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**LIFE SATISFACTION AND HEALTH RELATED
QUALITY OF LIFE AMONG OLDER PEOPLE (65+) IN
GHANA**



UNIVERSITY OF ALGARVE

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**LIFE SATISFACTION AND HEALTH RELATED QUALITY OF
LIFE AMONG OLDER PEOPLE (65+) IN GHANA**

Master's Degree in Healthcare Management

Dissertation Report made under the supervision of

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FACULTY OF ECONOMICS

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DECLARATIONS

From the master student:

I declare that I accept to carry out this Work Proposal according to the referred plan.

Daniel Kwaku Owusu

.....
(Signature)

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LIST OF ABBREVIATION

QoL.....	Quality of life
HRQoL.....	Health-related quality of life
LS.....	Life satisfaction
SWLS.....	satisfaction with life scale
SD.....	Standard deviation
PA.....	Physical activity
SEM.....	Structural equation model
NCDs.....	Non-communicable diseases
OECD.....	Organization for Economic Co-operation and Development
WHOQOL-BREF.	WHO Quality of Life-Brief Version
HD.....	Healthy days
LSI.....	Life satisfaction index
PWB.....	Psychological Wellbeing
MNA.....	Mini-Nutritional Assessment
PWI.....	Personal Wellbeing Index
ComQol.....	Comprehensive Quality Of Life
EFA.....	Exploratory factor analysis
CFA.....	Confirmatory factor analysis
RMSEA.....	Root mean squared error of approximation
CFI.....	Comparative fit index
TLI.....	Tucker-Lewis index
SRMR.....	Standardized root mean squared residual

ABSTRACT

Effective aging can be seen in the need for fulfillment, satisfaction with life, mental health, body emotions, happiness, and the way things are going in life. Still, there isn't a lot of research on the quality of life (QoL) of older people in Ghana's rural areas. Older people live in rural areas and urban slums in some developing nations where pension programs do not exist (Aikins and Koram, 2017; Kpessa-Whyte, 2018). The study sought to study the satisfaction with life and health-related quality of life (HRQoL) of people aged 65 and over in Ghana and explore how it affects their life satisfaction.

The study used a predominantly quantitative methodology to reach out to as many people as possible. 578 respondents were chosen using the snowball sampling approach and the purposive sampling technique. Questionnaires were used to gather the relevant information from the respondents. The questionnaire was divided into four sections: satisfaction with life scale (SWLS), personal wellbeing, HRQoL, and sociodemographic profile. Descriptive statistical analyses (i.e., mean, standard deviation [SD], frequencies, and proportions [%]) were carried out to describe the sample and the respondents' satisfaction with life and wellbeing. Parametric tests using correlation and SEM were conducted to analyze the sample.

The study found that older people in rural areas of Ghana have higher life satisfaction due to their own ideals, having an excellent life and not making changes. However, they are not satisfied with their lives and the number of things they have achieved in life. In terms of HRQoL, older people are more concerned about self-care, mobility, and their usual activities but less about their pain, discomfort, and anxiety or depression. HRQoL leads to life satisfaction. The study suggests that there should be a public policy on older people, as monitoring HRQoL and life satisfaction is critical to the development of sound public policy. The government should initiate a social intervention scheme to provide older people in rural areas with an apartment or building with a lot of elderly people to help them not feel lonely.

RESUMO ESTENDIDO

As pessoas que não conseguem cuidar de si mesmas podem ter uma ideia diferente do que significa ser feliz com suas vidas do que aquelas que ainda podem fazer algumas coisas por si mesmas. Quando uma pessoa passa de saudável e capaz de cuidar de si mesma sem ajuda para ter que viver com habilidades limitadas de autocuidado (Walker and Maltby, 1997), suas ideias sobre o que torna a vida satisfatória podem mudar. A OMS define QV como "a visão de uma pessoa sobre seu lugar na vida no contexto da cultura e sistema de valores em que vive, bem como seus objetivos, expectativas, padrões e preocupações" (Organização Mundial da Saúde, Divisão de Saúde Mental e Prevenção do Abuso de Substâncias, 1997). Os idosos são especialmente propensos a ter QV ruim devido a mudanças e eventos em sua saúde física, saúde mental, situação social e relacionamento com o ambiente.

Vários estudos mostram que a atividade física (AF) e o exercício são bons para a saúde a longo prazo. De acordo com a pesquisa de Reiner et al. (2013), a AF está ligada a taxas mais baixas de obesidade, ganho de peso, distúrbios relacionados à idade, como demência e doença de Alzheimer, doença cardíaca coronária e diabetes mellitus tipo 2. (McPhee et al., 2016) descobriram que a AF regular também reduz o risco de obesidade, doenças cardíacas e metabólicas graves, quedas, declínio cognitivo, osteoporose e fraqueza muscular. A AF também está associada a um menor risco de morte em pessoas obesas (Blair and Brodney, 1999), e o apoio social pode reduzir o estresse decorrente da incapacidade de fazer certas coisas (Pal, 2005). No contexto familiar, os vínculos não são voluntários (Pal, 2005), e o sentimento de obrigação de cuidar de um idoso pode ser um sinal de estresse tanto para a família quanto para o idoso. Além disso, a perda de funcionalidades pode ser atribuída ao "cuidado excessivo", que impede o idoso de realizar suas próprias atividades e o priva de tomar suas próprias decisões (D'Orsi et al., 2011; Neri and Vieira, 2013; Pal, 2005).

Com o envelhecimento da população, gestores, profissionais e acadêmicos estão cada vez mais preocupados em como ajudar o idoso a envelhecer de forma saudável. Pal (2005) e Rabelo e Neri (2015) afirmam que a família pode se tornar um sistema de apoio social ajudando os idosos de maneira prática, financeira, social e emocional e ajudando outros membros da família. Nessas casas, as pessoas podem optar por morar sozinhas, com o cônjuge ou com outros familiares. Isso é chamado de "arranjo familiar intergeracional" (Borges and Magalhes, 2011) e inclui membros da família que são passivos ou ativos na prestação ou obtenção de cuidados sociais. O arranjo domiciliar oferece opções para

manter o desempenho funcional na velhice, além de proteção. Os idosos, no entanto, podem achar estressante coexistir com as gerações mais jovens (Pal, 2005).

Nos países em desenvolvimento, há mais idosos do que nunca, mas as instituições sociais e de saúde que os atendem não cresceram na mesma proporção. Em países desenvolvidos e em desenvolvimento, o acesso dos idosos a cuidados de saúde de alta qualidade varia significativamente. O crescente isolamento e marginalização dos idosos são problemas em países em desenvolvimento como Gana (Atakro et al., 2021). Existem inúmeras preocupações com o envelhecimento que estão surgindo em Gana. A participação do Gana no Ano dos Idosos da União Africana em 1999, na Segunda Assembleia Mundial sobre o Envelhecimento realizada em Madrid, Espanha, em abril de 2002, e na Assembleia Mundial das Nações Unidas sobre o Envelhecimento em Viena, Áustria, em 1982 levou à criação do Política Nacional do Envelhecimento. A fim de incorporar as preocupações com os idosos nos processos de políticas públicas, Gana acabou desenvolvendo uma estrutura de política nacional em 2011. Gana National Aging Policy, 2010).

A satisfação com a vida relacionada à idade é um termo crucial no estudo psicossocial do envelhecimento. Choudhary (2015) realizou um estudo sobre “Satisfação com a Vida e Saúde na Velhice”. De acordo com os resultados do estudo, existe uma conexão entre a satisfação com a vida e a saúde física e mental. De acordo com o coeficiente de correlação de Pearson, existe uma associação substancial entre a satisfação com a vida e a saúde física e mental (Choudhary, 2015). Informações sobre a qualidade de vida de idosos residentes em favelas urbanas em Gana foram fornecidas por Attafuah et al. em 2022 e revelou que os idosos residentes em favelas apresentavam uma qualidade de vida física ruim e uma qualidade de vida psicológica, social e ambiental moderada. Embora os escores médios de QV sejam maiores do que o esperado, as necessidades específicas dos indivíduos mais velhos devem ser consideradas no desenvolvimento de políticas de saúde. Uma revisão recente da literatura sobre o envelhecimento em Gana descobriu que a pesquisa até agora se concentrou em (a) perfis demográficos e padrões de envelhecimento, (b) a saúde dos idosos, (c) sistemas de cuidados e apoio para os idosos, (d) os papéis e responsabilidades dos idosos, (e) como os idosos são retratados na sociedade e (f) questões relacionadas ao seu status socioeconômico (de-Graft Aikins et al., 2016). Ainda assim, não há muitas pesquisas sobre a qualidade de vida (QoL) de idosos nas áreas rurais de Gana. Os idosos vivem em áreas rurais e favelas urbanas em alguns países em desenvolvimento onde não existem programas de pensão (Aikins and Koram, 2017; Kpessa-Whyte, 2018). Portanto, o estudo procurou estudar a satisfação

com a vida e a QVRS de idosos em Gana e explorar como isso afeta sua satisfação com a vida.

Devido ao tipo de estudo e à necessidade de falar com o maior número de pessoas possível, foi utilizado um método predominantemente quantitativo. Usando o método de amostragem bola de neve e o método de amostragem proposital, 578 pessoas foram escolhidas para participar do estudo. Os questionários foram os instrumentos de recolha de dados utilizados para recolher informação relevante dos inquiridos. Os questionários foram digitados, impressos e aplicados aos respondentes em suas próprias residências. O questionário foi preenchido em inglês. O questionário foi dividido em quatro seções. Na primeira seção, foi avaliada a escala de satisfação com a vida (SWLS). A segunda seção abordou questões sobre bem-estar pessoal. A terceira seção foi dedicada a medir a QVRS do respondente. Por fim, a quarta seção incluiu questões para definir o perfil sociodemográfico dos respondentes. Análises estatísticas descritivas (ou seja, média, desvio padrão [SD], frequências e proporções [%]) foram realizadas para descrever a amostra e a satisfação dos entrevistados com a qualidade de vida e bem-estar. Testes paramétricos de correlação e SEM foram realizados para analisar a amostra.

O estudo estabeleceu que os idosos nas áreas rurais de Gana têm maior satisfação com a vida devido aos seus próprios ideais, tendo uma vida excelente e não fazendo mudanças. No entanto, eles não estão satisfeitos com suas vidas e com o número de coisas que conquistaram na vida. Em termos de qualidade de vida relacionada à saúde (QVRS), os idosos estão mais preocupados com o autocuidado, a mobilidade e suas atividades habituais, mas menos com sua dor, desconforto e ansiedade ou depressão. A qualidade de vida relacionada à saúde (QVRS) leva à satisfação com a vida. O estudo sugere que deve haver uma política pública para os idosos, pois monitorar a QVRS e a satisfação com a vida é fundamental para o desenvolvimento de políticas públicas sólidas. O governo deve iniciar um esquema de intervenção social para fornecer aos idosos nas áreas rurais um apartamento ou prédio com muitos idosos para ajudá-los a não se sentirem sozinhos

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Life satisfaction according to Gana et al., (2013) is particularly relevant to the research of subjective wellbeing in older persons because it is a lasting characteristic of wellbeing, a key component of wellbeing, and a personal indicator of successful ageing (Ghubach et al., 2010; Ní Mhaolain et al., 2012). A person's need on others increases as they become older because of the many responsibilities and functions they lose. This dependence may lead to a decline in quality of life (QoL) and overall life satisfaction, which is a manifestation of the need for other people. One of the social risk factors is the shrinkage of one's social circle as one ages, which is related to a decline in social activity. It is important to remember that becoming older is a vulnerable and risky time in life. In the contexts of social work and health, aged persons are thus seen as a unique category (Sahin, Ozer, and Yanarda, 2019). In older people, cognitive and psychosocial characteristics have been shown to influence things like survival, use of healthcare, health-promoting behaviour, and health-related quality of life (HRQoL) (Feng, Cramm, and Nieboer, 2020; Kostka and Jachimowicz, 2010; Panagioti et al., 2018; Stretton et al., 2006).

The idea of QoL has a direct connection to health and health-related characteristics. "A condition of full physical, mental, and social wellbeing and not only the absence of sickness or illness," according to the World Health Organization's (WHO) 1948 definition, is what health is (WHO, 2005). From civilization to society and from individual to person, the definition of wellbeing might change. The QoL and health may be compared as a result. In accordance with Diener's (2006) definition, QoL refers to a person's cognitive assessment of their own circumstances and responses to them. In theory, a large range of domains and components may be included in QoL. These include functional ability, role functioning (functional ability in different roles, such as in physical activities and achievement beliefs), the degree and quality of social interaction, psychological wellbeing, somatic sensations, happiness, life situations, life satisfaction, and need for satisfaction (Brown, Bowling, and Flynn, 2004). Sevinç and Akyol (2010) include sex, socioeconomic level, age, and generation as other elements that define QoL in this context. It also reflects life experiences, key life events, and the present stage of life.

