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REGIONAL INSTITUTE FOR POPULATION STUDIES

AT THE

UNIVERSITY OF GHANA

DOES AGEING RESULT IN A DISABILITY? CONCEPTUALIZATION OF AGEING AND DISABILITY BY YOUNG, MIDDLE-AGED, AND OLDER ADULTS IN THE GREATER ACCRA REGION

BY

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF

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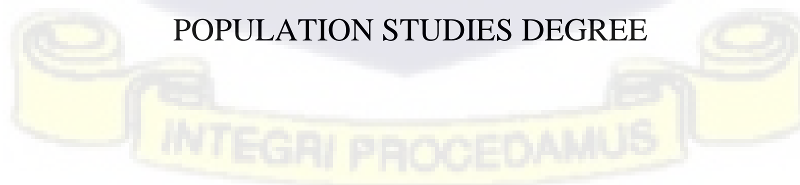
POPULATION STUDIES DEGREE



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ACCEPTANCE

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DECLARATION

I, Doris Akosua Tay, hereby declare that, except for references to other people's work, which have been duly acknowledged, this is the result of my own research, and it has neither in part nor in whole been presented for another degree elsewhere.

____ ________ ____4th December 2023____

DORIS AKOSUA TAY DATE

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DEDICATION

I dedicate this thesis to my lovely mother, Gladys Doku. I have come this far because of you. May God bless you for all you have done for me. And to my late father, Stephen Don Tay, I know you would have been proud to see me do this.

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To God be the glory for His mercy towards my life. If not for God, I would not have completed this work. He saw me through all the challenges and pressures that made it impossible for me to concentrate on my thesis. This is a wonderful miracle for me. Thank you, God.

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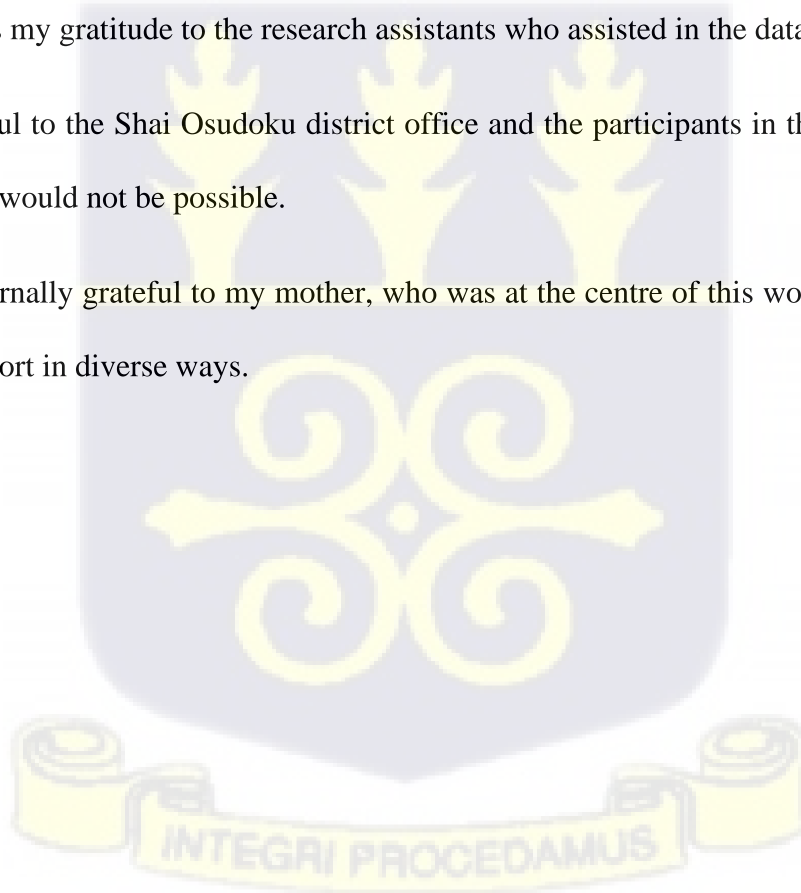

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ABSTRACT

Background: There is a dearth of knowledge on how ageing and disability is conceptualized among people, especially in Ghana and sub-Saharan Africa. Research has found that perceptions of ageing and disability vary among age groups. However, limited research exists on how these differences affect how people view and form knowledge of aging and disability.

Objectives: This thesis explored the conceptualization of ageing and disability among young, middle-aged, and older adults based on subjective perception of ageing, medical, and contextual factors. The study was informed by the medical, social, and biopsychosocial models of disability and also drew from concepts of ageing.

Methods: The study, guided by pragmatism, employed an exploratory sequential mixed methods research study design. The data from the qualitative study was used to develop an instrument for the quantitative study. Fourteen (14) participants for the qualitative study were purposively recruited while 175 participants were recruited for the quantitative study using systematic sampling technique. In-depth interviews and questionnaires were used for data collection during the qualitative and quantitative phases respectively. Constant comparative analysis was used for the qualitative data analysis. During the quantitative phase, Cronbach's alpha analysis and exploratory factor analysis were used to develop scales for subjective perception of ageing, medical factors, and contextual factors. These scales were a proxy for the dependent variable. Independent samples t-test and one-way ANOVA explored the differences in the means of the socio-demographic variables and the scales, while linear regression was used to explore the relationships between the socio-demographic variables and the three scales. IBM SPSS statistics version 22 and FACTOR 12.02.01 were used for the quantitative data analysis while Atlas.ti 9 assisted in the qualitative data analysis.

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Results: Subjective perception of ageing comprised cognition, physical attributes, and sensory impairment. Medical factors included diseases, performance of self-care activities, life activities, mobility, and health decline. Contextual factors comprised fear, social participation, beliefs, and experience. The age of the participant was not a significant predictor of subjective perception of ageing, medical factors, and contextual factors. Compared to young adults, older adults associated disability with ageing while middle-aged adults did not. Both middle-aged and older adults did not associate medical factors with disability, but young adults did. This suggests that young adults viewed an older adult with a mobility challenge and an inability to perform self-care and life activities as ageing with a disability. Marital status was an important factor in the conceptualization of ageing and disability across the three factors. Also, those with a disability and those who lived with an older adult with a disability associated ageing with disability. Furthermore, those with poor perceived wealth status, those who had no religion, and those who were previously married associated disability with ageing. Fear, beliefs, and experience influenced the perceptions of those who were previously married and those who lived with an older adult with a disability.

Conclusion: Young, middle-aged, and older adults conceptualize ageing and disability differently. Differences also exist in perceptions based on socio-demographic characteristics. Ageing is mostly perceived to be with disability. The findings suggest a lack of adequate knowledge of ageing and disability. The negative views reveal impediments in achieving the Madrid International Action Plan on Ageing, the second demographic dividend, and the National Ageing Policy. This calls for an intervention that focuses on educating the public on ageing and disability through schools, mass media, and community sensitization to improve on people's knowledge of the phenomena.

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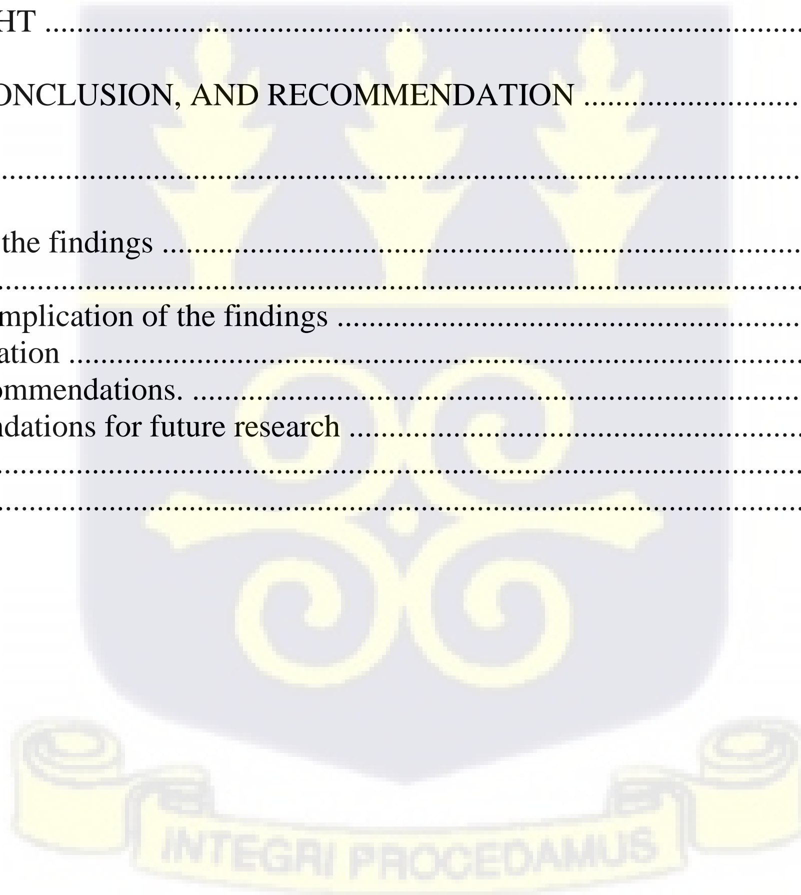

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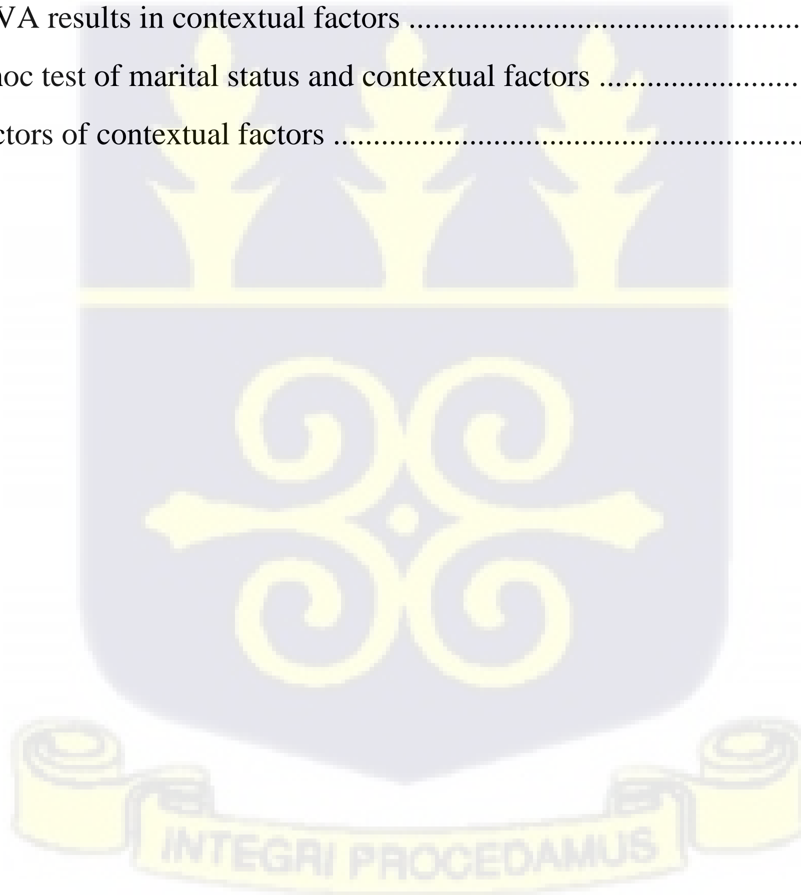

ABSTRACT

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Background: There is a dearth of knowledge on how ageing and disability is conceptualized among people, especially in Ghana and sub-Saharan Africa. Research has found that perceptions of ageing and disability vary among age groups. However, limited research exists on how these differences affect how people view and form knowledge of ageing and disability.

Objectives: This thesis explored the conceptualization of ageing and disability among young, middle-aged, and older adults based on subjective perception of ageing, medical, and contextual factors. The study was informed by the medical, social, and biopsychosocial models of disability and also drew from concepts of ageing.

