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The Lived Experience of Quality of Life of Older Adults in Rural Ghana

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Abstract

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ChE, Global Academy of Finance and Management, 2020

MPhil, Walden University, 2019

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The quality of life (QOL) of older adults in rural Ghana is of growing concern, locally and throughout the country. In Ghana, it is the tradition for family members to take care of older adults without any government support, but research has shown that changing economic and social structures make this tradition less optimal, so older adults suffer physically and emotionally. The purpose of this phenomenological study was to explore the lived experience of QOL for older adults in rural Ghana. The ecological systems theory was used to explore the integral role of family support and QOL in the microsystem, mesosystem, exosystem, macrosystem, and cronosystem. Giorgi and Giorgi's phenomenological approach was used to guide the development of the interview guide and analysis plan. Six participants were interviewed, and the transcribed data were analyzed using the three interactive steps: phenomenological reduction ("bracketing"), description of the reduced ("imagined") concepts, and search for essences. The results revealed that older adults can complete their daily activities without depending on others and locate healthcare services to maintain health, but they lack good transportation systems and adequate quality water. Safety in the community was a concern. Surprisingly, the result showed that the role of family in older adult care was minimal. It is recommended that further studies be conducted on the impact of family caregiving on QOL. This study promotes social change by educating healthcare providers in rural communities on the needs of the older adult population, specifically looking at how they can incorporate transportation as part of their healthcare delivery.

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Dedication

This work is dedicated to my entire family at Breman Bedum, Central Region, Ghana.

Acknowledgments

I would like to thank my current chair, Dr Sandra Rasmussen for her tremendous contribution toward the success of the dissertation process. Throughout my academic life, she is the only professor who has demonstrated an intellectual democracy. No professor has ever created this opportunity for me. Although I do not intend to challenge her suggestions, I believe it is a great source of motivation. Also, I want to thank Dr. Susan Marcus for her tremendous contribution towards the success of the dissertation. Again, I would like to thank my previous chair, Dr Anthony Perry for his hard work. He did great.

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Chapter 1: Introduction to the Study

In this study I explored the lived experience of quality of life (QOL) in older adults in rural Ghana cared for by their families. Research has documented the poor living condition in Ghana that have affected QOL of older adults in rural Ghana (Fonta et al., 2017). There are several factors that serve as pillars to enhance QOL, and when these factors are inaccessible, decreased QOL can result (Fonta et al., 2017). These factors include mental and physical health, structural support and resources, and social supports like family, friends, and community. These factors vary in importance by socioeconomic status and culture (Knesebeck et al., 2007). I hoped that the results of this study will contribute to improving support for older adult care in Ghana.

The healthcare system in rural Ghana often lacks the trained human resources and infrastructure to provide comprehensive care needed for older adults (Fonta et al., 2017; Nortey et al., 2017). Family members take on increasing roles in healthcare and may not be informed or trained. This is particularly relevant for older adults as aging comes with a decline in immunity and increase in health problems like cognitive decline, physical infirmities, and decline in ability to cope with psychological issues. Healthcare and related support facilities are crucial needs for ensuring the well-being of older adults.

In some countries, older adults are provided with assistance by the government (Steiner-Asiedu et al., 2010). Governments have created health, social service and community centers that enhance or replace family support. These supports, however, tend to be present in more densely populated areas rather than rural areas. Because there are no government supports for older adults in rural Ghana (Cooke et al., 2016), absence or

limitations in family support means the elders are left to fend for themselves, increasing risks for serious consequences like malnutrition, disease, and mental illness. Little is known about how QOL and caregiving is experienced in older adults (Lambert et al., 2017).

This chapter will address the background of the study, problem statement, the purpose of the study, and research questions. Other areas addressed include conceptual framework, nature of the study, scope and delimitations, limitations, significance, and summary.

Background

There is a natural tendency for aging to be compromised by increased mental and physical health problems. These issues can affect the experience of QOL. The World Health Organization (WHO, 2020) has defined QOL as "an individual's perception of their position in life in the context of the culture and values system in which they live and in relation to their goals, expectations, standards, and concerns" (p. 3).

There is evidence of lower QOL among older adults in rural communities when compared to urban areas of Ghana (Yiranbon et al., 2014). This relationship has also been found in other communities as well; for example, Khaje-Bishak et al. (2014) found that older adults who made daily visits to Tehran government-funded day center who suffered from serious health and mental conditions reported poor QOL compared to those who had fewer or less serious problems. In rural southern Ghana, older adults experience poor living conditions, and there is no support from the government (Cooke et al., 2016). This makes life in rural areas more difficult.

Another factor related to QOL in older adult is access to food. Healthy eating improves an individual's QOL (Steiner-Asiedu et al., 2010). The functional ability and health of older adults is partly contingent on their food choices and food security, which is defined as access to food needed for a healthy living. A recent meta-analysis documented the relationship between malnutrition and poor mental and physical health outcomes in older adults, and it suggested more research to be done to examine QOL as experienced by older adults when access to good nutrition is limited and unpredictable (Rasheed & Woodes, 2013).

Geest (2004) noted that older adults in rural Ghana experience loneliness due to the inability to get in contact with other people who are important to them. Family members may be far away or unable to attend to elders' needs more regularly. This issue is particularly important given that Ghanaian culture incorporates the role of family in elder care (Coe, 2017). A recent study in England found that social loneliness and emotional loneliness (feeling alone, low in self-esteem) in the elders in the United Kingdom contribute to reducing feelings of well-being (Dahlberg & McKee ,2014). Sováriová Soósová (2016) reported that QOL is related to social relationships, death and dying, and intimacy. QOL is reduced by depression, polymorbidity, and life without a partner. Geest (2004) and others suggested that future studies exploring family and social relationships as contributors to QOL are needed.

In sum, the research has revealed that QOL is an important concept in contributing to elder longevity and good health. While there are a considerable number of studies examining QOL in rural areas in the United States and elsewhere (Baernholdt et

al., 2013; Bourland et al., 2000; Brown & Barrett, 2011; Coffman, 2002; Dalton et al., 2003; Drewnowski, & Evans, 2001; Strauss & Hunt, 1993), research on how QOL is experienced in rural Ghana is limited. Ghana presents a unique case where most roads are untarred, water not accessible, and there are no government or community health care facilities. Therefore, it is important to understand how QOL is experienced by older adults in a community where government resources are scarce and family support is culturally acceptable but not always available. This study was needed to understand how older adults in rural Ghana experience their current living conditions and to serve as a foundation to improve the support for older adult care in Ghana.

Problem Statement

Many studies of elder health have been conducted in both developing and first world countries, and the results suggest that QOL in older adults is less affected when government and family services are available to provide physical health and mental health care services and support. Basic needs such as good housing, access to services and food security contribute to QOL and the ability to cope with stress (Andréa et al., 2010; Steiner-Asiedu et al., 2010). For example, Khaje-Bishak et al. (2014) found that older adults in Tehran, who were suffering from physical and mental health challenges and regularly attending government-funded community centers reported an acceptable QOL.

In the United States, there are healthcare centers that provide quality care for older adults, and this has been related to QOL (Soest-Poortvliet, 2012). Steiner-Asiedu et al. (2010) concluded that there are no public health institutions that provide healthcare for

older adult population in rural Ghana. Further, most of research has focused on quantitative assessment of QOL (Okoye & Asa, 2011) and therefore are less likely to capture the lived experience of these participants (Okoye & Asa, 2011).

The tradition of responsibility for older adult care to be shouldered by families in rural Ghana is becoming increasingly challenged because of changes in economic and educational opportunities for younger people. For example, Yiranbon et al (2014) surveyed more than 400 older adults in Ghana, who reported that while elders had high expectations for traditional forms of care (primarily adult children and grandchildren), less than 40% of those surveyed identified children or extended family as responsible for their primary care.

Studies have also shown that cultural norms play a role in how aging adults are cared for. Studies in England, Iran, and China, where culture dictates that family members take the primary role in elder care, have found that family caregivers' perceptions of caregiving differed from that of health workers who provide care (Shaibu & Wallhagen, 2002). Health workers perceive caregiving as a profession, whereas family caregivers perceive it as a family responsibility. In Ghana, cultural norms have played a significant role directing how family members took care of their elderly. However, changing economic patterns and geographic locations have made this cultural norm a less feasible alternative. Thus, understanding how caregiving is experienced in contemporary times is relevant to explore in this target group.

To summarize, research has revealed that QOL is an important concept in contributing to elder longevity and good health, but there is limited research in

understanding how QOL is experienced by older adults in a community where government resources are scarce, and family support is culturally acceptable but not always available. This study is needed to understand how older adults in rural Ghana experience their current living conditions and to serve as a foundation to understand how to improve the support for older adult care in Ghana.

Purpose Statement

The purpose of this phenomenological study was to explore the lived experience of QOL and family caregiving in older adults cared for by their families in rural Ghana. The primary phenomenon of interest was QOL, which was guided by the WHO's definition reported above. The second phenomenon was family caregiving, which is identified as members of the immediate and extended family who have traditionally been important participants in the elder care system (Coe, 2017). Family caregiving is conceptualized as care provided by immediate and/or extended family that includes (but is not limited to) health and medical, transportation, daily care, and emotional and social support (Dosu, 2014)

Research Questions

This research was based on the overall research question: What is the lived experience of older adults related to aging and QOL in rural Ghana?

RQ1: What is the lived experience of QOL in older adults cared for by their families in rural Ghana?

RQ2: What is the lived experience of family caregiving in older adults cared for by their families in rural Ghana?

Conceptual Framework

The focus of the study was QOL in older adult in rural Ghana. I utilized Bronfenbrenner's ecological system model (Bronfenbrenner, 1977) for the study. While this model is designed for human development and uses a set of "nested" fields or systems (Bronfenbrenner, 1977), it is also useful for understanding how different systems contribute to everyday living. The model defines four dimensions: process, person, time, and context (Bronfenbrenner & Evans, 2000; Bronfenbrenner & Morris, 2006).

The process aspect of the ecological system model concerns how to apply existing knowledge to arrive at new findings. The person component describes the participants and their interpersonal network, including family members, as well as special events or circumstances that constitute their point of reference (Bronfenbrenner, 1977). This component also involves how to influence dynamic interactions between individuals (Overton, 2013). The time component stems from the chronosystem, which posits that life goes through transitions, and individual changes happen over time. The context compnent describes the factors that surround the focal point of the study.

Using the ecological system theory as a conceptual framework helped me address the interaction between older adults from a family perspective (see Snyder, 2014). Snyder (2014) suggested that the ecological system theory helps explain the quality and nature of the interactions between people and their support systems. By considering older adults as individuals within an ecological system, a more holistic picture of their needs was developed, which illuminated support resources that improved QOL (Snyder, 2014).

Bronfenbrenner's ecological systems theory looks at the participants' development within the levels of systems of relationships that make up their environment. These levels are microsystem, mesosystem, exosystem, macrosystem, and cronosystem. I review them here briefly, with more depth of discussion in Chapter 2.

The microsystem coveres the relationships and interactions the participants have within their immediate surroundings (Berk, 2000). Examples of these structures are family and neighborhood. The mesosystem is the level that connects the structures within the participants' microsystem (Berk, 2000), for example, the connection between participants' caregivers and the caregivers' partners. The exosystem is about the social system in which the participants do not have direct interaction. The structures within this level affect the participants' development if they interact with some structures within their microsystem (Berk, 2000). Caregivers' workplace schedule is an example of exosystem. The macrosystem is the outermost layer within the participants' environment. This includes cultural values, customs, and laws (Berk, 2000). These structures impact the structures in other levels. For example, if it is the belief of the culture that either family member or government should be solely responsible for caring for older adults, it will impact older adults because ideally, they need both family and government assistance.

The chronosystem system relates to the relationship between the dimension of time and the participants' environments. For example, the physiological changes that occur in older adults as they age may determine how they react to their environment. I

utilized the concepts reflected in these different but interrelated systems to develop the interview guide questions and data analysis plan.

Nature of the Study

I used Giorgi and Giorgi's (2003) phenomenological approach for the study because my intent was to explore the lived experience of older adults in Ghana cared for by their families. I chose this method because it focuses on the researcher's effort to describe the phenomenon of interest, recognizing that engagement with the participant should be the primary focus of the interview process, and bracketing and other researcher-reflective processes entering during the analysis phase. This is further detailed in Chapter 3.

The phenomena of interest were QOL and family caregiving. QOL refers to an individual's personal functioning: physical, social, cognitive, emotional, and mental (Aboh et al., 2019). Also, QOL encompasses improvement in health status, required autonomy, role and activity, an individual's relationship, attitude and adaptation, an individual's emotional comfort, spirituality, home, neighborhood, and financial security (van Leeuwen, 2019). However, in this study, the descriptions of QOL that participants described to me were the focus so that they would accurately represent their lived experience. I also explored the family's role in caregiving and QOL. Family caregiving is conceptualized as care provided by immediate and/or extended family that includes (but is not limited to) health and medical, transportation, daily care, and emotional and social support (Dosu, 2014).

I collected the data from older adults in rural Ghana who were 60 years and above through interviews by asking open-ended questions and inviting dialogue. The next step after the interview was data transcription. After completing the transcription, I read the transcripts multiple times purposely to enhance familiarity with the data and to help develop an initial interpretation.

Definitions

Active aging. Aging within the dimensions of wellness to keep an individual involved and alert for a productive life.

Ecological systems theory. A framework for professionals to assess an individuals' relationships between their communities and the systems that make up their environment (Bronfenbrenner, 1977).

Food security. The persistent and regular supply of food (Steiner-Asiedu et al., 2010). Having the required amount of food with the right amount of nutrients helps improve QOL.

Lived experience. The representation of the experiences and choices of an individual and the knowledge the individual gains from such experiences and choices (Fonta et al. 2017).

Phenomenological approach. A research approach for studying people's experiences (Davidsen, 2013). It describes the overall essence of an issue by looking at it from the standpoint of those who experienced the phenomenon. It explores the subjective experience of individuals.

Quality of life (QOL). Adequacy in an individual's personal functioning: physical, social, cognitive, emotional, and mental.

Assumptions

The primary assumptions for the conduct of phenomenological research includes the access to participants who have experienced the phenomenon of interest; the ability of participants to speak clearly, honestly, and deeply about their experiences in order to generate thick and rich data; and the researcher's ability to focus the analysis on the inquiry into the participants' descriptions (Patton, 2002, Tufford & Newman, 2010). I assumed that participants who represented the phenomena under study could be located, invited, and recruited. Further, I used open-ended questions consistent with Giorgi's (2009) phenomenological research method to inquire into their present lived experience, and I assumed the participants could clearly understand the wording of the questions and were able to provide accurate descriptions of their experiences. Finally, I assumed that using the process of bracketing during the analysis would help discern and describe the shared meaning of the individual interviews.

Scope and Delimitation

This research addressed the phenomena of QOL and family caregiving for older adults in rural Ghana. I chose rural Ghana because older adults experience worse living conditions than their urban counterparts, and there is no support from the government (Cooke et al., 2016). I selected QOL and family caregiving for older adults because these two phenomena have been shown to be associated with the experience of well-being in aging (Fonta et al., 2017). From a social change perspective, it is important to better

understand their experience to contribute to efforts to improve their QOL and provide research-based information to key stakeholders and decision-makers (Cooke et al., 2016).

Language barrier was a potential delimitation in this research. English is the second language of all Ghanaians. Even those who have had a high school education cannot speak fluently as an American or European would. Possible issues that I anticipated include semantic barriers, distortions of meaning, the possibility of misconstruing the purpose of the study, mechanical errors in the responses, and inability of participants to express themselves as a result of not being sure how to frame the answer in English.

The study did not include older adults in urban areas of Ghana. The reason is that most older adults in urban areas of Ghana have access to facilities and will have a different perspective of QOL. Also, it did not include persons who cannot read because they would be unable to understand the research topic.

One issue of scope in a qualitative methodology is the length of time required to complete the research. Qualitative study involves interviewing many people, which takes time to complete. For example, I collected data when the participants were ready to participate. This takes time to complete if there are many participants.

