religions

3.3 Research design

For any investigation, the selection of an appropriate research design is crucial in enabling the researcher to arrive at valid findings, comparisons and conclusions. In scientific circles, the strength of an empirical investigation is primarily evaluated in the light of the research design adopted (Kumar, 1999: 16).

3.3.1 Cross-Sectional Survey

The research design of this study is a survey type, more specifically a cross-sectional survey that seeks to assess the impact of demographic transition on the socio-economic wellbeing of the elderly in the Ada East District.

This design is best suited to studies aimed at finding out the prevalence of a phenomenon, situation, problem, attitude or issue, by taking a cross-section of the population (Kumar, 1999:81). It is extremely simple in design. The researcher decides what he or she wants to find out, identify the study population, select a sample, and contact the respondents to find out the required information (Kumar, 1999).

3.4 Study population

The population of the study involved 250 elderly who were willing to participate in the study.

3.4.1 Inclusion criteria

- Only the elderly living at the study area were contacted
- Elderly living at the study area who were willing to participate in the study
- Only those who were not too weak were used as respondents

3.4.2 Exclusion criteria

- Any elderly person who was not willing to be used as study participants
- Elderly person who were seen as strangers in the study area

- Elderly persons who were less than 60 years old

3.5 Sample size determination

A sample size of 250 elderly persons in the study area was selected from the study population. The population of the elderly living at the study area is 7301 (GSS, 2010). Using the Sloven's formula with 7301 as the total population of the elderly, with 10% desired precision and 90% confidence level the required sample size was calculated to be 250. As calculated below

$$= \frac{N}{1 + N(e)^2}$$

Where;

n= Sample size

N= Total population

e= Precision level or confidence level desired

Therefore;

N= 7301

e= 0.1

$$n = \frac{N}{1+N(e)^2}$$

$n = 7301 \div (1+7301(0.1)^2)$

n=98.64

An attrition value of 151.36 was added to 98.64 to obtain the sample of 250.

3.6 Sampling technique

Simple random sampling technique was used to sample the respondents. Simple random sampling technique was used in order to avoid bias and to ensure that each elderly had an equal chance of being selected for the study. A pen was thrown on the ground and the tip of the pen was used to determine which direction to go for each household. This was to give each household and the elderly an equal chance to be selected. Where they were more than one respondent in the house, yes/no were written on pieces of papers and they were asked to pick. Those who picked yes were interviewed. All respondents were interviewed in the mornings only.

3.7 Data collection procedures

A self-designed questionnaire comprising of both close and open ended questions were used to collect the primary data from the respondents in the form of face-face interview interaction. Information on respondents' socio demographic characteristics, their socio-economic wellbeing and changing situation of the elderly in the context of demographic transition were collected.

The study used questionnaire because it can be administered to a number of respondents with uniform instructions. The data collection lasted for two weeks in the study area.

3.7.1 Dependent Variables

The study mainly seeks to find out how the wellbeing of the elderly in Ada East District has been affected by the dynamics of changing social, demographic and economic factors. The socio-economic wellbeing of the elderly is the dependent variable which is also sometimes known as the outcome variable of the study.

3.7.2 Independent Variables

Independent variables are factors that could possibly affect the level, behavior or nature of the dependent variable. Independent variables in this study include age, sex, occupation, level of education, income status of household head and household size. These variables have been explored in the study to assess their influence on the socio-economic wellbeing of the elderly in the study area.

3.8 Limitations of the study

This study was constrained by many factors among which were time, funds, and the uncooperative attitude of some respondents at the study area for fear of being mocked at by the researcher. Despite all these, the researcher made sure the openness of respondents was provided which made it possible for respondents to provide the needed information.

The researcher used the first ten minutes of every interview sitting to explain the meaning and purpose of the study to the respondents for them to feel relaxed and open up. Interviews were also conducted at the respondents own convenient time

and place but in the morning only. These helped to ensure the quality of their responses.

3.9 Data analysis and presentation

The data collected from the field, was collated and edited in order to address questions that have been answered partially or not answered by respondents. After editing, the open-ended questions were coded (that is, the assignment of numbers or codes to responses to make them computer readable).

After editing and coding the data, the data was then entered into the computer using Microsoft word and excel 2013 for the final analysis. The data was analyzed using basically descriptive and inferential statistics involving mainly frequency distributions and cross tabulations.

Logistic regression yielding odds ratio was used to establish the likelihood of an outcome between certain demographic characteristics of respondents and variables under the specific objectives of the study. All statistical tests were performed using two-sided tests at the 0.05 level of significance.

3.10 Ethical considerations

Ethical issues that were considered in this study included ethical clearance from the University for Development Studies. Informed consent was sought from each participant. Privacy of each study participant was maintained and respondents were informed that this information would not be made available to persons outside the study team.

The researcher obtained informed consent from all the respondents by means of a dialogue, during which each respondent was informed of the purpose of the study and also assured of the confidentiality of the data obtained and the anonymity of the respondents was assured as names were not written on the questionnaire.

CHAPTER FOUR

Results: Data presentation and analysis

4.1 Introduction

This chapter contains the results of the data from the study participants.

4.2 Socio-demographic background of respondents

The socio-demographic background of the respondents is shown in Table 4.1 under the following headings; age, sex, marital status, educational level, occupation, education, number of children, household structure, household head occupation and occupation of children.

Table 4.1: Socio-demographic characteristics of respondents

Socio-demographics	Frequency (250)	Percent (%)
Age		
60-65	122	48.8
66-70	35	14
70-75	71	28.4
75+	22	8.8
Sex		
Male	92	36.8
Female	158	63.2
Marital		
Married	161	64.4
Widower	38	15.2
Widow	34	13.6
Divorce	17	6.8
No. of Children		
3-4	142	56.8
5-6	35	14
6+	73	29.2
Household Structure		
Nuclear	167	66.8
Extended	83	33.2

Occupation		
Farmers	113	45.2
Petty Trader	84	33.6
Unemployed	53	21.2
Education		
No formal education	183	73.2
Basic Education or More	67	26.8
Occupation of children		
Farmers	205	82
Salaried workers	45	18

Source: Field data, 2015

From Table 4.1, 28.4% of the respondents reported their ages to be between the ages of 70-75 years while about 48.8% of the respondents were between (60-65) years. The study participants in terms of age were slightly more in the age bracket of 60-65 years. The study involved 63.2% respondents being females and the rest being males.

This result showed a deviation of the study participants towards study participants being females. From the results, 64.4% of the respondents were married whilst the rest were separated or divorced. The result also showed that 176 (70.4%) were of the Christian faith with 27 (10.8%) and 47(18.8%) being ATRs and Islamic faith respectively.