Methods: The study, guided by pragmatism, employed an exploratory sequential mixed methods research study design. The data from the qualitative study was used to develop an instrument for the quantitative study. Fourteen (14) participants for the qualitative study were purposively recruited while 175 participants were recruited for the quantitative study using systematic sampling technique. In-depth interviews and questionnaires were used for data collection during the qualitative and quantitative phases respectively. Constant comparative analysis was used for the qualitative data analysis. During the quantitative phase, Cronbach's alpha analysis and exploratory factor analysis were used to develop scales for subjective perception of ageing, medical factors, and contextual factors. These scales were a proxy for the dependent variable. Independent samples t-test and one-way ANOVA was employed to explore the differences in the means of the socio-demographic variables and the scales, while linear regression was used to explore the relationships between the socio-demographic variables and the three scales. IBM SPSS statistics version 22 and FACTOR 12.02.01 were used for the quantitative data analysis while Atlas.ti 9 assisted in the qualitative data analysis.

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Results: Subjective perception of ageing comprised cognition, physical attributes, and sensory impairment. Medical factors included diseases, performance of self-care activities, life activities, mobility, and health decline. Contextual factors comprised fear, social participation, beliefs, and experience. The age of the participant was not a significant predictor of subjective perception of ageing, medical factors, and contextual factors. Compared to young adults, older adults associated disability with ageing while middle-aged adults did not. Both middle-aged and older adults did not associate medical factors with disability, but young adults did. This suggests that young adults viewed an older adult with a mobility challenge and an inability to perform self-care and life activities as ageing with a disability. Previously married participants associated disability with ageing but those who were never married did not. Also, those with a disability and those who lived with an older adult with a disability associated ageing with disability. Furthermore, those with poor perceived wealth status, those who had no religion, and those who were previously married associated disability with ageing. Fear, beliefs, and experience influenced the perceptions of those who were previously married and those who lived with an older adult with a disability.

Conclusion: Young, middle-aged, and older adults conceptualize ageing and disability differently. Differences also exist in perceptions based on socio-demographic characteristics. Ageing is mostly perceived to be with disability. The findings suggest a lack of adequate knowledge of ageing and disability. The negative views reveal impediments in achieving the Madrid International Action Plan on Ageing, the second demographic dividend, and the National Ageing Policy. This calls for an intervention that focuses on educating the public on ageing and disability through schools, mass media, and community sensitization to improve on people's knowledge of the phenomena.

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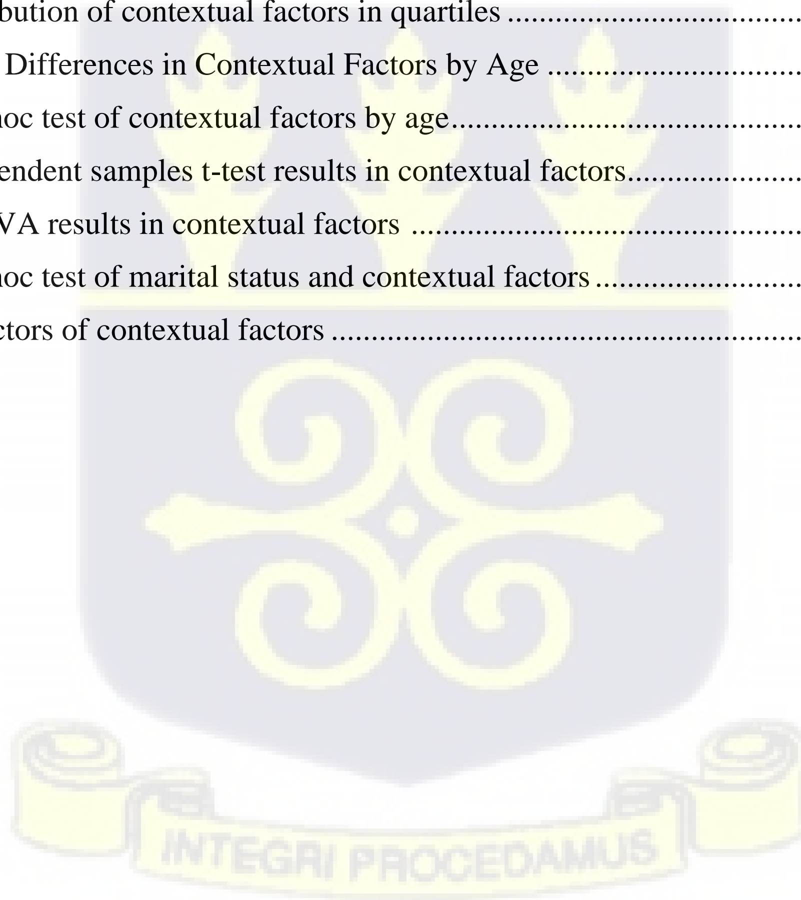

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CHAPTER ONE

1.0 Introduction

1.1 Background

Meanings attributed to ageing vary across cultures (Amin, 2017). The concept of ‘elderliness’ or ‘older’ in Africa is mostly a performance-related criterion than chronological or standard role changes (Sagner, 1999 p2; Apt, 1992). Although deterioration in physical capacities and abilities are associated with old age in Africa, importance is not placed on health and functionality in conceptualization (Sagner, 1999). Physical changes associated with ageing therefore do not determine the construction of elderliness (ageing) instead, emphasis is on social or relational variables rather than on the biological processes of the ageing body (Sagner, 1999; Apt, 2002). Old age is also seen as a period of decline and loss (Apt, 1992). In most poor societies, old age is linked to physical impairments, inability to work, and economic dependency (Apt, 2002 p40).

Interpretation of disability also, has been recognized to be related to what is regarded as normal functioning of the body and this varies with context, age group and income group (WBG & WHO, 2011). Older adults for instance may not identify themselves as having a disability although they may have a functional difficulty (WBG & WHO, 2011). This is because they may consider the deficit in optimum functioning to be normal for their age (WBG & WHO, 2011). Conceptualization of disability by older adults could also be influenced by their experiences from living with a disability (Warmoth et al., 2016). It is also noted that even among older adults certain constructs are based on whether a person is a male or female (van der Geest, 2001) and females are more likely to view themselves as disabled than males (Kelley-Moore et al., 2006).

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Moreover, an incongruity exists in how older adults perceive their functional status and disability (Kelley-Moore et al., 2006). This has not received much attention (Kelley-Moore et al., 2006). Young adults who hold negative stereotypes of ageing are more likely to have a future event of cardiovascular disease and reducing these negative perceptions will be beneficial to their health when they grow old (Levy, et al., 2010). Young adults also have more fear of ageing than older adults (Stein, 1995). Some young adults also equate old age with sickness (Okoye & Obikeze, 2005). Middle aged adults on the other hand, mostly associate ageing with physical changes such as pain, ache, and grey hair while older adults, view ageing in a positive light (Burke et al., 2014). Conceptualization of ageing and disability therefore varies among age groups.

By 2050, the world will have 1.5 billion people who will be 65 years and above (UNDESA, 2020). Older adults (60 years and over) in sub-Saharan Africa will make up 8.3 percent of the world's population by 2050 (WHO, 2014). Ghana is also projected to have 11.9 percent of her national population comprising of older adults by 2050 (WHO, 2014). Out of 3 percent of people living with a disability in Ghana, those who are 65 years and older make up the highest proportion (22.2 percent) with the remaining age groups each having a rate that is less than 10 percent (Kumi-Kyereme & Sasu, 2014). Currently, 8 percent (2,098,138) of the population of Ghana has difficulty in performing activities (Ghana statistical service (GSS), 2021b). This study therefore is timely as preparations are underway to meet the challenge of an ageing population both globally and in sub-Saharan Africa. Preparations include adoption of policies, promotion of active and healthy ageing, expansion of lifelong learning, as indicated in the Sustainable Development Goals (SDG), Goal 4 (Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all) and encouragement of private savings by older adults (United Nations Department of Economic and Social Affairs, UNDESA, 2020).

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1.2 Statement of the problem

Although evidence suggests that older age, and medical factors such as multimorbidity, self-rated health status, and depression are related to disability (Lestari et al., 2019; Biritwum et al., 2013; Debpuur et al., 2010; Amegbor et al., 2018) issues on disability among older adults are overlooked (Stuck et al., 2013). Ageing also is mostly portrayed as a period of disability and this may be related to research which show that many older adults are ageing with disabilities (Ansello, 2012; Holstein, 2018; Barlow & Walker, 2015; UNDESA, 2015; UNDESA, 2020). This narrative is purported to be pervasive because several studies mix disability with impairment, chronic conditions, and handicaps and fail to distinguish among them (Ansello, 2012). The existence of an impairment for instance may be presented as a disability although disability may not be present (Ansello, 2012). Apart from that, the definition of ageing and disability in a society are influenced by constructs that are related to the individual (include medical factors such as diseases and impairment) and his or her immediate social and wider environment (contextual factors) (Shih, 2018; Fox, 2005; Verbrugge & Jette, 1994; WHO, 2007). These constructs, however, have not been adequately explored especially in sub-Saharan Africa although context/culture is crucial in perceptions and experiences (Bonder, 2009; Martinson & Berridge, 2015; Iwamasa & Iwasaki, 2011).

Some older adults perceive ageing as being with disability (Kelley-Moore et al., 2006; Teems, 2016). Others also perceive ageing as a blessing, a period of dependency, accompanied with physical changes (such as grey hair, wrinkles, and memory loss), progressive social exclusion, fear of suffering, and loss of autonomy (Dosu, 2014; Lagacé et al., 2012; Escourrou et al., 2022). There exist therefore varying views about ageing whereby some attach ageing to disability while others do not.

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Regarding medical factors such as performance of activities, older adults give more importance to Instrumental Activities of Daily Living (IADL) than Activities of Daily Living (Philip et al., 1998). For quality of life of physical health (a medical factor), people perceive that older adults with disability have impaired mobility, pain and discomfort, low self-esteem, and minimum work capacity (Nantomah, 2019). Older adults ageing with disability also present new and unexpected needs for the family (Coyle & Mutchler, 2017). Formal systems which used to give support to them while they were young may not be effective in old age (Coyle & Mutchler, 2017) further burdening their lives and that of the family. These negative experiences of older adults seen by other age groups and experienced by older adults themselves could give a narrow conceptualization of what ageing and disability are among the populace (Lifshitz, 2002). However, how these experiences with older adults by other age groups influence their conceptualization is scarcely known, especially in Ghana.

Age stereotype is due to stereotype embodiment whereby, 1. stereotypes become internalized across the life span, 2. it functions unconsciously, 3. gains prominence from self-relevance, and 4. it uses multiple pathways (Levy, 2009). The ageing process therefore in part is a social construct (Levy, 2009). Conceptualization of ageing and disability may therefore be influenced by age stereotypes and social constructs that have been internalized by individuals. Internalization of social constructs may vary among different age groups. Evidence suggest that conceptualization of ageing differs among young, middle-aged, and older adults (Lifshitz, 2002).

Although ample research exists on ageing with disability (Petretto et al., 2019) most of these research studies are on experiences of disability, measurements/assessment of disability, and the focus is shifted to older adult participants (Üstün et al., 2010; Federici & Meloni, 2014; Biritwum et al., 2016; Rubio et al., 2009; Levy, 2009). However, aside the individual, social and

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environmental factors are relevant in models of ageing and disability dynamics (Petretto et al., 2019; Shih, 2018; Fox, 2005). Hence the importance of adding contextual factors in this research. This study is also relevant due to its contribution to knowledge to bridge the gap in knowledge between objective measures of disability in ageing and subjective perceptions of ageing and disability (Martinson & Berridge, 2015).

The study sought to fill the knowledge gap on medical and contextual factors that influence conceptualization of ageing and disability in sub-Saharan Africa with a focus on a district in Ghana. This study also aimed to address several theoretical and methodological gaps:

1. Previous research tends to treat ageing and disability as separate concepts rather than interconnected ones.
2. The impact of social constructs and stereotypes on the conceptualization of ageing and disability has not been thoroughly explored.
3. This study aims to provide a more comprehensive understanding of subjective views and their implications on conceptualization of ageing and disability.
4. Developing new scales for measurement to offer tools for future research and practice.
5. The role of cultural and environmental influences has been underexplored in the sub-Saharan African context. This study includes these factors to fill this gap.
6. Rarely explored variables such as perceived wealth status, children ever born alive, religious affiliation, experience with older adults with or without disability, and others have been in this study to determine their influence on conceptualization of ageing and disability.

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1.3 Research questions

The study sought to answer the following questions:

How do young, middle-aged, and older adults conceptualize ageing and disability based on medical and contextual factors?