Limitations

The limitations of the research were those features of design or methodology that impacted or influenced the data collection and the interpretation of the research result. A limitation with qualitative methodology is how to achieve dependability. Dependability is the examination and reporting of the stability or consistency of the process at different

times. This was enhanced by using a recognized methodological approach and applying consistent data gathering procedures across all participants (see Shenton, 2004). I also reported the processes within the research in detail, so that a future researcher can repeat the work, if not particularly to yield the exact results.

Another limitation was transferability. It refers to the extent to which the findings of qualitative research can be generalized or applied to other contexts or situations. The findings of qualitative research are primarily specific to a small group within a given environments and individuals, so there is a limited possibility to demonstrate that the results and conclusions can be applied to other situations (Shenton, 2004). However, I made efforts to provide rich and thick descriptions of process and results.

Also, the researcher's cultural and personal biases could influence the data gathering, analysis, and interpretation of results. However, bracketing, journaling, and memos were used to distinguish the researcher's opinions from the interview data. Also prescribed Giorgi and Giorgi's (2003) phenomenological data analysis techniques was used to document the process and results to reduce the risk of subjective bias.

Significance

The focus of this qualitative phenomenological study was lived experiences of QOL with family caregiving for older adults in Ghana. Khaje-Bishak et al. (2014) recommended that policies and programs are needed for improving the QOL in Ghana; therefore, there is the need for further studies to better understand QOL in older adult in rural Ghana.

I hoped that reporting on the lived experience of QOL in the rural older adults of Ghana would illuminate opportunities for improvement and change in their living, health, and social conditions. The results have been shared with gerontological institutions and the department of human services, which is proposed to be fully operated by the government of Ghana by 2024. In addition, as the older adult population continues to grow all over the world, I hope that the results of the study will be published and shared with many communities where care of the aging is an important issue.

Summary and Transition

In this section I discussed the background of the study relating to the gap in knowledge. I identified that there is government assistance for older adults in countries like United Kingdom and the United States of America, but because there is no government support for older adults in Ghana, there is a gap as to how QOL and caregiving is experienced in older adults (Lambert et al., 2017).

I addressed the purpose statement, which was to explore the lived experience of QOL of older adults cared for by family members in rural Ghana. I discussed the two main research questions about QOL and caregiving. Also, I discussed the ecological system model (Bronfenbrenner, 1977) as the framework I used to guide the development of the interview guide and data analysis process. I chose Giorgi and Giorgi's (2003) phenomenological approach because my intent was to explore the lived experience of older adults in rural Ghana cared for by their families. In describing the nature of the study, I also discussed how data was collected and analyzed. Other key concepts included scope, delimitations, and limitations like challenges of transferability and biases. In the

next chapter I will restate the problem and purpose and discuss articles related to QOL and caregiving.

Chapter 2: Literature Review

Ghana is officially called the Republic of Ghana, and it is located in West Africa. As of 2019, Ghana's population was 30.1 million, and it is the 48th most populous country in the world (Ghana Statistical Service, 2019). Adults 65 years and older constitute 4.3% of the population (557,155 males and 652,331 females; Ghana Statistical Service, 2019), and the number has grown over sevenfold from a total of 213,477 according to the 1960 population census to 1,643,381 in 2010 (Ghana Statistical Service, 2010). According to the Ghana Statistical Service (2010), population aging is occurring as a result of declining fertility rates and increasing life expectancy. Globally, the population aged 60 years and above is increasing at 3.2% per annum and will continue at this rate for the next few years, as projected by the Ghana Statistical Service (2010).

The research cited above points out how the older adult population in rural Ghana is increasing, and with this increase in size is a corresponding increase in demand for resources to care of them. Economic and geographic realities have created a woeful gap in resources, for example, governments do not have funding for community resources, and families who fled to urban areas to find work are no longer available to provide care. Thus, it is important to explore these concepts. The lived experience of QOL in older adults in rural Ghana has been overlooked by the government in Ghana (Steiner et al., 2010). Developed countries like United States and United Kingdom have standard gerontological services and policies that cater to the needs of older adults. Examples of these services include healthcare and assisted and residential living facilities. However, the circumstances in Ghana are different (Steiner-Asiedu et al., 2010) in that the

challenges faced by older adults are solely handled by families without any government intervention. The healthcare system in rural Ghana often lacks the trained human resources and infrastructure to provide the comprehensive care needed for older adults (Fonta et al., 2017; Nortey et al., 2017).

Global gerontology researchers recently concluded that policies and programs that provide access to shelter, services, food security, and family and social support would improve the QOL of older adults (Andréa et al., 2010; Asiedu et al., 2010; Khaje-Bishak et al., 2014; Sováriová Soósová, 2016;). However, more research is needed to understand the unique lived experience of QOL for older adults in Ghana and to explore the role of family in providing them with care and social support. Therefore, the purpose of this phenomenological study was to explore the lived experience of physical and mental QOL in older adults cared for by their families in rural Ghana.

Literature Search Strategy

The search engines that I used to gather literature for this study included EBSCO ebooks, Health and Psychosocial Instruments (HaPI), Health Services and Sciences Research Resources (HSRR), Google scholar, PsycARTICLES, PsycBOOKS, PsycEXTRA, and PsychiatryOnline. The key words that I used included *QOL, aging, older adults, lived experience, housing, pain management, healthcare support, loneliness, food security, transportation, policy documentation, water and sanitation, social support, pain management, childbearing, and social activities, rural older adults, rural aging, rural health*, and *Ghana*. The articles used for the literature review were published between 2008 and 2019.

Conceptual Framework

The Ecological System Model

The focus of the study was QOL in older adults in rural Ghana cared for by family members. I utilized Bronfenbrenner's ecological system model as a conceptual framework for this study. The ecological system model was designed for explaining human development and uses a set of "nested" fields or systems (Bronfenbrenner, 1977). In managing general health and functionality related to QOL in older adults, the ecological system model was ideal for this study because, as Lawton (1990) asserted, a person's functioning is based on (a) their biological, psychological, and social resources; (b) environmental characteristics; and (c) how ever-changing individuals fit into their ever-changing environments.

Lawton (1990) framed an individual as being nested within many spheres of influence and used Bronfenbrenner's model to describe a complex perspective of the individual and individual behavior bound by conditions and the interaction of the different spheres of influence. As applied to aging, when demands from social and physical environments exceed a person's resources, the individual will be less likely to age in their own place (Lawton et al., 1997). For example, if an older adult has a mobility difficulty and lives in a two-story house, they are less likely to manage staying in their home.

With the ecological system model as a conceptual framework I focused on the influential and dynamic transactions of people and different environmental contexts that ensure continuity and changes in human functioning across the life span and across four

dimensions, process, person, time, and context (see Greenfield, 2011). The process aspect is about how to apply the existing knowledge to arrive at new findings. Also, it is about how to influence dynamic interactions between individuals (Overton, 2013). The person component is about the participants and their interpersonal network, including family members, as well as special events or circumstances that constitute their point of reference (Bronfenbrenner, 1977). The time component stems from the chronosystem, which means that life goes through transitions, and individual changes happen over time. The context component is about the factors that surround the key ideas for the study. I examined QOL issues among older adults in Ghana from the four dimensions. The interview guide and analysis plan for the study incorporated these dimensions in order to explore the process of aging in rural Ghana and the interpersonal networks, particularly family systems that help sustain rural living. Also, I explored the changes that have been experienced over time in the context of the rural setting with limited resources.

Bronfenbrenner (1990) defined the levels or layers that affect the participants. Bronfenbrenner's ecological systems module is in levels. These levels are microsystem, mesosystem, exosystem, macrosystem, and cronosystem. The microsystem is the level that is closest to the participants, and it has the structures with which the participants have direct contact. The microsystem covers the relationships and interactions the participants have within their immediate surroundings (Berk, 2000). Examples of these structures are family and neighborhood. The relationships within the microsystem are either away from the participant or towards the participant. The mesosystem is the level that connects the structures within the participants' microsystem (Berk, 2000). An example is the

connection between participants' caregivers and the caregivers' partners. The exosystem is about the social system in which the participants do not have direct interaction. The structures within this level affects the participants' development if they interact with some structures within their microsystem (Berk, 2000). Caregivers' workplace schedule is an example of exosystem.

The macrosystem is the outermost layer within the participants' environment. This includes cultural values, customs, and laws (Berk, 2000). These structures impact the structures in other levels. For example, if it is the belief of the culture that either family member or government should be solely responsible for caring for older adults, it will impact older adults because ideally, they need both family and government assistance. The chronosystem relates to the relationship between the dimension of time and the participants' environments. The structures within this system could be external, for example, the timing of a partner's death. It could also be internal, for example, the physiological changes that occur in older adults as they age. Timing in older adults' aging may determine how they react to their environment. Thus, for the interview questions and data analysis plan I utilized these systems to explore QOL in the target population.

Literature Review Related to Key Variables

This section contains a review of articles that address the lived experience of QOL of older adults. Some of these articles are related to Ghana while others look at QOL from the perspective of other countries. The articles have been categorized into the following sections: (a) the definition of QOL, (b) the measurement of QOL, (c) QOL in rural older adults, (d) QOL of rural adults in Ghana, and (e) the role of family caregiving.

Definition of Quality of Life

QOL defines the overall well-being of individuals, taking into consideration negative and positive aspects of life. It consists of the expectations of an individual for a good life. One challenge of conducting research on this topic is that there are many, albeit overlapping, definitions of QOL. Some of the more recognized, and I describe the definitions for this study in this section.

According to the WHO, QOL is an individual's perception of their current position in life, taking into consideration culture and values system in which they live and with regard to an individual's concerns, expectations, goals, or standards (WHO, 2020). iIndividuals have their unique perceptions about QOL.

In studying the determinants of QOL in the elderly, Sováriová Soósová (2016) reported that QOL is related to social relationships, death and dying, and intimacy, and it is reduced by depression, polymorbidity, and life without a partner.

Van Leeuwen et al. (2019) described QOL as covering an individual's personal functioning: physical, social, cognitive, emotional, and mental. Also, QOL encompasses (a) improvement in health status, (b) required autonomy, (c) role and activity, (d) an individual's relationships, (e) attitude and adaptation, (f) an individual's emotional comfort, (g) spirituality, (g) home and neighborhood, (h) and financial security (van Leeuwen et al., 2019).

Fonta et al. (2017) examined predictors of self-reported health in older adult Ghanaians, and found that QOL was defined subjectively, and QOL consisted of multidimensional areas including (a) improvement in physical health status, (b)

psychological health, (c) degree of independence, (d) family support, (e) achievement of educational goal, (d) improved economic status, (f) religious beliefs, (g) sense of optimism, (h) availability of local services and transport, (f) availability of employment opportunities, (g) strong social network, (h) housing, and (g) congenial environment. The authors concluded that QOL can be determined on the basis of cultural orientation, values, personal expectations, and goals. QOL emanates from level of acceptance present condition as satisfactory.

QOL has been defined as an individual's overall wellbeing that varies for different age groups of the elderly population (Farquhar, 1995; Felce & Perry, 1995; Yiranbon et al., 2014b). These approaches identify QOL as more than healthful aging, and include measures of well-being, variety and frequency of social contacts, ability to cope with stress, food security, and the presence of supportive government policies and resources.

In sum, QOL has been approached in many different ways. However, the definitions of QOL tend to be consistent in the inclusion of social relationships, spirituality, religious beliefs, family, and social support, as well as physical health.

Measurement of Quality of Life

Most of the QOL research has been conducted using survey questionnaires, and QOL has been measured in a variety of ways. In this section, I haveincluded examples of typical measurement tools to provide insight about how QOL is measured. These include the RAND-36, SF-20, SF-36, the Multidimensional Index of Life Quality (MILQ) and, the Multidimensional QOL Questionnaire (Smith, Assmann, & Avis, 1999).

Hektner, Schmidt, and Csikszentmihalyi (2006) used the experienced sampling method (ESM) to conduct a study that required respondents answer questions when prompted randomly by watches, pagers, or palm pilots during the course of a day over a period of time such as a week. Responding to items on predetermined forms, individuals described what they were doing, what they wished they could do, who they were with, and how they felt. Unlike life experiences simulated in laboratories, the ESM captured the experiences and feelings of people, and the time they allocated to different activities as they occurred in their everyday lives. By randomly sampling the moments when an experience is happening, the ESM avoids some of the problems associated with time diaries that rely on retrospective events, making it possible for respondents to provide their current and unique experience (Hektner et al, 2006).

The RAND-36 (Hays & Shapiro, 1992; Brazier, Roberts, & Deverill, 2002) is a QOL measure that was utilized in a multi-year, multi-site Medical Outcomes Study (MOS) that examined variations in patient outcomes. The MILQ (Avis et al., 1996) is a psychometrically reliable and valid instrument for determining QOL of people with physical diseases. It is a series of questions administered to find out what it takes to be physically active or physically inactive. FS-36 is a 36-Item Short Form Health Survey that rate respondents' QOL (Moghaddam & Faghehi, 2003). The SF-20 consists of generic, coherent, and easily administered quality-of-life measurement (Holmes, Bix, & Shea, 1996)). The instrument was created to mitigate respondents' burden when establishing common standards of precision for purposes of group comparisons of variety of health dimensions.

The Multidimensional QOL (MQOL) describes the derivation, characteristics, structure, and many other applications of QOL. The rationale for creating the MQOL comprises of a restricted range of evaluated domains and an emphasis on health in a variety of standard assessment tools.

Another QOL measure is the use of the Mini-Mental State Examination (MMSE) and Montreal Cognitive Function Test (MCFT) (Amer, El Akkad, & Hassan, 2014). This is a 30-point questionnaire that is applied in clinical and research to determine an individual's cognitive impairment, as a way of determining if cognitive impairment affects QOL.

Another tool for measuring QOL is the use of the Quality of Life Scale (QOLS), created originally by American psychologist John Flanagan in the 1970's. QOLS is a 15-item instrument that measured five conceptual domains of QOL: material and physical well-being, relationships with other people, social, community and civic activities, personal development and fulfillment, and recreation (Burckhardt & Anderson, 2003). It focuses on domains that come from the qualitative descriptions of a wide range of adults across gender, cultural and language groups. The QOLS scoring is done by summing up all the score on each item to make a total score for the instrument. By summing up the scores, a higher score means a higher QOL.

In sum, most of these quantitative measures converge on the same constructs or variables. The constructs they have in common are the RAND-36, The Multidimensional QOL, Mini-Mental State Examination (MMSE), and QOLSare some of the tools that have been used to measure QOL. The results of this research will be compared to some of

these quantitative approaches to illuminate similarities and differences between metric and qualitative results.

Quality of Life in Older Adults

QOL in older adult has been studied globally, focusing on different cultures and conditions. The primary interest in this area is to see how QOL affects older adult of different countries and how QOL is affected by different factors.

Baba et al. (2010) explored the availability of health promotion efforts by conducting structured interviews with key members of Transylvania community in Romania. Questionnaire were used for 226 communes sampled from a total of 758 communes. Of 226 interviewed subjects, 94 (42. 3%) responded no health promotion activity in their commune. Also, 56.3% of the sample had not been involved in any health promotion activity. However, when the participants were interviewed about their interest in health promotion activities, 77% expressed interest. The findings could mean that health promotion activities are required in Transylvania. Health promotion targeted to older people differs significantly from that addressing younger generations (Golinowska, et al. 2016). This partly stems from the fact that the health of older people is generally less than perfect. Health promotion strategies for the elderly generally have three basic aims: maintaining and increasing functional capacity, maintaining or improving self-care, and stimulating one's social network (Golinowska, et al. 2016). Health promotion helps an individual to increase control over their health (WHO, 2016). It covers a wide range of social and environmental interventions that are designed to benefit and protect individual people's health and QOL by addressing and preventing the root causes of ill health, not

just focusing on treatment and cure. This can be achieved through good governance for health, health literacy, and healthy communities (WHO, 2016).