Table 4.1 further showed that 53 (21.2%) were unemployed while the rest were engaged in other form of occupational activities. A very high proportion 183 (73.2%) of the elderly in the study area had no formal education whilst the rest had at least basic education. From the results in Table 4.1, 14% of the respondents had 5-6 children, 29.2% respondents had over 6 children while 56.8% respondents had 3-4 children.

From the results in Table 4.1, 66.8% respondents' household composed of only their immediate family while 33.2% respondents' household structure was extended family system. From Table 4.1, most of the children of respondent (82%) were engaged in farming with 45(18%) being salaried workers.

Table 4.2: Binary Logistic regression analysis

Independent variables	Dependent variable	P-values	Odd ratio	95% Confidence interval
Sex	Wellbeing			
Male		0.041	7.3	0.3-1.81
Female				
Household structure	Wellbeing	0.031	9	1.4-9.4
Marital status	Wellbeing	0.005	7	13.1-10.1
Occupation of children	Wellbeing	1.381	6	2.1-10.2
Education	Wellbeing	0.002	5	1.2-6.8

Source: Field data, 2016

From Table 4.2, the findings from the binary logistic regression analysis revealed that men were 7.3 times more likely to get support from their friends, children and in-laws as compared to their female counterparts (OR =7.3; 95% CI: 0.3-1.81; P=0.041). This result from the study suggests that older men at the study area were more advantageous in terms of getting support from external sources of income as compared to their female counterparts.

It was also showed that elderly people in household structure of extended family system were 9 times more likely to visit the hospital always as compared to

elderly people who were leaving in a nuclear family system (OR =9; 95% CI: 1.4-9.4; P=0.031).

The assumption of this analysis is that in the extended family system elderly persons may be cared for by other family members who may not necessary be the direct children. With regards to the marital status of the elderly, analyses revealed that elderly who were married were 7 more likely to rate their perceived health status as good as compared to those who were not married (OR=7; 95% CI: 13.1-10.1; P=0.005). This could possibly be on the basis that married elderly persons may be cared for by their children wives who may normally leave with them or stay very close to them and may be concerned about their health.

Analyses also revealed that elderly men or women whose children were working were 6 times more likely to get their hospital bills paid for them than elderly men or women who children were not working (OR=6; 95% CI: 2.1-10.2; P=1.381). This assertion from the study might be right because a salaried worker might like to take care of an older person who probably may be the father or relative especially if they are staying together in the same house.

From the results in Table 4.2, it was showed that the elderly who were educated or had any form of formal educational training before were 5 times more likely to have one form of coping strategy to improve their wellbeing as compare to those who were not educated (OR=5; 95% CI: 1.2-6.8; P=0.002). This could suggest that may be educated older persons may be receiving pension benefits and can use that to care for themselves as compared to their counterparts who may have never worked before.

4.3 Socio-economic wellbeing of the elderly

Eighty percent respondents mentioned that their children rarely visited them while 20% respondents said their children were visiting them often. With this huge number of respondents claiming that their children do not visit them one is left in a doubt as to how they would be able to cater for themselves in times for need. From the analyses, majority of the respondents (80%) stated that their children were away from them, 5% respondents said their children were staying in the same area with them while 15% respondents said their children were staying with them in the same house.

From the analyses, 90% respondents perceived their economic status to be extremely bad while 10% respondents said their economic wellbeing was a little okay for them even though not all their needs could be met. With this huge number of respondents stating that their economic situation is bad, one could probable judge that all was not well with the elderly at the study area. Furthermore, 89% respondents at the time of the study perceived their financial situation as bad or very bad while 11% respondents stated that their financial situation was a little okay for them.

The majority said that diseases and pests or climate change affecting their crops and animals had caused their financial situation to worsen because that has always been their primary source of income. From the results obtained especially among the elderly who could not work again, their main source of livelihood was from their relatives. Respondents further revealed that their economic wellbeing were being influenced by the fact that they were feeling too weak to work this time and

their health status were fast deteriorating compelling them to invest their less resources on their health.

From the analyses, 25% of the elderly at the study area perceived old aged as normal, 20% respondents who were very frail and very weak perceived old age as a state of rejection from family members and relatives, 40% respondents perceived old age as an age of being alone without family members around you to comfort you and converse with you while 15% respondents however, perceived old age as being a state of joy and happiness having being on earth up to this time. Findings further revealed that, 60% respondents got assistance from friends and family members while 40% respondents said they were not getting any form of assistance from anywhere.

According to the former, the assistance given them considering their age and needs were not adequate while the latter stated that they had to do all the necessary things to keep body and soul together even in their weak and helpless state.

Respondents were asked to provide the types of assistance they were getting from friends and family members among those who were assisted in any form. From the analyses, 10% respondents mentioned that family members were always around them to run errands for them, 20% respondents said members and friends were providing them food sometimes and 30% respondents however, revealed that they were supported financially. All the respondents rated the assistance as inadequate.

Finding revealed that, 45% respondents who received assistance from either family members or relatives stated that the assistance was rarely provided to them. They mentioned that sometimes they had to go to their family members personally or send a relative to remind them that their items were finished before any assistance could be given to them while 15% respondents said their assistance was just always and they needed not to remind their children or relatives about it before they would be provided.

Table 4.3: Sources of support

Sources of support	Frequency (250)	Percent (%)
Children	100	40
Friends	53	21.2
In-law	36	14.4
NGOs	28	11.2
Relatives	22	8.8
Others	11	4.4

Source: Field data, 2015

All the respondents in the study area had one form of assistance or the other either meager or adequate depending on the assessment by the individual. From Table 4.3, 40% of the respondents mentioned that their main sources of support were from their children whilst the rest are showed in Table 4.3.

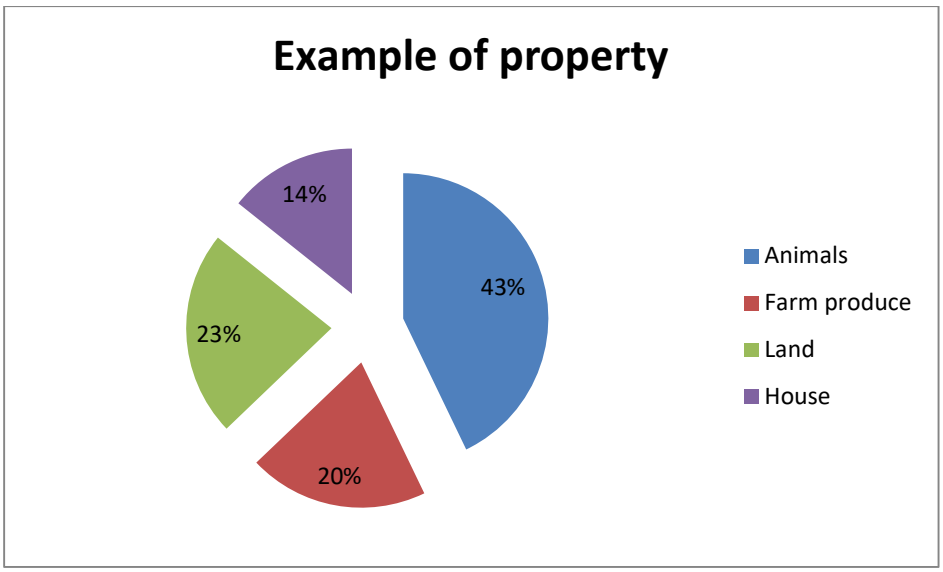
From the analysis in Table 4.3, it is clear that all the respondents had at least one source of support that they could rely on for assistance all the time. Respondents were quick to add that even though they were supported by family members and relatives or directly from their children, the support given them were not

encouraging and relatives were likely to be burnt out in the long run since this time they were leaving too long on earth.