The main modifiable method for health promotion via lifestyle, which is essential to QoL, focuses on adopting health-promoting behaviours. Activities that preserve or enhance

one's health, including physical, social, and emotional wellbeing, as well as those that promote good ageing, are all part of a lifestyle that promotes health (Lee, 2012). Improved health throughout the old person's remaining years is a result of living a healthy lifestyle (Mofrad, Jahantigh, and Arbabisarjou, 2016). Prior research has shown that leading a healthy lifestyle not only reflects one's subjective health but also prevents the onset of chronic illness and lessens its symptoms in older people (Feng et al., 2020; Buffart et al., 2015).

Life satisfaction is a person's assessment of their overall happiness, while QoL is the degree of overall health and wellbeing (Peeters et al., 2016; Giournta et al., 2020; Miniszewska et al., 2020). Both may be seen as a continuum, however according to some studies (Ferrans and Powers, 1992; Yildirim, Kilic and Akyol, 2013), life satisfaction is more individualised and is influenced by a person's mood at the time, while QoL can be quantified and varies less. However, a person's personal evaluation of their QoL may also be subjective, influenced by their state of mind or external factors (such as the current epidemic), and hence vary. According to Ryff et al. (2004) and others (Ryan and Deci, 2001; Waterman, Schwartz and Conti, 2008), subjective (hedonic) wellbeing, which emphasises joy and pleasure, and psychological (eudaimonic) wellbeing, which concentrates on the achievement of human potential, are two different types of positive wellbeing.

Numerous research have examined the relationship between variables related to older individuals' life satisfaction, including gender, age, education, marital status, and housing circumstances (Oshio, 2012). Regional variations have very seldom been studied, however. According to a study done in Halifax, Canada, life satisfaction varied greatly among urban-rural zones, including the inner city, suburbs, inner commuter belt, and outer commuter belt (Millward and Spinney, 2013). Researchers discovered that older adults' life satisfaction varied depending on their physical health, whether they lived in the inner city or the suburbs, whether they felt safe at night or not, and whether they travelled by car or other modes of transportation. They also discovered that older adults in the inner commuter belt reported being happier with their lives when they were physically healthy (Millward and Spinney, 2013).

In fact, a large body of research has looked at life satisfaction as a subjective measure of life quality in general (Fagerström et al. 2007), a crucial element of successful ageing (Tate, Lah, and Cuddy 2003; Jang 2004; Daatland 2005; Berg et al. 2006), and a sign of effectiveness in old age (Freund and Baltes 1998). Knowing the relationship between older people's circumstances and life satisfaction would thus be helpful for policy makers

(Pinquart and Sörensen 2000; George 2006; Gaymu and Springer 2010). In fact, Meléndez et al., have all shown that good health, stable finances, and social integration all have a favourable impact on older people's QoL, but the situation is still far from obvious (Meléndez et al., 2009).

1.2 Problem Statement

Those elderly individuals who are unable to do daily duties on their own may have a different understanding of what it means to be satisfied with life compared to those who still have some ability for self-care. When a person goes from being healthy and able to take care of themselves without help to being forced to live with restricted self-care capability, their opinion of the things that contribute to life satisfaction may shift as a consequence (Walker and Maltby 1997). Because of changes and events in their physical health, psychological state, social status, and connection to their environment, older people are more likely to have a lower QoL than younger people (Joshi, Chalise, and Khatiwada, 2018; Brett, Dykiert, Starr, et al., 2019; Haider, Luger, Kapan, et al., 2016). Studies have shown that in Taiwan, for example, the elderly population reports a higher level of life satisfaction as a result of the country's national health insurance scheme (Liao et al., 2012). Access to medical care has consistently been linked to a higher level of life satisfaction among older people in China (Zhang and Liu, 2007). In addition, a number of studies (Helvik, Engedal, Krokstad, and Selbk, 2011; Inal, Subasi, Ay, and Hayran, 2007) found that regular activities, which can include both physical and leisure activities, are significantly related to life satisfaction among older adults. On the other hand, not participating in activities was found to be associated with life dissatisfaction.

The majority of elderly people choose to live with either their immediate or extended families. After then, they are considered to be members of the family of a relative (Dsane 2010, Mba 2005). The elderly individuals get help and care from their family members as well as other individuals while they live in this sort of arrangement. In many cultures, it is customary to show gratitude to old people by taking care of them or providing some other kind of assistance in exchange for the assistance that they provided to younger members of their family or to other people earlier in their lives. As a result, policies in the public sector disregard senior citizens. The policies that govern human development do not meet their requirements in an appropriate manner (Dsane, 2010). Meanwhile, the amount of assistance that is provided to older people by their adult children and extended relatives has become less significant over time (Apt, 2002). Neglect, poverty, and bad health are only a few of the issues that are related to the existence of the elderly. A lack

of or restricted access to social infrastructure, housing, and amenities are also issues (Obiri -Yeboah 2002).

The increase in life expectancy offers new opportunities to developing countries to enhance programmes and policies that can sustain the trend and contribute to the wellbeing of the elderly population. Presently, however, the health status of the elderly poses challenges to both the 10 elderly population and the health systems of their countries. Non-communicable diseases (NCDs) remain the main types of diseases that afflict the aged. Even though a lesser proportion (70%) of all deaths due to (NCDs) are recorded among persons aged 60 years and above in the developing countries as compared with 87 percent in the developed countries (Population Reference Bureau 2012), the prevalence of NCDs among the elderly population in the developing countries poses great challenges to the elderly who are poor.

In general, older people who have had poor health have a low level of LS. Nonetheless, among the elderly, effective ageing necessitates a higher socioeconomic status, adequate family support, a higher level of satisfaction with one's living environment or condition, and the ability to continue living in one's own home. According to Zubarolu Yanarda, 2017, family members, friends, and significant others may be reliable providers of support and assistance, and these resources should be available to some degree.

According to a recent review of the literature on ageing in Ghana, the research on ageing in the country has so far focused on (a) demographic profiles and patterns of ageing, (b) the health of elderly people, (c) elderly care and support systems, (d) the roles and responsibilities of the elderly, (e) social representation of the elderly, and (f) issues relating to their socioeconomic status (de-Graft Aikins et al., 2016). However, there hasn't been a lot of research done on the QoL of elderly people in Ghana's rural regions. In certain developing countries, the majority of elderly people live in rural regions or urban slums, and such countries do not have pension programmes (Aikins and Koram, 2017; Kpessa-Whyte, 2018). As there are no studies, there is a need in studying this.

1.3 Objectives of the Study

General Objective

This study aims to study the satisfaction with life and HRQoL of people aged 65 and over in Ghana and also to explore how it affects their life satisfaction.

Specific Objectives;

The study specifically seeks;

1. To characterize the life satisfaction of people aged 65 and over in rural areas in Ghana
2. To study the wellbeing of people aged 65 and over in rural areas in Ghana
3. To describe the HRQoL of people aged 65 and over in rural areas in Ghana
4. To find if HRQoL affects the life satisfaction of people aged 65 and over in rural areas in Ghana.

1.4 Research Questions

1. What is the life satisfaction of people aged 65 and over in rural areas in Ghana?
2. What is the wellbeing of people aged 65 and over in rural areas in Ghana?
3. What is the HRQoL of people aged 65 and over in rural areas in Ghana?
4. How HRQoL affects the life satisfaction of people aged 65 and over in rural areas in Ghana?

1.5 Significance of the Study

The results of the research will provide light on the HRQoL of elderly individuals living in rural parts of Ghana and, more crucially, on the state of their health. The findings of the research will be used to characterise the level of contentment experienced by older individuals living in rural regions by identifying the factors that contribute to their contentment as well as the factors that do not. The results of the research will reveal whether or not the overall wellbeing of the older individuals is in excellent condition, and they will do so by indicating whether or not their overall wellbeing is good. Also, the findings of the study will indicate whether or not HRQoL has a positive effect on the life satisfaction of older people in Ghana. Additionally, it will add up to the existing literature in relation the HRQoL and life satisfaction and also serve as a reference point to scholars who are embarking on a similar study.

1.6 Organization of the Study

The study is organized into six chapters:

- Chapter 1: This introductory chapter provides the background of the study, statement of the problem, objective of the study, research question, significance of the study, the scope of the study, and organization of the study.
- Chapter 2 captures a comprehensive review of literature related to the elderly people, the concept of wellbeing, HRQoL and life satisfaction, HRQoL of older

people, life satisfaction of older people, wellbeing of older people and HRQoL on life satisfaction

- Chapter 3: this chapter highlights the methodology, research design, sample, and sampling procedure adopted for the study, data collection and instruments and finally data analysis
- Chapter 4 presents the findings of the study that is the results.
- Chapter 5 presents the discussion of the results and
- Chapter 6 presents the conclusion of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature review which covers literatures on the concept of wellbeing, HRQoL and life satisfaction, the elderly people (65+), the barriers of elderly people, HRQoL of elderly people, life satisfaction of elderly people, wellbeing of elderly people and HRQoL and life satisfaction.

2.2 The Concept Wellbeing, HRQoL and Life Satisfaction

At older ages, a person's psychological wellbeing and physical health are closely linked. Evaluative wellbeing, also known as life satisfaction, hedonic wellbeing, also known as feelings of happiness, sadness, and so on, and eudemonic wellbeing, also known as a sense of purpose and meaning in life are the three components that can be distinguished within psychological wellbeing (Steptoe, Deaton, and Stone, 2015). The term "QoL" is frequently utilised in the fields of medicine, psychology, and other health-related fields to refer to evaluations of an individual's overall experience of life (Kabisch et al., 2015; Lee and Hung, 2011; Marcheschi, Laike, Brunt, Hansson, and Johansson, 2015). A growing number of studies conducted in more recent times have shed light on the positive effects that natural environments and parks have on the QoL of local residents. (Askari et al., 2014; Camargo et al., 2017; Kabisch et al., 2015).

HRQoL is a multi-dimensional term that is extensively employed. It is a helpful measure of overall health since it collects information on the physical and mental health condition of people, as well as the influence of health status on QoL (Palermo et al., 2008; Revicki, Kleinman and Cella, 2014). When it comes to measuring the efficacy of various health care programmes and treatments, the evaluation of HRQoL is becoming an increasingly essential factor. As a component of what is often referred to as "patient-centered measures," the use of these kinds of measurements, in conjunction with those of indicators of patients' levels of contentment, has seen a meteoric rise (Edimac, 2002).

According to Koker (1991), life satisfaction can be defined as an individual's emotional reaction or attitude toward his or her life in general, including work, leisure, and other time periods. Individuals' lives and every facet of their lives count toward their overall level of life satisfaction. Expressions of the state of being good from a variety of perspectives, such as happiness, morale, and so on include: (Neugarten et al., 1961). The

degree to which a person is content with their life is one of the most critical aspects that influences both their mental health and their social relationships.

According to Neugarten, the key to achieving happiness and contentment in one's life is to examine the disparity between one's desires and the things that he or she really does (Onur, 1997: 368). According to Diener, Emmons, Larsen, and Griffin's (1985) definition of life satisfaction, it is a favourable judgement of a person's whole life in line with the criteria specified by the individual themselves. According to Pavot and Diener (1993), life satisfaction is the cognitive component of subjective wellbeing, and it is the evaluation of one's life as a result of comparisons between the individual's perception of living conditions and the criteria he imposes on himself. Specifically, life satisfaction is the appraisal of one's life as a result of comparing the individual's perception of living conditions with the criteria he imposes on himself (cited in: Chechen, 2007: 181). Satisfaction with one's life may be defined as an individual's emotional reaction or attitude toward their life in general, including their time spent at work, at play, and in other settings. The term "life satisfaction" refers to an individual's overall happiness with their life as well as all of its components. The condition of being good may be expressed in a variety of different ways, such as via one's happiness, morale, or level of contentment. According to Aydner (2011), one of the most crucial things that affects an individual's mental health as well as the social relationships that person has is the degree to which they are satisfied with their lives.

Because it informs us that individuals feel that their lives are going well, wellbeing is a positive result that is relevant for people and for many other facets of society. The ability to maintain adequate living circumstances, such as having a roof over one's head and a job, is essential to one's state of wellbeing. Monitoring these variables is critical to the development of sound public policy. However, many indicators that measure living conditions fail to measure what people think and feel about their lives, such as the quality of their relationships, their positive emotions and resilience, the realisation of their potential, or their overall satisfaction with life, which is referred to as their "wellbeing" (Diener and Seligman, 2004; Diener, 2009).