Wirtz et al., (2018) investigated the association between physical morbidity and health related QOL in older German adults. The study used a representative sample of the German general adult population. A total of 5,033 people participated in the study. Wirtz et al., (2018) found two key developments in the demographic structure and development of modern factors related to QOL. These developments are a fall in birth rate and an increase in life expectancy leading to an increase in the proportion of older adults in Germany. There are two scenarios about societal health and morbidity. These scenarios are compression of morbidity, which means that morbidity is a short period at the end of life. The other scenario is the extension of morbidity, which places an emphasis on the importance of prolonged period of morbidity that comes with an increased life expectancy and an improved healthcare. This is applicable to health-related quality of life (HRQOL) because HRQOL is a multi-faceted concept that encompasses domains related to physical, mental, emotional, as well as social functioning. The prevalence of multimorbidity is increasing worldwide, and older people with multimorbidity are frequent users of health care services (Klompstra et al., 2019). Since multimorbidity has a significant negative impact on HRQOLand is more common in older age it would be expected that factors related to HrQoL in this group might have been thoroughly researched, but this is not the case. Factors that are related to HrQoL in older people with multimorbidity and high health care consumption, living at home include Higher symptom burden, lower ability in activities of daily living and a higher degree of

depression were negatively related to HrQoL (Klompstra et al., 2019). With a rapidly increasing population of older aged people, epidemiological data regarding the prevalence of mental and physical illnesses are urgently required for proper health planning (Seby, Chaudhury, & Chakraborty, 2011). It was hoped that a truer picture of morbidity in the older adults would emerge and lead to a substantial overhaul in the current delivery of care to these individuals, whose wellness and disability play a major role in determining the health and wellbeing of the society in general (Seby, Chaudhury, & Chakraborty, 2011).

Bourassa et al. (2015) studied the dyadic approach to health, cognitive ability, and QOL in aging adults in Europe. The purpose of the study was to investigate the impacts of an individual's physical health and cognition on QOL of a partner. Close relationship offers an important context for human wellbeing. The study interviewed 86,000 romantic couples aged fifty and older from nineteen European Union countries and 1 country from Asia. These countries are Austria, Belgium, Czech Republic, Denmark, Estonia, France, Germany, Greece, Hungary, Ireland, Italy, Netherlands, Poland, Portugal, Sweden, Slovenia, Spain, and Switzerland and Israel. All the participants were non-incarcerated and non-hospitalized individuals. The data collection included the use of computer-assisted personal interviewing and self-administered questionnaires. When married or partnered couples age together, changes in a partner's functioning may have an impact the other partner's wellbeing. The study found that physical health and cognitive ability are two crucial areas of functioning for aging older adults, and both have vital impacts on elements on QOL. An aging adults' physical health and cognition have unique impact on

their partners' QOL. It will be increasingly important to understand the cognitive changes that accompany aging, both normal and pathologic. Despite that dementia and mild cognitive impairment are both common, those who asymptomatic of these conditions may go through subtle cognitive changes that are associated with aging (Harada, Natelson Love, & Triebel, 2013). It is important to understand these normal cognitive changes are important to understand because, first, they can have an impact on the older adult's day to day function and, second, they can help us differentiate between normal and disease states (Harada, Natelson Love, & Triebel, 2013).

Windsor, Curtis, and Luszcz (2015) investigated the sense of purpose as a psychological resource for aging well. The study examined the associations of individual differences in sense of purpose with rates and levels of change in indices of QOL in aging in South Australia. The study interviewed a sample of 1,475 participants with an average age of 77 years within 18 years. The study defined sense of purpose as having a goal in life, feeling the present and past life have meanings, holding a belief that give life purpose, and having aims and objective for one's life. Of the 1,475 participants, 72% reported having a sense of direction, setting goals in the past, and enjoyed making plans for the future. On self-rated health, 47% of the participants reported good health. Functional ability was determined by walking ability and lifting. A total of 27% reported a good functional ability. The study reported individuals with higher sense of purpose had lower levels of disability, a better self-rated health, and functional ability compared to those with lower sense of purpose. It has become important for elderly to live better rather than to live longer (Konagaya, 2009). This can be achieved by exploring the

relation between the QOL and the cognitive function. Cognitive function is considered to have more influence on QOL scores than gender or age (Konagaya, 2009). A growing body of literature suggests that having a strong sense of purpose in life leads to improvements in both physical and mental health and enhances overall QOL (Alimujiang et al. 2019). stronger purpose in life is associated with decreased mortality and purposeful living have health benefits. Future research should focus on evaluating the association of life purpose interventions with health outcomes, including mortality. In addition, understanding potential biological mechanisms through which life purpose may influence health outcomes would be valuable (Alimujiang et al. 2019).

Martin, Schneider, Eicher, and Moor (2012) investigated how functional QOL approach improves QOL in old age. QOL is considered the core outcome variable in research activities on health-enhancement or preventive measures in old age. Functional QOL approach is an intervention that improves or maintains QOL domains in old age. These domains include cognitive, physical, or social resources. Functional QOL approach is integration of multiple subjective representations of the functionality of resources. This approach fosters on reducing activity contradictions and potential overload in daily activities. The study found that, the functional QOL of older adults is higher when more resources for daily activities are available, and activities require the combined use of more resources. Moor et al (2012) asserted that QOL is increasingly being suggested as a crucial outcome variable for interventions that aim to maintain or improve health and psychological resources in old age. Sováriová Soósová (2016) assessed the effect of demographical factors like age and gender, health related factors like functional status, an

individual's level of anxiety, depression, and social relationships on QOL in older adult in the Košice community in Slovakia. There was a sample of 102 older adults. The author found that social relationship, death and dying, as well as the level of intimacy better improved QOL but participation in social activity was the least factor that improved QOL (Sováriová Soósová, 2016). They reported that QOL was reduced by level of depression, poly-morbidity, and the loneliness associated with life without a partner. Depression is a psychological problem that affects human functioning. Also, sometimes we need people to talk to about our concerns, so the absence of such people makes life a bit difficult (Sováriová Soósová, 2016). There is an association between socio-demographic factors and QOL outcomes among adults (Vigl et al., 2011). According to Vigl et al. (2011) socio-demographic factors can be significantly associated with the subjective well-being of adults. Most of research has focused on quantitative assessment of QOL (Okoye & Asa, 2011) and therefore are less likely to capture the lived experience of these participants (Okoye & Asa, 2011). Panday et al. (2015) conducted a study to compare the health status, lived experience related to QOL, and perceived QOL of older adults residing in older adult homes and with families. Panday et al. (2015) reported that the basic perception of family in India to offer support to older adult was changing and leading to disintegrated families in the sense that most older adults have left their primary families and are living in older adult facilities. The idea of old age homes is becoming rampant, and the rate at which older adult need old age home is alarming. The security system in an old age home offers them protection from intruders and helps them live a safe and secure life.

Suganya (2016) aimed at gaining more knowledge about the lived experience and perceived QOL in older adult residential facility in Chennai, India. There were 350 participants whose age raged from 60 years and more (Male = 82, Female 268) from 7 older adult residence in Chennai city of Tamilnadu (Suganya, 2016). The author found that there was a significant association between the form of older adult homes and lived experience and perceived QOL of residents. Factors including age, marital status, condition of the spouse, level of educational attainment, sources and level of income, number of roommates, as well as how long one has lived in an older adult facility, had an impact on the lived experience and perceived QOL on inmates in old age homes. On physical grounds and psychological well-being factors, male had high QOL points than female residents. However, females had higher QOL scores in social relationship, environment, and living condition factors than males. Although embraced as desirable by most, living into very old age is largely unexplored as a distinct season of life, with increased, varied, and cumulative changes during a unique time of vulnerability and frailty (Pusztai, 2015). The lived experience of the oldest-old is that of a parallel movement of loss and gain, negative and positive with the acknowledgement that the change toward decline is inevitable (Pusztai, 2015). While sharing common experiences, each individual is situated in a particular lifeworld that offers possibilities and constraints for their unique way of being in the xiv world (Pusztai, 2015). Most of research has focused on quantitative assessment of QOL (Okoye & Asa, 2011) and therefore are less likely to capture the lived experience of these participants (Okoye & Asa, 2011). Panday et al. (2015) conducted a study to compare the health status, lived experience related to

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Shen and Tanui (2015) assessed the examined QOL from social insurance standpoint in older adult population, and what local authorities could implement to better the living condition of older adults. Shen and Tanui (2015) reported that access to information regarding local facilities enhance QOL in older adult population. The study also found that 16.2% of rural older adults were still in poor health condition. Those 80 years and above needed healthcare. Many local programs and services administered by cities and counties create opportunities to provide health benefits to residents and users; for example, park and recreation services offer increased options for physical activity. Other examples of services provided by local agencies that improve health and safety include emergency planning, and elder care. For prevention and screening services, health insurance facilitates both the receipt of services and a continuing care relationship or regular source of care, which also increases the likelihood of receiving appropriate care. (Institute of Medicine, 2002). Insurance benefits are less likely to include preventive and screening services than they are physician visits for acute care or diagnostic tests for symptomatic conditions. The aging of populations raises concerns about the affordability

of publicly funded pension and health care programs in the future (PRC, 2014). Many developed economies already expend a sizable share of their GDP on these social insurance programs (PRC, 2014).

Sováriová Soósová (2016) found that the possibility of maintaining independence in daily activities had a significant impact on almost all QOL domains. Sováriová Soósová (2016) reported the need to create opportunities for social networks and the participation variety of leisure activities and programs. Sováriová Soósová (2016) recommended the screening of, and the treatment of depression and anxiety as an important step in enhancing QOL in older adult population. Instrumental activities of daily living (IADL) are helpful. They are those activities that allow an individual to live independently in a community. Although not necessary for functional living, the ability to perform IADLs can significantly improve the QOL. The major domains of IADLs include cooking, cleaning, transportation, laundry, and managing finances. IADLs are commonly assessed by occupational therapists in the setting of rehab to determine the level of an individual's need for assistance and cognitive function (Guo, H.J. & Sapra, A. 2019). Bekibele and Gureje (2008) proposed establishing health-care facilities that cater to the special and diverse healthcare needs of older adults, with an emphasis on the evaluation and intervention that will help improve functional independence. This will support the well-being as well as the QOL of older adult by utilizing community health professionals to offer the right health-care services for older adults within rural communities. This can be done by designing comprehensive program that recruits, educate, and train older adult volunteers who qualify to be part of health promoters.

Support of physical functions in older adults can be helpful in improving QOL and functional independence (Bozkurt & Yılmaz, 2016). Also, a holistic standpoint of the need for cognitive and emotional support is as important as addressing medical health concerns (Bozkurt & Yılmaz, 2016).

The United Nations General Assembly (UNGA, 2015) reported that the overall goal of sustainable development was to ensure improved lifestyle, and to promote well-being for older adults, with the recognition that health needs and considerations spans throughout an individual's life cycle. Despite the fact that many older adults maintain overall good health as well as functioning throughout their lives, UNGA (2015) reported that the aging process comes with an increased risk of poor health. Mitgang and Osher (2016) maintained that individuals aged 65 years and above currently constitute a greater portion of the population than in the past, and this target group is estimated to continue to grow both in absolute and relative terms to the rest of the entire population. Therefore, there is the need to promote their well-being. Studies on well-being promotion in old age revolve around the concept of successful aging (Depp and Jeste, 2006; Doyle et al., 2010). High levels of psychological well-being can counterbalance the negative consequences of chronic disease and disabilities (Bassi et al., 2014; Ryff, 2014). Due to the remarkable increase in life expectancy across countries, sustainable prevention strategies are needed to help individuals preserve psychophysical well-being in old age (Fave et al., 2019). In particular, the regular practice of a moderately intense physical activity is recommended by the WHO to enhance balance, prevent falls, strengthen muscles, and promote psychophysical well-being. Daily physical exercise represents a

beneficial and low-cost strategy, easily accessible to the general population and potentially customizable to specific needs through brief training programs (Fave et al., 2019).

Weber et al. (2014) evaluated the QOL in two separate community-based age groups (89 younger adults between the ages 36 and 55, and 92 older adults between the ages of 63 and 74 years), to establish a relationship between depressive symptoms and QOL, factors like psychosocial feature, current physical health status, as well as long-term personality traits were considered. A regression model was used to examine the relationship between QOL and depressive disorder. It was found that in young age, a better QOL has a unique association with lower depressive symptoms. Contrary, among older adults, a better QOL was associated with both lower depression and physical infirmities. It was recommended that there is the need for an accompanying consideration of physical and psychological factors of QOL in older adult population. Depression is a prevalent and disabling condition in older persons that increases the risk of mortality and negatively influences QOL (Sivertsen et al., 2015). Depressed older persons have poorer global and generic health-related QOL than nondepressed individuals (Sivertsen et al., 2015). An increase in depression severity is associated with a poorer global and generic health-related QOL. These associations appeared to be stable over time and independent of how QOL is assessed. An increase in depression severity is associated with a poorer global and generic health-related QOL. The association appeared to be stable over time and independent of how QOL is assessed (Sivertsen et al., 2015).

Shetty (2012) showed that the proportion of older adult is increasing globally but, by 2050, By 2050, 80% of older adults in the world will live in the developing countries. This raises the question of whether older adults are prepared to embrace the demographic shift. By 2050, the number of older adults 60 years and above in less endowed nations will increase (Shetty, 2012). The decline in the fertility rates, and the sudden rise in life expectancy due to an improvement in health care, especially in Asia, accounts for the rapidly growing older adult population. Life expectancy has increased rapidly since the age of enlightenment (Roser, Ortiz-Ospina, & Ritchie, 2013). In the early 19th century, life expectancy started to increase in the early industrialized countries while it stayed low in the rest of the world. This led to a very high inequality in how health was distributed across the world. Good health in the rich countries and persistently bad health in those countries that remained poor (Roser, Ortiz-Ospina, & Ritchie, 2013).

Fernández-Mayoralas et al. (2015) showed that active living helps improve life satisfaction as well as personal well-being. The purpose for this study was to elaborate on leisure activities for older adults, with regards to their sociodemographic characteristics and conditions related to their QOL. A sample was put into three categories active older adults (27%), moderately active older adults (35%), and inactive older adults (38%). The results showed that a higher activity related to better cognitive function, better health status and functionality ability, a higher frequency of socializing with others, and higher level of education (Fernández-Mayoralas, et al., 2015). The authors concluded that active aging comes with a better QOL. Foster and Walker (2009) reported that there are both negative and positive global perspectives about aging. The negative is inactivity and

dependency as a result of the aging process and the positive perspective is that older adults are considered resourceful in opinions about societal issues. Older adult may be resourceful in so many ways.

While it is well documented that visual abilities like visual acuity, contrast sensitivity, eye dryness, as well as stereo acuity have a relationship with fall risks, and other measures of QOL in the elderly (Bekibele & Gureje, 2008; Saftari & Kwon, 2018; Swagerty Jr, 1995). This makes it important to ensure a good visual care. Visual deficits are closely associated with a huge reduction in QOL, with long sightedness more likely to affect QOL than short sightedness. Miljanović, et al. (2007) studied 450 participants at Harvard University through questionnaire by asking how their everyday activities were impacted by dry eye syndrome, and to what extent it impacted their reading ability, driving, typing, their professional responsibility, and watching television program. Of the 450 participants, 85% reported difficulties in these activities. These are activities these activities are necessary for daily living so impairment could affect a person's QOL.

In sum, the studies that have investigated elderly QOL in rural living conditions found these common relationships that effect QOL: visual impairment, pain, social support, physical activities, participation in social activities, and functional independence. Other common relationships include loneliness and physical health status.

Quality of Life in Rural Older Adults

QOL in the rural elderly has been examined across a variety of countries, cultures, and conditions. The primary interest in this area is to see how physical aging (health and

morbidity) and its consequences influence or are influenced by tangible and intangible aspects of QOL.

According to Nash, Tramuto, and Coughlin (2017) each day 10,000 individuals reach age 65 globally, and this trend is estimated to continue through 2030. In comparison to those who live in urban areas, older adults in rural areas have limited access to services, resources, and activities, as well as social connections (Nash, Tramuto, & Coughlin, 2017). Individuals aged 65 years and above currently constitute a greater portion of the population than in the past and this calls for a promotion of the well-being of the older adults (Mitgang & Osher, 2016).