Further findings revealed that, 35% respondents stated that they were having property to sell for money to meet their needs when the need arise while 65% respondents said they had no property to sell even if they had no money to buy the food or go to the health centre.

Among the former, they however, stated that their property was just too small and were even reducing because of constant sales all the times. They stated that sometimes family members and relatives deliberately refuse to assist them because they think that they had property to sell and they had no option but to rely on such property to sell since they have to survive.

Figure 4.1: Example of property



Source: Field data, 2015

From Figure 4.1, 43% respondents had farm animals to sell, whilst the rest also identified other properties they could sell for income. Respondents suggested ways by which the elderly way of living could be improved in the study area and Ghana as a whole.

They mentioned that provision of support from relatives and family members should be always and not occasionally since the aged could not work again to feed themselves, frequent visits by children and relatives to let people know that they have children or family members, support from government and free medical checkups and drugs for the elderly.

4.4 Changing situation of the elderly in the context of demographic transition

From the analysis, almost all the respondents representing 95% agreed with the statement that demographic transition was affecting the wellbeing of the elderly while 5% disagreed with the statement. From analyses, 42% respondents said that the aged were now living more than their expected years on planet earth, 21% respondents said people were now concentrating on only their immediate family while 5% respondents said this time no one cares for the aged as compared to the past years where extended family system used to support people during old age. Eleven percent respondents also mentioned that children were no longer staying with their parents compelling them to do things for themselves.

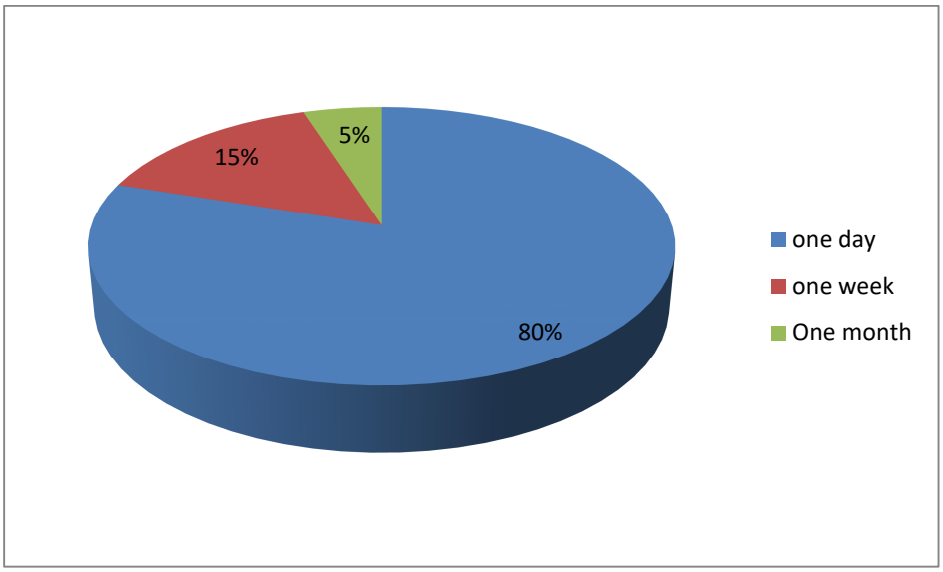
From the analyses, majority of the respondents (95%) were not satisfied with the support they were getting from their main source while 5% respondents said they were okay with the support they were receiving from their main source. Nearly,

78% respondents stated that they had their relatives, family members and children who do come as visitors from the cities and other communities within the district to just say hello to them most especially during festive occasions such as Easter and Christmas.

When probed further to know whether these visitors do carry along any form of material or financial support, 58% of the respondent who have visitors said yes while 42% of the respondents who have visitors said sometimes or occasionally they do carry some form of material or financial support for them.

It was also revealed that 70% respondents said most of the visitors were always from the family or relatives who live long distance away from the community while 30% respondents said they were just people from the community who cares about them and mostly childhood friends.

Figure 4.2: Duration of visitors



Source: Field data, 2015

From Figure 4.2, 80% respondents revealed that relatives, friends and family members who visit them do spend only one day with them in the community, 5% respondents said the visitors normally spend one month mostly during festive occasions and 15% respondents mentioned that they do spend one week according to the conditions of them especially if they are family members.

Further findings shown that, 87% respondents said they were not satisfied with the durations of their visitors while 13% respondents said they were satisfied with the duration of their visitors. It was revealed by the respondents that people were no longer coming to sit and converse with them even in the night. Some direct quotes from few respondents are illustrated below.

- "You can see this is where I spend the whole day except if I feel like bathing and I occasionally do it at the yard, I am always inside this room alone no one to communicate with 'hmm' old age is not good. I am just alone in this room. Loneliness will kill me soon" (Kofi, 2015)
- "I have four children, all of them are married and have left the house, I find it very difficult sometimes to get food to eat, but I have to manage because if I go to beg they will not be happy but the care they give me is not enough" (Maame Abena, 2015)
- "In this house, nobody takes what I say serious because some of them think that I am no longer of a sound mind to reason. Family decisions are taken without my concern and approval. Sometimes I just do not like sitting without anybody to talk to in this house" (Old soldier,2015)

- "Is it day or night? I do not know the last time I went outside this room. I am always here no body to talk to, old age is not good" (Abena, 2015)
- "As of now, I am not well because I am sick but I do not have the money to go to hospital for treatment so I am just here only God alone knows how am feeling" (Kwame, 2015)
- "I am very old, as for me I have seen so many things. I have been in this community before a good number of people. What the young ones are doing now is not very good. They do not even like to come back to the community to say hello to their parents. Imagine me having six children and have to go sometimes to do things for myself because no child is with me.