The attainment of an optimal level of subjective wellbeing as well as overall life satisfaction has been cited as one of the primary purposes of human existence by a significant number of academics and scientists. How a person views his or her own life has a significant impact on his or her level of subjective wellbeing. It has been shown that a person's level of happiness may be predicted by the degree to which his or her personal objectives and the degree to which the individual is capable of accomplishing those goals

are compatible or incompatible with one another (Rask et al., 2002). The idea of "subjective wellbeing" is comprised of two primary components: the first component explains the aspect of cognitive functioning, and the second component defines the aspect of emotional functioning. Dorahy and others in their research from the year 2000, they hypothesised that cognitive factors have a role in determining how people feel about their lives. According to Rask et al research's from 2002, the emotional component encompasses both positive and negative affect levels. A good opinion of one's own life is an indicator of one's subjective wellbeing. The Buddha brought together good affect, satisfaction, devotion, attachment, and the purpose of life (Diener and Seligman, 2004). People's subjective wellbeing can be measured by comparing their ideals to their real lives (Ahin, 2008: 24). This is done in an unconscious or unconscious manner, and it is important to pay attention to the difference between a person's life circumstances and how they evaluate those circumstances. Subjective wellbeing research tries to find out what makes people feel good about their own lives, such as life satisfaction, happiness, positive emotions, and morale. Research has also looked into ways to improve a person's quality of life and level of happiness with their life, such as improvements in the medical field, meditation, and new technology (Ozgen, 2012).

2.3 Elderly People

Elderly people are people aged 65 or more years old, according to Organization for Economic Co-operation and Development (OECD, 2023). With an aging population, managers, professionals, and academics are becoming more and more concerned with how to provide care options for the elderly so that aging is a well-aided process. The family can develop into a social support system by helping the elderly with functional, financial, social, and emotional support as well as by supporting other family members (Pal, 2005; Rabelo and Neri, 2015). Living alone, with a spouse, or with other relatives can all be options for these homes, creating an intergenerational household arrangement (Borges and Magalhes, 2011) with these family members, whether they are passive or active in giving or receiving any kind of social care. The living arrangement offers options to maintain functional performance into old age in addition to protection. Elderly people, however, may find it stressful to coexist with younger generations (Pal, 2005).

Aging is characterized by declines in physical health and functional capacities and by the loss of significant roles and relationships, experiences that challenge QoL. Aging is also associated with declining economic resources, decreasing cognitive ability, deteriorating physical health and weakening social support (Ian et al., 2009). A protective factor that

moderates the impact of these phenomena is psychological wellbeing. Both hedonic (positive affect and life satisfaction) and eudaimonic (purpose in life, positive social relations) aspects of wellbeing have been linked to better physical health and reduced biological risk of disease (Friedman and Ryff, 2012; Pressman and Cohen, 2005; Ryff, 2014; Steptoe, Dockray, and Wardle, 2009). A recent meta-analysis of existing studies confirms poor self-rated health status and the presence of chronic disease as significant risk factors for depression among the elderly (Huang et al., 2010).

2.4 The barriers of elderly people

Loneliness, emptiness and frustration

After retirement, many people's living spaces shrink, and their number of friends and acquaintances dwindles, both of which contribute to feelings of tedium and boredom in such individuals' lives. In particular, it is challenging for individuals to adjust to the changes in their positions in society and how they function in their daily lives. Because of the enormous changes that have taken place in contemporary society, economics, politics, and cultures, the original knowledge structures and skills possessed by a large number of elderly persons who have reached retirement age are no longer adaptable.

Loneliness has been connected to poor self-esteem, sadness, and physical sickness, all of which are particularly deleterious to the health and wellbeing of the senior population (Liu and Rook, 2013; Salimi, 2011; Shankar et al., 2011). According to Liu and Rook (2013, page 814), social exchanges have an effect on both emotional and social loneliness, and the risk of loneliness increases with advanced age due to poor health, residential relocation, and the loss of members of one's social network, and consequently opportunities for socialising. Older persons are at a higher risk of experiencing emotions of loneliness and social isolation because of their advanced years (Shankar et al., 2011). The degree to which an elderly person experiences loneliness is a significant element in determining both their mental health and their QoL.

Geriatric depression

In point of fact, the phrase "geriatric depression" refers to a cluster of mental conditions that are more common in older adults. These conditions often include main and secondary major depression, neurotic depression, and reactive depression (Blazer, 2003; Fiske, Wetherell, and Gatz, 2009). Depression in older adults is a somatic symptom that may be traced back to a variety of different mental diseases. As is the case with hypertension and diabetes, this condition is difficult to attribute to a specific cause. When compared with their youth, older adults get less family and social support from other senior people, both

in and outside of their own families. They experience a significant increase in feelings of isolation and depression, particularly as certain customary celebrations get closer.

Retirement syndrome

The elderly are particularly susceptible to developing a mental condition known as retirement syndrome (De Vries, 2003). The term "retirement syndrome" refers to a pattern of passive emotions experienced by elderly persons, including feelings of isolation, disappointment, anxiety, despair, sorrow, and dread. According to the available data, around 30 percent of those who have retired may be affected by retirement syndrome to varying degrees. Because of their inability to adjust to sudden changes in their living circumstances, elderly individuals are at increased risk of developing clinical depression, engaging in abnormal behaviours, and even contracting illnesses.

Syndromes of empty-nest families

"Empty-nest families" are families in which the elderly members do not have any youngsters to keep them company. (Mitchell and Lovegreen, 2009; Su et al., 2012). "Empty-nest elders" are elderly individuals who do not live together with their children, (Li and Lu, 2014).

2.5 HRQoL of elderly people

Attafuah et al. in 2022 offered information that shed light on the QoL of older adults who lived in urban slums in Ghana. The QoL of elderly people living in two slums was assessed in the research using a community-based cross-sectional design between April and May in the year 2020. The QoL was evaluated with the use of the WHO Quality of Life-Brief Version (WHOQOL-BREF) questionnaire. Participants originated from two different slums in Ghana; one was located in a location where fishing is the predominant economic activity, while the other was situated in an industrialised region. The findings of this research indicate that elderly people who lived in slums had a reasonable QoL psychologically, socially, and environmentally, but a poor QoL in terms of their physical health. Even if the mean QoL ratings is higher than what was anticipated, the specific requirements of older adults must be taken into account when creating health policy.

A research was carried out by Nakamura et al. (2022) with the purpose of determining the connections that exist between shifting levels of ageing satisfaction and 35 potential future health and wellbeing outcomes. The Health and Retirement Study is a national, diverse, and longitudinal sample of 13752 adults in the United States who are over the age of 50. The cohort study examined whether changes in ageing satisfaction (between combined cohorts from 2008 to 2010 and 4 years later, in 2012 and 2014) were

subsequently associated with 35 indicators of physical, behavioural, and psychosocial health and wellbeing in 2016 and 2018. The time frame that the statistical study included was from July 24, 2020, all the way through November 6, 2021. According to the findings of this research, a greater level of contentment with the ageing process is associated with improved future health and wellbeing. These results give recommendations for policymakers and interventionists trying to enhance specific health and wellbeing outcomes by emphasising potential effects that may result from the creation and implementation of scalable ageing satisfaction treatments at scale. It is possible that in the future, therapies designed to enhance health and wellbeing in later life would place a significant emphasis on ageing satisfaction.

The effects of becoming older and diseases that are associated with getting older may be seen in both the HRQoL and the expenses associated with health care. As a result of a lack of available funds in the healthcare industry and a growth in the number of patients requiring medical attention (Harrefors, Savenstedt and Axelson , 2009). The assessment of HRQoL in older adults may give researchers and stakeholders with relevant information that can be used for the most effective treatment of both physical and mental problems in these individuals.

Brown et al., 2015 examined a large group of elderly people living in the United States to determine the utility and relative value of several measures of HRQoL as predictors of death. The participants were all above the age of 60. They used Cox proportional hazards models to analyse the association between general self-reported health and three "healthy days" (HDs) measures of HRQoL and mortality at short-term (90-day) and long-term (2.5 years) follow-ups. The short-term follow-up period was for 90 days, and the long-term follow-up period was for 2.5 years. In conclusion, it was shown that HRQoL measures were significant predictors of both short-term and long-term mortality, which provides additional evidence for the importance of these measures in health monitoring and as indicators of risk for preventative initiatives that are targeted. Although there was a substantial correlation between all four HRQOL measures and mortality, general self-rating of health and age were shown to be more relevant predictors than the HDs.

A few research focused on the correlations between living arrangements and HRQoL; however, the majority of these studies did not employ conventional measuring methods such as the SF-36, EQ-5D, etc (Sun et al., 2011). According to the findings of a research conducted by Kharicha et al. (2007), those who lived alone were more likely to report having an HRQoL that was either fair or poor (poor vision, difficulties in instrumental

and basic activities of daily living, worse memory, and mood, lower physical activity, and worsening function).

A cross-sectional survey with two parts was done with 1,958 older people. Using the SF-36 questionnaire, an analysis of the patient's HRQoL was done. The measures that assessed vitality, mental health, and general health yielded the lowest scores, while the components that assessed social functioning and limits in role as a result of emotional and physical problems yielded the highest results. HRQoL was shown to be poorer among women, in those at advanced ages, those who professed evangelical faiths, and those with lower levels of income and education. Additionally, HRQoL was found to be worse among individuals who practised evangelical religions. The scores on the SF-36 showed the biggest disparities across the different groups with regard to functional ability and physical variables (Lima et al., 2009).

Dai, Jia, and Liu (2015) assess the HRQoL of senior persons who live in Jinzhou and find the factors that predict HRQoL. There were a total of 1015 adults over the age of 60 who participated in the cross-sectional survey that was carried out in Jinzhou. The authors found that medical health checks, age, socio-economic status, NCDs, smoking, excessive drinking, and insufficient exercise affected HRQoL. The study also found that medical health checks, age, and socio-economic status also affected HRQoL.

Qadri et al. (2013) investigated the pattern of physical morbidity in the rural senior population in order to examine HRQoL and usage of health services among them. In addition, they aimed to discover the pattern of physical morbidity in the rural elderly population. The gathering of samples was done using a method of straightforward random sampling. For the objective of the research, a total of 660 people younger than 60 years old were recruited to take part. An overwhelming majority of senior people, around 68.2 percent, reported having an excellent QoL, while less than 15 percent reported having a satisfactory or below-average QoL. In terms of their physical, psychological, social, and environmental wellbeing, males had a higher overall QoL. It was more prevalent among those who had completed their education, were now married, belonged to a caste that was not scheduled, and lived in extended households (p 0.001). The majority of the study participants were suffering from anaemia (64.5 percent), dental difficulties (62.2 percent), and joint aches (62.2 percent) (51.4 percent). Due to the considerable distance between their homes and the nearest government-run medical centre, the vast majority of the study's participants (92.7 percent) sought medical attention at a private establishment (33.3 percent).

After the devastating flood that occurred in Bazhong city in 2011, Wu et al. (2015) conducted a research to explore the health state and the HRQoL of the senior residents of that city. A total of 1183 people over the age of 60 who were residents of Bazhong city's eight different villages were selected at random for the survey. Both the rate of people seeking healthcare during a two-week period and the incidence of chronic illnesses were reported anonymously. The SF-36 was used as the instrument for measuring HRQoL (HRQoL). In order to discover the variables that are related with low HRQoL, a multivariate regression analysis was carried out. The two-week healthcare-seeking rate among post-flood Bazhong elderly was significantly higher than the references rate among rural elderly in Sichuan province (59.3 percent versus 55.7 percent, $\chi^2 = 5.134$, $p = 0.013$), however, Bazhong elderly demonstrated a significantly lower prevalence of chronic disease (33.2 percent versus 44.4 percent, $\chi^2 = 48.847$, $p = 0.001$) than rural elderly in Sichuan province. This finding was the scores on every dimension for the old people in Bazhong were much lower compared to the results for the elderly people in rural Sichuan. A number of factors, such as advancing age, being single, having bad sleep patterns, having chronic conditions, and so on, contributed to poor physical health. Several Iranian research have investigated HRQoL in the country's older population; nevertheless, the conclusions of these studies are inconsistent with one another. Tanjani and colleagues came to the conclusion that the HRQoL in Iran is well comparable with the values obtained in other countries. On the other hand, Tajvar and colleagues discovered that the HRQoL of old people in Iran is especially bad and low (Tanjani, Motlagh, Nazar and Najafi, 2015; Tajvar et al., 2022).

2.6 Life satisfaction of elderly people

The concept that engaging in regular physical activity (PA) and exercise is beneficial to one's health in the long run is supported by a significant body of research that has been made public. According to the findings of a study conducted by Reiner et al. (2013), PA is associated with decreased rates of obesity, weight gain, age-related illnesses such as dementia and Alzheimer's disease, coronary heart disease, and type 2 diabetes mellitus. Physical activity on a regular basis reduces the risk of several health conditions, including obesity, severe cardiovascular and metabolic problems, falls, cognitive decline, osteoporosis, and muscular weakness (McPhee et al., 2016). In addition, PA is connected with lower mortality rates in cases of obesity (Blair and Brodney, 1999) and with protection from cognitive decline (Newson and Kemps, 2006). Additionally, acts of social support may alleviate the stress associated with functional constraints (Pal, 2005). Pal

(2005) says that family relationships aren't made on purpose, and that feeling like you have to take care of an elderly person may be a sign that both the family and the elderly person are stressed. In addition, the loss of functionalities can be attributed to "excessive care," which prevents elderly individuals from performing their own activities and deprives them of the ability to make their own decisions (D'Orsi et al., 2011; Neri and Vieira, 2013; Pa'l, 2005).