In 2009, China launched a new rural social endowment insurance program to ensure a better living condition for older adults in rural communities (Shen & Tanui, 2015). This research examined QOL for the rural older Chinese. The study examined four factors: economic status, physical health status, older adults care, and loneliness. Six hundred sixty-four older adults over 60 years were interviewed. It was found that 16.2% of them were experiencing poor health conditions, with an emphasis on those who were over 80 years old as being particularly in need of healthcare and medical payment assistance (Shen & Tanui, 2015). Older adults who have insurance plans on the individual market, the average out-of-pocket costs for premiums and health care are typically two-and-half times higher than the costs paid by people their age who have employer-sponsored coverage or Medicaid (AARP, 2020).

In addition to health issues, older adults in developing countries have become especially vulnerable to lack of social support because of the increasing social changes

that are recorded in most of these countries (Gureje et al., 2008). Until recently, older adults in rural Nigeria were accorded a considerable social status, respect, care, and social and psychological support by their families (Gureje et al., 2008). The rate of migration, variations in value systems and aspirations, changes in the responsibilities of women, as well as the breakdown of the family system have had a negative impact on traditional familial support, and this leads to poor living condition for older adults (Gureje et al., 2008). There is almost no social support for older adult people outside the family (Gureje et al., 2008). Aging is associated with an increased reliance on health-related and support services (Yue et al, 2015). Old age often goes hand in hand with increasingly complex and often interrelated problems, encompassing physical, psychological, and social health (Yue et al, 2015). The lack of social support in elderly populations incurs real societal costs and can lead to their poor health (Yue et al, 2015).

Gureje et al. (2008) conducted a study to determine the factors that affect QOL among older adult in rural Nigeria. The authors sampled 200 older adults aged 65 years and over. The authors used the Andersen's behavioral model (Anderson, 1995) to assess QOL among older adults. This model is used to investigate the use of health services in relation to different chronic or acute diseases. The authors reported three dimensions of QOL: emotional well-being, social functioning, and quality health. A sample from across China, that consisted adults 65 years and older was used. Of the 200 older adults, 80% reported social support as a key factor of QOL, and 20% reported other factors like healthcare improvement, participation in social activities, and good nutrition. The study further concluded that the percentage of older adults over 65 old is higher in rural

communities in Nigeria compared to the urban communities, and this target group is projected to increase in the next decade. the day. Given that quality has become such a key factor in healthcare.

To integrate older adults in societal programs, the United Nations Economic Community for Europe (UNECE, n. d) recommended that there should be social programs in rural and remote communities where older adults tend to be isolated and do not have access to their immediate families or social infrastructure. This is one of the ways of ensuring QOL, and it helps in maintaining independent living. Due to the fact that older adults in rural communities have difficulties accessing health and social services, UNECE (n. d) recommended that special attention should be paid to them to improve their QOL. Although much of the policy debate on welfare reform has concentrated on the urban poor, nearly 20 percent of welfare recipient families reside outside of central cities and metropolitan areas. They, along with other rural working families, rely on various social services to help them move toward self-sufficiency. Affording rural residents' access to social services is a challenge even in the best of times. With the decline in state revenues expected to continue, the challenge will be greater. Furthermore, rural agency staff sometimes find it hard to identify families in need because the sociological and psychological deterrents to reliance on public assistance are more prevalent in rural communities (Weber, Duncan, & Whitener, 2002).

Erickson, Call, and Brown (2012) asserted that the rural older adult has limited access to services like shopping centers, healthcare facilities, and recreation. The authors asserted that older adults in rural communities have lower incomes than those in urban

communities. Poor health and mobility challenges make rural elders less able to perform their daily activities. To further explain this, two studies evaluated health of older adults in rural communities. Both studies concluded that the rural older adults experience poor health and mobility challenges, and these affect QOL. Ensuring programs of diverse activities in the rural areas would be helpful because just a few activities are available in the rural community (Kang & Russ, 2009).

Kang and Russ (2009) assessed activities that older adults in rural communities participate in. They reported an increasing area of interest in healthy living, and this corresponded to the comprehensive whole person wellness model that posits that physical well-being, emotional well-being, spiritual well-being, intellectual well-being, occupational well-being, and social dimensions enhance QOL of older adult population. Their findings showed that only 16% of these activities were engaged in the rural communities (Kang & Russ, 2009). Kang and Russ recommended that programs of diverse activities should be made available in the rural areas because older adult in rural communities will increase by 2050 (Shetty, 2012).

Tham et al. (2011) examined the health service in rural Australia over a 6-year period, by looking at (a) structural domains (This consists of the performance of health service, sustainability, as well as the quality of care); (b) The process domains (This comprises of health service utilization as well as satisfaction); and (c) outcome domains (These are the health behaviors, health outcomes, and the viability of the community). Community surveys, interviews, and focus group discussions were used. It was found that cervical smear tests enhance the early detection as well as the treatment of cervical

cancer. This enhances the survival and QOL of the citizens. Also, it was found that immunization is a crucial public health measure that prevents the spread of common infectious diseases among older adults. Early detection and treatment of cancer and public immunization could be made possible if there are good health facility liked well-resourced clinics. Erickson, Call, and Brown (2012) asserted that rural older adults have limited access to services like shopping centers, healthcare facilities, and recreation. Ensuring programs of diverse activities in the rural areas would be helpful because just a few activities are available in the rural community (Kang & Russ, 2009).

In sum, the studies that have investigated older adult QOL in rural living conditions found these common relationships that effect QOL: visual impairment, pain, social support, physical activities, participation in social activities, and functional independence. Other common relationships include loneliness and physical health status.

Quality of Life of Rural Adults in Ghana

QOL of older adults in Ghana has been examined across a variety of situations, cultures, and conditions. The primary interest in this area is to see how aging and its consequences influence or are influenced by tangible and intangible aspects of QOL.

De-Graft Aikins et al. (2016) conducted research on aging in Ghana from the 1950s to present, and the purpose was to document the knowledge on aging studies to improve future research, policies, and interventions. The authors reviewed 115 studies that had already conducted and they all had certain things in common: (a) the aging population in Ghana is growing over the last four decades (b) the incidence of chronic health conditions like hypertension, stroke, and diabetes, has surged in the older target

group, creating comorbid conditions; (c) which will likely have adverse implications on healthcare costs, psychosocial well-being, and family caregiving.

De-Graft Aikins et al. collected data from already existing research studies on six empirical areas: (a) demographic profiles and patterns of aging; (b) the health status of older Ghanaians; (c) care and support for older Ghanaians; (d) roles and responsibilities of older Ghanaians; (e) social representations of aging and social responses to older Ghanaians; (d) socio-economic status, (e) social and financial protection, and (f) other forms of support for older people.

There is an evidence of low QOL in older adults in rural communities, when compared to urban areas of Ghana (Yiranbon et al., 2014). In rural southern Ghana, the target group experiences poor living conditions, and there is no support from the government (Cooke et al., 2016). There are better facilities in the urban areas compared to the rural areas. For example, good drinking water, access to electricity, reliable means of transportation, and good private health centers are available in the urban areas.

Health support is a major concern in Ghana among older adults, and self-reported health status are commonly used to explore one's current health as well as QOL (Fonta et al., 2017). The hardships in rural Ghana as a result of poor living conditions adversely impacted older adults' general health, and a majority (79.9%) of them rated their health status as poor (Fonta et al., 2017). These hardships include food insecurity, lack of access to good water, and unreliable means of transportation. Improvement of QOL through a good healthcare system requires policies about healthcare. One of the main problems for older adults in Ghana is lack of comprehensive and well-structured policy on healthcare

on older adults (Yiranbon et al., 2014). Such policies include public health policies that promote healthier diet patterns (Gorski & Roberto, 2015). This is necessary because over the past 2 decades, global eating trend has changed significantly (Gorski & Roberto, 2015). Population diets have changed towards a huge consumption of processed and ultra-processed foods that are mostly low in nutrients and at the same time high in energy (Gorski & Roberto, 2015).

Another factor related to QOL in older adults is access to food. Healthy eating improves a person's QOL (Steiner-Asiedu et al., 2010). The functional ability and health of older adult is partly contingent on their food choices and food security, which is defined as consistent access to food needed for a healthy living (Steiner-Asiedu et al., 2010). Sasson (2012) reported food insecurity as hardship in rural Ghana compared to the suburbs. Sasson (2012) asserted that economic hardship constitutes a constraint on an individual's ability access to good food choices. Aging cannot be prevented but the process can substantially be slowed down by healthy eating behaviors (Steiner-Asiedu et al., 2010). As a result, Steiner-Asiedu et al. (2010).

Razavi and Staab (2008) aimed at describing the health status of older adults in rural Ghana, and to determine factors that are related to their self-rated health. The data were accessed from a survey in the Kassena-Nankana area in rural Ghana. There were 4,584 participants aged 50 and above. The participants provided information about their health status, appraisal of well-being, and overall QOL. Most of the participants in older adult in rural Ghana evaluated their health status as normal, but the oldest among older adults reported poorer health status (Razavi & Staab, 2008). Older adults who had higher

levels of functional challenges rated their health status as poorer compared to their counterparts with fewer disabilities (Razavi & Staab, 2008). There was a significant association between household income, with wealthier participants rating their overall health status as good (Razavi & Staab, 2008). Ageing is seen as a global challenge which will impact developing countries greatly; therefore investing in health during the life course will ensure that a good number of people reach old age in good health (Ayernor, 2012). A key question in the ageing literature that remains unresolved is what proportion or of aspects of mobility loss could be attributed to the ageing process and what proportion could be associated with independent diseases (Ayernor, 2012).

Fonta et al., (2017) reported that those reporting poor health was 2.5 times higher among older adults compared to younger adults. Older adults with one or more chronic conditions described their health as poor (Fonta et al., 2017). The authors found that people with disabilities and morbidity difficulties are most susceptible to unsatisfied healthcare needs with a limited support system from government as well as family (Fonta et al., 2017). Participating in regular physical activity is an important part of healthy aging (Ashe et al., 2009). There is an increased risk for inactivity associated with aging and the risk becomes greater for adults who have a chronic disease (Ashe et al., 2009). However, there is limited information on current physical activity levels for older adults and even less for those with chronic diseases (Ashe et al., 2009).

Falls in old age affect QOL, and factors that contribute to falls in old age are the use of medication, cognitive impairment, and aging related sensory deficits (Potter et al., 2013). Falls affect the general physical health in older adult population, and it affects

QOL (Potter et al, 2013). Older adults who survive a fall go through significant morbidity. (Fuller, 2000). Hospital stays are almost twice as long in older adult patients who are hospitalized after a fall than in older patients who are admitted for a different health condition (Fuller, 2000). Compared to older adults who do not experience falls, those who fall go through greater functional decline in their activities of daily living (ADLs) and in their physical or social activities, and they experience a high possibility of subsequent institutionalization (Fuller, 2000).

The visual healthcare status in older adults in Ghana is not well documented although it has been found that it affects QOL in older adult (Potter et al, 2013). Availability of assistive devices as well as eye surgery varies widely across Ghana. Data acquired from a regional study based on gender found a high proportion of men who use visual impairment aids compared to women (Potter et al, 2013). Cataract remains the major cause of blindness and low vision worldwide (Ackuaku-Dogbe, Yawson, & Biritwum, 2015). Surgical intervention has been found to have greater cost benefits compared to no surgical intervention for those with cataract (Ackuaku-Dogbe, Yawson, & Biritwum, 2015). Intensive public education, engagement of community groups and increased access to cataract surgery at health facilities and outreach services need consideration at national and sub-national levels (Ackuaku-Dogbe, Yawson, & Biritwum, 2015). Further investigations to garner equity in national eye care efforts are recommended for rural older adults (Ackuaku-Dogbe, Yawson, & Biritwum, 2015).

According to Biritwum et al. (2013) good source of water and proper sanitation have been found to be determinants of QOL. A large percentage of older adult in rural

Ghana is at higher risk of diseases due to inaccessibility to quality water and sanitation. Although 84.7% of respondents had access to better drinking source of water, only 15% of the respondents lived in urban areas. One of the main factors that affect access to a good source of water is an individual's level of income. High level of income makes it possible to have access to a good source of water and better sanitation system (Biritwum et al., 2013). There are many challenges regarding access to good source of water and sanitation in rural Ghana. A large proportion of the older population of rural older adult in Ghana are at higher risk of diseases transmitted by the faecal-oral route, and there are major inadequacies in access to improved water sources (WHO, 2014).

Ahadzie and Doh (2009) reported that access to a good housing system significantly affected QOL. Ahadzie and Doh (2009) found that a significant percentage of older adults in rural Ghana could not afford good housing. Of 800 participants in rural Ghana, only 13% lived in a personal self-contained house and 44.4% lived in compound or shared housing. Almost three quarters of older adult participants shared bedrooms with their partners, siblings, and grandchildren and, in some cases, other relatives. This finding shows that the participants do not have access to good housing, and this affected their QOL because poor housing system comes with discomfort, inconveniences, and hazardous conditions which pose a threat to their physical well-being. Some of the materials used in building houses in Ghana carry health risks. Earthen floors, for example, develop cracks and crevices easily and can serve as suitable hiding places for pests and disease vectors (WHO, 2014).

Older adults in urban community experience better living condition through participation of social activities. Steiner-Asiedu et al. (2010) reported that lifestyle and social activity patterns of older adults in the urban communities revealed that a vast majority of participants (80%), both males and females, attended gatherings like church service. Older adults believed interaction with other people reduces stress and improves the lifestyle. Majority of the participants (90%) reported that they participated in these gatherings weekly. The concept of social participation is highly valued in old age (Manijeh & Farahnaz, 2020). However, there is ambiguity and disagreement in the definition and attributes of this concept among the elderly (Manijeh & Farahnaz, 2020). Social participation include emphasis on community-based activities and interpersonal interactions, based on resource sharing, active participation and individual satisfaction (Manijeh & Farahnaz, 2020). Social participation among the older adult have individual, environmental, and social antecedents as well as individual and environmental consequences (Manijeh & Farahnaz, 2020).

Boudiny and Mortelmans (2011) found that the application of the active ageing model can be used to evaluate the QOL in older adult population. WHO (2012) suggested that the active model is a good guide for any community that wants to ensure that older adults live healthier and dignified. This model has three pillars: health, participation, and security. The model is governed by seven principles namely activity, inclusiveness, disease prevention, development of two inter-generational solidarity, right and responsibility, participation, empowerment, and honor of diversity.

Aging could come with pains, and it affects QOL (Dueñas et al., 2016). Pain has a severe detrimental effect on their social and family environment, as well as on health care services (Dueñas et al., 2016). According to Aziator et al. (2016) chronic pain in older adult impacts many aspects of their life to the point that their QOL has been compromised. Pain affects the mobility of older adults, and this exerts impact on their daily activities. Many elderly people tend to dismiss joint pain and body aches as part of ageing and would rather self-medicate or quietly endure the pain. But untreated pain can become chronic and greatly diminish their QOL.

In sum, the studies that have investigated older adults in rural Ghana found these common relationships that effect QOL: pain, participation of social activities, and good housing system. Other relationships include: a good source of water and proper sanitation.

The Role of Family Caregiving

The role of family caregiving has been examined across a variety of countries, situations, cultures, and conditions. The primary interest in this area is to see how caregiving and its consequences influence or are influenced by tangible and intangible aspects of QOL.

Okoye and Asa (2011) examined the caregiver burden and stress in rural Ghana They investigated 330 caregivers (201 females and 129 males) with median age of 27 years in south eastern Ghana. Participants answered a questionnaire on their relationship with the care receiver and their level of stress. The results showed that there was a significant relationship between caregivers' ages and the levels of stress. The study found

that many factors lead to stress. One of these factors is the attitude of the caregivers towards older adults. For instance, some caregivers believe older adults' troubling behavior is caused by the illness, so the caregivers are less burdened compared to caregivers who believe older adults' strange behavior is deliberate. Also, caregivers who perceive older adult as emotionally demanding or dependent may feel burdened than those who perceive older adults as disabled. A variety of psychosocial and pharmacological interventions have shown mild to modest efficacy in mitigating caregiver burden and associated manifestations of caregiver distress in high-quality meta-analyses (Adelman et al., 2014). Psychosocial interventions include support groups or psychoeducational interventions for caregivers (Adelman et al., 2014). Caregiver assessment and intervention should be tailored to the individual circumstances and contexts in which caregiver burden occurs (Adelman et al., 2014).