  As for leaving alone I think I used to see my father leaving alone in his very old age so I would just be there until one day I finally go to meet them peacefully" (Kofi, 2015)
- "Old age is good because your children will provide all the needed things for you without any form of requesting. As for me my children give me what I request for except that it is very meager" (Abena, 2015)

Table 4.4: ANOVA

Description			
Variable	**Mean**	**Std. Deviation**	**P Value**
Age			
60-70			
71+	1.41	0.492	0.121
Parity			
1-3			
4+	1.33	0.412	0.004

Source: Field Survey, 2016

An analysis of variance (ANOVA) was done to establish any significant association involving demographic characteristics of respondents and changing situation of the elderly in the context of demographic transition. Results from the study in Table 4.4, revealed that there was no statistical association between respondents age and where their sources of support came from ($P < 0.121$).

It was however established that there was a relationship between marital status and frequency of visitors at respondents' home at the study area ($P > 0.000$). Additionally, analyses also showed that, there was a relationship between respondents' parity and duration of visitors at respondents home ($P=0.004$).

4.5 Coping mechanisms used by the elderly to improve their economic wellbeing

Respondents were asked to state how they were feeding in these times and many times that they were not cared for by family members, friends or others adequately. Analyses revealed that, half (50%) of the respondents mentioned that any time they were not having money they call their children for support, 23% respondents said they would usually managed at home until someone comes to their need one day, 24% respondents said they would usually go to their friends while a relative number (3%) said they beg from neighbors in the same locality for support.

Others also mentioned that they were engaging in backyard farming (60%), 7% respondents mentioned petty trading, 10% respondents mentioned selling of personal property, 20% respondents mentioned depending on children while 3% respondents said they were depending on begging family members, relatives and friends for survival.

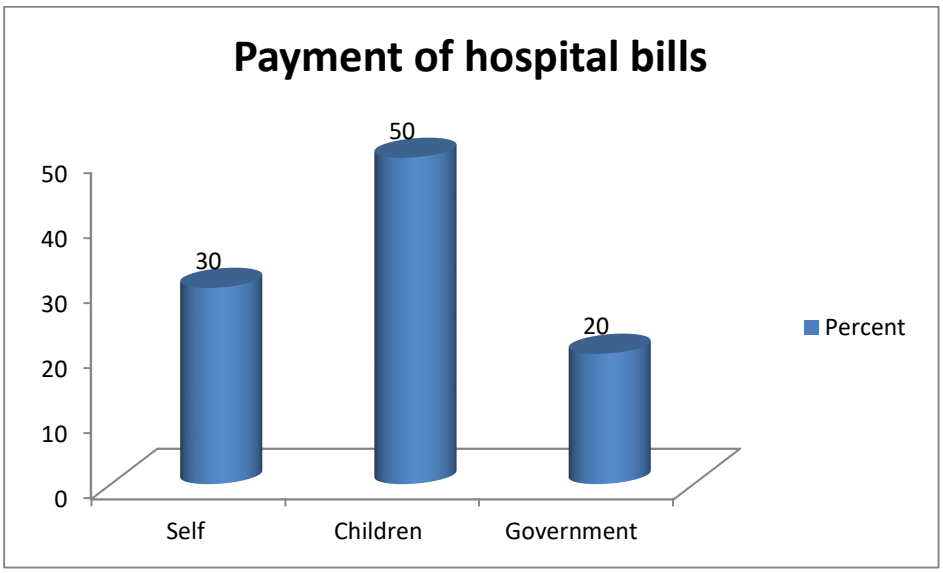
Further interaction with respondents revealed that about 33% also adopted skipping meals such as breakfast, reducing the food portion size or reducing the quality of the food as a way of managing their resources under their control.

From the analyses, 60% respondents mentioned that the coping strategies they adopted were good for them to survive while 40% respondents said it was bad because it did not conform to their status in the community they were staying.

4.6 Socio-economic wellbeing and perceived health condition of the elderly

Analyses also showed that, 70% of the respondents said they had no money to visit the health centre always and so they rarely visited the health centre while 30% respondents mentioned that they always visited the health centre. From the interactions with respondents at the study area, some of the respondents also mentioned that herbal medicines were also used to treat certain illnesses in the community and most elderly preferred such treatment option. From the analyze it was revealed that, 96% respondents rated their health status as weak while 4% respondents mentioned that their health status was good.

Figure 4.3: Payment of hospital bills



Source: Field data, 2015

From Figure 4.3, 50% of the respondents mentioned that their children pays their medical bills for them, 30% respondents stated that they were responsible for their own health care in the hospital while 20% respondents said their bills were being

paid by the Government (LEAP or NHIS). Despite poor health or difficulties in maintaining good health, older people do get satisfaction from health care providers.

Respondents (57%) also mentioned that when they are healthy, they also assist the family by engaging in other family businesses such as funerals and occasionally take care of their grandchildren while their mothers were engaged in household activities. Others (41%) stated that they do occasionally take part in the farming activities while 2% also mentioned that by the fact that they are alive, they protect the traditions of their families.

It was observed that 47% respondents' health status in the community were assessed by people in the family by using certain variables such as how well he/she eats, how well she/he was engaged in physical activity in the house especially his/her ability to perform activities of daily living such as bathing washing, cooking and eating and how frequent he/she was able to come out from the room after every morning.

It was revealed by the study that, many (65%) respondents may lack the physiological capability to deal with their own health problems and be able to afford transport, medical fees and other costs associated with using the health services at the health centers therefore, compounding their already ailing health status.

Furthermore, 75% of the respondents mentioned that living alone and feeling lonely has adverse effect on their quality of life. Quarter (25%) of the respondents mentioned that the younger generation must also be taken into account when

considering how to improve quality of life for vulnerable older people and enhance their functional ability to live an independent life.

Also from the results it was observed that 80% respondents mentioned that they were not emotionally fit while 20% respondents said that they were emotionally fit. Three quarters (75%) of respondents mentioned that living alone and feeling lonely has adverse effect on their quality of life.

Emotional fitness of respondents was assessed. From the analyses, 92% of the respondents mentioned that they were not socially fit while 8% respondents said that they were socially fit. When probed to know why, respondents mentioned that people no longer visit them in their houses and rooms to chat with them. From the analyses, 77.2% respondents said loneliness was a major problem in old age while 22.8% respondents said they were always unhappy which in the long run affect their emotional feelings.

Also from the findings, 82% respondents admitted that they have ever been abused before at home whiles 18% respondents said contrary. What constitute abuse included; insults, disrespectfulness, neglect and marginalizing one because of his/her disability.

Similarly, it was also revealed by 63% of the elderly not only have they ever been abused at home but also at the community level with the hospital and market as the leading places where abuse usually takes place. The 95% went further to explain that they were not also given the needed attention in hospitals and clinics.

Table 4.5: Types of abuse

Category of Abuse	Frequency	Percent
Neglect	100	40
Psychological	45	18
Social	25	10
Emotional	55	22
Sexual	10	4
Society description	15	6
Total	**250**	**100**

Source: Field data, 2015

From 4.5, nearly half (40%) of the respondents mentioned neglect by family members and community members as a form of abuse they have been experiencing, whilst the rest are shown on the table. From the analyses also48.4% of respondents identified physical disability as a risk associated with abuse of the elderly while 4% respondents mentioned madness (further probing showed that the dementia was what was being referred to as madness) because the aged are always alone.