There are now more old people than at any other time in the history of developing countries; nevertheless, the social and health care institutions that cater to the needs of the elderly have not kept pace with the population growth of the elderly. Access to medical care of a sufficient standard is considerably more or less available to elderly people in different ways throughout industrialised and developing countries. In developing countries like Ghana, an increasing number of older people are being left behind in society, which may lead to isolation and marginalisation (Atakro et al., 2021). Ghana's population is aging, and the country is facing a number of age-related challenges. The National Aging Policy of Ghana was developed as a direct result of the country's participation in the Year of Older People celebrations held by the African Union in 1999, the Second World Assembly on Aging, which took place in Madrid, Spain, in April 2002, and the United Nations World Assembly on Aging, which was held in Vienna, Austria, in 1982. In the end, Ghana came up with the idea for a national policy framework in 2011, with the intention of addressing issues that affect older people and including them in the processes that determine public policy. (Ghana National Ageing Policy, 2010).

A research project entitled "Life Satisfaction and Health in Old Age" was carried out by Choudhary (2015). The research was conducted using data collected from a sample of one hundred residents of the Jammu area. The sample consisted of grown adults who had a permanent residential address and were part of a family unit. The purpose of the study was to investigate the degree to which one's QoL in later years is connected with one's physical and mental health. Two different scales were used by the researcher so that he could get more accurate findings. The first one is called the Satisfaction with Life Scale (SWLS), and it gauges a person's overall evaluation of how satisfied they are with their life. It is believed that the degree to which a person's actual experiences are consistent with their idealised versions of those experiences is a major factor in how satisfied they are with their lives. The second scale was based on the PGI Health Questionnaire, which assesses the degree of physical and mental health in senior citizens. This questionnaire is used to assess the health of senior citizens. The outcomes of the research indicate that there is a correlation between life satisfaction and both physical and mental health.

According to Pearson's coefficient of correlation, there is a significant relationship between being happy with one's life and both one's physical and mental states of health (Choudhary, 2015).

Aging and the experience of older adulthood generally result in a decreased level of life satisfaction for adults 75 years of age or older (Hermann, 2007; Mollaoglu, Tuncay, and Fertelli, 2010); studies also indicated a slightly greater level of life happiness for males (Ferring et al., 2004). Achieving a certain level of education has a major and beneficial bearing on one's level of contentment with life (Heo and Cho, 2008; Lee and Lee, 2011, 2013; Li, Chi, and Xu, 2013; Zhang and Liu, 2007). There is a strong link between being married and being happy with life. Widowhood is linked to lower levels of life satisfaction, while married older people often report more happiness with life than single people (Hsu, 2012; Liu and Guo, 2008; Mroczek and Spiro, 2005).

Living arrangements are consistently connected to life satisfaction among older individuals, according to the findings of a number of studies; more particularly, living alone is associated with lower levels of life happiness (Liao, Chang, and Sun, 2012; Silverstein, Cong, and Li, 2006; Zhang and Liu, 2007).

The researchers Mollaolu, Tuncay, and Fertelli (2010) examined the relationship between life satisfaction and mobility disability in elderly people who lived in nursing home residences. Specifically, they focused on the relationship between life satisfaction and mobility disabilities. The research was carried out on a total of 78 senior citizens who were residing in two different nursing homes. A personal information form, the Rivermead mobility index, and the life satisfaction scale were used to collect the information that was used in their research. It was found that elderly people had average levels of life satisfaction; the vast majority of them experienced mobility disabilities; and there was a significant correlation between mobility and life satisfaction. It was also found that life satisfaction levels were significantly correlated with mobility. Mobility in the elderly was found to be influenced by age, gender, and chronic illnesses, whereas life satisfaction was linked to age, education level, and health perception level. The QoL of older individuals may be significantly altered by the presence of a disability, which is a factor that has a substantial influence.

Kudo et al. (2007) conducted research to investigate the elements that contribute to the level of life satisfaction experienced by elderly individuals. The morale scale developed at the Philadelphia Geriatric Center was used to conduct the study that examined the degree of life satisfaction. Two thousand one hundred fifty-one older people, which is approximately 99 percent of all older people (2165 subjects) in a rural town in Tashiro,

Akita Prefecture (Japan), responded to the questionnaire. Approximately 10% of the population was elderly people who relied on themselves for self-care. According to the findings of the research, elderly women who took care of themselves alone and without assistance had lower levels of morale than their male counterparts. The morale of elderly people who were responsible for their own self-care and cared for themselves declined with age in both men and women. When it came to self-care independent males, morale ratings were higher when they were healthy, had a job, and participated in social activities in the community. Regarding self-care, independent women's morale scores were higher when they were healthy and had hobbies. Education was not a predictor in determining morale ratings; however, other aspects of one's life, such as the makeup of their family, their dependence on themselves for self-care, their income, and the behaviours they engage in to promote their health,

Taghiabadi et al. (2017) investigated the connection between having spiritual experiences and being satisfied with one's life and having less worry about dying at this point in one's life. During the autumn and winter of 2016, 190 senior citizens visited the health and medical facilities in Neyshabur, Iran, as part of a cross-sectional study conducted by Taghiabadi and colleagues. The study used a descriptive-analytical research methodology. According to the findings of the research, it is feasible to reduce the stresses that occur at this period of life, including the anxiety that is associated with the prospect of death, by making use of spiritual experiences and boosting one's level of life satisfaction.

Kimm et al. (2012) conducted a study to investigate the connection that exists between an older population's level of life satisfaction and their risk of passing away. Among the 3,600 people who took part in the Kangwha Cohort Study and were still alive in 1994, there were 1,939 people who responded to the Life Satisfaction Index (LSI)-A questionnaire. These people were included in the study (men, 821; women, 1118). The Cox proportional hazard model was used in order to do the analysis necessary to calculate the mortality risk from the beginning of the study period to December 2005. According to the findings of the research, senior adults of either gender who had a lower LSI score were at a higher risk of dying prematurely due to any cause, and a low LSI score was also connected with the death rate from cardiovascular disease.

Li, Chi, and Xu (2013) conducted a study to investigate the variables that are connected with the level of life satisfaction experienced by older Chinese individuals who reside in rural towns. The China Research Center on Aging's Sample Survey on Aged Population in Urban and Rural China, conducted in the year 2000, was used to compile the data used

in their research. In all, there were 10,084 elderly people from rural areas of mainland China who participated in this research. According to the findings of the survey, 60.2% of older individuals living in rural areas expressed contentment with their lives. A multinomial logistic regression analysis was performed, and the results showed that life satisfaction reported by rural older Chinese adults was significantly related to education, financial resources, self-rated health, financial support from children, satisfaction with children's support, house sitting for their children, visiting neighbours, and being invited to dinner by neighbours. Additionally, life satisfaction was significantly related to house-sitting for their own children.

Maheswaran and Ranjit (2013) focused their research on longevity syndrome (LS) as well as the effect of demographic variables on LS in older persons. According to the findings, the vast majority of the respondents had a relatively low degree of LS. In addition, the degree of long-term care insurance coverage held by older respondents is significantly impacted by demographic parameters, particularly gender and the respondents' savings habits. The amount of LS is only marginally affected by factors like religious affiliation, number of children, health difficulties, ownership of a home or property, and monthly income.

Ng, Tey, and Asadullah (2017) conducted research to evaluate the factors that determine the level of life satisfaction experienced by the oldest-old (i.e., those aged 80 or more) in China. In this particular piece of research, they made use of data from the 2011/2012 Chinese Longitudinal Healthy Longevity Survey, which had a total sample size of 6530 individuals. Logistic regression is used to analyse the impact of socio-demographic, economic, health, instrumental activities of daily living, family, and community variables on life satisfaction and depression among China's oldest-old population. According to the findings of the survey, the vast majority of elderly people in China who were asked about their level of happiness with life assessed it as either excellent or very good. The outcomes of the research indicate that one's state of health and economic standing are, by far, the most important factors in determining one's level of happiness in life.

2.7 Wellbeing of elderly people

The ultimate objective of public policy and the aspiration of every person should be wellbeing. However, given the contemporary context of countries that are increasingly ageing, the growth of wellbeing with age provides a particularly attractive study subject important to not just policymakers but to all sectors of society. The relationship between

ageing and wellbeing has been the subject of much writing, yet experts, politicians, and the media continue to disagree on this topic (The Economist, 2010)

The health of the elderly is a primary priority for public policy in a society that is becoming older (Meggiolaro and Ongaro, 2015). The relationship between wellbeing and physical and mental health, as well as its potential critical role in socioeconomic problems and economic growth, are important factors influencing this widespread interest (Boehm et al. 2011; Greenspoon and Saklofske 2010; Seaford 2011; Stiglitz et al. 2009).

Among order to promote psychological wellbeing in older individuals living in the community, Friedman et al. (2018) conducted a pilot test of a new group intervention (the Lighten UP! programme). The goal of Lighten UP!, an eight-week programme with 90-minute group sessions, is to help participants recognise and appreciate happy experiences in many spheres of eudaimonic wellbeing. It was given to 103 men and women who were in the 60+ age range and were evaluated before and after the intervention using the Ryff's Psychological Wellbeing Scale (PWB), the Life Satisfaction Scale, the Geriatric Depression Scale, the Symptom Questionnaire, and items measuring sleep complaints and social wellbeing. After the 8-week period, individuals reported considerably higher PWB, life satisfaction, and social wellbeing along with reduced levels of sadness, less somatic symptoms, and fewer complaints about their sleep. Individuals with lower pre-program PWB levels saw these benefits with more vigour.

In addition to reviewing recent developments in the area, Steptoe, Deaton, and Stone (2015) offer fresh research on the pattern of wellbeing throughout ages and the link between wellbeing and longevity. Age and evaluative wellbeing in wealthy, English-speaking nations have a U-shaped connection, according to the Gallup World Poll. However, respondents from the former Soviet Union and Eastern Europe demonstrated a significant fall in wellbeing with advancing age, defying the generalisation of this trend. An essential goal of economic and health policy is the wellbeing of the elderly.

For senior inhabitants of Lebanese nursing homes, Doumit and Nasser (2010) evaluated QoL in relation to wellbeing. The goal of the research is to comprehend how structures, procedures, and abilities affect older health condition. 33 nursing facilities provided 220 senior participants who were cognitively intact. Using the Geriatric Depression Scale, the Activity of Daily Living, the EuroQol EQ-5D, and the Mini-Nutritional Assessment (MNA) tools, a quasi-experimental method assessed psychological and health-related aspects. It was determined that there was a very significant prevalence of moderate sadness among older inhabitants, as well as a lack of mobility. Elderly people in good health who were still able to function had regular meals and did not overexert themselves.

According to Allerhand, Gale, and Deary (2014), wellbeing is seen as a resource that may help people age well. Healthy ageing depends heavily on sustaining psychological wellbeing. (Daz-López et al., 2017; López Ulloa, Mller, and Sousa-Poza, 2013) The protective impact of positive wellbeing endures after adjusting for negative affection and depression. According to Allerhand et al. (2014), "depression had a bigger influence upon this connection for individuals with better wellbeing; nevertheless, exercise preserved cognitive function against the deleterious effects of lower wellbeing of the elderly." Therefore, in research on healthy ageing, having a good sense of psychological wellbeing is an important marker of mental health

2.8 HRQOL and Life Satisfaction

The term Life satisfaction refers to a judgement procedure in which people assess their QoL using a certain set of criteria. The socioeconomic circumstances and reduced labour performance of the elderly make them more susceptible to their LS and health problems (Lee and Jeon, 2005).

Yanarda, ahin, and zer (2019) examined the connection between adults 65 years of age and older's QoL, life satisfaction, and multidimensional perceptions of social support. According to the analysis's findings, the individuals' levels of life satisfaction, life quality, and perceived social support were moderate. The three factors' regression analysis produced significant findings. As a result, the older people's perceived social support and QoL rose, which raised their degree of contentment. As a result, facilitating senior citizens' access to health and social services as well as providing socioeconomic assistance for older people in need contribute to the promotion of life satisfaction, QoL, and social support.

According to a survey conducted by the Gallup organization in 132 nations, there is more evidence that as age and degree of disability rise, so do health and LS among the elderly. This research also points to variations between developed and developing countries, since the rate of reduction in LS with age and disability was higher in developing and undeveloped countries (Deaton, 2007).

In 2016, Puvill, Lindenberg, de Craen, et al. looked at how older individuals assess their lives in the face of illness and disability. It was decided to employ the Leiden 85-plus Study, a prospectively studied cohort of a cohort of a cohort of a middle-sized Dutch city, all of whom were 85 years old, and who were age-representative of the overall population. It was determined that whereas poor physical health was only marginally associated with poorer life satisfaction, poor mental health was significantly associated with the latter.

This suggests that physical health is less important for a happy old age and that mental health has a higher influence on life satisfaction in old age than physical health.