In Ghana, Shaibu and Wallhagen (2002) examined the cultural sensitivity in older adult care by using grounded theory to explore the experiences of 24 caregivers of older adult family members. They observed that family caregivers' perceptions of caregiving differed from that of health workers who provide care. Health workers perceive caregiving as a profession whereas family caregivers perceive it as a family responsibility. The authors reported three categories of perception about caregiving: stigma; appropriate-inappropriate forms of care; and sense of place. Three caregivers hesitated to receive support from the government for caregiving due to the stigma attached to such programs. Forms of care varied and were determined as appropriate-inappropriate depending on the needs of the care receivers (Shaibu & Wallhagen, 2002).

Caregiver burden is associated with the stress and challenges. From a scientific standpoint, caregiver burden is theoretical. The conceptual basis for the appraisal of the care situation is the Transactional Model of Lazarus and Folkman (Gräßel & Adabbo, 2011). The subjective assessment of the care situation by the caregivers is important for the development and maintenance of subjective burden. In line with the transactional model, people appraise stressful situations by assessing the stressor and resources (Gräßel & Adabbo, 2011).

Nortey et al. (2017) asserted that the healthcare systems in low and lower-middle income nations, especially in sub-Sahara Africa, do not possess the necessary resources needed for the provision of comprehensive care for older adult populations. In most cases, the close-to-client area-based system are considered low-cost alternatives for providing care. A greater proportion (78%) of the family members who provided care expressed a high level of care-giving burden. Female caregivers reported a relatively higher level of cost than male caregivers. Additionally, majority of the family caregivers reported financial stress as an indirect cost of caregiving. Nortey et al. (2017) concluded that if the financial difficulties and the economic burden family caregivers face are not addressed, the situation will negatively affect their ability to care for older adult in their communities. Nortey et al. (2017) advocated for policies and programs that would alleviate challenges related to the financial needs as well as the security of the caregivers.

Ayenibiowo, Obashoro, and Ayeni (2013) reported that caregivers have favorable attitudes toward older adult care receivers in studies across the sub-region. Contrary to this, Dosu (2014) indicated that there is lack of respect for older adults cared for in recent

times in the Ghanaian rural community due to the fact that there is lack of resources and this constitutes a burden.

Chiu-Yueh (2010) assessed gender effects on family demands, social support, and caregiver burden as well as to examine the contributing factors of caregiver burden in caring for family members with mental illness. Providing continued care and support for people with mental illness is demanding and challenging. Findings of earlier caregiving studies on the role of caregiver gender in response to caregiver burden and caregiving-related factors have been inconsistent. Little research has been undertaken to examine gender effect on family demands, social support, and caregiver burden in Taiwanese family caregivers of individuals with mental illness. Data from 43 families, including at least one male and female family caregiver in each family, were analyzed using descriptive statistics, principal component analysis, and mixed linear modeling. Demographic data, Perceived Stress Scale, Perceived Social Support, and Caregiver Burden Scale-Brief were used to collect data. Female family caregivers perceived less social support and experienced higher degrees of caregiver burden compared with male family caregivers. In contrast, no significant gender effect was associated with family demands. Family caregivers with greater family demands and less social support experienced higher degrees of caregiver burden. Also, the assessment of stress and how it affects the health of family caregivers should be followed by guidance and individualized interventions to attenuate the health consequences (Bevans & Sternberg, 2012). The mere act of assessing and listening to the caregivers' needs communicates empathy which may in itself improve outcomes. A growing body of evidence also supports simple stress

management practices such as walking, meditating and adopting nutritional changes such as the Mediterranean diet that may help reduce fatigue, improve sleep and reduce the risk of some stress-related illnesses in caregiving (Bevans & Sternberg, 2012).

In sum, the studies that have investigated the role of family caregiving found these common relationships that effect QOL: caregiver burden and family demands. Others include caregivers' attitude and family resources.

Summary and Conclusion

Older adult in Ghana has grown over seven-fold from a total 213,477 in 1960 to 1,643, 381 in 2010. According to the 2010 population census, 6.7% of the total Ghana's population were 60 years and above. Of the 6.7%, a higher part of them were women aged 70 and above. An increase in this population without a corresponding improvement in their well-being is a problem which needs to be addressed. The literature review highlighted some factors of QOL. For example, food security, reasonable housing, pain management, participation in social activities, improvement in healthcare, and strong social relationships and network are the known factors that improve QOL. Reviewed from global perspectives, it is clear that there are few policies that have been put in place to enhance the wellbeing of older adults in other countries. The literature showed that older adult homes are becoming common. This means that living in such facilities creates another lived experience from home, which the rural Ghanaians are lacking. The research method for this study has been discussed in chapter 3, including the research design and rationale, the role of the researcher, procedures for recruitment, participation, and data collection, issues of trustworthiness, and ethical procedures.

Chapter 3: Research Method

The purpose of this phenomenological study was to explore the lived experience of QOL in older adults cared for by their families in rural Ghana. The exploration of the lived experience of older adults regarding QOL will improve understanding of QOL of rural Ghanaians. This chapter includes the research design and rationale, the role of researcher, methodology, and issues of trustworthiness that informed the study. Issues of trustworthiness covered credibility, transferability, dependability, and comfortability. Finally, this chapter provides a summary of the key subsections.

Research Design and Rationale

This research was based on the overall research question: What is the lived experience of older adults related to aging and QOL in rural Ghana?

RQ1: What is the lived experience of physical and mental QOL in older adults cared for by their families in rural Ghana?

RQ2: What is the lived experience of family caregiving in older adults in rural Ghana?

QOL consists of multidimensional areas including improvement in physical health status, psychological health, degree of independence, family support, achievement of educational goals, improved economic status, religious beliefs, an individual's sense of optimism, availability of local services and transport, availability of employment opportunities, strong social network, housing, and congenial environment. An individual's QOL can be determined on the basis of cultural orientation, values, personal expectations, and goals of what an individual intends to achieve in life. QOL has been

measured and studied in many ways. For example, Megari (2013) described QOL as self-satisfaction, which is subjective and likely to change. The WHO (2020) has defined QoL as "as an individual's perception of their position in life in the context of the culture and values system in which they live and in relation to their goals, expectations, standards, and concerns" (p. 3). For the purpose of this study, I selected the WHO definition as the basis for the exploration of this concept in the target group.

Research on QOL also identified factors that were incorporated into the current inquiry. These included strong social support (Sováriová Soósová, 2016), ability to cope with stress (Andréa et al., 2010), improvement in healthcare (Schatz & Seeley, 2015), food security (Steiner-Asiedu et al., 2010), and policy documentation about older adults (Yiranbon et al., 2014).

Family caregiving is the other phenomenon of interest that was explored. This concept has been extensively studied in research in Ghana and other countries and refers to care provided by immediate and/or extended family that includes (but is not limited to) health and medical, transportation, daily care, and emotional and social support (Dosu, 2014).

I used a phenomenological approach to investigate these phenomena of interest. I employed Giorgi and Giorgi's (2003) phenomenological approach to guide the development of the data collection tools and processes, specifically the interviews with open-ended questions and the use of dialogue. The steps included the assumption of the phenomenological attitude, reading the entire written account of the interviews for a sense of the whole, outlining meaning units, changing the meaning units into

psychologically sensitive statements of their lived-meanings, and synthesizing a general psychological structure of the experience based on the components. I sought the first-person psychological perspective the so that an empathetic position could be adopted by the end-user of the research.

I considered other approaches but deemed them less appropriate. For example, one was narrative analysis, which demonstrates how an individual's experience reflects the larger life influences that created the experience. Another rejected approach was grounded theory, which provides an explanation or theory behind an event.

To understand the QOL from the perspective of older adults, I utilized the ecological systems theory. It is a model designed for human development and uses a set of "nested" fields or systems (Bronfenbrenner, 1977). The ecological system model was ideal for the study because human functioning is based on intersecting spheres of biological, psychological, and social resources; environmental characteristics; and how individuals fit into their ever-changing environments (Lawton, 1990).

By considering older adults as individuals within an ecological system, a more holistic picture of their needs was developed, which helped determine external support resources that will improve their QOL (see Snyder, 2014). Utilizing the ecological systems theory as the conceptual framework provided me the opportunity to explore beyond what is already known about QOL.

Role of the Researcher

My role in the research was as the interviewer. There were no personal or professional relationships between the participants and me, particularly none with respect

to supervisory or instructor relationships that could have granted me an influence over the participants. Participants were purposefully selected from Breman Bedum and Breman Asikuma in a manner that avoided researcher bias and power relationships.

Cultural and other type of bias can arise in research. Almost every human being has biases, whether aware of them or not. Bias exists when a person consistently views issues through a fixed lens. Bias is mostly negative. I am a human, and I could be naturally but unintentionally biased in the study. I am originally from Ghana, and I lived there for 27 years before I migrated to the United States. I completed elementary and middle school in Ghana from 1986-1998. Also, I had my high school education in Ghana from 1998-2001. After completing high school, I pursued a 3-year practical teaching program at Assin Foso Teacher Training College from 2002-2005. I became a registered teacher in July, 2005, and I taught in middle school in Ghana from 2005 to 2009.

Shenton (2004) recommended triangulation as a possible way of avoiding research bias. This helps a researcher admit their own predispositions about the research topic. However, as this was a phenomenological study, triangulation of data sources was not possible because the key criterion for sampling was homogeneity in experience of the phenomenon. Additionally, because only interview data were collected, no triangulation of methods could occur. Therefore, I used audit trails to document procedures and bracket biases, which allows future researchers to replicate the conduct of the research. Shenton also recommended the use of iterative questioning in data collection dialogues that is devoid of the researcher's personal experience. I employed this technique.

In the present study I used member checking. This was achieved by sharing a summary of the results with the individuals who participated in the study. It offered them the chance to clarify their intentions and correct errors, and it provided further information as needed. Also, I used a coding approach.

Reflexivity is considered essential in qualitative research (Watt, 2007). Through reflection, an awareness is created for researchers to identify what allows them to see as well as what could hinder their seeing. This requires a tactical consideration of the phenomenon of interest and how the researcher's personal assumptions and behavior could affect the inquiry (Watt, 2007). To achieve reflexivity, I used a research journal. This helps a researcher make a retrospective examination of their own research to establish relevant links between theory and practice (Maxwell, 2005). This instills confidence in meaningfully constructing a sense of being a qualitative researcher (Holliday, 2002.).

Methodology

Participant Selection Logic

The sampling strategy used for the study was the complete target group strategy. This strategy is used to include everyone within a unique group of interest to create a participant group of different genders, occupations, beliefs, and religions (Patton, 2002).

The target group for this study was older adults in rural Ghana. The participants included older adults 66 years and above who had at least a high school diploma. The participants were known to meet the criteria because the age requirement was in alignment with the United Nations' definition of older adult. Also, having a high school

diploma was a guarantee that the participant could be interviewed in English because English is the medium of instruction in Ghana, and it is a required subject at all institutions in Ghana. Again, the participants were selected from the rural area of Ghana, specifically Breman Bedum because the rural communities experience a poor standard of living when compared to urban areas of Ghana (Cooke et al., 2016).

Data saturation is the quality and volume of information in a qualitative research study. Saturation is achieved at a level when nothing new is reported and observed in a study. To achieve data saturation, 10 to 12 participants are recommended for interview-based studies using homogenous samples (Guest et al., 2006).

To achieve saturation, data should be considered from rich and thick perspective (Dibley, 2011) instead of merely focusing on the size of the sample (Burmeister & Aitken, 2012). In seeking data saturation, I was led to ask clarifying questions and to receive detailed responses instead of just considering the number of participants. Also, another way to achieve saturation is to choose a data collection methodology that has been used in previous studies (Burmeister & Aitken, 2012).

Instrumentation

The primary instrument for the study was interview, which is in line with Giorgi's (2003) approach. The basis for the instrumentation was derived from the data collection instruments and sources that were reviewed in chapter 2. I demonstrated content validity in Appendix A, showing each interview question and the concept the question was derived from, along with the associated scholarly reference (Brod, Tesler, & Christiansen, 2009). I completed the interview with each participant in one session. The

specific primary interview questions are as follow; probing questions are located in the appendix:

1. Quality of Life
    - What does quality of life mean to you?
    - Tell me about your health. What is your most important health concern?
    - What are you satisfied with regarding your physical health?
    - What brings you joy?
2. Family Caregiving, Ecological Systems Theory (Bronfenbrenner, 1977)

    a. Microsystem

    - Tell me about the relationship between you and your family.
    - Tell me more about how you interact with your family members.
    - Tell me about why you depend on your family members.
    - Tell me about the family support you receive on a typical day
    - How does independence affect your quality of life?
    - Share with me about your access to nutrition
    - What is your most important health concern that involves your family?

    b. Mesosystem

    - Describe your interaction with your family members' partners?
    - Describe how the relationship between your family members and their partners affect your living condition.
    - Describe how the relationship between you and your neighbors affects your living condition.

- Describe how the relationship between you and your friends affects your living condition.

c. Exosystem

- Share with me how education could affect your living condition.

d. Macrosystem

- Tell me about how government health services affect your quality of life
- Tell me about how housing affects your quality of life
- Describe the facilities that have been provided by the government and how they enhance your living condition.
- How does your economic status affect your quality of life?

e. Cronosystem

- What have you seen in how younger people are moving away from the country and into the city?
- How does your physical environment affect your living condition?

f. Last Questions

- Is there anything else you would like to tell me about your quality of life and what it means?
- What is the one thing you believe would improve your quality of life?

Procedures for Recruitment, Participation, and Data Collection

The use of phenomenological investigation comes with several methods as well as procedures to ensure an organized, disciplined, and systematic study (Moustakas, 1994). Below are the procedures for collecting the data. No official approval is required from

any institution in Ghana because the target group are not residents or employees of any institution. It worth noting that these procedures were a bit informal due to the nature of the participants and geographical location.

There was concurrent data collection and analysis. I proposed to conduct data collection for 5 weeks, which included audiotaped phone interview. I started the process with establishing a good rapport, completing consent form, and taking general notes about their lived experiences. Interviewing provides more information because it helps respondents provide information that cannot be obtained through observation, and it allows the participants to share their unique perspectives Patton (2002). With regards to taking additional notes, field notes, including observations during the interview, variations in time and place of recording, how data are stored, as well as the materials for writing were documented. Debriefing the participants occurred at the conclusion of the interview and included a review of how the data will be used, member-checking, and the process for sharing the results.

Data Analysis Plan

Giorgi's method (2003) indicated that raw data need to be reduced and transformed through an interactive process of reading, describing, and interpreting. According to Giorgi, pre-existing concepts must be rejected prior to data analysis to avoid filtering and distortion that may impair authenticity.

The data consisted of transcribed interviews completed by research participants and I. After completing the transcription, I read the transcript a few times purposely to

enhance familiarity with the data, and to help develop an initial interpretation. Giorgi's (1997) descriptive method occurred in three interactive steps:

1. Phenomenological reduction ("bracketing")
2. Description of the reduced ("imagined") concepts
3. Search for essences (general structures from individual meanings)

One coding strategies from Saldana (2013) was employed to move from data to essence.

Issue of Trustworthiness

Credibility

I proposed the following strategies to establish trustworthiness: credibility, transferability, dependability, and confirmability. Credibility is relevant in research. To establish credibility, a well-tested methodology like Giorgi and Giorgi (2003), using audio recording and transcription, and member checking was used for the study.

Transferability

Another tool for establishing trustworthiness is transferability. To accomplish this, detailed description of my research procedures and provide descriptions of the data analysis and interpretation process were provided.

Dependability

Dependability is the test of checking stability or consistency of the process at different times. Dependability can be achieved by looking for errors in data collection, interpretation of the findings, as well as reporting findings. I achieved this by utilizing a reflective appraisal of the study by evaluating how effective the process was (Shenton,

2004). Also, I sent my findings to the dissertation committee for review and critique. Also, I provided methodological specifics that made room for duplication of the research.