Also, 24% respondents mentioned depression, 8% respondents mentioned emotional unstable while 9.6% respondents mentioned isolation as factors that predisposes one to forms of abuse in the community.

CHAPTER FIVE

Discussion of findings

5.1 Introduction

In this chapter, the results of the study have been discussed by relating the major findings to available literature presented in chapter two of this thesis.

5.2 Socio-economic wellbeing of the elderly

In Ghana and for that matter, the Ada East district, most of the youth move to urban centers to search for job because they are non-existent in the rural communities. These and many other factors lead to the neglect of the elderly, leaving them in a state of loneliness with poor economic conditions and deteriorating health.

Findings from the study shown, that respondents had properties that they could sell to support their socio-economic status. It was however, showed that, an over whelming majority of the respondents (83%) perceived their socio economic wellbeing to be bad. Some of the reasons attributed to this included inadequate financial support from family members couple with the fact that their children were also staying very far from their reach.

This finding from the study agrees with the research done by Dyson (2010) where elderly persons in Zambia were disadvantaged in terms of social and economic support because their children have abandon them and have moved to the cities for job.

Results from the study also showed that, 89% respondents perceived their financial situation to be very bad. Respondents' perceptions were explored to assess their knowledge on what an elderly or old age means to them in the community. From the responses it was discovered that respondents perceived old age as either good or bad depending on how well they were being treated at home, at the community level and socio-economic wellbeing.

Findings from this study have it that nearly half (40%) of the respondents perceived old age as a state in which one becomes alone and no one cares about them again. This finding from the study is similar to the study done by Ayernor, (2012). This was evident at the study area as most of them who were contacted in their private solitary rooms mostly without any visible family member.

Despite these frustrations expressed by these respondents at the study area on how they perceived old age, 15% respondents however, perceived old age to be a period of joy and happiness where children and family members now in turn look after the elderly.

This finding from the study seems to disagree with the findings made by Ayernor, (2012) and Asante (2012) where the elderly in Africa see old age as a stage of neglect and abandonment by children. Results from the study revealed that, majority of the respondents (89%) said their living condition was bad. Respondents used their health status, years and how well friends and family members were visiting them to assess their living condition. This finding from the study supports the study conducted by Ogunbodede (2013) where the elderly in

Nigeria used their eating pattern and their physical activeness to determine their health status and standard of living.

5.3 Changing situation of the elderly in the context of demographic transition

Results from the research revealed that majority (95%) of the respondents reported that demographic transition was affecting the welfare of the elderly in Ghana. Respondents could not hide their frustration when they further explained that mass migration of the youth to the urban centers, people now concentrating on only their immediate family, neglect of the extended family system which used to be a source of hope and support for the elderly is now eroding.

From the study, 70% respondents stated that their main source of support was from their children. This finding from the study is similar to the study done by Asante (2012) where similar results were identified. This they said sometimes, if their children are not able to support them in times of needs, then, it means that, they will not get any money to do their normal activities.

It was also revealed that, majority of the respondents (95%) were not happy with the amount of support they were receiving from their children in the form of finance. This finding from the study supports the finding by Chen (2013) where the elderly in Kenya were leaving in poverty which was not noticed by close relatives.

Many older persons in developing countries also remain active in the labor force, and the household often includes younger children and grandchildren who depend partly or entirely on the older generation for their livelihood. This is especially

likely to be the case for people in their sixties, who may have children that are still in school or that have not yet established themselves in the labor force.

5.4 Coping mechanisms used by the elderly

Respondents identified various coping strategies employed to survive including having to beg for money from friends and family members in extreme cases where they have no option in other to get something to eat. This finding from the study seems to suggest what Barrett (2013) revealed when it was mentioned that coping is seen to be related to human personality trait and a time changing process in accordance with the situation the individual finds himself or herself.

It was observed that most of the respondents did not feel comfortable employing these coping mechanisms by them to survive while other felt likewise. This is evident from the results obtained, as more than half (60%) of the respondents mentioned that the coping strategies they were adopting were not good to them while 40% respondents mentioned that the coping strategies were good for them because according to them that was the only option available.

This finding from the study is similar to the study done by Asante (2012) where elderly persons in Ghana identified similar coping mechanisms. The finding from the study also supports the study done by Kuria (2012) where the elderly in Nigeria resorted to petty trading, farming, selling of personal property, and alms begging as a way of coping with the hard economic conditions. Although attitudes of people in the world towards the elderly are based in part on the social and economic position of older persons in society, ageing stereotypes abound in all

societies and play a key role in dictating how older persons are perceived and treated even when societal agreement on the necessity of material support for the ageing population is strong.

The results further revealed that one third of the respondents felt that older persons were all alike and considered themselves bored, miserable and lonely because all the time there is no one to talk to them. More than one in four believed that the majority of older people were not happy in their lives.

This is not to say that families invariably can or do provide adequate support. This is true for this study as more than half (70%) of the respondents identified their children as the only source of hope and support for them. This finding from the study is similar to the study done by Dyson (2010) where children were identified as the major sources of income for the elderly persons in Africa. The finding is also similar with the study done by and Asante (2012) where elderly persons in Ghana identified their children as the major sources of income.

This study observed that among older adult men reported better health status than women, and that health status, quality of life and physical ability deteriorated markedly with increasing age. This is in line with empirical knowledge of the physiological processes of ageing and linked to disease and ill health.

5.5 Socio-economic wellbeing and perceived health condition of the elderly

Health problems including chronic conditions and diseases, impairments, and disabilities increase the risk of injury and death for the elderly in rural

communities in the world. Living alone constitutes an additional risk factor for older persons in emergency situations.

Older persons who have disabilities and live by themselves are particularly vulnerable, since they are likely to need assistance but may be overlooked. Findings from the study revealed that majority of the respondents representing 70% were of the opinion that they were not very well. Further findings from the study revealed that 96% respondents rated their health status as weak. This finding from the study supports the study made by Cowgill, (2013) where self-reported health assessment by elderly persons in a survey considered as a good predictor of future health care use, hospitalization, disability and mortality.

However, the study appeared to be at variance with the study done by Ogunbodede (2013) where few elders persons in Nigeria cited that they were not very well in a cross sectional survey. It was discovered that respondents identified isolation, neglect and impolite treatment as forms of abuse they have ever experienced. Some risk factors predisposing the elderly for abuse includes social isolation, the societal depiction of older persons, and the erosion of bonds between generations, disability and poverty.

People living in developing countries not only have lower life expectancies than those in developed countries, but also live a greater proportion of their lives in poor health. The average global prevalence of moderate and severe impairment is about three times higher among persons aged 60 years or over than among those aged 15-59 years.