1.3.1 Specific research questions

1. How are ageing and disability conceptualized by the participants based on their subjective perception of ageing?
2. How do medical factors determine conceptualization of ageing and disability among the participants?
3. How do contextual factors influence conceptualization of ageing and disability by the participants?

1.4 Objectives of the study

1.4.1 General objective

This study examines the conceptualization of ageing and disability among young, middle-aged, and older adults based on medical and contextual variables.

1.4.2 Specific objectives

1. To determine conceptualization of ageing and disability among the study participants based on their subjective perception of ageing.

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2. To explore how medical factors determine conceptualization of ageing and disability among the study participants.
3. To examine how contextual factors influence the participants' conceptualization of ageing and disability.
4. To recommend policies for ageing and disability based on the findings of the study.

1.5 Rationale of the study

Compared to other parts of the world, sub-Saharan Africa, has limited research on ageing and the few that are done is mostly in South Africa (Kalu et al., 2021). Available literature has focused mostly on noncommunicable diseases, HIV-related studies, physical functioning, cancer, quality of life or well-being, dementia/cognitive impairment, neurological-related studies and disability studies (Kalu et al., 2021). Evidence also suggests that ageing studies in Ghana have focused on six main areas namely, demographic profiles and patterns of ageing, health status of older adults, older adult care and support systems, roles and responsibilities of older adults, social representation of older adults, and socioeconomic issues among older adults (Kpessa-Whyte, 2018).

However, no study has been identified in Ghana on how ageing and disability is conceptualized among young, middle-aged, and older adults although ample research exists on ageing perceptions, experiences, and ageing with disability (van der Geest, 2004; van der Geest, 2002a; Apt, 1992; Apt, 2002; Aboderin & Ferreira, 2008; Aboderin, 2011; and Warmoth et al., 2016; Biritwum et al., 2016; Debpuur et al., 2010; Agyeman et al., 2019; Amegbor et al., 2018; Santosa et al., 2016; Lestari et al., 2019; Koyanagi et al., 2015; Tyrovolas et al., 2015; Rahman & Singh, 2019; Williams et al., 2015; Capistrant et al., 2014). This situation though is not entirely different from the situation in sub-Saharan Africa although context is crucial in conceptualization.

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There is therefore little information on how people relate ageing to disability or dichotomize the two and how that is connected to the experiences of older adults and attitudes towards them. Hence the need of this study in exploring how people conceptualize ageing and disability.

Research findings have also shown that contextual factors such as fear (Stein, 1995; Chonody, 2019) and cultural beliefs (Chonody & Teater, 2018; Hung et al., 2010; Lane & Smith, 2018) and medical factors such as impairments (Agyeman et al., 2019) influences views on ageing. However, how these medical and contextual factors influence knowledge formation on ageing and disability is not largely explored. While Chonody (2019) has iterated the need for more research to disentangle how emotional factors relate or predict anxiety of ageing especially among older adults; Grischow et al. (2018) has also called for an intensive analysis of cultural beliefs towards disability in Ghana. There is therefore the need to examine how these contextual factors influences people's perception about ageing and disability to generate a wholistic understanding and generate different world views that would contribute to filling the knowledge gap.

The findings of this study are expected to contribute knowledge to improving older adults health and well-being. Research findings show that negative ageing perceptions are linked with poor health outcomes (Andrew Achenbaum, 2015; Robertson et al., 2015; Freeman et al., 2016; Burke et al., 2014). For instance, elevated levels of negative ageing perceptions predicts the start and tenacity of depression, anxiety, and future disability (Freeman et al., 2016; Mohammadpour et al., 2018; Moser et al., 2011). Such findings have produced interventions that have modified negative ageing perception to improve health outcomes in old age (Levy, 1996; Freeman et al., 2016; Wurm et al., 2017; Mendoza-n et al., 2018). This suggests that exploring how people conceptualize ageing and disability is crucial to revealing negative conceptualizations that contribute to poor health

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outcomes among older adults. The findings therefore are likely to direct policies and actions that will help address the identified problems.

Furthermore, apart from ageing perceptions influencing health and well-being of older adults, it is established that the development of perceptions as older adults is dependent on the expectations they had before reaching old age and their daily encounters during old age (Moser et al., 2011; Burke et al., 2014; Munyi, 2012). This suggests that exploring how young and middle-aged adults conceptualize ageing and disability is important to reveal negative perceptions among them that is likely to result in future negative ageing experiences. Hence the importance of including young and middle-aged adults in this study.

This study therefore is expected to fill the gap in knowledge and contribute to global knowledge on how ageing and disability is conceptualized differently by different age groups considering cultural contexts. Young and middle-aged adults are part of the sociocultural environment of older adults and the experience of ageing could be influenced by them. Another important factor is that they are the future ageing population, and their conceptualization is relevant to determine preparations that have to be made to assist their future ageing experience; or how they look forward to that experience. This is achievable if negative conceptualizations of ageing and disability are modified, and positive ones enhanced to help older adults contribute to society.

This study will serve as a basis for other studies to be carried out especially longitudinal studies that will examine how conceptualization of ageing and disability by young and middle-aged adults influence their future ageing process. Findings from this study therefore will help direct development and implementation of interventions that will meet the various health needs of the various age groups. Policy makers and various stakeholders will also be able to develop

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interventions that will help in reconstructing people's mindsets, health, and counselling strategies for instance. It will promote the overall health and well-being of older adults and reduce fear among younger populations.

1.6 Organization of the study

This study is organized in eight chapters. Chapter one comprises of the background to the study, the statement of the problem, the research questions, the objectives of the study, and the rationale of the study. Chapter two includes a review of relevant literature, definitions and issues connected to ageing, and models that explain disability. Definitions on ageing covered cultural definitions of ageing, the ageing process, the process of ageing, chronological, biological, psychological, sociological, and prospective ageing. Models that explain ageing and disability include the medical model, social model, and the biopsychosocial models of disability.

Topics covered for some relevant literature include conceptualization of ageing and disability in relation to subjective perception of ageing, difference in conceptualization of disability from the normal process of ageing, medical factors that determine conceptualization of ageing and disability, environmental factors that influence conceptualization of ageing and disability, personal factors that influence conceptualization of ageing and disability, and predictors of conceptualization of ageing and disability. Chapter two also contains the conceptual framework for the study and the research hypotheses.

Chapter three of the study details the methods employed to answer the research questions and hypotheses. It details approaches used for both the qualitative and quantitative study. The description of the methods used for both study designs are integrated. The description of the socio-

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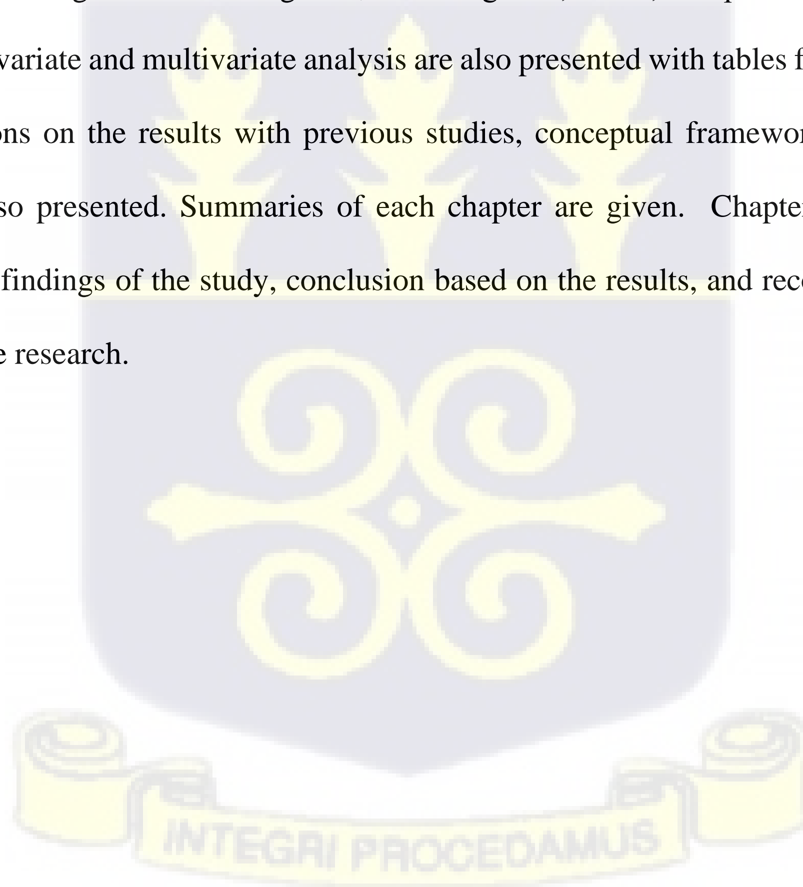
demographic characteristics of the respondents for both the qualitative and quantitative study are presented in Chapter four of the study. The results are presented in tables and charts. A summary of the results was also presented.

How the respondents conceptualized ageing and disability based on subjective perception of ageing are presented in Chapter five. Chapter six describes the conceptualization of ageing and disability based on medical factors while Chapter seven presents the contextual factors that influenced conceptualization of ageing and disability by the respondents for both the qualitative and quantitative study. For Chapters five, six, and seven, themes that emerged from the qualitative study are described together with categories, sub-categories, codes, and participants' statements. Results of the bivariate and multivariate analysis are also presented with tables for the quantitative study. Discussions on the results with previous studies, conceptual framework, and models of disability are also presented. Summaries of each chapter are given. Chapter eight contains a summary of the findings of the study, conclusion based on the results, and recommendations for policy and future research.



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CHAPTER TWO

REVIEW OF RELEVANT LITERATURE

2.0 Introduction

Understanding the conceptualization of ageing and disability requires a comprehensive review of existing literature. This chapter explores previous studies and theoretical frameworks that inform the understanding of these concepts. The objective is to identify gaps in the literature and establish a foundation for the current study.

The literature review covers the following key areas:

1. Conceptualization of ageing and disability in relation to subjective perception of ageing.
2. Difference in conceptualization of disability from the normal process of ageing.
3. Medical factors that determine conceptualization of ageing and disability.
4. Environmental factors that influence conceptualization of ageing and disability.
5. Personal factors that influence conceptualization of ageing and disability.
6. Predictors of conceptualization of ageing and disability.

By reviewing these areas, the chapter aims to provide a thorough understanding of the factors influencing perceptions of ageing and disability, highlighting gaps in the literature that the current study seeks to address.

2.1 Concepts and issues connected to ageing

Cultural definitions of ageing is reported to have emanated from prevailing patterns of deteriorating physical and mental functioning during the earlier periods (Crews, 1994). Ageing as

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a concept encapsulates biological, physiological, and social alterations which is evident in functional, psychological, and physical debility (WHO, 2015;Cohen & Menken, 2006). Determination of old age varies across countries and cultures and could be based on chronological age, biological age, physical attributes or appearance, status roles or morbidity profiles (WHO, 2015;Cohen & Menken, 2006). An example is in Ghana, specifically in twi it is suggested that the term 'old' is a verb and a continuous process and not an adjective as used in the English language (van der Geest, 2002b). Old age is not about the number of years lived by a person, but it is dependent on the life conditions and status of the individual such as his or her family and the way he or she carries him or herself as an elder (Apt, 1992; Geest, 2002b). In other locations, the meaning attributable to ageing may be different.

Chronological ageing deals with retrospective age and is a measure of the number of years lived by the person (Scherbov & Sanderson, 2019). Another aspect of ageing is prospective age. It determines the expected years remaining for a person and this pivots on life expectancy (Scherbov & Sanderson, 2019). Biological ageing however, focuses on changes in the body of an individual and is neither linear nor constant; not linked to age per say but a whole complex of cellular and molecular impairments (WHO, 2017). This results in a slow decline in ability, physiological deposits, and high risk of diseases (WHO, 2017).

Psychological and sociological ageing traverses biological ageing thereby initiating transformations and shifts in roles in the society and social positions, that reflects continuous advancement in psychological capacity linked to new view points and social contexts (WHO, 2017). The ageing process which is referred to as normal ageing (biological changes) is dichotomized from the process of ageing (WHO, 2001b). Biological changes associated with

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ageing do not always come with serious clinical effects (WHO, 2001b). Therefore, the ageing process is not influenced by diseases and environmental effects (WHO, 2001b).