Conformability

The final tool for establishing trustworthiness is confirmability. It measures the extent at which the findings are affected by personal interests or the biases of the researcher. To achieve confirmability, I organized the data and saved them in a manner that allowed others to replicate the research procedures. Also, I documented the activities for rechecking data and clearing circumstances that contradict past observations. I did these accurately to reduce the effect of research bias (Silverman, 2001).

Ethical Procedures

The nature of the study is qualitative phenomenology, so the confidentiality of the participants is crucial. Individuals who participated in the study are among the vulnerable population, so additional steps were taken to ensure their comfort by asking them to choose the exact location they wanted to be interviewed.

As a requirement to offer protections to human beings who chose to participate in research study, they were accorded with respect, beneficence, and justice. This was done in conjunction with all the ethical obligations mandated by Walden Institutional Review Board (IRB), and this was in accordance with all legal requirements. The IRB approval number is 9-2-20-0624141

This consisted of appropriate informed consent (Walden's template), providing them with the necessary information to help them make an informed decision, and a discussion of related risk involved in the study. The Walden University Research Ethics

Planning Worksheet which describes 40 ethical standards for consideration for research was also helpful in enhancing the welfare for participants.

Before beginning the study, I involved the IRB in acquiring guidance on the appropriate forms that needed to be sent to the board to help acquire study approval. I filled the form according to IRB requirements. This helped clarify all issues that could have an adverse impact on the participants.

I did the recruitment after an authorized representative moved from house to house to distribute research brochure. I am a regular visitor to these communities, so my presence was not a concern.

I informed participants of the rationale for the study, the risks and benefits of participation, the confidentiality of the study, and the right to withdraw participation at any time. I assigned fictitious names to the data to protect the privacy of the participant. The data is accessible only, the Walden IRB, the research committee, and me. A summary of the results has been sent to participants.

Summary

In this chapter, I discussed the research method, design, and tradition. Also, I discussed semi-structured interviews that I used for the qualitative phenomenological research. Also, I discussed research journal and field notes to record participants' information. Again, I included detailed information about the methodology. This include recruitment of participants, data collection, data, and analysis. Also, I provided detailed information on issue of trustworthiness. Other issues discussed are participants selection logic, data analysis, and instrumentation. These covered credibility, transferability,

conformability, and dependability. In the next chapter, I will discuss into details, the research findings and interpretation of the result.

Chapter 4: Result

Introduction

The purpose of this phenomenological study was to explore the lived experience of QOL and family caregiving in older adults cared for by their families in rural Ghana. The research questions were:

RQ1: What is the lived experience of QOL in older adults cared for by their families in rural Ghana?

RQ2: What is the lived experience of family caregiving in older adults cared for by their families in rural Ghana?

This chapter will present the setting, demographics, data collection, data analysis, evidence of trustworthiness, the result, and summary.

Setting

I planned to have a representative walk from house to house in the designated areas distributing invitational flyers. Interested participants were to contact me, and I would proceed with the informed consent process and schedule the phone interviews. The setting followed the plan, so the representative did a good job by distributing as many flyers as possible at Breman Bedum and Breman Asikuma. Upon receipt of flyers, I received calls from prospective participants. I screened the prospective participants based on the participation criteria: aged 60 years and above, living in rural Ghana, and ability to speak basic English. I scheduled participants and reviewed the informed consent with them. I scheduled a phone interview and collected data.

Demographics

I interviewed 6 older adults with the following demographics: four females and two males. The ages of the females were 60, 65, 68, and 70, and All four women had completed secondary school. I interviewed two men with the ages of 61 and 82. Of these participants, one completed secondary school, and the other one completed technical institute. Of the six participants, two were married, one was divorced, and two were widowed. Two of the participants lived with their grandchildren, one lived with her 90-year old mother, two lived by themselves with regular contact with children, and one lived by herself because she does not have a child. None of the participants was on government payroll. None of them was currently working as a profession but some of them did some menial work to keep active. An example of such menial work was backyard gardening. Participants shared these data during the pre-interview conversation.

Data Collection

Primary data about the lived experience of QOL were collected from six participants. Data were collected via a phone interview within a 2-week period. The length of the interviews ranged between 45 and 55 minutes. Each participant was interviewed within a day. After seeking their consent to record their responses, I recorded data on a tape recorder. I called participants from an android phone and put it on speaker. There was no variation in data collection from the plan presented in Chapter 3.

Data Analysis

Bracketing

There is a natural tendency for aging to be compromised by increased mental and physical health problems. These issues can affect the experience of QOL. Because I have lived in rural Ghana before, I perceived there is lower QOL among older adults in rural communities when compared to urban areas of Ghana.

Prior to the data collection, I suspected that the responsibility of caring for older adults by their families in rural Ghana is becoming increasingly challenging, and this may affect QOL. As a Ghanaian, I knew it is the tradition for family members to take care of older adults without any government support, but research has shown that changing economic and social structures make this tradition less optimal, and elders suffer. I knew there are poor living conditions in Ghana, and this has affected QOL of older adults in rural Ghana. Also, I knew there are several factors that serve as pillars to enhance QOL. These factors include mental and physical health, structural support and resources, and social supports like family, friends, and community. When they are inaccessible, decreased QOL can result.

I had the opinion that the healthcare system in rural Ghana often lacks the trained human resources and infrastructure to provide comprehensive care needed for older adults. It was my belief that family members take on increasing roles in healthcare and may not be informed or trained. This is particularly relevant for older adults as aging comes with a decline in immunity and with health problems like cognitive decline,

physical infirmities, and decline in ability to cope with psychological issues. Healthcare and related support facilities are crucial needs for ensuring the well-being of older adults.

Also, I had the belief that older adults need to be provided with assistance like healthcare, social service, and community centers that enhance or replace family support by the government. However, these supports tend to be present in more densely populated areas rather than rural areas.

Also, I knew that older adults in rural Ghana experience loneliness due to the inability to get in contact with other people who are important to them. Family members may be far away or unable to attend to elders' needs more regularly due to the fact that the majority of the youth migrate to the cities and other countries.

As a resident of the United States, I can say there are healthcare centers that provide quality care for older adults and this has improved QOL, but I thought there were insufficient public health institutions in Ghana to provide healthcare for the older adult population, especially in rural Ghana.

I had the opinion that food insecurity is a problem in rural Ghana compared to the urban area. Access to food is a problem, and this can adversely affect QOL. Economic hardship constitutes a constraint on an individual's ability to access good food choices. Older adults need proper nutrition to boost their failing immunity.

Based on articles I read (e.g., Gould,1960; Taaffe, et al., 1963) I was thinking Ghana currently has a great transportation development. These authors proposed six linear phases for transportation development in Ghana: (1) scattered ports, (2) penetration lines and port concentration, (3) development of feeders, (4) beginnings of

interconnection, (5) complete interconnection, and (6) emergence of high priority main streets.

Finally, I knew there was lack of clean drinking water, and sanitation systems were a severe public health concern in Ghana, contributing to diseases in Ghana. Widespread use of plastic drinking water sachets due to lack of available potable water has also led to increased plastic pollution, often polluting water bodies, choking stormwater drains, and causing death of livestock.

Analysis

The data analysis plan was Giorgi and Giorgi's (2013) methodology. Specifically, I followed the following steps: the assumption of the phenomenological attitude, reading entire written accounts for a sense of the whole, outlining meaning units, changing the meaning units into psychologically sensitive statements of their lived-meanings, and synthesizing a general psychological structure of the experience based on the components of the experience. The process used to move inductively from coded units to larger representations included a preparation of raw data files. This was done by formatting the raw data files in a common format of font size and margins. The second step was close reading of text. When the text was prepared, I read the raw text in detail so I was familiar with the content and gained an understanding of the themes and details in the text. These themes were originally identified using the provisional coding method (Saldana, 2016), whereby broad concepts that were anticipated from the literature review and theoretical framework (see Chapter 2) guided the coding process. Then, I went to the original text of each participant and coded in vivo (extracting bits of text verbatim from the transcript)

into Excel spreadsheets. Then, I organized the codes and grouped them into categories, moving back and forth between codes, categories, and themes to accurately summarize the meanings of the participants across cases.

Table 1

Codes, Categories, and Themes from Data Analysis

Theme	Category	Examples of codes
Environment	Typical problems	P1: Physical environment is bad P6: Environment is not good.
	Consequences of environmental problems	P1: We inhale the smoke badly P2: Because of no tree the sun is too high making life hard
	Recommendations for solutions	P3: We need good air P6: I feel something should be done about it
Education	Educational level	P1: I attended technical school P3: I have education at secondary level
	Impact of education on QOL	P2: It has helped me to read most of the health tips. P4: Education has increased my knowledge
	Emotional effect	P1: Without secondary school education, I will not be police
Housing	Residential stability quality of residence-repair	No information provided P2: It is an old house which needs renovation P5: My roof is always leaking
	Quality of residence: co habitant	P6: There are too many people living in this house

		P6: One of the rooms contains 7 people
	Emotional effect	P1: People build houses and don't do toilet. P6: The housing issue is a big one
Family	Access to nutrition/What is missing	P1: I have food to eat and I get all the nutrients P6: Food is not a problem but the distance to the market is a problem
	Dietary habit/food choices	P2: because of my hypertension, I am advised to be careful with my eating P4: the only habit that can affect me is too much oil
	Cooking/meal preparation	No participant provided a response.
Health	Personal health status	P1: I don't feel any disease or pains or anything P3: I have a knee problem
	Health services	P3: The health center in my nearby community P5: They provide many services like insurance, and they charge low prices
Nutrition	How they maintain their health	P1: I have a backyard garden I work on three days a week P2: just water
	Satisfaction with health service	P5: I did not have this some years ago P6: I am happy about these services and satisfied
	Emotional/physical concerns expressed	P1: I don't want to become weak soon so I do my garden behind my house. P4: the only problem I have is that the facility is

		too small so it cannot take more patients
Transportation	Access to transportation	P1: There are taxi around P3: There are enough taxi to take me to different towns
	Effect of services on participants.	P1: It is a lot so transportation is too much costly so we still have the same problem P4: Most of the roads leading to our villages are untarred which make us dirty when we travel
Migration	frequency of migration	P6: That has been the truth for a long time P3: Yes, it is going on
	consequences of migration	P1: they travel and come home with more money for their families and friends P2: There are enough job in the urban area so they travel for better opportunities
	social impact on family	P2: When the youth leave, they return for home visit. P5: No effect on the family interaction
Other government services	Availability of public facility	P1: Education is good here, there is a clinic too P5: we have good nurses to treat me when I go to the community hospital
	How the facilities are helping participants	No response provided
	Emotional effects	P3: There was a day I had a car accident which attracted so many people to attend to me.
Typical Day	things the elderly participants do	P1: There is no safety here P4: I start my day by waking up and brushing my teeth and I do bathing

		P3: one of friends is the queen mother of the community. She will always invite me to all functions in the community to give advice.
	emotional expression	P1*:* The good relationship I have with people is making life easy and enjoyable
		P2*:* I talk to my neighbors and friends and fetch water from their pipe and use it
	physical QOL	P2: To me, seeing people is just like taking medicine and it is important to me. they visited whenever I was sick and that helped me a lot to get well.
	emotional QOL	P1: Having a good relationship with others builds a peaceful environment
Overall QOL	Unique definition of QOL	P1: According to my mind, quality of life talks about many things but specifically to me it means having all my needs
		P2: Quality of life is how I can live a better life and having all the important things to enable me to live better
	Personal experience	P2: There are most things that make life hard in the rural area for example violence and bad road and poor housing
		P6: I don't think so because if I compare how life was in the city, I think my life now is not quality

There were no discrepant cases in the interview participants. However, within some of the results, individual participants shared unusual or different answers. These are discussed in detail in the results.

Evidence of Trustworthiness

Trustworthiness helped in strengthening the overall value of the research. Trustworthiness was achieved by establishing credibility, transferability, dependability, and confirmability (Amankwaa, 2016). Trustworthiness determines the extent of thoroughness and accuracy of the research, and this was achieved by a consistent, accurate, precise, and exhaustive analysis of the data collected. The trustworthiness for the research was achieved through many strategies in data collection and analysis.

Credibility

Credibility is defined as establishing the confidence in the truthfulness of the results (Amankwaa, 2016). I stated in chapter 3 that I will use a well-tested methodology of Giorgi and Giorgi (2003), audio recording before transcription, and member checking for the study. All responses were audio-recorded. After completing each transcript, each participant was given the opportunity to review their transcript to ensure the accuracy of their responses. During the interviews, participants were also encouraged to offer an in-depth and detailed information about their experiences to ensure that no significant or relevant information concerning the study will be missed in the analysis process.

Transferability

Establishing transferability involves demonstrating the findings are applicable in other contexts (Amankwaa, 2016). As stated in chapter 3, I provided a detailed

description of research procedures and a description of the data analysis and interpretation plan. Also, I used thick description for the purpose of achieving external validity. During the interviews, each participant was encouraged to provide in-depth and detailed information about their experiences. Also, I used probing questions during the interviews and got more information about experiences the participant would not have willingly expressed, and this helped ensure the transferability of the research.

Dependability

Dependability involves establishing the study's findings are consistent and can be repeated by other researchers (Amankwaa, 2016). As proposed in chapter 3, the audio recordings and transcripts were successfully reviewed several times for accuracy. The process of data collection and analysis were also documented to establish the dependability of this study. Also, I achieved dependability by looking at errors in data collection, interpretation of the findings, as well as reporting findings. Also, the findings were sent to the dissertation chair for a preliminary review or critique. Finally, the chair and second committee member helped with establishing dependability through external audits by offering feedback and guidance on developing stronger and better results.

Confirmability

Confirmability is the extent of neutrality to which the results are influenced (Amankwaa, 2016). In line with the proposal in chapter 3, an audit trail was used, which entailed detailed descriptions of the steps I employed to conduct this research. The audio recordings of the interviews also helped achieve the confirmability of the study. To conform with the proposal in chapter 3, reflexivity was used and it helped to be mindful

of any possible personal experiences or biases. In view of this, I used bracketing during data analysis to ensure that the data were devoid of my personal biases and opinions.

Results

Theme 1: Typical Day

The theme, *typical day*, was composed of four categories: things the elderly participants do, emotional expression, physical QOL, and emotional QOL. In the first category, participants described ordinary self-care (e. g, washing, bathing, brushing teeth, haircare); and indoor household chores (sweeping, cleaning). Two participants also spoke of outdoor activities being part of the typical day, including talking to neighbors, outdoor sweeping and farming. For example, P4 described, "I start my day by waking up and brushing my teeth and I do bathing." In addition, P3 indicated that "one of friends is the queen mother of the community. She will always invite me to all functions in the community to give advice. Also, P1 stated that "there are lots of dust around so when I wake up my household chore is sweeping. I sweep the entire compound by myself"

Emotional expression included a range of positive and negative experiences. Having relationships with others was most often expressed as positive emotion; i.e., the enjoyment of family company, or the pleasure of conversing with neighbors.

"The good relationship I have with people is making life easy and enjoyable and there are always things I can do with neighbors like social activities so my relationship with them is making life great and that is important to me" (P1). Also, P2 asserted that "I talk to my neighbors and friends and fetch water from their pipe and use it." Having "a good sleep" (about 7 hours) was a pleasurable experience. Negative emotional

expressions included loneliness and lack of assistance to complete house chores. P2 stated that “I am thinking may be if I am sick nobody will come around and even I won’t feel comfortable calling people to come because I don’t know what they will observe and go tell other people.”

For the physical QOL category, the participants described the presence of people, and good sleep. This was interesting, as the researcher was attempting to create discrete categories, but many of their descriptions easily fell into more than one category.

> To me, seeing people is just like taking medicine and it is important to me. they visited whenever I was sick and that helped me a lot to get well. The presence of people gives me some relief and it is like medicine. (P2)

Some of the emotional QOL among the participants include having a good relationship and having a social support. For example, P1 asserted that “having a good relationship with others builds a peaceful environment and you know peace is very important than money because if I have everything without peace life will be hard.”