CHAPTER THREE

METHODOLOGY

3.1 Population and Target population

Ghana has a population of 33,475,870 people as of 2022, according to Knoema (2022). While rural regions make up 41.4% of the population, urban account for 58.6% of it. In 2022, there were 3.6% people in Ghana aged 65 years of age or older. Therefore, the population of the study was estimated to be the 1,205,131 elderly citizens in Ghana. The target population of the study was all the elderly (with more than 65 years and over) living in the Ashanti Region.

3.2 Sampling and Sampling Technique

Due to budgetary constraints and time limitations, a single Region was selected as the study area, Ashanti Region. This region has the highest population of elderly people according to Ghana Statistical Service, 2010 Population and Housing Census.

Almeda, Capistrano, and Sarte (2010) suggest that a method for ascertaining the appropriate sample size may be used in cases when the full population is unattainable.

$$n = \frac{(Z_{\alpha/2})^2}{4(e)^2}$$

Where:

- n = Number of samples
- $Z_{\alpha/2}$ = normal level of distribution at a significant level of 5% = 1.965
- e = Margin of Error Max, which is the maximum error rate of sampling that can still be tolerated or desired.

Using a maximum error margin of 10%, the minimum number of samples that can be taken are:

$$n = \frac{(1.965)^2}{4(0.05)^2}$$

$$\Rightarrow \frac{3.8612}{4(0.0025)} \Rightarrow \frac{3.8612}{0.01} \Rightarrow 386.12$$

Therefore 386 was the sample size used for the study. The sample size was expanded by 60% to meet the final sample size and to allow for incorrect completion and non-return

of the questionnaire (that is, mitigating the non-response effect that affects virtually all acts of data collection from primary sources).

As a result, 617 questionnaires were delivered in order to increase response rates. However, 578 responses were received. According to Hair et al. (2014), the sample size for a quantitative study should be more than 300 and above to be considered fit for a structural equation modeling analysis.

The 578 respondents for the study were chosen using the snowball sampling approach and purposive sampling technique. Purposive sampling represents a group of different non-probability sampling techniques. Also known as judgmental, selective or subjective sampling, purposive sampling relies on the judgement of the researcher when it comes to selecting the units (e.g., people, cases/organizations, events, pieces of data) that are to be studied. The main goal of purposive sampling is to focus on particular characteristics of a population that are of interest, which will best enable you to answer your research questions (dissertation.laerd.com).

Although it must be recognized that the use of non-probability sampling selection techniques represents a weakness of this study, such an option results from the difficulties posed by the institutional and social contexts that currently prevail in Ghana. Rather, it is a choice, the purpose of which varies depending on the type of purposive sampling technique that is used. Snowball sampling is a non-probability sampling method in which current research participants assist in the recruitment of future study respondents (Simkus, 2022).

The study first used the purposive sampling in selecting some of the elderly people before applying the snowball sampling technique. The purposive sampling helped to select older people who resided in Ghana specifically rural areas and had the ability to walk and to speak and were 65 years and above. After that the elderly people who were recruited firstly for the study assisted in recruiting other elderly people in the area.

3.3 Data Collection

The primary source of data was utilized in gathering information from people. Questionnaires were also utilized to retrieve data from the older people. The questionnaires were typed, printed and administered to the respondents at their own home. The questionnaire were applied in English.

The questionnaire had different scales for each set of questions. A Likert scale is a type of rating scale that is used to assess views, attitudes, or behaviours. It is made up of a statement or a question, followed by five or seven answer statements. Respondents select the choice that best expresses their feelings about the statement or topic (Bhandari and Nikolopoulou, 2022).

In the process of gathering data, four people from Ghana who were willing to assist with the data collection were contacted. These people were chosen because they have a high level of self-assurance and can communicate extremely well in Twi, the Ghanaian language. They traveled from one town to the next in the Ashanti Region with the printed questionnaires in order to gather the data. In order to acquire all of the data, it took them three weeks. Following the end of the data gathering process, data screening was carried out, during which various mistakes were eliminated prior to the data being processed.

3.4. Questionnaire

The questionnaire was divided into four sections. In the first section, Satisfaction with life scale (SWLS) was assessed. The second section covered questions on personal wellbeing. The third section was dedicated to measuring the respondent's HRQoL. Finally, the fourth section included questions to define the sociodemographic profile of the respondents. The questionnaire had an average duration of 20 minutes.

3.4.1 Satisfaction with life

Satisfaction with life was measured using the Satisfaction with life scale (SWLS). The SWLS is a short 5-item instrument designed to measure global cognitive judgments of satisfaction with one's life. The scale usually requires only about one minute of a respondent's time, where respondents answer on a Likert scale (Diener et al., 2013). Five likert scale point was applied in which respondents were required to tick whether they agree or disagree to the issues raised.

3.4.2 Wellbeing

Wellbeing was measured using the Personal Wellbeing Index (PWI). The Comprehensive Quality Of Life Scale (ComQoL) served as the basis for creating the Personal Wellbeing Index (Cummins, McCabe, Romeo and Gullone, 1994). Details of this test's creation, which included both an objective and a subjective assessment of life quality, have been published in the relevant literature (Cummins, 1991; Gullone and Cummins, 1999; Marriage and Cummins, 2004). A review of domain names mentioned in the literature

was the first step in locating the ComQoL domains. The seven broad areas that made up the scale were then created using a three-phase procedure (Cummins et al., 1994) and empirical validation (Cummins, 1997). A likert scale with 11 points which begins with 0 and ends with 10 was applied in which respondents were asked to tick how satisfied they are in relation to their personal wellbeing.

3.4.4 Sociodemographic profile

The questionnaire included six (6) questions to characterize the respondents in terms of gender, age, educational background, religion, marital status and number of children.

3.4.3 HRQoL

HRQOL was measured using the EQ-5D-5L. The EuroQol-5-dimensions (EQ-5D) is a standardised measure of self-perceived health status that provides a simple, generic measure of individuals' health. This instrument is applicable to a wide range of health conditions and treatments, and its descriptive system can be converted into a single index value for health status that can be used in clinical and economic evaluations of healthcare and in population-level health surveys (Rabin et al., 2008). The EQ-5D descriptive system includes five dimensions: mobility, self-care, habitual activities, pain and/or discomfort and anxiety and/or depression (Rabin et al., 2008). In this study, the EQ-5D-5L version was used, where respondents are asked to give their answers in a scale with 5 levels of severity, that range from no problems (level 1) to extreme problems/ unable to (level 5) (Ferreira et al., 2019).

3.5 Data Analysis

Following data collection, data was entered in SPSS version 26 and Stata 15. These statistical softwares were used to analyze the data. Descriptive analysis and inferential statistics were used. The Structural Equation Method (SEM) were used to assess how QoL of the older people affect their life satisfaction.

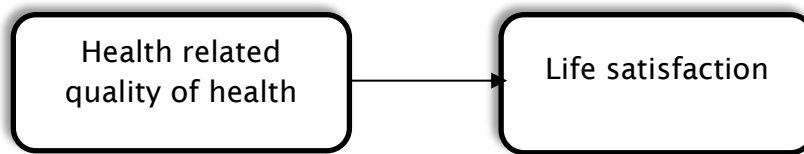
Descriptive statistical analyses (i.e. mean, standard deviation [SD], frequencies and proportions [%]) were carried out to describe the sample, the respondents' HRQoL satisfaction with life and wellbeing. Parametric test using correlation and SEM were conducted to analyse the sample.

Cronbach's alpha test (reliability test), exploratory factor analysis (EFA), and confirmatory factor analysis (CFA) were employed to assess the model before SEM was applied. de Vaus (2013, p.184) said that the rule of thumb alpha should be at least 0.7

before we say that the scale is reliable. The Cronbach's Alpha of each dimension is over 0.7, which is considered sufficient.

KMO and Bartlett's tests was first conducted using the EFA and finally common method bias was employed which included eigenvalue. EFA with factors with an eigenvalue (a number showing how much variance there is for that underlying factor) larger than or equal to 1.0 being considered acceptable (Guttman, 1954). The principal axis factoring with rotation of orthogonal varimax rotation was used, which can accommodate non-normal data distribution (Costello and Osborne, 2005).

The study employed goodness of fit test using CFA. Model fit statistics was used to evaluate model fit: root mean squared error of approximation (RMSEA), comparative fit index (CFI), Tucker-Lewis index (TLI), and standardized root mean squared residual (SRMR). The study followed commonly acceptable criteria regarding goodness of fit: RMSEA (≤ 0.06), CFI and/or TLI (≥ 0.95), SRMR (≤ 0.08) (Hu and Bentler, 1999).



Research Model, figure 1

Researcher's construct, 2023

CHAPTER FOUR

RESULTS

4.1 Study sample

Table 1 presents the distribution of the respondents according to their various demographic information.

According to table 1 below, the majority of respondents were female, accounting for 59.3 percent of the total, and the majority of respondents (53.8% of the total) were from the ages of 65 to 68. In the overall sample (41.7%), the majority of respondents held a junior/senior high school certificate. In relation to their marital status, the majority of respondents were found to be widow / widower (67.3%), and In terms of the number of children they have, the majority of respondents had 7 and more children (44.3%). In addition, the respondents' religion is analyzed, and the results show that the majority of them were found to be traditionalist.

Table 1, Study sample

	Frequency	%
Gender		
Male	235	40.7
Female	343	59.3
Age		
65-68	311	53.8
69-72	197	34.1
73+	70	12.1
Educational background		
No formal education	168	29.1
Junior/ Senior high school	241	41.7
Training college	135	23.3
Tertiary education	34	5.9
Marital status		
Married	57	9.9
Single	16	2.8
Divorced/ Separated	116	20.0
Widow/ Widower	389	67.3

Number of children		
1-3	119	20.6
4-6	203	35.1
7+	256	44.3
Religion		
Christian	181	31.3
Muslim	137	23.7
Traditionalist	243	42.0
Others	17	3.0

Source: Field Survey, 2023

4.2 Life satisfaction

The descriptive statistics presents the mean, standard deviation of life satisfaction. This was done to find out describe the life satisfaction of older people in the rural areas (Ashanti Region).

Table 2. Life satisfaction

	Mean	Std. Deviation
In most ways my life is close to my ideal.	2.43	.727
The conditions of my life are excellent.	2.41	.576
I am satisfied with my life.	2.28	.541
So far I have gotten the important things I want in life.	2.22	.777
If I could live my life over, I would change almost nothing	2.36	.662

Source: Field Survey, 2023

According to table 2, “In most ways, my life is close to my ideal” had a mean score of 2.43 and a standard deviation score of 0.727. “The conditions of my life are excellent” had a mean score of 2.41 and a standard deviation of 0.576. “I am satisfied with my life” had a mean value of 2.28 and a standard deviation of 0.541. “So far I have gotten the important things I want in life” had a mean value of 2.2 and a standard deviation of 0.777. “If I could live my life over, I would change almost nothing” also had a mean and a standard deviation score of 2.36 and 0.662 respectively.

From the findings, older people in the rural areas had higher life satisfaction in “In most ways, my life is close to my ideal”, “the conditions of my life are excellent” and “If I could live my life over, I would change almost nothing”. However, older people in the rural areas have lower life satisfaction in “I am satisfied with my life and ‘so far, I have gotten the important things I want in life”

4.3 Personal wellbeing

The descriptive statistics presents the mean, standard deviation of personal wellbeing. This was done to study the wellbeing of older people in rural areas in Ghana (Ashanti Region).

Table 3, Personal wellbeing

	Mean	Std. Deviation
How satisfied are you with your life as a whole?	4.44	2.770
How satisfied are you with your standard of living?	4.63	2.688
How satisfied are you with your health?	5.23	2.750
How satisfied are you with what you are achieving in life?	4.20	2.903
How satisfied are you with your personal relationships?	4.03	3.158
How satisfied are you with how safe you feel?	4.07	2.678
How satisfied are you with feeling part of your community?	4.99	2.982
How satisfied are you with your future security?	4.94	3.008
How satisfied are you with your spirituality or religion?	4.3045	3.01711

Source: Field Survey, 2023

According to table 3, “How satisfied are you with your life as a whole” had a mean score of 4.44 with it standard deviation of 2.770. The mean score and the standard deviation of “How satisfied are you with your standard of living” was 4.63 and 2.688 respectively. “How satisfied are you with your health” had a mean score of 5.23 and a standard deviation of 2.750. “How satisfied are you with what you are achieving in life also had a mean score of 4.20 and a standard deviation of 2.903. “How satisfied are you with your personal relationships” had a mean value of 4.03 and a standard deviation of 3.158. “How satisfied are you with how safe you feel” had a mean value of 4.07 and a standard deviation of 2.678. “How satisfied are you with feeling part of your community” had a mean value of 4.99 and a standard deviation of 2.982. “How satisfied are you with your

future security” had a mean value of 4.94 and a standard deviation of 3.008. Finally, “How satisfied are you with your spirituality or religion” had a mean score of 4.3045 and a standard deviation of 3.01711.

Regards to personal wellbeing, it is evident from the table that, older people in rural areas of Ghana had gain higher satisfaction with their health, feeling part of their community, their future security and their standard of living. However, they have gain lower satisfaction in relation to their life as a whole spirituality or religion, what they are achieving in life, their safety and also their personal relationships.