Several of these long-term physical, mental, intellectual or sensory impairments, in interaction with various barriers, may constitute a disability and interfere with the full and effective participation of older persons in society. Many of the conditions that represent the leading causes of disability among older persons are the same in high-income and low /middle-income countries, with hearing loss, vision problems, arthritis, ischemic heart disease, and obstructive lung disease being among the most common in both groups of countries.

Services that are inaccessible to the older population, dismissive or impolite treatment by health service staff, and the lack of appropriate medicines for dealing with chronic health conditions are among the problems mentioned repeatedly in several studies of services for older people in Africa, Asia, and Latin America and the Caribbean.

Results from the survey indicated that majority of the respondents (95%) have ever been abuse before in the hospital. This finding from the study is similar to the study done by Ogunbodede (2013) where elderly persons in Nigeria cited that they had ever been abused before in a cross sectional survey.

CHAPTER SIX

Summary, Conclusion and Recommendations

6.1 Introduction

This chapter presents a summary of the key findings, conclusion and recommendations.

6.2 Summary of findings

From the results, 66.4% of the households' heads were unemployed with25.6% as petty traders and 8% as farmers. Majority of respondents' children (82%) were engaged in farming with 18% being salaried workers. Results from the study indicated that 80% respondents' children were away. Furthermore, 89% respondents perceived their financial situation as bad and 20% respondents perceived old age as a state of rejection from family members and relatives.

Sixty percent respondents got assistance from friends and family members while 40% respondents said they were not getting any form of assistance from anywhere. Results further revealed that 95% respondents reported that demographic transition was affecting the wellbeing of the elderly. It was also found that abuse was common among the elderly. The study noted that 80% of respondents admitted that they have ever been abused before whiles 20% respondents said contrary.

6.3 Conclusion

The study explored the various determinants of the socioeconomic wellbeing of the elderly in the Ada East District. The social and economic wellbeing of the elderly in this district is in a peril state. About 89% of the elderly who took part in the study gave reasons such as disability, neglect, loneliness, poverty, immobility, disrespectfulness of younger ones, societies perception about the aged and abuse as the major reasons affecting the social wellbeing of the elderly.

Some coping strategies adopted by the elderly such as skipping meals, reducing the size, quantity and quality of meals can have serious implications on their health. Furthermore, alms begging as one of the coping strategies adopted by some elderly can predispose them to abuse and being marginalized by some members of the community.

Loneliness and neglect was the most common challenge of the elderly as expressed in the findings of this study and some of the elderly attributed it to people being more self-centered or more interested in their nuclear family and unemployment in the district leading to family members traveling to far places in search of jobs. The elderly in the Ada East District perceive disability, neglect, loneliness, poverty, and immobility, disrespectfulness of younger ones, society's misconceptions about the aged and abuse as the major challenges affecting the social and economic wellbeing of the elderly. The study found that elderly who were married and living together with their spouse were 7 times more likely to perceive their health to be good as compared to elderly who were living alone. Loneliness could therefore be said to be inversely related to good self-reported

health at the study area. The study also found out that the elderly who had any form of formal educational training before were 5 times more likely to have one form of coping strategy to improve their wellbeing as compared to those who were not educated. Formal education could therefore be seen as a tool to help reduce the impact and shocks of demographic transition on the elderly.

The research revealed that one of the major challenges of the aged at the study area was the issue of always being alone without the company of beloved ones.

6.4 Recommendations

- The Ada East District Assembly should strengthen and expand measures to assist the aged through the livelihood empowerment against poverty program.
- Government and Nongovernmental organizations should look into the viability of providing aged care homes or centers in the district to provide aged friendly health services, protection, and more especially to keep them company in order to reduce the loneliness
- Nongovernmental organizations should also assist or support the aged in Ada East District by empowering them through the provision of animals for rearing or engaging them in an animal farming program so that the elderly can rely on them in times of difficulties.
- The Ada East District Assembly should embark on an awareness creation or advocacy program on the need for the aged to be respected, protected and properly cared for in their respective families and

communities in the district.

- Further studies should look into old age related forms of abuse in the District.

REFERENCES

Agyei-Mensah, S. A. and Anase, H. (2014). Patterns of fertility change in Ghana. A time and space perspective.*GeografiskaAnnaler*.80B: 203-213.

Asante, R.K. (2012). 'Growing old in Ghana: Health and Economic Implications'; Symposium organized by Ghana College of physicians and surgeons. 29/11/2012.

Asis, E. Maruja, M. Lita, D. John, K. andKalyani, M. (2013) 'Living Arrangements in Four Asian Countries: A Comparative Perspective', *Journal of Cross-Cultural Gerontology*. 10: 145-162.

Ayernor, P. K. (2012). "Diseases of Ageing in Ghana". Ghana Medical Journal. Volume 46, Number 2 Supplement. Regional Institute for Population Studies, University of Ghana P.O. Box LG96, Legon, Accra, Ghana.pp23-27.

Barrett, A. (2013). ''Socioeconomic Status and Age Identity: The Role of Dimensions of Health in the Subjective Construction of Age.''Journal of Gerontology. 58:101–109.

Basu, A.M. (2012). "Why does education lead to lower fertility? A critical review of some of the possibilities", *World Development*. 30: 1779-1790.

Basu, A.M. (2013). "Fertility decline and increasing gender imbalance in India, including a possible South Indian turn around"; *Development and Change*.Vo. (30) 2: 231-63.

Bauer, J. (2011). "Demographic change, development, and the economic status of women in East Asia", in A. Mason.*Population Change and Economic Development in East Asia. Challenges Met, Opportunities Seized*, Stanford University Press. pp359-384.

Bhat, P. and Mari, N. (2012).“Returning a favor: Reciprocity between female education and fertility in India”, *World Development*. 30: 1791-1803.

Bledsoe, C.H. (2013). Contingent Lives. Fertility, Time, and Aging in West Africa, Chicago and London: The University of Chicago Press.p23

Bloom, D. and Canning, D. (2014). “Cumulative causality, economic growth and the demographic transition”, in N. Birdsall, A.C. Kelley, and S. Sinding (eds.). *Population Matters: Demographic Change, Economic Growth and Poverty in the Developing World*, Oxford: Oxford University Press.pp28-33.

Boersch-Supan, A. and Ludwig, D. (2010). “Old Europe is Aging: Reforms and Reform Backlashes,” In: Shoven, J. (Ed.), *Demography and the Economy*, Chicago: University of Chicago Press. 169-204.

Bryant, J. (2013). Projecting numbers of living children of old people, with examples from Korea and Thailand. In S. Tuljapurkar, I. Pool and V. Prachuabmoh (eds), *Riding the Age Waves: Population, Resources and Development.* Dodrecht: Kluwer/Springer. p38

Caldwell, J.Reddy, P. and Caldwell, P. (2012).“The causes of demographic change in rural south India: A micro approach”, *Population and Development Review*. 8: 689-727.