The ageing process excludes disability from ageing. Ageing is moreover seen or regarded as a concept on its own and not associated with disability or viewed as a cause of disability in the older adult. It also confirms that there are problems that could accompany ageing due to decline or changes in biological process but that should not cause serious clinical effects or disability. The process of ageing on the other hand is linked with changes that come with ageing but not because of ageing (WHO, 2001b). Unlike the ageing process, the process of ageing is directly affected by environmental, lifestyle factors, and disease conditions (WHO, 2001b). Although a person may be young based on chronological age that same person may be functionally old (WHO, 2001b). Across their lives, people could get diseases or impairments (WHO, 2001b) that is not associated with growing old but connected to the exposures of the individual. These exposures may be related to availability of community resources for individuals, socioeconomic status, life choices, genetic conditions, birth anomalies, etcetera. These factors are not associated with ageing but part of normal life occurrences. A person therefore may acquire disability in the process before ageing. These two definitions demonstrate that ageing is not a cause of disability or associated with it.

An understanding of what ageing is, and the dichotomy of the ageing process and the process of ageing is incredibly significant in determining how people construct ageing and disability. Each choice of definition also determines how ageing and disability is constructed. For instance, if biological ageing is accepted then decline in physical health is blamed on ageing and ageing is equated to disability. If psychological and sociological ageing is chosen, the focus of disability will be related to performance of social roles and may not necessarily be connected to a frail body. In another case however, ageing may not be related to disability where the older adult for instance

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can still perform their expected roles of counselling despite the presence of debility. Each definition therefore is relevant as it is likely to influence how people construct knowledge and views about ageing and disability.

Ageing also comes with an accompaniment of increased tendency of disability and disease which is due to aggregation of various damaging deviations in the body (WHO, 2014;WHO, 2015;Cohen & Menken, 2006).

Ageing in populations is faced with many challenges. Poverty is a characteristic phenomenon among older adults in many developing countries and in Africa it is either lower or slightly higher than the entire population (UNDESA, 2013). Gender disparity also is prominent in ageing where females outlive males (UNDESA, 2013). While many older adults (three quarter) in developed countries live independently, in developing and least developed countries such as in Africa, only a quarter and one-eighth do so respectively (UNDESA, 2013). The dynamics about labour force participation also vary among various regions. Whereas older adults in developed regions have more labour force participation, those in less developed world are minimal and decreasing (UNDESA, 2013). All these factors determine how the phenomenon is conceptualized.

Ageing is an important concept of interest because it not only has demographic, social, and economic consequences for the older adult population only but for future generations and economic development of a country (Badasu & Forson, 2013).

INTEGRI PROCEDAMUS

2.2 Disability

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Disability's explanation according to Meijers (1997 cited in Clifton, 2005 p2) is confusing due to varying usage of the terminology by people living with disabilities and the representative groups, governments, professionals and legislatures. Disability's definition comes from 3 models namely, medical, social, and biopsychosocial models.

2.2.1 Medical and social model of disability

The medical model of disability as connected to ageing could be identified in the definition by the International Classification of Impairments, Disabilities and Handicaps (ICIDH-1) where functional limitations were described as characteristics of disability (WHO, 1993). Functional limitation has been placed squarely within impairment in ICIDH-2 (WHO, 1993). Impairment is reflected in a loss or abnormality, mental, physiological or bodily structure function (WHO, 1993). The ICIDH-2 however which is an improvement of ICIDH-1 describes disability as "in the context of health experience, a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" (WHO, 1993 p28). This definition leaves disability at the individual level where the inability of an individual to meet societal expectations qualifies him as being disabled. The description of disability as an individual activity and performance limitation is a source of contention for those who propose that disability is a social/socio-political phenomenon. Hence the one directional linkage that was established by ICIDH-2 where disease is linked to impairment to disability and to handicap was unacceptable by advocates of the social model (Bickenbach et al., 1999; Simeonsson et al., 2000). It has also been argued that the ICIDH failed to incorporate a lifespan

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perspective and its focus was on adults and little attention on children, youth and older adults (Simeonsson et al., 2000).

The social model was developed by people with disability to contest and reject existing models which characterized disability as an individual, medical or charitable phenomenon (Bickenbach et al., 1999; Lisicki, 2015). The social model also challenges the notion of activity limitations related to impairments in description of disability as put forward by the medical model (Lisicki, 2015). The problem with disability is not the individual with disability but the problem is with the disabling world (Lisicki, 2015). The Union of the Physically Impaired Against Segregation (UPIAS) and the Disability Alliance argued that disability "is a situation caused by social conditions and is imposed on top of the impairments of people living with a disability by them being unnecessarily isolated and excluded from full participation in society" (Oliver, 1976 p3). The social model according to Oliver (1990) 'does not deny the problem of disability but places it squarely within society.' Oliver (1990) further stipulates that disability stems from a failure of society to offer appropriate and adequate services that supports and guarantees that; the needs of persons with disability are fully considered in the social organization. Hence disability is not an individual's limitations in any form (Oliver, 1990).

Since disability is blamed on the social environment, that implies that it is the duty of society to provide and facilitate the necessary changes such as attitudes, policies and laws that will ensure their full participation in society (Bickenbach et al., 1999; WHO, 2001). The necessity of social action brings to the fore political and human right issues making disability a political problem (Bickenbach et al., 1999; WHO, 2001).

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Other scientists who support the social standpoint such as Jenkins (1991) argue that disability and handicap are closely knit with social factors which in turn impact on the nature and scale of the problem that is either minimizing or compounding it. Delving into the social construction and stratification of disability and ageing, Jenkins (1991) stipulated that as the population ages, older persons are predisposed to acquiring some degree of impairment, that notwithstanding, not every impairment leads to disability and not all disability is natural or inevitable.

Moreover, cultural definitions, access and proximity of resources and medical interventions are some factors that determine if the disability is inevitable or not (Jenkins, 1991). This argument reflects the notion that ageing can be separated from disability and the two not put together as if the process of ageing results in disability. Kennedy & Minkler (1998) however have a different view regarding differentiating between the two. They suggest that although distinguishing between disability and ageing is a useful one, it may rather be a potential of stigmatization for older persons with disability (Kennedy & Minkler, 1998).

Ageing and disability are distinguished based on aetiology and there have been many discussions and promotion of viewing it through a life-course perspective lens. Jenkins (1991) condemns and tagged as crude, categorization of disability based on life-course and aetiological perspectives which include groupings into 'aged whose impairment occurred at birth or during childhood,' 'those from subsequent disease or injury' and 'those whose impairment is from the normal ageing process' (which is the largest group). Being disabled is undoubtedly linked to economic inequality, may be intergenerational where disability produces a class structure and inequality and run in the family, labour force exit, and it creates dependency both among care givers in the family and the older adults with disability themselves (Jenkins, 1991). These views seem to have seeped well into the media such that they have bought into it and propagated its views; and since the media is a

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powerful source of social construction, they may have influenced some people in society. Burns & Haller (2015) observed in a study that social construction of disability is evident in media representations of disability where the social pathology model was usually considered in traditional media and only a few with medical model.

Kaufman et al. (2004 p736-737) argues that "biomedical technique provides the most powerful logic, the most pervasive method, to show our care and demonstrating care and love for the oldest generation outside the frame of medical treatment, and then outside the rhetoric of rights and entitlement, is nearly impossible in an American society." This notion portrays how society makes it impossible for medical science to operate outside its scope. It can therefore be gleaned that society is responsible for the maintenance of medical science standpoint and society is also responsible for the social science standpoint. Others within the medical sphere however proposed viewing disability as a socially constructed phenomenon even in medical science in order to question medicine as being value free and non-judgemental (Tripp, 1997 p20). Moreover, medicine is situated in society and is empowered by the same to better care for its subjects (Tripp, 1997 p20).

Kennedy & Minkler, (1998) however, suggest that although chronic diseases are referred to as causes of disability, they are not sufficient or necessary causes. Instead, disability is a dynamic social complex that is associated with cultural norms, socioeconomic status, and physiological conditions (Kennedy & Minkler, 1998). Not all roles are relevant to the broader social system instead it is private to the individual and becomes a social problem when it incurs public cost (Kennedy & Minkler, 1998).

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Katz (2010) bemoaned how social gerontologists have neglected the historical and theoretical significance of the ageing body, marginalized, or abandoned the physical dimension of the body and have rather embraced social, political, economic, geographical, spiritual, and global issues.

These arguments underscore the fact that ageing and disability is a dynamic and complex phenomenon and cannot be viewed through medical and social standpoints only although the significance of these models separately cannot be underestimated or overlooked. Where needed these models individually speaks to issues regarding ageing and disability and are responsible for modifications in approaches that have been generated. However, issues regarding ageing and disability must be tackled from various angles to help older adults age gracefully whether with or without disability.

The medical and social models both have strengths and weaknesses. Regarding strengths, the medical model emphasizes accurate diagnosis through medical assessments and testing, leading to evidence-based treatments; it provides consistent and proven therapies, improving patient outcomes; and it also drives innovations in medical technology and treatments. The medical model, however, focuses primarily on biological factors, often neglecting social and psychological aspects. It can contribute to viewing disabilities as abnormalities, leading to social stigma. The medical model relies heavily on medication, which may not address root causes.

The strengths of the social model on the other hand, emphasizes the capabilities and rights of individuals with disabilities, fostering empowerment; it advocates for societal changes to ensure accessibility and equal opportunities; and finally, it considers the social determinants of health, promoting a more comprehensive understanding of disability. The social model, however, may

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oversimplify the varied experiences within the disabled community by focusing mainly on external barriers and efforts to create social change can sometimes be perceived as tokenistic.

The medical model is widely used in clinical settings to diagnose and treat diseases, focusing on biological aspects. It also applied in rehabilitation to improve functional abilities through medical interventions. The social model is used in public health to address social determinants of health, such as housing and employment. It is also implemented in disability studies to advocate for policy changes and improve accessibility in various environments. Both models models were integrated in this research to provide a balanced approach and to understand the biological aspects and societal barriers that influence conceptualization.

2.2.2 Biopsychosocial perspective (International Classification of Functioning, Disability and Health, ICF)

The ICF's description of disability is an amalgamation of both medical and social models into a biopsychosocial explanation which covers biological, individual, and social standpoints (WHO, 2001a). According to the ICF "disability is an umbrella term for impairments, activity limitations and participation restrictions and denotes the negative and positive aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors) (WHO, 2001 p221; WHO, 2013). The cause of disability according to ICF's perspective lies on the various entities concerned (WHO, 2001a). This leaves the argument on ageing and disability mainly on the various entities involved. The biopsychosocial perspective gives the opportunity to see the phenomenon in a wider lens although at the same time it gives both medical and social model credit for their arguments. It is also observed from the ICF's

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perspective that disability has been modified from being an individual problem as stipulated in ICIDH-2 and situated in the social environment where the interaction between the individual, environmental, and personal factors determine or directs how the issue is viewed or assessed. Issues therefore are expected to be viewed holistically and not leaning toward a particular perspective whether medical or social.

The ICF's perspective has brought gains in public health/medical approach towards disability where intervention includes environmental factors which promotes full social participation of people living with disability (Lollar & Horner-Johnson, 2017).

2.3 Conceptualization of ageing and disability in relation to subjective perception of ageing.

How people form knowledge about ageing could reveal their views about ageing and disability if not directly expressed. Conceptualization of ageing and disability based on subjective perception of ageing may be related to what is regarded as ideal or not by society or older adults themselves. These meanings inform whether a deviation from the ideal is regarded as a disability in ageing or not. Discussions on meaning of ageing currently has been on successful ageing and its variants; positive ageing, active ageing, ageing well, and healthy ageing. A significant amount of literature has been narrowed to these. Although this may be the case, findings may hint definitions about ageing and disability based on what is regarded as successful.

Ageing successfully for instance is described by some older Japanese Americans as optimum functioning of physical, mental, cognitive, social, spirituality, and financial security (Iwamasa & Iwasaki, 2011). Physical functioning was tagged as the most important variable thus having good

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health, with no medical difficulties, doing regular activities and being physically fit (Iwamasa & Iwasaki, 2011). The psychological, cognitive, social, and spirituality dimension included having positive attitude, well-functioning brain, performing social roles and keeping faith and belief with God respectively (Iwamasa & Iwasaki, 2011). Successful ageing represents maintenance of autonomy with a minimal risk of disease or disability, being active in life with high functioning both cognitive and physical (Stordal et al., 2012).