4.4 Health Related Quality of Life (HRQoL)

The descriptive statistics method was used to calculate the mean, standard deviation frequencies, percentages and significance value (sig) of HRQoL using SPSS. This was done to describe the HRQoL of older people in rural areas in Ghana (Ashanti Region). According to the Status of EQ-5D-5L Valuation using Standardized Valuation Methodology (2022), EQ-5D-5L is still on-going in the study area or country (Ghana). However, EQ-5D-5L index was calculated using Portugal values.

Table 4, Health Related Quality of Life

	Frequency (%)	EQ-5D-5L Index		Sig
		Mean	Std. Dev	
Mobility		.0705	.0787	0.001
<ul style="list-style-type: none"> • No problems • Slight problems • Moderate problems • Severe problems • Unable to 	120 (20.8%) 235 (40.7%) 189 (32.7%) 0 34 (5.9%)			
Self-care		.061	.0391	0.001
<ul style="list-style-type: none"> • No problems • Slight problems • Moderate problems • Severe problems • Unable to 	54 (9.3%) 331 (57.3%) 125 (21.6%) 68 (11.8%) 0			
Usual activities		.0486	.0383	0.001

<ul style="list-style-type: none"> • No problems • Slight problems • Moderate problems • Severe problems • Unable to 	<p>86</p> <p>292</p> <p>187 (32.4)</p> <p>0</p> <p>13 (2.2%)</p>			
Pain/ discomfort		.056	.0393	0.001
<ul style="list-style-type: none"> • No problems • Slight problems • Moderate problems • Severe problems • Unable to 	<p>121 (20.9%)</p> <p>230 (39.8%)</p> <p>227 (39.3%)</p> <p>0</p> <p>0</p>			
Anxiety/ depression		.0448	.0353	0.001
<ul style="list-style-type: none"> • Not anxious • Slightly anxious • Moderately anxious • Severely anxious • Extremely anxious 	<p>168 (29.1%)</p> <p>183 (31.7%)</p> <p>227 (39.3%)</p> <p>0</p> <p>0</p>			

Source: Field Survey, 2023

According to table 4, Mobility had a mean score of .0705 and a standard deviation of .0787. Self-care had a mean value of .061 with its standard deviation being .0391. Usual activities had a mean score of .0486 and a standard deviation of .0383. Pain/ discomfort had a mean score of .056 and a standard deviation value of .0393. Anxiety/ depression also had a mean value of .0448 and a standard deviation of .0353

The empirical result established that the older people in the Ashanti Region are very much concerned about their self-care, mobility and usual activities. However, they are less concerned about their pain/ discomfort and their anxiety/ depression.

The study also determined the EQ-5D-5L health states. The study employed Ferreira et al., 2022, EQ-5D-5L of Portugal for the study since the researcher is studying in Portugal.

Table 5, Ten most frequently reported EQ-5D-5L health states

Overall sample (n=202) Health state (%)	Sport activities (n=67) Health state (%)	Leisure time activities (n=85) Health state (%)
11111a (24.8)	11111 (34.3)	11111 (25.9)
11121 (16.8)	11122 (14.9)	11121 (20.0)

11122 (10.4)	11121 (10.4)	11122 (15.3)
21121 (3.0)	11131 (3.0)	21121 (3.5)
21122 (2.5)	22232 (3.0)	21131 (3.5)
21131 (2.5)	11123 (1.5)	11221 (2.4)
11123 (1.5)	11135 (1.5)	22121 (2.4)
11131 (1.5)	11143 (1.5)	22232 (2.4)
31222 (1.5)	11221 (1.5)	11112 (1.2)
11112 (1.0)	11231 (1.5)	11133 (1.2)

(Ferreira1, Pais, Ilchuk and Santos, 2021)

The 5-digit code describes the respondents' health state and shows the combination of a problem level for each of the 5 dimensions; each dimension has 5 response levels: no problems, slight problems, moderate problems, severe problems and unable to/extreme problems.

Table 5 shows that there was a clear ceiling effect in the whole sample, with almost a quarter of the seniors saying they were in perfect health (health state 11,111). As expected, more people in the nearly senior subgroup (31.4%) said they were in great health than in the senior subgroup (21.2%). This effect is even bigger for older people who played sports (34.3%) or did other things for fun (25.9%) (see Table 5). There were also differences in the number of health states that were said to be present. As a whole, 74 out of 3,125 health states (2.4%) were found in the sample, while 28 (0.9%) were found in the subgroup of people who do sports and 29 (0.9%) were found in the subgroup of people who do leisure activities. No one answered that they were in the worst health state, which the EQ-5D-5L calls 55,555. Notably, six of the top 10 health states most often stated by the whole sample and the subgroup of people who did leisure activities were related to "no problems" in movement. For people who do at least one sport activity, this number goes up to 9 of the top 10 health states.

4.5 Demographic Characteristics Relationship With Personal Wellbeing, HRQOL, and Life Satisfaction

T-statistics was used to conduct and compare the relationship that exist between socio-demographic characteristics of the respondents to personal wellbeing (PW), HRQol and life satisfaction (LS). Mean and standard deviation were used to compare the items of the socio-demographic characteristics and HRQol, PW and LS. The highest mean indicates

how they are demographic characteristics are well pleased with their LW, HRQoL and PW.

Table 6, Socio-demographic information, PW, LS and HRQoL

			LS	HRQoL	PW	
Age	65-68	Mean	2.3350	.0566	4.5651	
		SD	.49983	.03381	1.14695	
	69-72	Mean	2.3421	.0561	4.5539	
		SD	.49826	.03316	1.20745	
	73+	Mean	2.3543	.0545	4.5964	
		SD	.49010	.03454	.99664	
Education	No formal education	Mean	2.3429	.0561	4.5275	
		SD	.49483	.03396	1.18920	
	Junior/ Senior high school	Mean	2.3353	.0562	4.5877	
		SD	.49879	.03339	1.13056	
	Training college	Mean	2.3363	.0557	4.5028	
		SD	.49815	.03412	1.12929	
	Tertiary education	Mean	2.3706	.0584	4.8382	
		SD	.51671	.03302	1.16715	
	Marital Status	Married	Mean	2.3018	.0586	4.4715
			SD	.51564	.03451	1.25446
		Single	Mean	2.4250	.0574	4.5234
			SD	.49464	.03490	1.01880
Divorced/ Separated		Mean	2.3448	.0545	4.5323	
		SD	.48889	.03301	1.14637	
Widow/ Widower		Mean	2.3404	.0563	4.5903	
		SD	.49860	.03373	1.14251	
Number of children		1-3	Mean	2.3496	.0562	4.5924
			SD	.49760	.03384	1.14373
	4-6	Mean	2.3399	.0565	4.5702	
		SD	.50043	.03352	1.16213	
	7+	Mean	2.3352	.0559	4.5483	
		SD	.49659	.03374	1.14593	
	Religion	Christian	Mean	2.3392	.0561	4.5276

		SD	.49448	.03412	1.18076
	Muslim	Mean	2.3460	.0571	4.6296
		SD	.50846	.03307	1.13156
	Traditionalist	Mean	2.3383	.0560	4.5370
		SD	.49791	.03346	1.16017
	Others	Mean	2.3176	.0523	4.8456
		SD	.46936	.03765	.75069

Source: Field Survey, 2023

In terms of age range and life satisfaction, 73 years and above had the highest mean (2.3543) with a standard deviation value of .49010 while age range 65 years to 68 years had the lowest mean (2.3350) and a standard deviation of .49983. This implies that 73 years and above are well pleased with their life satisfaction. Also, in relation of the age range and HRQol, 65 years to 68 years had the highest mean (.0566) and a standard deviation of .03381 while 73 years and above had the lowest mean (.0545) with a corresponding standard deviation of .03454. This implies that 65 years to 68 years are well pleased with their HRQol. In addition, regards to age and personal wellbeing (PW), 73 years and above had the highest mean (4.5964) with a standard deviation of .99664 while 69 years to 72 years had the lowest mean (4.5539) and a standard deviation value of 1.20745. This means that 73 years and above age range are content with their personal wellbeing.

Regards to educational level and life satisfaction, tertiary education had the highest mean (2.3706) with a standard deviation value of .51671 while Junior/ Senior high school had the lowest mean (2.3353) and a standard deviation of .49879. This implies that older people with tertiary education are well pleased with their life. Also, in relation of the educational level and HRQol, tertiary education had the highest mean (.0584) and a standard deviation of .03302 while training college had the lowest mean (.0557) with a corresponding standard deviation of .03412. This implies that older people with tertiary education are well pleased with their HRQol. In addition, regards to education level and personal wellbeing (PW), tertiary education had the highest mean (4.5028) with standard deviation of 1.12929 while training college had the lowest mean (4.5539) and a standard deviation value of 1.20745. This means that older people with tertiary education are content with their personal wellbeing.

In terms of marital status and life satisfaction, single older people had the highest mean (2.4250) with a standard deviation value of .49464 while married older people had the

lowest mean (2.3018) and a standard deviation of .51564. Also, in relation of the marital status and HRQol, married older people had the highest mean (.0586) and a standard deviation of .03451 while divorced/ separated older people had the lowest mean (.0545) with a corresponding standard deviation of .03301. In addition, regards to marital status and personal wellbeing (PW), older people who are widows/ widowers had the highest mean (4.5903) with standard deviation of 1.14251 while married older people had the lowest mean (4.4715) and a standard deviation value of 1.25446. This means that married older people are content with their life and HRQol while widow/ widower older people are well pleased with their personal wellbeing.

In terms of the number of children, older people with 1-3 children had the highest mean (2.3496) with a standard deviation value of 0.49760 while older people with 7+ children had the lowest mean (2.3352) and a standard deviation of 0.49659. Also, in relation of the number children and HRQol, older people with 4-6 children had the highest mean (.0565) and a standard deviation of .03352 while older people with 7+ children had the lowest mean (.0559) with a corresponding standard deviation of .03374. In addition, regards to the number of children and personal wellbeing (PW), older people with 1-3 children had the highest mean (4.5924) with standard deviation of 1.14373 while older people with 7+ children had the lowest mean (4.5483) and a standard deviation value of 1.14593. This means that older people with 1-3 children are content with their life and personal wellbeing while older people with 4-6 children are well pleased with HRQoL.

In relation to respondents religion and life satisfaction, older people who are Muslims had the highest mean (2.3460) with a standard deviation value of .50846 while other religion older people had the lowest mean (2.3176) and a standard deviation of .46936. Also, in relation of the religion and HRQol, older people who are Muslims had the highest mean (.0571) and a standard deviation of .03307 while other religion older people had the lowest mean (.0523) with a corresponding standard deviation of .03765. In addition, regards to the religion and personal wellbeing (PW), other religion older people had the highest mean (4.8456) with standard deviation of .75069 while older people who are Christians had the lowest mean (4.5276) and a standard deviation value of 1.18076. This implies that older people who are Muslims are content with their life and HRQol while older people who other religion apart from Christians, Muslims and Traditionalist are well pleased with personal wellbeing.

4.6 Assessment of Measurement Model

The data gathered was assessed using reliability test, exploratory factor analysis and confirmatory factor analysis.

4.6.1 Reliability

Table 7, Test of Alpha

Variables	Items	Alpha
Health Related Quality of Life	5	0.806
Life satisfaction	5	0.837

Source: Field Survey, 2023

Health Related Quality of Life and life satisfaction had a Cronbach alpha values of 0.806 and 0.837. The values are consistent with de Vaus (2013) who refers to 0.70 as a 'reliable scale'. This means that the variables are reliable for the study as presented in table 7.

4.6.2 Exploratory Factor Analysis (EFA)

4.6.2.1 KMO and Bartlett's Test

In the table below (table 7), the KMO and Bartlett's tests were run, and their results are shown. Hair et al. (2010) said that the test of Kaiser-Meyer-Olkin and Bartlett's ($\chi^2 = 126.774$, KMO = 0.500, df = 1, p 0.000) proves that factor analysis can be used and is appropriate. Also, the results show that the methods used were good enough for the factor analysis that was done.

Table 8, KMO and Bartlett's tests

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.500
Bartlett's Test of Sphericity	Approx. Chi-Square	126.774
	Df	1
	Sig.	.000

Source: Field Survey, 2023

4.6.2.2 Common Method Bias

To avoid common method bias (Podaskoff et al., 2012), this study did what Podaskoff et al. (2003) suggested and used exploratory factor analysis to do a Herman one factor test. The results show that no single factor explained more than 40% of the variation. This was less than the 50% threshold that Podaskoff and Organ suggested (1986). This showed that bias from the common method was not a problem in this study. As shown in Table 9, the results showed that the first factor and subsequent components explained 44.368% of the total variance. This is well below the 50% threshold for common method bias. So, it's safe to say that the study's data doesn't have common method bias or common method variance.