Caselli, W. Graziella, H. and Jacques, V. (2014).Mortality and population ageing.*European Journal of Population*, (Amsterdam,Netherlands). vol. 6, No. 1, pp. 1-25.

Chayovan, N. and John, K. (2013).A Report on the Survey of the Welfare of the Elderly in Thailand.Bangkok: Institute of Population Studies, Chulalongkorn University. p40

Chayovan, N. John, W. N. and Siriwan, S. (2013). Thailand's Elderly Population: A Demographic & Social Profile Based on Official Statistical Sources. Comparative Study of the Elderly in Asia, Research Report No. 90-2, Population Studies Center, University of Michigan. p44

Chen, M. (2013).Perpetual Mourning: Widowhood in Rural India, Oxford and New Delhi: Oxford University Press.p40

Coale, A. J. (2013). "How a Population Ages or Grows Younger". In Ronald Freedman (ed.), Population: The Vital Revolution, New York: Anchor Books. pp. 47-58.

Cowgill, D. O. (2013).Aging Around the World. Belmont, Ca.: Wadsworth Help Age International. 2013. *The Ageing & Development Report*. London: EarthscanHelpAge International (HAI). Coping with Love: Older people and HIV/AIDS in Thailand. Chiang Mai Thailand, HelpAge International.pp25-29

Cowgill, D.O. (2012). The role and status of the aged in Thailand. In D. O. Cowgill& L. D. Holmes (eds.), *Aging and Modernization,* New York: Appleton-Century-Crofts. pp. 91-101.

Creswell, J. W. (2005). Educational research: Planning, conducting, and evaluating quantitative and qualitative research (2nd ed.). Upper Saddle River, NJ: Prentice-Hall.

Dyson, T. (2010). Population and Development: The Demographic Transition. London: Zed Books. p12

The District Assembly Report (AEDA, 2012). The District Assembly Report

Galor, O. (2010). 'The Demographic Transition: Causes and Consequences'. Department of Economics, Brown University, Providence, RI. p22

Ghana Statistical Service (2011). 2010 Population and Housing Census Provisional Results: Summary of Findings. Ghana Statistical Service: February. pp34-40.

Ghana Statistical Service (GSS), (2000a).Family and Health Findings from the 1998 Ghana Demographic and Health Survey. Accra: GSS.p10

Ghana Statistical Service, (2000b). Ghana Living Standards Survey: Report of the Fourth Round (GLSS4).p23

Ghana statistical service. (2002). Ghana 2000 Population and Housing Census: Summary of report of final results. March, 2002: Accra: Ghana statistical service. p23.

Gruber, J. and Wise, H. (2014).Social Security and Retirement Around the World.Chicago, London: University of Chicago Press. pp33-37.

Hermalin, Q. and Albert, I. (2012)."Drawing policy lessons for Asia from research on ageing."Asia-Pacific Population Journal. 12(4): 89-102.

Hermalin, Z. Albert, I. and Mary, B. (2013). Future characteristics of the elderly in developing countries & their implications for policy.Ann Arbor, MI, Population Studies Center. Research Report 06-62, Comparative Study of Elderly in Asia. pp45-48.

Idler, A. Ellen, L. and Yael, B. (2014)."Self-rated health and mortality: A review of twenty-seven community studies," *Journal of Health and Social Behavior*.36: pp21-37.

Kannisto, E. and Vaino, N. (2014).Development of Oldest-Old Mortality, 1950-1990: Evidence from 28 Developed Countries.Odense,Denmark: Odense University Press.pp34-42.

Knodel, S. John, F. and Mary, H. (2013). Gender & Aging in the Developing World: Where Are the Men? *Population & Development Review*.29(4):677-98

Knodel, W. John, O. and Chanpen,U. (2014). AIDS & Older Persons: The View from Thailand. In P. Lloyd-Sherlock (ed), *Living longer. Ageing, development & social protection*. London: ZED. 2004, pp. 249-274.

Kuria,W. (2012).Coping with age related changes in the elderly. Degree thesis – Nursing.ARCADA.Kustaankartano.Förnamn Efternamn.pp23-29.

Kuria,W. (2012).Coping with age related changes in the elderly. Degree thesis – Nursing.ARCADA.Kustaankartano.Förnamn Efternamn.p30

Manuh, T. (2013).“A Study of Selected Voluntary Development Organizations in Ghana”.In Women as Agents and Beneficiaries of Development Assistance.pp45-56.

Marmot, M. (2013). ‘‘Epidemiology of Socioeconomic Status and Health: Are Determinants within Countries the Same as between Countries?’’ Annals of the New York Academy of Science. 896:16–29.

Martin, L. (2012). Changing inter-generational family relatives in East Asia; Annals of the American Academy of Political and Social Science. 510: pp102-14

Martin, L. and Kevin, K. (2014).Research on the demography of aging in developing countries. In: *Demography of Aging*, Linda Martin and Samuel Preston, eds. Washington, D.C.: National Academy Press.p45

Mba, C. J. (2010). ``Population Ageing in Ghana: Research gaps and the way forward'' in Journal of Ageing research, vol. 2010 (2010), article ID 672157, 8 pages doi: 10.4061/ 2010/672157: Regional Institute for Population Studies, University of Ghana.

Ogunbodede, E. O. (2013). Population ageing and the implications for oral health in Africa.Volume 30. DOI: 10.1111/ger.12041.

Olson, L.K. (ed.), (2014). The Graying of the World: Who Will Care for the Frail Elderly? The Haworth Press Inc., Binghamton, New York.p10.

Oppong, C. (2014). Gendered family strategies and responsibilities of grandparents in sub-Saharan Africa.University of Ghana Institute for African Studies Occasional Research Paper Series. No. 6, 1–51.

Poterba, J. (2014). "Impact of Population Aging on Financial Markets in Developed Countries."Federal Reserve Bank of Kansas City Annual Symposium, Jackson Hole, WY.

Seike, X. and Atsushi, J. (2013)."Pensions and Labour Market Reforms for the Ageing Society," in Conrad, Harald, Victoria Heindorf, and Franz Waldenberger, (eds.), *Human Resource Management in Ageing Societies*, Palgrave Macmillan.29-42.

Stock, J. and Wise, F. (2013). "Pensions, The Option Value of Work, and Retirement." *Econometrica*.58: PP1151-1180.

United Nations (2013). Urban and rural areas by sex and age: the 1992 revision. ESA/P/WP/120.

United Nations Population Division (2011).*World Population Prospects: The 2013 Revision.* New York: UN Population Division. p37.

United Nations Population Division (2012). "Replacement Migration: Is it a Solution to Declining and Ageing Populations?". New York: UN Population Division.p45

Wachter, T. Kenneth, R. John, P. Knodel, O. & Mark, L. (2013). "Parental Bereavement: Heterogeneous Impacts of AIDS in Thailand." *Journal of Econometrics.*112: 193-206.