Successful ageing is tagged to be one without disability which in effect excludes older adults who age with a lower risk of disease and disease related disability (Berridge & Martinson, 2018). Older adults' view of successful ageing is multidimensional and covers physical, functional, psychological, and social health (Phelan et al., 2004). Some older adults views on successful ageing comprises relationships with people and God, comfort resources, health, active independence, positive outlooks, freedom and valuable contribution (Troutman-Jordan & Staples, 2014). Active ageing according to a group of older adults meant having a sense of safety, preserving skills and learning, good health and fitness, actively involved, a good living arrangement, having good associations and support, and being empowered (Buys et al., 2008).

Meanings associated with old age is usually negative and continues to be associated with disability (Holstein, 2018). For instance, among some women old age include being physically or mentally debilitated, not socially active, and not involved in life (Holstein, 2018). Older adults equate prevalent poor health in old age to disability (Kelley-Moore et al., 2006) and because ageing is associated with disability it is easy for older adults to equate their age with disability although they may not actually be disabled (Kelley-Moore et al., 2006). Ageing is considered as incapacitating (Teems, 2016); and this is also associated with biomedical theories (Bowling & Dieppe, 2005).

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Physical decline or condition is considered to be more important in construction of ageing and disability (Teems, 2016).

Successful ageing among some group of older adults are in terms of self-acceptance or contentment, and engagement with life and self-growth through social interactions, having a positive attitude and giving to others (Reichstadt et al., 2010). On what influences ageing well, older adults described it as being influenced by positive feelings like being joyful, having a good purpose, contentment, financially secure, good physical health and being active socially with good mental health (Halaweh et al., 2018). Active ageing among Thai older adults involves self-reliance, active in society, spirituality, having a healthful lifestyle, actively learning and management of late life security (Thanakwang et al., 2014).

Positive ageing among a group of Hongkong Chinese people means having good health, positive life attitude, being active in society, sense of support from family and friends, financial security, and living at a place with emotional ties (Chong et al., 2006). Positive ageing also includes having a healthful lifestyle, positive thinking, encouraging family, and interpersonal relations (Chong et al., 2006). Successful ageing among black older adults meant independence, healthy, family relations and spirituality (Troutman et al., 2011). Old age or ageing affectively is viewed as threatening and frightening (Lifshitz, 2002).

Names given to older adults describe meanings given to ageing. An example is in Akan an older man and woman are called ‘akokora’ and ‘abrewa’ respectively because they are seen as having weak joints, weak veins, unable to carry out activities, remaining at one place, and awaiting death (van der Geest, 1998). Some physical characteristics include weakness, and inability to weed or work on the farm, partial blindness, and impotency (van der Geest, 1998). Grey hair however is not seen as a sign of old age since it could come at a young age (van der Geest, 1998). A difference

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is struck between sickness by old people and the young. Young people are purported to get well when they get sick but older adults do not get well even after receiving medical care (van der Geest, 1998). Some older adults describe themselves as having depleted strength, lose interest in things, and have unhappiness because of inability to work (van der Geest, 1998).

Description given to successful, positive, and active ageing are ones that is usually difficult to achieve (especially for poor people and older adults with disability) although possible for a few (Lane & Smith, 2018). A study computed the prevalence of successful ageing using a biomedical model, expanded biomedical model, social functioning model, psychological resource model, and lay model (Martinson & Berridge, 2015). It was discovered that rates of successful ageing among the older adult population was 16 to 24 percent (Martinson & Berridge, 2015). These demand therefore has a tendency to create issues with ageism and fear of ageing with a disability among people (Lane & Smith, 2018). It could become a burden on older adults themselves since they may perceive that they fall short of the normal. Deviating from the normal can easily be tagged as disability. The negative conceptualizations that are associated with ageing, like equating health issues to disability further makes the requirements of ageing well impossible. These findings depict how ageing is easily associated with disability whether present or not. These ideations further create marginalization and alienation of older adults in society. They are seen as frail, disabled, unneeded, and may be denied the resources due them thereby risking their mental, physical, and social health and well-being. Apart from preserving stability between abilities and challenges, older adults view of active ageing include having positive personal characteristics (Dogra et al., 2022). This is also possible if negative conceptualizations of ageing are transformed to help older adults see themselves in a positive light. Adopting a method of definition that transcends the simple

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existence or absence of chronic disease can augment standpoints of active ageing and public health (Dogra et al., 2022).

2.4 Difference in conceptualization of disability from the normal process of ageing.

Normal process of ageing or usual ageing is regarded as one without disability but high risk of disease (Minkler & Fadem, 2002; Rowe & Kahn, 1997). Disability may be related to physical, social, or functional deficit.

Functional limitation, bodily/physical ability decline has been observed to be cues for older adults to equate ageing with disability (Teems, 2016). Normal ageing is purported to be associated with decline in cognition especially in episodic memory functions and speed processing while procedural memory, information, and reasoning are normal (Stordal et al., 2012).

Some older adults identify themselves as strong and not weak and this was in relation to loss in functional ability and inactiveness in character and personhood (Rush et al., 2013). This would mean that instead of conceptualizing ageing as a period of frailty (loss of functional ability), some older adults still regard themselves as strong and not disabled. Although normal ageing is identified as having cognitive decline in some parts, pathological ageing has more marked decline caused by diseases (Stordal et al., 2012). Successful ageing on the other hand has well-kept cognitive function (Stordal et al., 2012). Ageing well is linked to living to an advanced age with no cognitive malfunction, possession of a good memory, and being socially active (Laditka et al., 2009).

Physical activity (Beyer et al., 2015) and ability to carry out ADLs like walking, personal care, and ability to perform tasks with hands are important factors in determination of status of disability by older adults (Partridge et al., 1996). It is also noted that older adults perception of disability is based on health decline (Kelley-Moore et al., 2006). Discrepancies were observed in objective

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assessment of disabilities among older adults and their subjective assessments (Partridge et al., 1996). It is suggested that the difference between the objective and subjective valuations may be related to the individual's assessment of their abilities and beliefs about features that influence disability (Partridge et al., 1996). Cognitive impairments, low vision and amassing fragility which could affect some IADLs are related to perceived disability by older adults (Kelley-Moore et al., 2006).

On the behavioural aspect older adults are seen as helpless and useless with numbered days and this defines how ageing is conceptualized (Lifshitz, 2002). It is seen as a period of dependency on society without contributing to it (Lifshitz, 2002).

Findings portray a biomedical view of ageing and disability whereby disability is defined by deficits in abilities and functions that is solely carried out by older adults. These conceptualizations may tag old age as a disability period. Disability is viewed as being caused by witchcraft, a curse, punishment from God, and being a part of God's plan (Stone-MacDonald, 2012). It is important to change public attitudes towards disability and design disability interventions that is drawn from culture and tradition (Grischow et al., 2018).

2.5 Medical factors that determine conceptualization of ageing and disability.

Unlike conceptualization of disability from the normal process of ageing, medical factors depict biomedical, biological, or bodily conceptualizations of ageing where disease, debility, and ability of the body for instance are the focal factor. Diseases are equated to disability, making older adults the susceptible group.

Although caring for older adults with chronic diseases and physical impairments influences negative perceptions of ageing it is observed that tagging ageing as a period of poor health has

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declined especially among older adults (Plikuhn et al., 2014). Construction of ageing among some older adults is dependent on factors such as pain in the knee, neck and shoulder and a medical condition (Teems, 2016). Some regard ageing as being a cause of chronic illness and bad health consequences (Stewart et al., 2012). Ageing generally is described as a period of deterioration of physical health, sedentariness, social isolation and dependency and lack (Weber & Wolfmayr, 2006).

Regarding ageing some older adults in Malaysia have a fear of deteriorating health and chronic diseases which are regarded as disabling in late life such as cancer, Alzheimer's disease, and heart attack (Awang et al., 2018). Cognitively some people describe ageing based on physical characteristics which is usually negative such as walking with a cane, has white hair, gets sick, lives in old age care home, and in the cemetery (Lifshitz, 2002).

It is established that early conditions which include personal, environmental and individual factors predisposes people to late-life disability through disability related chronic diseases (Monteverde et al., 2009). Mental condition is purported to be sound although ageing has set in (Teems, 2016). In healthcare, ageing or old age is focused on decline and failure of the body (Bowling & Dieppe, 2005). Disability in ageing has been associated with deficit in physical activity, inability to function or perform of activities of daily living and instrumental activities of daily living, disease, health and cognitive decline normal (Stordal et al., 2012; Rush et al., 2013; Laditka et al., 2009; Beyer et al., 2015; Kelley-Moore et al., 2006).

It is evident in the literature that medical variables are important in conceptualization of disability in relation to ageing by both older adults and other age groups. It is suggested however, that biomedical standpoints of successful ageing has to be balanced with social and psychological perspectives (Bowling, 2006).

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Putnam (2002) emphasizes the need to integrate social theories of ageing with disability models to better understand the experiences of individuals ageing with physical impairments. Putnam (2002) argues that traditional social theories of ageing often fail to adequately address the cumulative experience of disability over the life course. This oversight can lead to a fragmented understanding of ageing and disability as separate phenomena, rather than interconnected aspects of the human experience (Putnam, 2002). This perspective aligns with the aim of this research to explore how medical and contextual factors influence the conceptualization of ageing and disability among different age groups in Ghana.

Putnam (2002) proposes the use of social models of disability as frameworks within ageing theories. This approach can help operationalize physical impairment and disability more clearly, providing a more nuanced understanding of how these factors interact over time.

Putnam (2002) also emphasizes the importance of considering both objective assessments and subjective experiences in research on ageing with physical impairments. Ideological differences between disability service programs and ageing service programs highlights the need for a more integrated approach to service delivery (Putnam, 2002). Understanding these differences can inform the development of policies that better address the needs of older adults ageing with disabilities, ensuring that services are more inclusive and effective.

INTEGRI PROCEDAMUS

2.6 Environmental factors that influence conceptualization of ageing and disability.

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Humans are social beings and are affected by social and environmental factors that influence health and well-being, hence evidence of social stress on ageing (Bribiescas, 2020); and their conceptualization of various phenomena.

Meaning associated with ageing is said to be contextualized and dependent on circumstances (Fry, 2010). While older persons participation in society is crucial in North America and Hongkong, it was unimportant in Africa and Ireland (Fry, 2010). Functional ability also determines if ageing is good or not and this is dependent on whether a society expects them to provide food or not (Fry, 2010). Societies perceptions of ageing have been influenced by globalization, urbanization, migration and community change (Fry, 2010). Older adults who are unable to participate socially consider themselves as disabled (Kelley-Moore et al., 2006). Disability in old age is related to presence of more children alive, satisfied social life and companions (Kelley-Moore et al., 2006).

Barrett et al. (2012) argue that cultural devaluation of older adults is displayed in how people regard themselves with younger identities than their chronological age although they are older (Barrett et al., 2012; Holstein, 2018; Kelley-Moore et al., 2006). Negative attitude towards ageing which include ageing stereotypes is purported to be reinforced by society, family and media which become personalized to the individual (Plikuhn et al., 2014). Culture has been documented to influence how individuals interpret ageing experiences and expectations. The influence of culture in the interpretation of ageing varies across societies (Bonder, 2009). Some societies attach successful ageing to social participation, while others view it in light of being physically active, functional status and productivity (Bonder, 2009).

Ageing in place is an important phenomenon to older adults. Ageing in place was not only linked to a house but linked to social and community levels (Wiles et al., 2012). It is a sense of attachment

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and social connection in the communities in which they lived (Wiles et al., 2012). Cultural context plays a significant role in how Thai and Australian older adults embodied subjectivities about ageing (Fox, 2005). Their construction was based on experience, cultural frameworks and ways of life, factors such as wealth, health social organization of care, and care relationships (Fox, 2005).

Among the oldest old only a few perceive society treats them well but most of them perceived society treated them poorly (Knuutila et al., 2021). The environment one lives in influences negative stereotyping (Doncel-García et al., 2022). Environmental factors are important in conceptualization of ageing and will be relevant in formation of perceptions and knowledge on ageing and disability.

2.7 Personal factors that influence conceptualization of ageing and disability.

Personal factors are factors that relate to an individual as a person that influence their conceptualization of ageing and disability in the society and by older adults.