Table 9, Total Variance Explained

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	
1	1.44	72.232	72.232	.887	44.368	44.368	
5							
2	.555	27.768	100.000				
Extraction Method: Principal Axis Factoring.							

Source: Field Survey, 2023

4.6.3 Confirmatory Factor Analysis (CFA)

4.6.3.1 CFA of HRQoL.

Before checking for fitness using CFA, factor loading was conducted. Items with factor loadings of less than 0.5 were taken out, as suggested by (Hair et al., 2010).

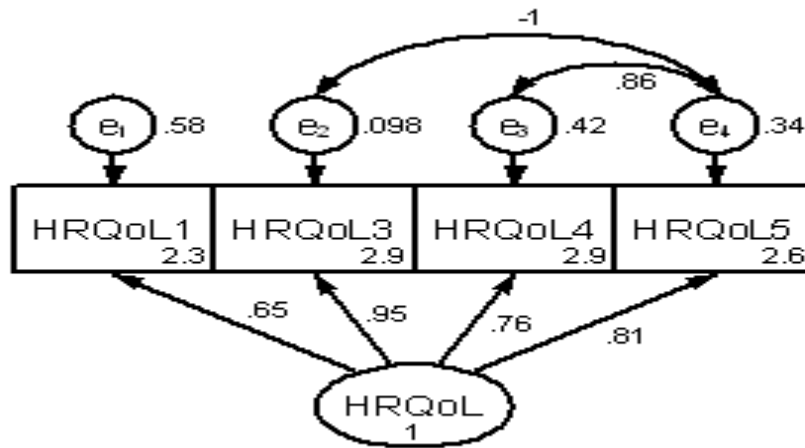
Table 10, Factor loading of HRQoL

	Loading
HRQoL1	0.67
HRQoL2	-0.47
HRQoL3	1.00
HRQoL4	0.76
HRQoL5	0.85

Source: Field Survey, 2023

Because of this, 1 item (HRQoL2) from HRQoL leaving 4 scale items (that is HRQoL1, HRQoL3, HRQoL4 and HRQoL5), which were enough to get the best-fit indices as presented in table 10 (see appendix 1, figure 5; HRQoL CFA model)

Figure 2, Final HRQoL CFA Model



Source: Researcher Construct, 2023

Table 11 Fitness threshold of HRQoL

Measures	Criteria	Study Outputs (Estimates)
SRMR	Close to 0.06 or below	0.000
TLI	Close to 0.95 or greater	1.000
CFI	Close to 0.95 or greater	1.000
RMSEA	Close to 0.0 6 or below	0.000

Source: Field Survey, 2023

From the confirmatory factor analysis carried out on HRQoL, there is an indication that all the values obtained for the various measures met the set criteria given by Hu and Bentler (1999) as tabulated in Table 11. As a result of that, the study considered the measurement model for HRQoL presented in the Figure 2, as a good fit for the SEM.

4.6.3.2 CFA of Life Satisfaction

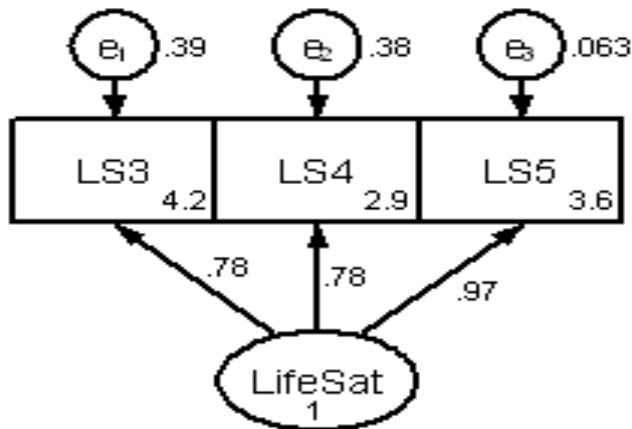
Items with factor loadings of less than 0.5 were taken out, as suggested by (Hair et al., 2010). Because of this, 2 item (LS1 and LS2) from HRQoL leaving 3 scale items (that is LS3, LS4 and LS5), which were enough to get the best-fit indices as presented in table 12 (see appendix 1, figure 6; Life Satisfaction CFA model)

Table 12 Factor loading of Life Satisfaction (LS)

	Loadings
LS1	0.44
LS2	0.4
LS3	0.82
LS4	0.79
LS5	0.93

Source: Field Survey, 2023

Figure 3, Final Life Satisfaction CFA Model



Source; Researcher’s Construct, 2023

From the confirmatory factor analysis carried out on life satisfaction, there is an indication that all the values obtained for the various measures met the set criteria given by Hu and Bentler (1999) as tabulated in table 13 below. As a result of that, the study considered the measurement model for HRQoL presented in the Figure 3, as a good fit for the SEM.

Table 13, Fitness threshold of Life Satisfaction

Measures	Criteria	Study Outputs (Estimates)
SRMR	Close to 0.08 or below	0.000
TLI	Close to 0.95 or greater	1.000
CFI	Close to 0.95 or greater	1.000
RMSEA	Close to 0.08 or below	0.000

Source: Field Survey, 2023

4.7 Correlation Analysis

The correlation matrix was employed to analysed the sample to determine the relationship that exist between HRQoL and Life Satisfaction before conducting the SEM.

Table 14, Correlation matrix

		Life Satisfaction	HRQoL
Life Satisfaction	Pear Corr	1	.445**
HRQoL	Pear Corr	.445**	1
**. Correlation is significant at the 0.01 level (2-tailed).			

Source: Researcher’s Work, 2023

According to table 14, there is a positive relationship between the HRQoL and life satisfaction with a coefficient value of 0.445. This implies that the positive changes in life satisfaction of older people is influenced by HRQoL.

4.8 Test of Hypothesis

One way Anova was used to find out whether HRQoL influences the life satisfaction of older people in the rural areas in the Ashanti Region of Ghana.

From table 15 (ANOVA) below, it is indicated that, the significant values is 0.000 which is less than 0.05 which implies that the model used for the study is actually fit and statistically significant and thus HRQoL affects the life satisfaction of older people in rural areas in Ghana.

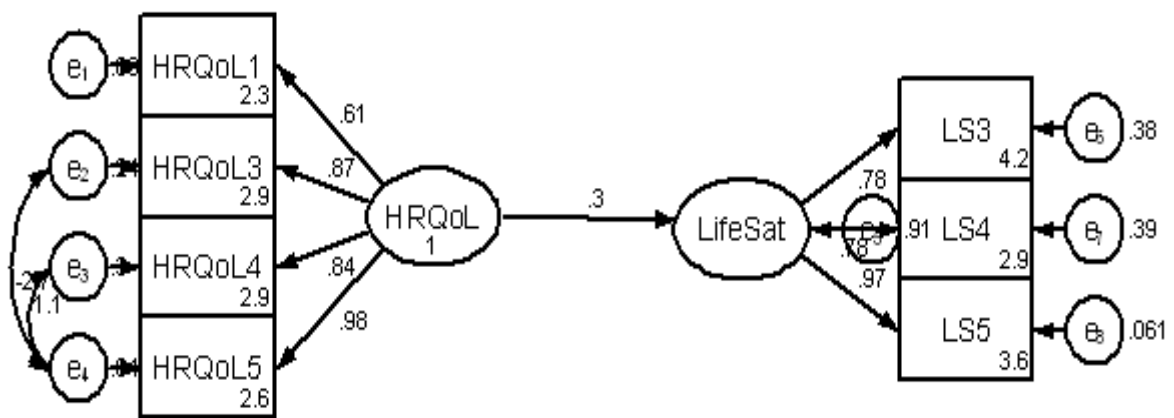
Table 15, ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	117.131	7	16.733	75.133	.000
Within Groups	126.946	570	.223		
Total	244.077	577			

Source: Field Survey, 2023

4.9 Assessment of Structural Equation Model

Figure 4, path diagram



Source: Researcher’s Construct, 2023

Table 16, Coefficients of variable

	Beta	Z	P>z
HRQoL → LifeSat	0.300	8.03	0.000
Note: HRQoL stands for Health related quality of life LifeSat stands for life satisfaction			

Source: Field Survey, 2023

Table 16 shows that the path HRQoL → LifeSat gave a positive and significant path results (Coeff = 0.300, Z = 8.04, and P > [z] = 0.000). This finding backs up the idea that a good HRQoL have a great impact on life satisfaction of older people. In reality, a 1% change or variation in health related quality of life is likely to make older people in the rural area 30% satisfied with their life (Coeff = 0.300).

CHAPTER FIVE

DISCUSSION

5.1 The life satisfaction of people aged 65 and over in rural areas in Ghana

From the findings, one's own ideal is his or her source of strength and power. The higher degree to which an elderly person in the rural area of Ghana puts his ideas to work brings about life satisfaction. Choudhary (2015) found in a study that the degree to which a person's actual experiences are consistent with their idealized versions of those experiences is a major factor in how satisfied they are with their lives. In contrast, Pal (2005) says that family relationships aren't made on purpose and that feeling like you have to take care of an elderly person may be a sign that both the family and the elderly person are stressed. In addition, the loss of functionalities can be attributed to "excessive care," which prevents elderly individuals from performing their own activities and deprives them of the ability to make their own decisions (D'Orsi et al., 2011; Neri and Vieira, 2013; Pal, 2005). According to Neugarten, the key to achieving happiness and contentment in one's life is to examine the disparity between one's desires and the things that he or she really does (Onur, 1997: 368).

Having an excellent life brings out the best in elderly people and makes them have a higher level of life satisfaction. Excellent health means being free of several health complications. Many of the elderly people made several changes in their lives. However, in this study, the elderly people indicated that if they were to start life all over again, they would not make any changes, and that would lead to a higher level of life satisfaction. According to the findings of a study conducted by Reiner et al. (2013), physical activity is associated with decreased rates of obesity, weight gain, age-related illnesses such as dementia and Alzheimer's disease, coronary heart disease, and type 2 diabetes mellitus. Physical activity on a regular basis reduces the risk of several health conditions, including obesity, severe cardiovascular and metabolic problems, falls, cognitive decline, osteoporosis, and muscular weakness (McPhee et al., 2016).

In addition, elderly people in the rural areas of Ashanta Region are not satisfied with their lives and what they have achieved in life. Life satisfaction is the appraisal of one's life as a result of comparing the individual's perception of living conditions with the criteria he imposes on himself (Chechen, 2007: 181), which is consistent with the study findings. In 2013, Li, Chi, and Xu (2013) conducted a study to investigate the variables that are connected with the level of life satisfaction experienced by older Chinese individuals who

reside in rural towns. According to the findings of the survey, 60.2% of older individuals living in rural areas expressed contentment with their lives.

5.3 The HRQoL of people aged 65 and over in rural areas in Ghana

The empirical study revealed that growing older makes one more concerned about their own care. Kudo et al. (2007) found that elderly women who took care of themselves alone and without assistance had lower levels of morale than their male counterparts. Self-care was higher when people were healthy, had jobs, and participated in social activities. The elderly are very concerned about their mobility. Doumit and Nasser (2010) evaluated QoL in relation to wellbeing. It was determined that there was a very significant prevalence of moderate sadness among older residents, as well as a lack of mobility. Mollaolu, Tuncay, and Fertelli (2010) studied the relationship between life satisfaction and mobility disability in elderly people living in nursing home residences. They found that life satisfaction was significantly correlated with mobility and was influenced by age, gender, chronic illnesses, education level, and health perception level. The presence of a disability can significantly alter the quality of life of older individuals.

As they age, they begin to care more in relation to usual activities. Brown et al. (2015) examined a large group of elderly people living in the United States to determine the utility and relative value of several measures of HRQoL as predictors of death. Although there was a substantial correlation between all four HRQoL measures and mortality, general self-ratings of health and age were shown to be more relevant predictors than the HDs. Kharicha et al. (2007) reported that those who lived alone were more likely to report having an HRQoL that was either fair or poor (poor vision, difficulties in instrumental and basic activities of daily living, worse memory and mood, lower physical activity, and worsening function).

In addition, elderly people in rural areas care less about their pains or their discomfort. This can be attributed to their age range. Also, most do not have the funds to take good care of their health. The effects of getting older and the diseases that are associated with getting older may be seen in both the HRQoL and the expenses associated with health care. As a result of a lack of available funds in the healthcare industry and a growth in the number of patients requiring medical attention (Harrefors, Savenstedt, and Axelson, 2009).

Allerhand et al. (2014) revealed that "depression had a bigger influence upon this connection for individuals with better wellbeing; nevertheless, exercise preserved

cognitive function against the deleterious effects of lower wellbeing in the elderly." Therefore, in research on healthy aging, having a good sense of psychological wellbeing is an important marker of mental health. However, an empirical study indicated that elderly people have less concern about their anxiety or depression. Depression in older adults is a somatic symptom that may be traced back to a variety of different mental diseases. As is the case with hypertension and diabetes, this condition is difficult to attribute to a specific cause. When compared with their youth, older adults get less family and social support from other seniors, both in and outside of their own families. They experience a significant increase in feelings of isolation and depression, particularly as certain customary celebrations get closer.