Theme 2: Health

The theme, *health* was composed of five categories: personal health status, health services, satisfaction with health service, health maintenance, and health concern. In the first category, participants described their current health status. Four participants described their health as good. Two participants have health concerns: knee pain and hypertension. Those with good health expressed it with joy. For example, P1 stated that “I don’t feel any disease or pains or anything. I am old but I still look strong” Also, P6 indicated that “For the past two years I am fine no diseases or illness”. Similarly, P4

asserted that “no serious illness right now. I don’t use a walking stick or anything”. Contrary, P2 stated that “I am afraid that it can cause many problems. Hypertension can damage my body for years and it can lead to disability or low life” and P3 asserted that “I have a knee problem”

In the second category, the participants described the availability of health services. All the six participants responded positively about the availability of health services. Their responses included the availability of health centers both public and private, adequate nurses and doctors, and the availability of medicines. Other participants complimented other services like health insurance. Also, they stated that the services are offered with respect. For example, P5 stated that “They have lots of nurses who are respecting patients. Also, they have a good doctor now who takes good care of me when I go to hospital”. Also, P1 indicated that “the government is doing well about health services. There are many healthcare centers around this area. I can visit with small sickness, so I am satisfied” Similarly, P5 asserted that “they provide health insurance for needy people like me”

In the third category, participants described their health maintenance. Two participants maintain their health by eating vegetables and fruits. One participant maintains his health by ensuring he gets adequate sleep. The remaining three maintain their health through productive activities like working in backyard garden, sewing, folding and ironing clothes. For example, P5 stated that “I normally have a lot of sleep for eight (8) hours on the average.” Also, P1 asserted that “. I haven’t got sick for like 6

years may be due to the natural vegetables I eat daily." In addition, P2 indicated that "I am mostly eating just fruits"

In the fourth category, participants described their satisfaction with health services. Of the six participants, five were satisfied with the health services. Only one participant expressed dissatisfaction. Her dissatisfaction emanates from the lack of availability of adequate medicine applicable for her condition. Also, patients who pay cash are treated better than those who have insurance. For example, P3 stated that "when I go there with health insurance, they don't serve me well but if I go there with cash they treat me well and take money" Also, P4 asserted that "I am okay with the health service in my community". In addition, P2 indicated that "Nowadays they provide quality health care for people and I am satisfied about it"

In the fifth category, the participants expressed their health concerns. The participants described how their health were in the past compared to the present. One participant expressed concern about becoming weak if they don't maintain their health. Two participants expressed concern about high cost of treatment. All the six participants expressed concern about having to travel to a bigger hospital in case of a serious health condition due to the size of the hospital. For example, P3 stated that "If it is a major disease I have to travel to the central hospital where things are expensive." Also, P1 stated that "I don't want to become weak soon, so I do my garden behind my house." In addition, P4 stated that "the only problem I have is that the facility is too small so it cannot take more patients"

Theme 3: Environment

The theme, *environment*, composed of three categories: typical problems, consequences of environmental problems, and recommendations for solution. In the first category, all six participants stated that the environment is not good for them. For example, P1 stated that "My physical environment is bad. People burn things anyhow and the smoke is disturbing me" Also, P4 stated that "People take the sand anyhow and make a lot of slopes around" Again, P6 asserted that "The environment is not good. This has been a problem for a long time and we are still having it here".

In the second category, two participants expressed concern about inhaling contaminated air. For example, P1 stated that "we inhale the smoke badly" Also, P3 stated that "It makes it difficult to breath in a good air and this has been a problem all the time" One participant expressed concern about indiscriminate felling of trees leading to excessive sunlight. For example, P2 stated that "because of no tree the sun is too high making life hard" One participant expressed concern about eating contaminated fish from contaminated water. For example, P4 indicated that "When this fish is eaten I fall sick. When this water is dirty and I drink I also become sick." This was in reaction to the fact that fishermen use chemicals to catch fish which end up contaminating their source of water. P6 did not comment on this category.

In the third category, five participants stated that effort should be made to improve the environmental situation without specifically stating what typically needs to be done. For example, P2 stated that "there should be a way to secure the environment

from such activities" Also, P3 stated that "We need good air" Again, P6 stated that "I feel something should be done about it." P1 stated that a specific thing that needs to be done.

> If you go to the cities, they have a container that you can put your old things in and they will carry them away and may be destroy them but here, we burn lots of thing to destroy the air. (P1).

Theme 4: Education

The theme, *education*, composed of three categories: education level, impact of education on QOL, and emotional effect. In the first category, five participants stated that they completed high school. For example, P1 stated that "I completed secondly school. Now they call it high school but during my time it was called secondary school" Also, P2 stated that "I went to secondary school" and P3 indicated that "I completed secondary school in Oda in 1950" P6 completed technical school and he stated that "I attended technical school"

In the second category, all participants shared their experience about how education has helped them. For example, in effective communication, job acquisition, problem solving, and critical thinking. For example, P3 stated that "It has given me the ability to think and know good and bad. Education helps me to be able to read and write. It has increased my ability to do things easily" P1 indicated that "I was a police officer and they asked for secondary school certificate" and P4 said "Education has increased my knowledge"

In the third category, only P1 commented on the emotional aspect of having or not having education by saying that "Without secondary school education, I will not be

police" P5 shared unusual answer and outlined how the community is benefiting from his education. When there is a problem in my community, people invite me to go and sit them down and solve it for them. I listen to both parties and I think deep about it and I solve the problem and this makes me feel proud. It is a free service for my community. (P5). Also, P3 shared unusual answer and defined what education is by stating that "Education is process of learning to develop individuals as a whole. Education develops both physical, social, moral and psychological"

Theme 5: Housing

The theme, *housing*, composed of four themes: residential stability, quality of residence-repair, quality of residence-co habitants, and emotional effect. All six participants did not comment on the first category.

In the second category, three participants complained about repair-related problems. Some of these problems include lack of toilet and leaky roofing making life uncomfortable. For example, P1 stated that "Where I live now, there is no toilet" and P2 said "When it rains, I need to stay awake until the rain stops" P2 provided this information to support the fact that his roof is leaky. Also, P5 said "My roof is always leaking". Two participants indicated that that they are satisfied with the quality of their residence. For example, P4 said "My house is not bad" and P3 said" the house I live in now, they build it just this year, so it is better and no problem." P6 did not comment on this category.

In the third category, only P6 commented by stating that “There are too many people living in this house. Too many. They talk a lot and makes a lot of noise” and “One of the rooms contains 7 people”

In the fourth category, four participants expressed negative emotions about the state of their residence, describing it as uncomfortable. For example, P1 said, “Housing is a problem for me and I can’t hide this truth.” Also, P2 said. “It has not been easy but life must go on but housing is a problem,” and P5 said “all is not well about housing”. Two participants expressed positive emotions due to the fact that they are satisfied with where they live and it is positively impacting on their QOL. For example, P3 said “now things are ok” and P4 stated “Wherever I lived, I had no problem and it gave me stable peace of mind to work”

P5 shared unusual answer by generalizing that housing is generally a problem in rural Ghana. P5 stated that “If I move out right now, I am going to face the same problem again so I have just decided to stay here and see how things will go”

Theme 6: Nutrition

The theme, *nutrition*, composed of four categories: access to nutrition/what is missing, dietary habit/food choices, impact of diet on health, and cooking/meal preparation. In the first category, all the six participants indicated that they have access to food and they feel happy about it. For example, P1 said “I have food to eat and I get all the nutrients. P3 stated that “food is not a problem” and P4 said “I have food, but I eat with carefulness”

In the second category, two participants indicated that they avoid the habit of eating heavy food as it may have impact on their health. One participant avoids excessive sugar due to diabetes, one participant avoids processed foods and meat, one participant avoids eating too much carbohydrate due to the possibility of gaining too much weight, and one participant avoids eating too late. For example, I don't have to eat too much sugar. If I eat lot of sugar, my diabetes will come again. It comes and go so I am careful with sugar. Eating too much sugar is a habit that bring me sickness. (P1). Also, P2 stated that "The habit that will affect me is if I eat too heavy or too much of any food at all" Also, P5 stated that "I have to watch the habit of the time I eat"

In the third category, one participant indicated that dietary habit will increase their diabetes. Three participants asserted that their dietary habit may resort in excessive weight gain. One participant was concerned about faster heartbeat and one participant stated that they will feel indigestion if they do not follow proper dietary habit their dietary habit.

In the fourth category, none of the participants provided responses. There were three unusual issues where participants shared their experiences about why they miss meals on a typical day. For example, P1 stated that "It happens when my grandchildren are not around and I can't go to the market to buy food. Sometimes I have food but maybe I don't have appetite for it, so I go to bed with empty stomach" Also, P4 stated that "I don't normally miss my meal unless I just don't want to eat." I fast during Easter convention. It is a time to remember how Christ died, so I fast to remember him and also

renew my strength. Many Christians don't do it but me I do it every year and it means a lot to me by drawing me close to Jesus that is why I fast and miss a meal. (P6).

Theme 7: Transportation

The theme, *transportation*, composed of two categories: access to transportation and effect of services on participants. In the first category, all participants stated that they have access to transportation although the transportation service needs improvement. For example, P1 stated that "There are taxi around". Also, P3 said "There are enough taxi to take me to different towns" and P4 stated "Transportation is not difficult to be accessed in general"

In the second category, two participants complained about high cost of transportation as an obstacle to travelling. One participant complained about the nature of the road as untarred leading to a high rate of accidents. One participant complained about delay in getting a taxi. Two participants complained about other risks related to travelling like armed robbery. For example, P1 said "It is a lot so transportation is too much costly so we still have the same problem and I am not sure when the fare will go down a little". Also, P4 said "Most of the roads leading to our villages are untarred which make us dirty when we travel but there are taxis, but the roads are not good and the fare is high" and P6 indicated that "People rob passengers all the time so me I am scared to travel". P3 shared unusual answer and highlighted how natural phenomenon like rain affects transportation. "They are not good. As a result, they charge high fare. When it rains, it is hard to get a taxi because no car can move"

Theme 8: Family System

The theme, *family system*, composed of four categories: family relationship, family activity, dependence on family, and interaction with family members' partners. In the first category, three participants indicated that they live with their grandchildren. One live with her 90-year old mother, one lives alone, and one lives with children. For example, P2 stated "I live with my mother, she is 90 years. I have children but they live in another house. They come sometimes to help when I am tired." P5 stated "I don't have a nuclear family because I did not give birth but my extended family, they are good" and P4 indicated that "Especially my two sons. They send me money monthly through mobile money and I use it to take care of me and their children who live with me."

In the second category, five participants indicated that they meet quite often with family and mostly participate in cookouts and making fun. One participant said most of the interactions is on the phone. For example, P3 stated "I cook and make sure that everything is in order." Also, P4 stated "For my sons when they come we mostly cook together and we talk about their children's progress" and P5 indicated that "For my family, they are all busy people so we don't meet so much for activities but we call each other very often and talk on phone."

In the third category, five participants stated they depend on family members for social support, encouragement, or happiness when they are sick. One participant stated he depend on his family for both food and social support. For example, P2 stated "I only depend on them for like social help when I am sick." Also, P4 stated "I depend on them for encouragement when I am sick or when my close friend dies." And P6 said "It is about depending on each other as a source of happiness"

In the fourth category, five participants stated they interact with their in-laws often and they have a good relationship with them. For example, P1 stated "My in-laws and me, we have good interaction. P2 stated "my in-laws are cool with me" and P5 said "I have a good relationship with them and I interact with them but occasionally." P4 said she does not have a good relationship with her family members' partners. She stated that "The relationship between me and my family's partners always make me to cry when I am alone. They make me cry always. I love them as family, but they are not. They don't regard me."

Two participants shared unusual answers. They indicated that in case they are in need, they will rely on their income from their investment or they will apply for a loan from the bank instead of relying on families. For example, P5 stated that "If I need money, I talk to a bank manager called Mr. Koomson and explain everything to him and he will give me loan and I pay back so no money issue with family" and P2 stated that "Even if my daughter stops paying my rent right now, I will be ok because of my investment. I started it when I was sixty years. I have been doing it for about 9 years"

Theme 9: Migration

The theme, *migration*, composed of three categories: frequency of migration, consequences of migration, and social impact on family. In the first category, all participants said migration to the cities has been the norm in the rural area. For example, P6 said "That has been the truth for a long time" Also, P3 stated that "Yes, it is going on" and P5 said "People go and come back with new life and new behavior"

In the second category, all participants said job opportunity for the youth in the rural area is the consequence of migration. For example, P1 said “they travel and come home with more money for their families and friends” Also, P2 stated “There are enough job in the urban area so they travel for better opportunities” and P5 said “They come with new job skills like plumbing and share with the young ones” P5 believes that learning a new life and behavior are the consequences of migration. Life in the city is different so when they go they learn a lot and they come home to share. I remember during my youth age I travelled to the city for some time before I came and things are different there than here so people should travel and come back. (P5).

In the third category, all participants stated that migration does not pose any negative social impact on families due to the fact that those who travel visit often and they communicate often through phone calls. For example, P2 stated “When the youth leave, they return for home visit. They make calls to their families back home to find out how things are moving on with home so they are still together like they have not travelled” Also, P5 said “No effect on the family interaction” and P6 stated “I don’t think so because most people have phone to call their family and ask questions or talk to them so I think it will not affect anything concerning interaction” P1 shared unusual information by indicating how long the youth could be gone. “Some people go for a long time before they come. Others go for short time”

Theme 10: Other Government Services

The theme, *other government services*, composed of three categories: availability of public facility, how the facilities are helping participants, and emotional effects. In the

first category, all participants stated that education is good at the rural area. Four participants stated that apart from education, health facilities are available in the rural areas. For example, P1 stated “Education is good here, there is a clinic too” P5 also stated “we have good nurses to treat me when I go to the community hospital” and P2 said “Education is ok here and have hospital” P3 mentioned electricity “we have electricity” and P4 mentioned that taxies are available. “There are schools and also taxi for travelling”

In the second category, none of the participants provided information. In the third category, two participants expressed worry about lack of safety in the rural area. For example, P1 stated “There is no safety here. Always scared and thinking may be thieves will come or not” and P5 said “Many people including me are not fine with this thing fearing us so I need to advise the government to send soldier people or police people to come and catch thieves and people who use guns” P6 expressed concern about poor road network leading to accidents. “Many people are dying because of road accident because of the bad road with many potholes” Also, P3 stated the same concern “There was a day I had a car accident which attracted so many people to attend to me. All my family was around to sympathize with me. It is all because of bad road” P4 expressed concern about no government policy leading to improper disposal of trash “People throw rubbish in the rivers and they and anywhere and they smell bad” P2 did not comment on this category. P6 made a direct request and specifically asked that their concerns are relayed to the government. “If you know some people in the government tell them. The road is bad and the dust comes to our house when the cars are passing”

Theme 11: Overall QOL

The theme, *overall QOL*, composed of two categories: defining QOL; and what is lacking. For the first category, the common elements of QOL in older adults included access to food and water, having people around, access to proper transportation, and safety. Below are the quotes:

> According to my mind, quality of life talks about many things but specifically to me it means having all my needs like good food, a peaceful house to sleep in, and good drinking water. You know sometimes it is hard to get food even if I have money because I cannot cook sometimes. The market is far so, when I am tired and I cannot cook, I have to go to bed with empty stomach. Also, we have water bodies like the big river and the pipe, but they are not clean and the house I am living in right now, I rent it and there are too many tenants so there is always noise around. So, quality of life means good things in life. (P1).
>
> Quality of life is how I can live a better life and having all the important things to enable me to live better and enjoy the good things of life such as good water, good house, police patrol, and good road. It means I have what it takes to succeed in life. With quality life, I can eat good food and a balanced diet. I should be able to provide everything for myself including dresses. (P2).
>
> To me quality of life is the well- being of people living in an area. If one person is having money and others are not having, it cannot be term as quality of life. So, quality of life is enjoying life with people and programs I want. (P3).

> Quality means anything good and can be used for the benefit of man. Quality of life cannot be provided by oneself, but one enjoys quality life when people come together. This are all I can say about quality of life. (P4).

> To me, quality of life is just about having life. So far as I am alive, I have quality of life. Because I have life, I can do many things to make myself happy. I can grow crops, go fishing, join a live band for music, continue my sewing, and choose which person to be my friend. It is like I am alive, so I have the ability to make myself happy in a moral way. I can choose to do anything that dead or sick people cannot do so to me quality of life is all about being alive. (P5).