Age influences construction of ageing (Lifshitz, 2002) and disability. In Ballet (a dance), for instance a 30 year old individual is regarded as old due to decline in performance related to aches and pain associated with the ageing body (Wainwright & Turner, 2006). Perceived age is associated with health outcomes among older adults (Demakakos et al., 2007). Stereotypes of ageing begin in childhood and endures through adulthood and these are said to be influenced by previous experiences and encounters (Plikuhn et al., 2014).

Ageing affects older adults employability and continuance in employment or active working life due to beliefs about inability to perform jobs (Plikuhn et al., 2014). Some older adults associate old age with bodily decline and disability (Teems, 2016). Construction of ageing and disability in a section of older adults is related to numerical age and physical condition than it is to mental

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condition (Teems, 2016). It is purported older adults' construction of ageing is gendered whereby women are more likely to have disability than men (Russell, 2007).

Conceptualization of ageing is noted to be related to the age of a person (Lifshitz, 2002). Old age stimulates revulsion and terror in younger and middle-aged adults (Lifshitz, 2002). People who have intellectual disability have difficulty in conceptualization of old age and a relationship is observed between conceptualization and level of retardation (Lifshitz, 2002).

Perception of some younger adults designate older adults as being dependent and forgetful; and they associated progressive physical deterioration to old age (Verhage et al., 2021). Younger adults moreover considered that older adults who have good cognitive functioning and are able to carry out activities as not old age (Verhage et al., 2021).

Racial/ethnic variations have been spotted in perceptions of ageing well. Some ethnic groups such as the Chinese do not connect ageing well with mental viewpoint and physical activity, neither do Indian Americans link it to diet and physical activity (Laditka et al., 2009). Vietnamese were not likely to relate ageing well with independent living (Laditka et al., 2009).

Individual characteristics have been observed to influence how older and middle-aged adults define successful ageing (Bowling, 2006). Sex is reported to influence perception of fear of ageing (Brunton & Scott, 2015). Conceptualization of healthy ageing varies by level of education. Lay perspectives of healthy ageing focused on independence, adaptation, being financially secure, individual growth and spirituality (Hung et al., 2010). Academic conceptualization of healthy ageing however, is based on physical health, mental health and social functionality (Hung et al., 2010). Personal factors that influence conceptualization of ageing include variables such as age, sex, level of education, ethnicity, employment, and health status.

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2.8 Predictors of conceptualization of ageing and disability.

Predictors of disability in ageing/old age has been documented to include poverty, poor nutrition, and failure to access healthcare (Barlow & Walker, 2015). Physical ability and appearance have shown to be important to older adults regrading views of their body image (Jankowski et al., 2016). Negative stereotypes of ageing have been observed to influence ageing perceptions among older adults. Negative stereotypes predicted lower levels of risk taking, subjective health and extraversion, heightened feelings of loneliness and increase in frequency of health seeking behaviour (Coudin & Alexopoulos, 2010). These therefore can affect older adults perception of their functionality and increase dependency (Coudin & Alexopoulos, 2010).

Predictors of successful ageing among middle-aged and older adults include self-rated health status and quality of life (Bowling, 2006). However having a chronic limiting illness was not significant in definition of successful ageing (Bowling, 2006). Transitions such as relocation or loss of a spouse influences views of successful ageing (Rossen et al., 2008). Some older women in transition view successful ageing as acceptance of change, engagement, and comportment (Rossen et al., 2008).

For ageing anxiety, grandchildren's perceptions is influenced by physical proximity with their grandparents, contact medium, contact quality, contact frequency, and emotional closeness (Wise & Onol, 2021). High emotional closeness of grandchildren with grandparents results in less ageing anxiety than less closeness (Wise & Onol, 2021). The level of closeness therefore determines the psychological concerns grandchildren have about their own future ageing (Wise & Onol, 2021). There is no significant relationship between perception of grandparents physical appearance and fear of losses (Wise & Onol, 2021). This borders on experience. Experience is observed to factor

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in decreased ageism (Chonody & Wang, 2014). Physical characteristics is said not to have influenced ageist attitude but psychological factors have (Chonody & Wang, 2014).

Consciousness and comprehension of ageing is said to increase significantly with age (Lifshitz, 2002). Increasing age therefore is a predictor of ageing perceptions. Predictors of fear of older adults among college students is significantly associated with sex and contact (Chonody et al., 2014). Predictors of attitudes towards ageism include contact with older adults, sex, fear of ageing, positive ageism, and negative ageism (Chonody et al., 2014). More quality contact with older people is associated with less ageing anxiety (Brunton & Scott, 2015). Ageism is correlated with more ageing anxiety (Brunton & Scott, 2015).

In relation to ageism, women more than men, younger participants, people with lower incomes, family care givers, those with lower self-rated health and mental well-being mostly perceive that older adults are treated poorly by society (Knuutila et al., 2021). Negative stereotype towards ageing is mostly among younger people (Doncel-García et al., 2022) and people with intellectual disability's conceptualization of ageing is influenced by stereotypes (Lifshitz, 2002). These factors are important to determine conceptualization of ageing and disability because ageism which is pervasive in society has in it a perception of disability associated with ageing.

2.9 Gaps identified in the literature

Most research is on conceptualization of ageing and successful ageing and its variants. Furthermore, older adults are the central participants with a few young and middle-aged adults. Secondly, although ageing perceptions hinted some elements of perceptions of disability, disability's inclusion is on experience of ageing with disability; perception of people with disability on ageing; older adults' perception of ageing with disability or not and perceptions of

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ageing or disability among different age groups. Also, scarce are studies on formation of knowledge and perceptions or conceptualization of ageing and disability among young, middle-aged, and older adults whether they have a disability or not.

2.10 Conceptual framework

The conceptual framework for this study, depicted in Figure 2.0, is informed by a comprehensive review of literature, including empirical research and various models such as the medical, social, and biopsychosocial models. Key sources include the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) and the International Classification of Functioning, Disability, and Health: Children and Youth Version (ICFDH) (Üstün et al., 2010; World Health Organization, 2007). This framework illustrates how ageing and disability are conceptualized based on different socio-demographic characteristics.

The dependent variable in this study is the conceptualization of ageing and disability. Ageing is conceptualized as either being with disability or without disability, influenced by both medical and contextual factors. These factors serve as proxy measures for the dependent variable.

To clarify the pathway through which the outcome variable is influenced by the predictor variables, the framework integrates various socio-demographic characteristics. These characteristics are analysed to determine their impact on the conceptualization of ageing and disability. The framework guides the analysis by linking these characteristics to the dependent variable through the following steps:

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1. The framework is grounded in established models and empirical research, providing a theoretical basis for the study.

2. Themes and categories derived from qualitative data inform the development of proxy measures for the dependent variable.

3. The proxy measures are used in the quantitative analyses.

By following this pathway, the framework ensures that the analysis is systematically guided by both theoretical and empirical foundations, providing a clear connection between the literature, conceptual framework, and the study's findings.

Based on the medical model, in relation to age, for instance, a young adult could base their conceptualization on pathology. Pathology could either be a disease, injury or inborn/developmental condition (s) and this is as a result of a biochemical or physiological deviation (Verbrugge & Jette, 1994). This could mean that based on pathology, an older person may be labelled as having a disability or not. In this conceptual framework however, disease and health decline are the focus of pathology. Kelley-Moore et al. (2006) observed that poorer health is associated with perceived disability.

Impairment, which is a medical factor, include dysfunctions and abnormalities that have dire consequences on physical, psychological, or social functions (Verbrugge & Jette, 1994). The impairments in this study include physical, sensory, and cognitive impairments. Impairments have been described as a normal process of ageing (Agyeman et al., 2019) and ample research has been carried out on how various impairment relates to disability. The study examined how people use impairment to conceptualize ageing and disability.

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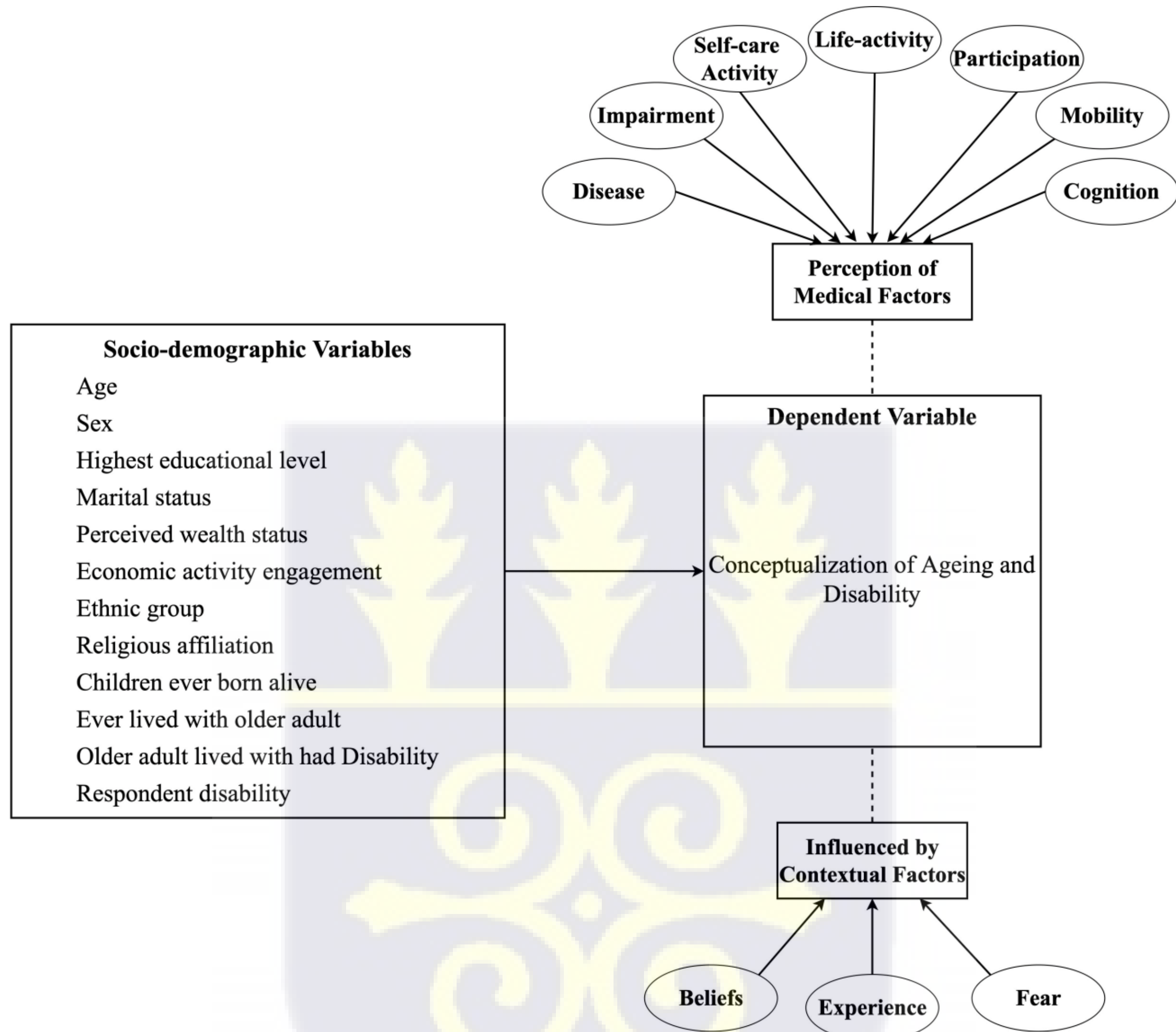
Figure 2.0 Conceptual framework showing conceptualization of ageing and disability



Source: Author's Construct

Two other medical factors are self-care and life activities. Self-care includes the ability of an older adult to perform hygiene, dressing, eating, and staying alone (Üstün et al., 2010; World Health Organization, 2007). Life activities on the other hand deals with difficulty in executing day to day

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activities such as work, leisure, and domestic responsibilities (Üstün et al., 2010; World Health Organization, 2007). Life activities and self-care are encapsulated in performance of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Inability to perform activities in life is regarded as disability in the medical model and this could be caused by chronic conditions for instance (Verbrugge & Jette, 1994). An older adult's inability to perform basic ADLs and IADLs could be conceptualized as ageing with disability or not. This is because any deficit in expectation from society is labelled as either disability (according to the social model) or ageing without disability.