5.4 HRQoL affects the life satisfaction of people aged 65 and over in rural areas in Ghana

According to the study, an improvement in HRQoL of elderly people in rural areas results in a 30% increase in life satisfaction. This implies that there exists a weak positive relationship, and for elderly people to keep on achieving higher life satisfaction, much effort must be expended on their health-related quality of life. Yanarda, Ahin, and Zeer (2019) examined the connection between adults 65 years of age and older's QoL, life satisfaction, and multidimensional perceptions of social support. According to the analysis's findings, the individuals' levels of life satisfaction, life quality, and perceived social support were moderate. The socioeconomic circumstances and reduced labor performance of the elderly make them more susceptible to their LS and health problems (Lee and Jeon, 2005). In contrast, Puvill, Lindenberg, de Craen, et al. (2016) looked at how older individuals assess their lives in the face of illness and disability. It was determined that, whereas poor physical health was only marginally associated with poorer life satisfaction, poor mental health was significantly associated with the latter. This suggests that physical health is less important for a happy old age and that mental health has a higher influence on life satisfaction in old age than physical health.

5.2 The wellbeing of people aged 65 and over in rural areas in Ghana

The empirical result indicates that elderly people in rural areas of Ghana had higher satisfaction with their health, feeling part of their community, their future security, and their standard of living. This implies that good personal wellbeing is a result of proper health care, helping with community activities, or being part of the community, which makes them enjoy life and not feel lonely. The elderly's future security is as a result of members of the community, children, family, and NGO's coming to their aid to support them, and finally, a higher standard of living improves the wellbeing of the elderly. The ability to maintain adequate living circumstances, such as having a roof over one's head and a job, is essential to one's state of wellbeing (Diener and Seligman, 2004; Diener, 2009). Achieving a certain level of education has a major and beneficial bearing on one's level of contentment with life (Heo and Cho, 2008; Lee and Lee, 2011, 2013; Li, Chi, and Xu, 2013; Zhang and Liu, 2007).

The empirical study also revealed that the more elderly people meddle in spirituality or religion, the more they experience satisfaction in relation to their wellbeing. In their study, Taghiabadi et al. (2017) investigated the connection between having spiritual

experiences, being satisfied with one's life, and having less worry about dying at this point in one's life. According to the findings of the research, it is feasible to reduce the stresses that occur at this period of life, including the anxiety that is associated with the prospect of death, by making use of spiritual experiences and boosting one's level of life satisfaction.

The study revealed that an increase in elderly people striving to achieve something in life leads to a decline in their wellbeing. This means that they will put all their effort into making their dreams come true, but it will eventually cause life dissatisfaction and can also affect their health as a whole. According to Allerhand, Gale, and Deary (2014), wellbeing is seen as a resource that may help people age well. Healthy aging depends heavily on sustaining psychological wellbeing.

Researchers discovered that older adults' life satisfaction varied depending on their physical health, whether they lived in the inner city or the suburbs, whether they felt safe at night or not, and whether they traveled by car or other modes of transportation (Millward and Spinney, 2013). The current study established that elder people in the rural areas of the Ashanti Region are not satisfied with their safety, which leads to a lower level of wellbeing for the elderly. This implies that the elderly people are not well taken care of by their families and relatives, and as a result, they worry about their safety.

Also, the study established that the personal relationships that exist between the elderly people and the community they found themselves in—their friends, children, relatives, and family—are not strong. This means that there is a weak and unhealthy relationship between the elderly and the people around them. This weak relationship leads to dissatisfaction in elderly people, resulting in lower wellbeing. Aging is characterized by declines in physical health and functional capacities and by the loss of significant roles and relationships—experiences that challenge QoL. Aging is also associated with declining economic resources, decreasing cognitive ability, deteriorating physical health, and weakening social support (Ian et al., 2009). The living arrangement offers options to maintain functional performance into old age in addition to protection. Elderly people, however, may find it stressful to coexist with younger generations (Pal, 2005). According to Liu and Rook (2013, page 814), social exchanges have an effect on both emotional and social loneliness, and the risk of loneliness increases with advanced age due to poor health, residential relocation, and the loss of members of one's social network and consequently opportunities for socializing.

CHAPTER SIX

CONCLUSION

Indicators of effective aging include life satisfaction, a crucial element of wellbeing. It pertains to an individual's conscious evaluation of their own circumstances and reactions to them, and it can include functional ability, role performance, social interaction, psychological wellbeing, physical feelings, contentment, life scenarios, life satisfaction, and need for fulfilment. In order to promote health through lifestyle, which is centered on acquiring health-promoting behaviours, lifestyle is the primary changeable factor. According to research, elderly people's quality of life is positively impacted by their physical and financial security as well as their social inclusion. Because of changes and occurrences in their physical health, psychic condition, social position, and link to their surroundings, elderly people may have a different view of what it means to be content with life.

Along with absence of access to societal structures, housing, and utilities, neglect, poverty, and poor health are also problems. Non-communicable diseases (NCDs) are the most common illnesses that affect the elderly, and the prevalence of NCDs presents significant hurdles for the old who are low income. The capacity to continue living in one's own house, a higher financial standing, sufficient family support, a higher level of happiness with one's living conditions, and a higher level of satisfaction with one's living surroundings are all necessary for successful ageing.

At older ages, psychological wellbeing and physical health are closely linked. The term "QoL" is used to refer to evaluations of an individual's overall experience of life. HRQoL is a multi-dimensional term that is used to measure overall health since it collects information on the physical and mental health condition of people, as well as the influence of health status on QoL. Life satisfaction can be defined as an individual's emotional reaction or attitude toward their life in general, including work, leisure, and other time periods. Expressions of the state of being good from a variety of perspectives, such as happiness, morale, and so on. The degree to which a person is content with their life is one of the most critical aspects that influences both their mental health and physical health.

Neugarten, Diener, Emmons, Larsen, and Griffin's definition of life satisfaction is a favourable judgement of a person's whole life in line with the criteria specified by the individual themselves. Pavot and Diener define life satisfaction as the cognitive component of subjective wellbeing, and it is the evaluation of one's life as a result of comparing the individual's perception of living conditions with the criteria he imposes on

himself. Satisfaction with one's life may be defined as an individual's emotional reaction or attitude toward their life in general, including their time spent at work, at play, and in other settings. One of the most crucial things that affects an individual's mental health as well as the social relationships that person has is the degree to which they are satisfied with their lives. Wellbeing is a positive result that is relevant for people and for many other facets of society, and the ability to maintain adequate living circumstances is essential to one's state of wellbeing. Monitoring these variables is critical to the development of sound public policy, but many indicators that measure living conditions fail to measure what people think and feel about their lives, such as the quality of their relationships, their positive emotions and resilience, the realisation of their potential, or their overall satisfaction with life.

The study of aging in Ghana has concentrated on ageing demographic profiles and trends, old people's health, care and support systems, duties and obligations of the elderly, and societal representation of the elderly. This study aims to study the satisfaction with life and HRQoL of people aged 65 and over in Ghana and also to explore how it affects their life satisfaction. The study found out that a higher life satisfaction is exhibited by older people through their own ideals, having excellent life and they not making changes in their life if they are to start all over again. Also they are not satisfied with their life and the number of things they have achieved in life.

Regards to personal wellbeing, older people in rural areas of Ghana had gain higher satisfaction with their health, feeling part of their community, their future security and their standard of living. However, they have gain lower satisfaction in relation to their life as a whole spirituality or religion, what they are achieving in life, their safety and also their personal relationships. In addition, in terms of health related quality of life (HRQoL), Older (elderly) people are very much concern about self-care, mobility and usual activities. However, they are care less about their pain/ discomfort and their anxiety/ depression. The study concluded that HRQoL of older people in rural areas in the Ashanti Region leads to life satisfaction of the older people.

The study suggests that there should be a public policy on the older people, this because, monitoring HRQoL and life satisfaction is critical to the development of sound public policy. Many indicators that measure living conditions fail to measure what people think and feel about their lives, such as the quality of their relationships, their positive emotions and resilience, the realisation of their potential, or their overall satisfaction with life, which is referred to as their "wellbeing". Government must initiate a social intervention scheme in which the older people in rural areas will be catered for in an apartment or

building with a lot of aged people. This will help the older people not to feel lonely and also this will cater for the less concern older people places on their pain/ discomfort and anxiety/ depression. Also the study suggest there should be a further study on the topic in which the study will look at the support children gives to older people in the society they find themselves in relation to HRQoL and life satisfaction.

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APPENDIX I

Figure 5, HRQoL CFA model

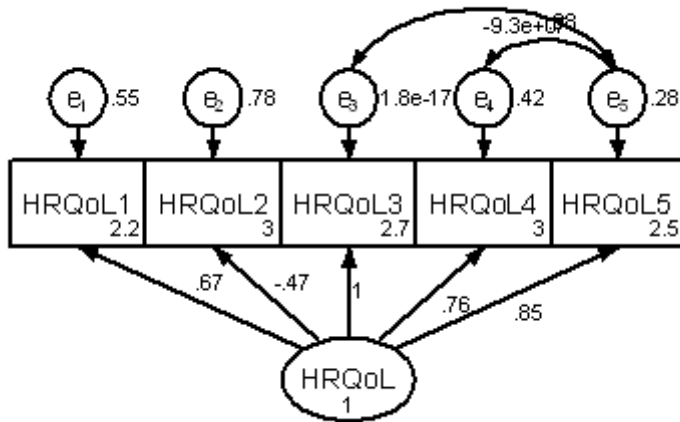
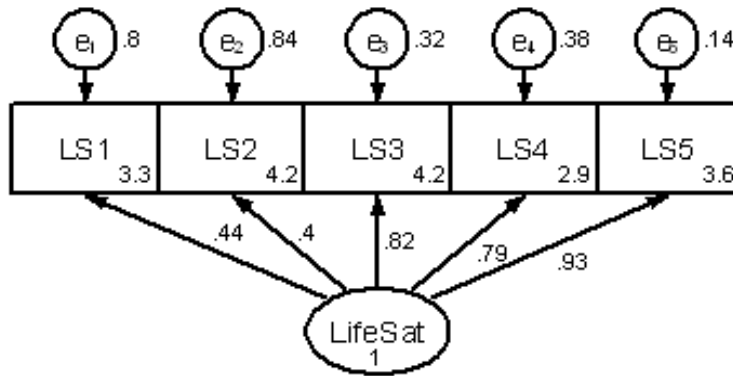


Figure 6, Life Satisfaction CFA model



APPENDIX II

QUESTIONNAIRE

LIFE SATISFACTION AND HEALTH RELATED QUALITY OF LIFE AMONG OLDER PEOPLE (65+) IN GHANA

This questionnaire aims at collecting data on life satisfaction and health related quality of life among older people (65+) in Ghana. It is solely for academic purposes and your confidentiality is assured in the collection and analysis of the data. Your candid opinion is therefore kindly requested. Thank you for your cooperation.

SECTION A -*Satisfaction with life scale (SWLS)*

We would like to know how satisfied you are with your life. Below are five statements that you may agree or disagree with. Using the 1 – 5 scale below, indicate your agreement with each item by ticking [x] your answer as may be required. Please be open and honest in your responding.

1 – Strongly disagree, 2 – Disagree, 3 - Neither agree nor disagree, 4 – Agree, and 5 – Strongly agree

	1	2	3	4	5
In most ways my life is close to my ideal.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The conditions of my life are excellent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
So far I have gotten the important things I want in life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If I could live my life over, I would change almost nothing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B - Personal Wellbeing Index – Adult - 5 (PWI-A)

The following questions ask how satisfied you feel, on a scale from 0 to 10. 0 means you feel no satisfaction at all and 10 means you feel completely satisfied. Please tick [√] the ONE box that best describes your satisfaction level.

	0 – No satisfaction at all	1	2	3	4	5	6	7	8	9	10 – Completely satisfied
1. Thinking about your own life and personal circumstances, how satisfied are you with your life as a whole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. How satisfied are you with your standard of living?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. How satisfied are you with your health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. How satisfied are you with what you are achieving in life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. How satisfied are you with your personal relationships?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. How satisfied are you with how safe you feel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. How satisfied are you with feeling part of your community?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. How satisfied are you with your future security?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thinking about your spiritual or religious beliefs, how satisfied are you with your spirituality or religion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C -*Health related quality of life*

Under each heading, please tick [√] the ONE box that best describes your health TODAY.

10. MOBILITY

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

11. SELF-CARE

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

12. USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

13. PAIN / DISCOMFORT

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

14. ANXIETY / DEPRESSION

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

SECTION D: DEMOGRAPHIC PROFILE OF RESPONDENTS

Please tick [√] your answer in each

15. Gender Male
 Female
16. Age _____
17. Education background No formal education
 Junior/ Senior high school
 Training college
 Tertiary education
18. Marital status Married
 Single
 Divorced/separated
 Widow/ Widower
19. Number of children _____
20. Religion Christian
 Muslim
 Traditionalist
 Other

Thank you for your collaboration.