> I am thinking that quality of life means if I have a peaceful environment, then I feel my life is quality. You know I can have everything like money, big farm, and other things but if there is no peace, then I cannot cope and it will affect my quality of life, so if I should make it simple for you to understand my point, then to me quality of life is to live in a peaceful environment. Maybe you have your meaning, but this is my own and also having good road to prevent accident. (P6).

In the second category, all participants maintained that life is good in some way but not exactly how they want it. For example, P6 stated that “I don’t think so because if I compare how life was in the city, I think my life now is not quality” Also, P4 stated that “I have a quality life in some aspect and other aspects are not quality” and P2 said “There are most things that make life hard in the rural area for example violence and bad road and poor housing. It makes life not the best compared to the cities” P5 shared unusual

answer by saying that QOL is all about being alive. “No but I have life so that is the most important thing.”

Reflections on Bracketing

There were several findings that contrasted my original expectations, described in the earlier section. For example, I expected that there was poor or no healthcare facility in the rural areas but the findings suggest that in rural Ghana, health care facilities are available and there are better facilities a few miles away from the rural communities. This makes it possible for the older adults in the rural areas to access healthcare. Also, I expected that family played a huge role in caregiving, but the findings show that older adults rely mainly on public facilities and self-reliance.

Summary

The purpose of this phenomenological study was to explore the lived experience of QOL and family caregiving in older adults cared for by their families in rural Ghana. The findings are presented below to address the research questions.

The Lived Experience of QOL in older adults cared in rural Ghana

I found overall QOL is experienced through the actions of self-care, connections with neighbors, friends, family, and the availability of public services. For example, P6 stated “it is about depending on each other as a source of happiness” Participants mentioned education, health facilities, other government services, and nutrition as the primary factors that affect their QOL, both positively and negatively. For example, P5 stated “because of education, I am able to communicate ideas with different people.” Also, P1 mentioned that “I am old, but I still look strong.” Participants also mentioned

housing, the environment, and transportation as the primary concerns that negatively impact their QOL based on their lived experiences. For example, P1 said “where I live now, there is no toilet” and P6 said “The environment is not good. This has been a problem for a long time, and we are still having it here”

The lived experience of family caregiving in older adults in rural Ghana

I anticipated that family would play a huge role in older adult caregiving, but the findings showed otherwise. The results indicated that the role of family caregiving is minimal. These were experienced by the participants in the questions about “a typical day”. Their responses clearly showed that older adult complete basic chores by themselves. Also, they take care of their own personal hygiene? The theme of *migration* revealed that the youth travel to the cities and leave the older adults behind, but they are still able to survive by completing their activities of daily living and maintaining connection to the outside world. For some, it is neighbors and being involved in local activities. For others, watching the news. The participants responses also revealed considerable reliance on government services, triangulating the sense of minimal family involvement in older adult caregiving.

All efforts to produce trustworthy results were explained and no discrepancy was identified? These results will be interpreted in light of the published literature in Chapter 5. I will also discuss limitations and recommendations for future research and policyChapter 5: Discussion, Conclusions and Recommendations

The purpose of this phenomenological study was to explore the lived experience of QOL and family caregiving in older adults in rural Ghana. The phenomena of interest

were QOL and family caregiving. QOL refers to an individual's personal functioning: physical, social, cognitive, emotional, and mental (Aboh et al., 2019). Also, QOL has been described as encompassing improvement in health status, required autonomy, role and activity, an individual's relationship, attitude and adaptation, an individual's emotional comfort, spirituality, home, neighborhood, and financial security (van Leeuwen, 2019).

Interpretation of the Findings

Comparison to the Literature

The study confirms many aspects of what has been found in the peer-reviewed literature described in Chapter 2. These six participants gave a general definition of QOL as being able to complete typical day activities and live an independent life. This is represented in the QOL theme. For example, Sováriová Soósová (2016) found that the possibility of maintaining independence in daily activities had a significant impact on QOL. Also, Bozkurt & Yilmaz (2016) asserted that support of physical functions in older adults can be helpful in improving QOL and functional independence. But Kpessa-Whyte and Tsekpo (202) asserted that the elderly phase of life is often associated with degenerative conditions that affect the human capacity to function effectively and requires specialized care and assistance. This study also found that participants expressed some personal dissatisfaction or disappointment in certain aspects of daily living, for example, dissatisfaction with roads, safety, and security. According to National Caregivers Library (n.d.), there are currently about 8.4 million senior citizens who

depend on others for their transportation, and the availability of transportation in the community will depend on the nature of the road in the community.

Another important theme that emerged was health and healthcare. My study results showed that older adults in rural Ghana are in good health and have access to health facilities. The literature in Chapter 2 made it clear that health care facilities in rural Ghana are inadequate and not available to the older adults. But the responses from all six participants showed otherwise. For example, Fonta et al., (2017) reported that those reporting poor health was 2.5 times higher among older adults compared to younger adults, and older adult with one or more chronic conditions described their health as poor. But P1 stated, "I don't feel any disease or pains or anything. I am old, but I still look strong," and P6 indicated that "for the past 2 years I am fine, no diseases or illness." They all indicated that they have access to good healthcare systems.

Also, unlike the literature that shows that older adults depend on their caregivers, the data in this study showed that some of them are independent. Some of them are caregivers who cater to the needs of their grandchildren and mothers. For example, P2 stated, "I live with my mother, she is 90 years, so I do everything by myself," and P5 said, "I don't have caregivers."

What was most surprising was the relative absence of discussion of the role of the family. As mentioned in Chapter 2, the role of family in older adult care is considered significant, but the results from my research did not confirm it.

Conceptual Framework

I utilized the ecological system model (Bronfenbrenner, 1977) to organize the data collection tool and provide a point of view for interpreting the results. The results indicated that older adults receive some care and others are caregivers. This makes them part of an integrating and interactive system. The ecological system model portrays the social environment and emphasizes a social focus when working to address problem situations (Payne, 2005). The model reveals how older adults relate with their natural environments, which include caregivers, care recipients, and neighbors. This exemplifies how human beings or groups relate to their existing environments, which is linked with human ecology. The data show older adults are in constant interaction with their environment and are encircled with networks that can impact an individual or a family in both positive and negative ways. As the results revealed that older adults are sometimes caregivers, this addresses the ecological system model as it shows how individuals and their numerous and complex environments are interactive and synergistic with each other in ways that simultaneously affect one another (Weiss-Gal, 2008).

The different levels of the system revealed that QOL issues relate to the macrosystem, which is the outermost layer of the participants' environment. This includes cultural values, customs, and laws (Berk, 2000), specifically, government services (Steiner-Asiedu, 2010) and housing system (Gupta et al., 2014).

Caregiver assessment and intervention should be tailored to the individual circumstances and contexts in which caregiver burden occurs (Adelman et al., 2014). The

literature addressed caregiving in detail, but the data obtained reported a minimal family caregiving.

Limitations of the Study

Issues of trustworthiness were accomplished. I used audio recording and transcription for the purpose of credibility. Also, I provided detailed description of research procedures, data analysis, and interpretation process for the purpose of transferability. In addition, the findings are available for the dissertation committee for review or critique for the purpose of dependability. Finally, the study is devoid of personal interests or biases. I strictly analyzed the responses of the participants, and this helps improve confirmability.

However, there were a few limitations. These limitations included the possibility of compromised credibility in the sense that I was the only researcher. There were no other interviewers with whom to triangulate the quality and results of the interviews and no other coders with whom to compare my work. Thus, the reduction of bias may not have been sufficient. Also, the interview data may be of questionable dependability, as I only interviewed each participant one time and did not corroborate their answers with other sources. I recommend that before a researcher begins the interview, they should create a rapport through ice breakers or through discussing practical or meaningful local issues. This helps participants to feel comfortable and more likely to provide rich and thick data. Also, I recommend that the research questions should be presented like a typical informal conversation so that participants will feel like they are engaging in a regular discourse, further enhancing the gathering of rich, thick data.

Also, the interviews were conducted at only one village, so transferability and saturation could be limited to some extent (see Amankwaa, 2016). Saturation is achieved at a level when nothing new is reported and observed in a study (Guest et al., 2006). The result shows that family involvement in older adult care is minimal. This is a new finding compared to the literature review.

Recommendations

I recommend that future research should be done in different rural communities to observe similarities and differences so that the findings could be more transferable. In addition, I recommend more studies about family life and QOL. Based on the literature, I anticipated that the results would show that family caregiving plays a huge role in older adult care, but the results here showed otherwise. Given this reason, I recommend that future studies should be done to examine the role of family caregiving in older adult care, comparing urban and rural settings. QOL may occur differently if elders remained in closer proximity to their families.

Implications

From a social change perspective, it is important to better understand this experience to contribute to efforts to improve the QOL of the elderly in rural Ghana and provide research-based information to key stakeholders and decision-makers. Most of the participants indicated that they need a good transportation system and security to improve QOL. This idea can help policy makers to consider extending the police service to the rural communities.

From a social change perspective, it is important to better understand their experience to contribute to efforts to improve their QOL and provide research-based information to key stakeholders and decision-makers. Some of these policies may include liaising with private road construction companies to tar rural roads. If the roads and the security system in the rural area are improved, it will reduce the rural-urban migration because the rural areas will attract investors and open companies and employ the rural youth. By reducing migration, the older adult will have people within their immediate reach for social support.

Personally, what I can do to promote social change in this discipline is to offer education and training to healthcare providers in rural communities about gerontology or geriatrics, specifically looking at how they can incorporate transportation as part of their healthcare delivery. I also plan to share the results of this study in the scholarly literature.

Conclusion

QOL is more complex than it seems; the term is sometimes used interchangeably with life satisfaction, but they are indeed two separate concepts. Life satisfaction is the evaluation of one's life as a whole, which can be examined from the perspective of the older adults or people who have knowledge about the older adult. QOL refers to the general well-being, and an individual's assessment of their QOL could be subjective and affected by many factors, including mood and environmental factors. QOL research should endeavor to address the general well-being from the perspective of the older adult through a phenomenological approach so that it is not confused with life satisfaction research. Also, the Ghanaian economy is changing, and this will lead to the need to

address the well-being of older adults. It is important to me that the change in the economy reflects a positive change in the well-being of older adults.

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Appendix A: Interview Guide

Sources	Question	Probe
Quality of Life		
Overall QOL (WHO, 2020) and (Megari,2013)	What does quality of life mean to you?	Tell me about the household chores you complete on a typical day. How is your relationship with your caregivers? Tell me more about your relationship with your friends. How does your relationship with others inform your societal integration? How satisfied are you with the health services in your community? Tell me about how well you sleep.
Health QOL - (Megari, 2013)	Tell me about your health. What is your most important health concern?	How do you address this concern? What is the role of your family in helping you with this concern? Pain? How well are you able to take care of yourself? How much energy do you have to take care of yourself? Share with me about your access to adequate medical treatment. Tell me about how well you sleep?
	What are you satisfied with regarding your physical health?	Give me an example of the productive things you do
Psychological health (Megari, 2013)	What brings you joy?	Share with me the experiences that bring you happiness on a typical day.

Microsystem		
Social Network (Soósová, M. S. (2016).	Tell me about the relationship between you and your family.	Tell me what happens on a typical day when you spend time with your family.
Social Network (Soósová, M. S. (2016).	Tell me more about how you interact with your family members.	Tell me more about how your interaction with your family members is on a typical day.
Social Network (Soósová, M. S. (2016).	Tell me about why you depend on your family members.	Give me an example of safety needs you depend on your family for. What about financial support? Tell me about how you depend on your family for news and information
Family Support (Fonta et al., 2017)	Tell me about the family support you receive on a typical day	Describe how family support affects your quality of life on a typical day. Share with me whether support comes from the nuclear family or the extended family
Degree of Independence. Steiner-Asiedu et al. (2010)	How does independence affect your quality of life?	Share with me how you feel under the control of others. How does it differ if you are on your own?
Good nutrition (Steiner-Asiedu et al., 2010).	Share with me about your access to nutrition	How does your dietary habit affect your quality of life? Share with me a typical day that you missed a meal and why
QOL - health (Megari, 2013)	What is your most important health concern that involves your family?	How do you address this concern? What is the role of your family in helping you with this concern?

Mesosystem		
Social network (Soósová, M. S. (2016).	Describe your interaction with your family members' partners?	Tell me what happens on a typical day when you spend time with your caregivers' partners. Share with me about your happiness with where you are living.
Social network (Soósová, M. S. (2016).	Describe how the relationship between your family members and their partners affect your living condition.	Tell me about how you spend time with your caregivers and their partners on a typical day.
Social network (Soósová, M. S. (2016).	Describe how the relationship between you and your neighbors affects your living condition.	Tell me about how you spend time with your neighbors for fun on a typical day
Social network (Soósová, M. S. (2016).	Describe how the relationship between you and your friends affects your living condition.	Tell me about a typical day when you spent time with friends for fun
Exosystem		
Achievement of educational goal (Fernández-Mayoralas, 2015).	Share with me how education could affect your living condition.	Specifically, how will improving the stock of knowledge and the analytical skills guide your health behavior? How will it inform your life preferences? How will it inform the constraints/opportunities presented you have?

Macrosystem		
Government Health Service Steiner-Asiedu et al. (2010)	Tell me about how government health services affect your quality of life	Discuss what specific features of health services affects your quality of life
Housing (Gupta et al., 2014)	Tell me about how housing affects your quality of life	Tell me about your preference with regards to private residence or an institutional residence. Discuss what specific features of housing affects your quality of life
Availability of local services (Fonta et al., 2017)	Describe the facilities that have been provided by the government and how they enhance your living condition.	Share with me how transportation service affects your living condition, with regards to getting connected to important destinations. How does access to electricity affects your daily living? On a typical day, how does life look like when using a recreational facility like a well-resourced community park?
Availability of employment and improved economic status (Fonta et al., 2017)	How does your economic status affect your quality of life?	Tell me more about your source of income. Share with me how your current standard of living is compared to your young adult age. Share with me your satisfaction with your current job opportunity.
Cronosystem		
Movement from rural to Urban. (Jobes & Williams, 1990)	What have you seen in how younger people are moving away from the country and into the city?	How has the number and types of people changed? How has this affected you?
Congenial environment (Ahadzie and Doe, 2009).	How does your physical environment affect your living condition?	Share with me your concern about the safety of your environment. Tell me about how the degradation of the environment, through air pollution, noise, chemicals, and poor quality water affect your life.
General		

Additional questions about QOL	Is there anything else you would like to tell me about your quality of life and what it means? What is the one thing you believe would improve your quality of life?	

Appendix B: Recruitment Process for Older Adults Study

Sixteen older adults were interviewed because Morse (1994) suggested that 5-25 sample size in a phenomenological research. The specific procedure for how participants were identified, contacted, and recruited include the following:

1. Researcher had a third party walk from house to house or streets in rural Ghana, specifically, Breman Bedum and Breman Asikuma, all in central region of Ghana, to distribute invitation flyers.
2. Potential participants directly contacted researcher to inquire about the study
3. Upon receiving calls from potential participants, researcher reviewed the program description letter that introduces the purpose and what is required of them. The content of the project description letter was in simple English, precisely at third grade level, and was reviewed over the phone.
4. Researcher reviewed informed consent letter over the phone, providing details on the nature of the study, specifically indicating the participation is totally voluntary and have their consent to record their responses.
5. Check backed in a week to find out if they had made participation decision. Researcher avoided coercion or pressure to participate by reiterating that participation was strictly voluntary, and that they could withdraw at any time even if they decided to participate.
6. Scheduled interested participants for a phone interview. This was done after the informed consent was obtained and recorded.
7. Began the interview and recorded the participants' responses as agreed.

8. Applied snowball sampling by asking the respondents who would like to recommend other older adults to participate.
9. Transcribed their responses verbatim based on data analysis plan.
10. Followed-up with verbal appreciation for their participation.
11. Performed member checking. The purpose of member checking was to establish the tenet of credibility in trustworthy. This was done by sharing a brief summary of the findings research participants. Below was the proposed verbiage.