Participation includes social engagement such as community activities, social roles, and other relevant contextual factors that allow a person to function in the social environment (Üstün et al., 2010; World Health Organization, 2007). People's conceptualization of ageing and disability could be dependent on the degree of function of an older adult in a society or performance of a social role. In a study by Kelley-Moore et al. (2006) it was observed that being less contented with one's social life and becoming less contented with a person's social life is linked with a higher rate of labelling oneself as having a disability.

Cognition, a medical factor according to Üstün et al. (2010) and World Health Organization (2007) includes communication and thinking activities related to concentrating, remembering, problem solving, learning, and communicating. Ageing could be conceptualized as either with or without a disability based on any of the cognition domains.

Research has shown how experiences of older adults influence their perception of ageing (WBG & WHO, 2011; Jandt, 2009). Experience is conceptualized as whether the participants have ever lived with an older adult and whether the older adult lived with had a disability or not. It is observed

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that experiences of younger people is influenced by their life interaction with older people (Burke et al., 2014; Warmoth et al., 2016). When young people have less experience with older people they are more likely to believe negative stereotypes about ageing (Chonody & Teater, 2018).

Another contextual factor, cultural beliefs, has been observed to inform social norms and values about people's construction of ageing and the expected functions of the older adult (Chonody & Teater, 2019; Jandt, 2009). Cultural beliefs has also been linked with fear about death and perception of ageing (Chonody, 2019). Culture and tradition have also been characterized as ingrained in perception of disability (Grischow et al., 2018). Examining these constructs determined linkages between cultural beliefs and variables such as ability to carry out ADLs and IADLs and conceptualization of ageing and disability.

Research has demonstrated how fear influences perception of ageing and these have been found to emanate from ageing bias and adopted stereotypes (Stein, 1995; Chonody, 2019; Mahoney, 2018). Fear is a contextual factor that is generated either from the environment or personal factor. Fear whether it exists or not, what people fear, and how it relates to conceptualization of ageing and disability were examined.

Socio-demographic variables such as age, highest level of education, perceived wealth status, sex, children ever born alive, engagement in economic activity, and religion have been associated with ageing experience and disability (Fox, 2005; Hung et al., 2010; Hung et al., 2010; Plikuhn et al., 2014). These variables were also explored on how they influenced conceptualization of ageing and disability based on the medical and contextual factors. The interpretation of disability by the participants were through the three models of disability that is medical, social, and biomedical

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models. Based on the interpretation of what is regarded as disability ageing was either conceptualized as being with disability or without disability.

2.11 Research hypotheses

The study hypothesized that:

1. There is no significant difference in conceptualization of ageing and disability based on subjective perception of ageing among young and middle-aged adults.
2. There is a significant difference in conceptualization of ageing and disability based on medical factors among young adults and older adults.
3. There is a statistically significant difference in conceptualization of ageing and disability based on contextual factors among middle-aged adults and older adults.

2.12 Theoretical Framework

The theoretical framework for this study is grounded in key theories that provide a comprehensive understanding of the conceptualization of ageing and disability. These theories include the Theory of Planned Behaviour, Self-Perception Theory, Social Identity Theory, Symbolic Interactionism, Social Constructionism, and Lifespan Development Theory. Each theory offers unique insights and has its own set of criticisms, which are important to consider.

Theory of Planned Behaviour (Ajzen, 1991)**:** This theory posits that individuals' attitudes, subjective norms, and perceived behavioural control influence their intentions and behaviours. In the context of ageing and disability, attitudes towards ageing can shape broader conceptualizations.

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Criticism: It may oversimplify the complex interplay between attitudes and behaviours, assuming a linear relationship that doesn't fully capture the nuanced nature of ageing and disability perceptions.

Self-Perception Theory (Bem, 1972)**:** This theory suggests that individuals infer their attitudes and beliefs from observing their own behaviour. For example, maintaining an active lifestyle despite ageing can lead to a more positive conceptualization of ageing and disability.

Criticism: It may not fully account for external influences and social pressures, focusing primarily on internal self-observation and potentially neglecting societal and cultural factors.

Social Identity Theory (Tajfel & Turner, 2019)**:** This theory emphasizes that individuals' identification with their social groups influences their self-concept and behaviour. Positive identification with one's age group can lead to more positive perceptions of ageing and disability.

Criticism: It may not adequately address the diversity within age groups and the varying experiences of ageing, assuming a homogeneity that may not reflect individual differences and intersectional identities.

Symbolic Interactionism (Kanter & Blumer, 1971)**:** This theory focuses on how individuals create meanings through their interactions with others. The meanings ascribed to ageing and disability are shaped by these interactions.

Criticism: It may overlook structural and systemic factors that influence interactions and meanings, focusing on micro-level interactions and potentially neglecting macro-level influences such as policy and societal norms.

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Social Constructionism (Berger & Luckmann, 1966)**:** This theory suggests that knowledge and meaning are not objective realities but are constructed through social interactions, cultural norms, and shared experiences. It emphasizes how societal beliefs, language, and power dynamics shape individual perceptions and understanding of concepts like ageing and disability This theory posits that ageing and disability are socially constructed phenomena, with individual perceptions influenced by broader societal constructs.

Criticism: It may be criticized for its relativism, which can make it challenging to address objective realities and biological aspects of ageing and disability. The emphasis on the fluidity of social constructs may complicate efforts to develop consistent and actionable policies.

Lifespan Development Theory (Paul, 1987)**:** This theory posits that human development is a lifelong process influenced by biological, psychological, and social factors. It highlights how individuals adapt and change across the lifespan, with perceptions of ageing playing a crucial role in shaping developmental trajectories. This theory suggests that individuals' perceptions of ageing influence their development and adaptation processes.

Criticism: It may be critiqued for its potential determinism, implying that early perceptions set a fixed trajectory for ageing. It may not fully account for the potential for change and resilience in later life stages.

2.13 Relevant Legislation and Policies

The Persons with Disability Act, 2006 (Act 715) (Government of Ghana, 2006) was enacted to protect the rights of persons with disabilities in Ghana. This Act aims to reduce discrimination and

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ensure equal opportunities for persons with disabilities in various aspects of life, including employment, education, healthcare, and access to public services. The Act established the National Council on Persons with Disability, which is responsible for implementing policies and programs to support persons with disabilities

In the context of this research on the conceptualization of ageing and disability, Act 715 is crucial as it provides a legal framework that influences societal attitudes and policies towards disability. By ensuring rights and access, the Act helps shape how disability is perceived and managed, which in turn affects the broader conceptualization of ageing with disability. This aligns with the study's objective to explore how medical and contextual factors influence these perceptions.

The National Ageing Policy (Ministry Of Employment and Social Welfare, 2010), titled "Ageing with Security and Dignity," was developed to address the challenges faced by older persons in Ghana. This policy aims to ensure that older adults can age with dignity, security, and active participation in society. It outlines strategies to improve the health, well-being, and social inclusion of older persons, and emphasizes the importance of integrating older adults into the national development process.

This policy is relevant to this research as it provides a comprehensive framework for understanding the societal and governmental approaches to ageing. The policy's focus on dignity and security for older adults directly relates to the conceptualization of ageing in Ghana. By promoting positive ageing and addressing the needs of older adults, the policy helps shape societal attitudes towards ageing and disability, which is a key theme in this study.

Incorporating these legislative frameworks in this research enhances the understanding of how legal and policy measures influence the conceptualization of ageing and disability. The Disability

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Act, Act 715 (2006), and the National Ageing Policy of Ghana, 2020, provide essential context for analysing how societal attitudes and policies are shaped. These frameworks support the exploration of medical and contextual factors in this research, offering a more comprehensive view of the interplay between ageing, disability, and societal constructs.

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CHAPTER THREE

METHODOLOGY

3.0 Introduction

A robust methodology is crucial for ensuring the validity and reliability of research findings. This chapter justifies the methodological choices made in the study, explaining why specific techniques were selected to address the research questions. The objective is to provide a detailed description of the research design, sampling methods, data collection procedures, and analytical techniques. Both qualitative and quantitative research approaches employed for the study are discussed, highlighting their respective strengths and how they contribute to a comprehensive understanding of the research problem.

3.1 The philosophical underpinning and design of the study

The philosophical assumption that guides this study is Pragmatism. Pragmatism relies on intersubjectivity instead of objectivity or subjectivity (Nelson & Evans, 2014). Objectivity is guided by the assumption that there is a single real world while subjectivity assumes that all persons have different interpretations of that world (Nelson & Evans, 2014).

Pragmatism believes in singular and multiple realities and practicality are its epistemology, and methodologically it combines methods (Nelson & Evans, 2014). It focuses on abduction and transferability (Nelson & Evans, 2014). Pragmatism is therefore problem-centred, pluralistic, and it is real-world practice oriented (Creswell, 2014). Instead of focusing on the methods, the research problem is emphasized and all approaches to understanding the problem are used (Creswell, 2014).

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It is not devoted to any system of philosophy and reality but looks at 'what' and 'how to' research based on planned consequences (Creswell, 2014). Research approaches must be eclectic and designed based on circumstances. This denotes that approaches used must not be restricted to a particular method but methods that will answer the research problem. Behaviour also is better understood when it is observed or studied in its natural setting.

3.2 The research design

An exploratory sequential mixed methods research design was employed for this study. This design was chosen to comprehensively explore and understand the variables related to the phenomenon of ageing and disability. The study was conducted in two distinct phases: a qualitative phase followed by a quantitative phase.

The qualitative component of the study utilized a case study design. This approach was selected to deeply explore the subjective perceptions of ageing among participants. The qualitative phase aimed to identify and understand the medical and contextual factors that influence participants' conceptualizations of ageing and disability. This phase involved in-depth interviews with a purposive sample of participants, allowing for rich, detailed data collection on their personal experiences and perceptions.

Following the qualitative phase, the study employed a cross-sectional survey design for the quantitative component. The purpose of this phase was to test and quantify the relationships between the variables identified in the qualitative phase. The qualitative findings were used to develop a structured survey instrument, which was then administered to a larger sample of

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participants. This approach allowed for the statistical testing of hypotheses and the generalization of findings to a broader population.

3.3 Integration of Qualitative and Quantitative Components

The integration of the qualitative and quantitative components was achieved through a process known as "building." The qualitative results informed the development of the quantitative survey instrument, ensuring that the survey items were grounded in the participants' lived experiences and perceptions. This sequential integration allowed for a comprehensive exploration of the research questions, with the qualitative data providing context and depth, and the quantitative data offering breadth and generalizability.

3.4 Selection of the study site

This study was conducted in the greater Accra Region. The greater Accra Region is made up of sixteen (16) districts/municipalities. The total population, the urban and rural population, the older adult population, and the rate of disability among each population both urban and rural were listed in each district. According to the 2010 Population and Housing Census results, the districts/municipalities with the highest rate of older adult population and disability were selected. The districts/municipalities with the highest percentage of older adults out of its total population include Shai Osudoku (7.4 percent), Ada West (6.7 percent), Ningo-Prampram (6.6 percent), Ada East (6.5 percent), Ga South (6.5 percent), Tema Metropolitan (6.0 percent) and Accra Metropolitan (5.9 percent). Regarding disability, the districts/municipalities with the highest

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percentage of disability in their total population include Ada East (4.3 percent), La Dade-Kotopon (3.4 percent), Accra Metropolitan (2.8 percent), La-nkwantanan Madina (2.7 percent), and Shai Osudoku (2.6 percent) (GSS, 2014).

The district with the highest percentage of older adults among its total population was selected for the study. Shai Osudoku district has the highest percentage of older adult population among its total population.

Purposeful sampling technique was used to select a town for both qualitative and quantitative studies. A list of all towns in Shai Osudoku district was generated. Dodowa was selected for the study because it is the capital town of the district and has migrants from the rural communities and Accra. It is therefore expected that Dodowa will have people with different socio-demographic characteristics including people with different ethnic backgrounds as compared to other towns in Shai Osudoku district. Dodowa has the highest total population, 12070 that is 23.3 percent of the population of Shai Osudoku district. The town also has the highest older adult population. The participants who were within the target population were approached in their homes for the interviews.