Williams, A, E. Bennet, V. Himmavanh, N. and Salazar, K. (2014)." They just go home & die": Health care & terminal illness in rural northeast Thailand. *Asian Studies Review.*20:98-108.

Wongboonsin, E. &Kua, B. (2014).The demographic dividend & M-curve labour-force participation in Thailand.*Applied Population & Policy.*1(2): 115–122.

World Bank (2010).World Development Indicators 2010.Washington: The World Bank.

World Bank. (2013). *Averting the Old Age Crisis*. New York: Oxford University Press

Zimmer, E. Zachary, V. and Pattama, A. (2014). Socioeconomic Status & Health Among Older Adults in Thailand: an Examination Using Multiple Indicators. Social Science & Medicine. 52(8):1297-1311.

APPENDIX

Questionnaire

UNIVERSITY FOR DEVELOPMENT STUDIES

SCHOOL OF MEDICINE AND HEALTH SCIENCES

DEPARTMENT OF ALLIED HEALTH SCIENCES

Informed consent

Good morning/afternoon Sir/Madam, my name is ……I am a student of University for Development Studies reading M.phil in Community Health and Development. I am conducting a research on assessing the impact of demographic transition on the socio-economic well-being of the Ghanaian elderly aged 60 years and above in the Ada East District as part of the requirements for the award of the degree. I would very much appreciate your participation in this study. This information will help decision making bodies in the country enact policies that will help improve the situation of the elderly especially in this part of the country.

The survey will take between 15 to 25 minutes to complete. Whatever information you provide will be kept strictly confidential. In this survey, participation is voluntary and you can choose to answer any/some or all the questions or withdraw at any point in time should you decide to do so without any consequences. However I hope that you will participate in this study since your views are important.

Section a: Bio- data of respondent

1. Age of respondents in years A. 60-65 ( ) B. 66-70 ( ) C. 71-75 ( ) D. 75+ (

)

2. Marital status, A. Single ( ) B. Married ( ) C. Cohabiting ( ) D. Widow ( ) E. Divorced ( ) F. Widower ( ) G. Others (specify)……..
3. If married number of wives A. one () B. two ( ) C. here ( ) d. Four ( )
   2. Religion, (A) Islam (B) Christian, (C) Other (specify)……..…
   3. Occupation (previous) (A) public servant ( ) (B) Unemployed ( ) (C) Self-employed ( ) (D) Farmer ( ) F. Others (specify)……
   4. Occupation (current) (A) public servant ( ) (B) Unemployed ( ) (C) Self-employed ( ) (D) Farmer ( ) F. Others (specify)……
   5. Educational level, (A) No formal education ( ) (B) O level ( ) (C) Middle/A level ( ) (D) Technical/vocational ( ) (E) Tertiary ( ) F. Others (specify)……
6. Parity of respondents…….
7. Household structure A. nuclear family ( ) B. Extended family ( ) C. Others (specify)…….
8. Occupation of household head A. salaried workers ( ) B. Farmer ( ) C. Others (specify)…….
9. Occupation of children A. salaried workers ( ) B. Farmers ( ) C. Others (specify)……

10. Frequency of visit by children A. Often ( ) B. Always ( ) C, rarely ( ) D. Others (specify)……..
11. Where children are staying a. away from respondents ( ) B. With respondents ( ) C. Others (specify)……

Section B: Socio-economic wellbeing of the elderly aged 60 years and above

12. How do you feel being old? A. Rejected ( ) B. Normal ( ) C. Happy ( ) D. Others (specify)……
13. Do you get assistance in any form? A. yes ( ) B. No ( )
14. What form of assistance do you get? A. yes finance ( ) B. Social( ) c. others (specify)……..
15. If yes how often do you get assistance A. always ( ) B. Rarely ( ) C. Others (specify) ( )
16. Where can your assistance come from? (Tick more than one) A. children ( ) B. Relatives ( ) C. Friends ( ) D. In-law ( ) E. others (specify)…….
17. Do you have any property that you can sell for money? A. yes ( ) B. No ( )
18. If yes what is it? A. land ( ) B. Farm produce ( ) C. Animals ( )
19. Do you think your leaving condition is good? A. yes ( ) B. No ( )
20. Do you think your economic wellbeing is good? A. yes ( ) B. No ( )
21. If any why?.....

22. What can be done to improve the living condition of the aged in this community?.....

Section C: Changing situation of the elderly aged 60 years and above in the context of demographic transition

23. Do you think demographic transition has an effect on the welfare of the aged? A. yes ( ) B. No ( )
24. If yes how?.....
25. What has been your main support? A. household ( ) B. Children ( ) C. Family members ( )
26. Are you satisfied with the support provided? A. yes ( ) B. No ( )
27. How frequent do you receive visitors? A. always ( ) B. Sometimes ( ) C. Rarely ( )
28. Are these visitors mostly your relatives? A. yes ( ) B. no ( )
29. How long do they normally stay with you? A. one day ( ) B. one week ( ) C. one month ( )
30. Are you satisfied with the frequency of visits by your relatives? A. yes ( ) B. no ( )

SECTION D (INTERVIEW GUIDE): Coping mechanisms used by the elderly to improve their socioeconomic wellbeing in the phase of demographic transition

31. If you do not have money how do you survive?

    ……

    ……

    ……

    ……

32. Besides what you have told us above in question 32, what else do you do when you are out of funds and food?.....

    .....

    .....

33. Tell us something about the things you do to survive always……

    ……

34. How are the elderly in this community coping or doing to survive amidst these

    challenges?.....

    .....

.....

...

35. How are these coping strategies affecting the wellbeing of the elderly in this community?

SECTIONE: Relationship between socio-economic wellbeing and perceived health (self reported health) of the elderly aged 60 years and above

36. How often do you visit the health centre? A. always ( ) B. Rarely ( ) C. Often ( )
37. How would you rate your health status? A. good ( ) B. Weak ( ) C. Others ( )
38. Who pays your medical bills?.....
39. Do you think you are physically fit? a. Yes ( ) b. No ( )
40. If any why?.....
41. Do think you are emotionally fit? a. Yes ( ) b. No ( )
42. If any why?.....
43. Do think you are socially fit?.....
44. What can be done to improve the health of the elderly?.....
45. Have you ever been abused before? A. yes ( ) B. No ( )
46. If yes why?.....
47. Have you ever been abused emotionally? A. yes ( ) B. no ( )
48. Have you ever been abused socially? A. yes ( ) B. no ( )
49. Have you ever been abused physically? A. yes ( ) B. no ( )

50. What have been your greatest health challenge? A. hearing problem ( ) B. Seeing problem ( ) C. Dementia ( ) D. others (specify)……

Thank for you time