3.5 Description of the study site

According to the results of the 2010 Population and Housing Census, Shai Osudoku district is made up of 19 towns with its capital as Dodowa (Ghana Statistical Service, 2014). Shai Osudoku district is the district with the highest older adult population compared to its total population (Ghana Statistical Services, 2014: 20-25, 52-53, 84). The district has a total population of 51913 with older adults constituting 7.4 percent (Ghana Statistical Services, 2014). Shai Osudoku district

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constitutes approximately 1.3 percent of the total population of the Greater Accra region. Males constitute 48.7 percent of the population with females making up 51.3 percent (Ghana Statistical Services, 2014). The district has a sex ratio of 95 percent (Ghana Statistical Services, 2014). The rural localities make up 76 percent (29843) of the population while 23.3 percent (12070) is urban (Ghana Statistical Services, 2014). People living with a disability in the district constitute 2.6 percent of the population (Ghana Statistical Services, 2014). Available data on people aged 20-39 (15871, 30.6%), 40-59 (7172, 13.8%) and 60 and above (3792, 7.3%) make up 51.7 percent of the total population in Shai Osudoku district (Ghana Statistical Services, 2014). With these estimates, young adults are about 31 percent, middle-aged adults are about 14 percent and older adults about 7 percent of the total target population.

The majority (85.3%) of the population in Shai-Osudoku is affiliated with Christianity, Muslims comprise 7.6 percent, Traditionalists (2.0%), and those affiliated with no religion (4.0%) (Ghana Statistical Service, 2014). Regarding marital status, the population married is 39.8 percent, never married is 40.7 percent, widowed, divorced and separated are 6.1 percent, 3.3 percent and 2.9 percent respectively while those in union/living together comprise 7.2 percent (Ghana Statistical Service, 2014).

For economic activity engagement, 69.2 percent of the population is economically active (Ghana Statistical Service, 2014). About 70.7 percent of the population are literate and 49.8 percent of those currently attending school are in primary school (Ghana Statistical Service, 2014). About 7.2 percent of those who attend school are in the Nursery, 15.6 percent in Kindergarten, 49.8 percent in primary and 17.8 percent in JSS/JHS, 6.6 percent are in SSS/SHS, while those in the Tertiary are 2.1percent (Ghana Statistical Service, 2014).

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Regarding children ever born (CEB), those born by females 12 years and above are 47,084 out of which 40,414 (85.5%) are surviving. For the children surviving, 20,186 (49.9%) are males and 20,228 (50.1%) are females (Ghana Statistical Service, 2014).

3.6 Sample design

For the qualitative case study, a two-tier purposive sampling technique was employed. The first stage involved the selection of the site, and the second stage comprised of selecting participants based on various characteristics. Participants who have ever lived with an older adult with no disability, lived with an older adult with a disability, never lived with an older adult and older adults themselves were selected for the study. The number of participants was determined by saturation. Saturation was reached when no new themes emerged from the data as new themes were tracked through memos and reflective journalling. No new insights were observed after the fourteenth respondent.

For the quantitative study, a systematic sampling technique was employed to select participants. The process began at the junction of the street in Matekye that links the main Dodowa road to the Shai Osudoku district office. From this starting point, the first house was selected, and subsequently, every second house was chosen for sampling. This method ensured a systematic and unbiased selection of respondents across the community.

The decision to sample the first house and every second house was informed by the need to improve access to the target population and increase representation. This approach was chosen because some houses were either empty or had residents who were not part of the target population.

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By selecting every second house, the likelihood of reaching eligible participants was increased, thereby enhancing the representativeness and efficiency of the sampling process.

After selecting the first house, every second house along the street was included in the sample. The number of participants selected from each sampled house depended on the availability of eligible respondents within the target population. If a house had multiple eligible participants, all were included in the study to ensure comprehensive data collection and to increase representation.

3.7 Methods of data collection

Primary data was collected for the study. The qualitative study design incorporated both face-to-face (in-person) and telephone interviews to collect data. This dual approach accommodated participants' preferences and availability, ensuring a more comprehensive and flexible data collection process. Semi-structured interviews were employed for the data collection. Telephone interviews were recorded on a mobile phone and face-to-face interviews on a MP3 recorder. Permission was sought from the participants before the recording started. The participants were informed about follow-up interviews if the need arises. In addition to conducting interviews, field notes were taken to capture observations and contextual details during the data collection process. These notes included reflections on the interviews and the researcher's thoughts and insights, which were recorded in researcher journals. This practice helped to document the research process comprehensively and provided valuable context for interpreting the qualitative data. Research assistants who were fluent in Dangme were recruited and trained to assist with data collection.

The researcher assessed her beliefs about the phenomenon and positionality before the field work was conducted. As she interviewed the participants, she tried to bracket her views. Information

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that was given by the participants was reiterated to them to confirm if it reflected the meaning they intended to give.

On the other hand, the quantitative data was gathered using a questionnaire. Computer-Assisted Personal Interview (CAPI) using Kobo Toolbox was used in the execution of the survey. The questionnaire included questions on socio-demographic variables as well as themes and codes derived from the qualitative results. The themes refer to the main topics or patterns identified from the qualitative data, while codes are specific labels assigned to segments of data that represent these themes. These themes and codes were used as variables in the questionnaire to ensure that the quantitative data collection was aligned with the insights gained from the qualitative study. This approach helped to integrate the qualitative findings into the quantitative phase, providing a comprehensive understanding of the research questions.

The questions were explained to the participants' understanding, and they were allowed to choose responses with no influence from the researcher and research assistants.

3.8 The study participants

The participants for both qualitative and quantitative studies comprised of young, middle-aged, and older adults whose ages ranged from 20-39, 40-59, and 60 and over years, respectively. This follows the categorization of adulthood in Lachman (2001). Milestones (graduation, marriage, career, family) and various dynamics are associated with each stage of adulthood that is young, middle-aged, and older adulthood (Lachman, 2001). The study excluded people who were below 20 years.

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3.8.1 Participant recruitment and selection

For the qualitative study, the participants who met the inclusion criteria were interviewed by the researcher and assistants after they were introduced to the participants at their homes. Questions were asked in Dangme and English. Before the data collection, the purpose of the study was explained to the participants. Questions on the guide were explained to the understanding of the assistants so they could understand the purpose and essence of the research. This was important because it helped the research assistants to understand and appreciate the study so they could easily recruit participants for the study.

The respondents who were eligible for the study in every second house were interviewed by the researcher and research assistants in Dangme, Twi, and English for the quantitative study.

3.8.2 Sample size

The interviews for the case study design, was in session until it was observed that saturation point was reached by the 14th respondent. Interviews were therefore discontinued because no new themes emerged.

The sample size for the quantitative study was estimated using a sample size calculator. Available data on people aged 20 years and above living in Dodowa is 6633 out of the total population of 12070 (Ghana Statistical Service, 2014). This is 55 percent of the total population. Using the target population of 6633, the sample size estimated was 167 considering:

- A margin of error of 7.5 percent
- Confidence level of 95 percent and

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- Response distribution at 50 percent. During field work however, 175 participants were interviewed to make up for any sampling errors.

3.9 Research instrument

Semi-structured interview guide was used for the qualitative case study. The interview guide had questions generated based on the objectives of the study. There were probes for the questions to elicit information (experiences, views/viewpoints, and opinions) from the participants. Questions that were not on the interview guide were also asked when they emerged during the interviews. The interview guide was partitioned into 7 parts. Part one contained questions on the socio-demographic characteristics of the participants such as the age, level of education, marital status, and religious affiliation.

Part two of the guide had screening questions on whether the participant has ever lived with an older adult. If they had they were required to tell if the older adult had a disability or not. Parts three to seven of the interview guide has questions on the subjective perception of ageing, disability, and ageing with disability, differentiation between disability and the normal process of ageing, medical factors, personal factors, and environmental factors and conceptualization of ageing and disability. The details of the interview guide are shown in Appendix 1.

A questionnaire with a set of closed ended questions with few open-ended questions was used to collect the quantitative data. The questions had both ordinal and nominal questions. The questionnaire collected information on the socio-demographic variables, themes, and codes (used as variables) based on the objectives of the study and the results of the qualitative data analysis. Part one of the questionnaire required information about the socio-demographic characteristics of

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the participants. The questionnaire also required information on the sex of the participant, age at last birthday, ethnicity, religious affiliation, marital status, education, economic activity, children born alive, perceived wealth status, and ever lived with an older adult.

Part two of the questionnaire included questions on the subjective perception of ageing. This part had questions on communication features, physical impairment, sensory impairment, and possibility of disability during ageing. Part three asked questions on conceptualization of ageing and disability based on medical factors. The questionnaire further required information on diseases that cause ageing and disability and whether presence of a disease is ageing with disability. Part three of the questionnaire also required participants to answer questions on whether inability to perform self-care, life activities, and participation restrictions is ageing with disability.

The final part of the questionnaire contained questions on contextual factors and ageing and disability. The questions comprised of both personal and environmental factors. The environmental factors include performance of social function, engagement in social activities, and whether society contributes to ageing with disability. Other environmental factors include influence of other people, cultural and religious factors, media, and educational institution on conceptualization of ageing and disability. Questions that covered personal factors include expectation of future ageing, fear of ageing, lineage and ageing with disability, and witchcraft accusation and ageing and disability. The detailed questionnaire is presented in Appendix 2.

The concepts on the questionnaire were guided by the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) and the International Classification of Functioning, Disability, and Health: Children and Youth Version (ICFDH) (Üstün et al., 2010; World Health Organization, 2007). The WHODAS 2.0 and ICFDH are organized into the 'body components' which include functions of

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body systems and body structures and 'contextual factors' which comprise of personal and environmental factors. The WHODAS 2.0 covers understanding and communicating, getting around, self-care, getting along with people, life activities, and participation in society. These collectively makeup the medical and contextual factors components of the questionnaire.

3.9.1 Pre-testing of the research instruments

The instruments were pretested before use for both qualitative and quantitative study on 10th August 2021 and 15th to 17th September 2022 respectively. Eleven participants from Shiashie in East Legon and Sebrepor in the Kpone Katamanso district partook in the pretesting of the research instruments. Shiashie and Sebrepor were selected for the pre-testing of the instruments due to demographic similarities to the main study area. These locations provided a relevant context for testing the questionnaire, ensuring that any issues with the survey design could be identified and addressed before the main data collection. Additionally, the accessibility and willingness of the residents in these areas to participate in the pre-test made them suitable choices for this phase of the research.

The pilot study helped in detecting ambiguities and confusion in some of the questions that the participants answered. Questions that were difficult for the participants to comprehend were also simplified. Feedback was also received from the participants on their views on the questions and these helped in modifying the questionnaire for the main field work. Repetitive questions were identified and removed. Pre-testing the research instruments also gave an idea of the time interviews would take and this helped in modifying questions to improve the timespan for the interviews.

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3.9.2 Training of the research assistants

On the 20th of September 2022, a one-day training session was held at the Computer Lab of the Regional Institute for Population Studies (RIPS) for four research assistants. The researcher introduced them to the purpose of the study. The research assistants were also taken through each question on the questionnaire. Questions they asked were addressed and the details of the recruitment strategy was described to them. They also gave some suggestions which helped in the modification of the questionnaire.

3.10 Data collection procedure

The data collection began on 26th August 2021 and ended on 16th September 2021 for the qualitative study and was conducted from 21st to 26th September 2022 for the quantitative study at Dodowa in the Shai Osudoku district of the Greater Accra Region. Prior to the data collection permission was sought from the Shai Osudoku District Office. An introductory letter from RIPS was obtained and presented to the district office. Approval was given by the Acting Coordinating Director and the researcher was introduced to the Presiding assembly member. He granted access to the various electoral areas in the district by giving the researcher access to the various assembly members of the electoral areas. The coordinating director assisted the researcher to get a research assistant in the community who was fluent in Dangme and could assist the researcher during the interviews and participant recruitment. The research assistant was one of the National Service Personnel working in the district. But eventually her work with the district ended so the researcher had to look for another research assistant to work with. The assembly member of the Wedokum

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electoral area referred a member of the office to assist the researcher. Because the recommendation came from the assembly member, the research assistant was very willing to assist with the interviews. The research assistant spoke to most of the participants days before the interview to prepare them. The participants were therefore in anticipation of the interview before it began. The participants were willing and contributed substantially because they believed the issues that were discussed were personal and drew their attention to issues about ageing that they did not previously think about. Almost all the interviews therefore were conversational for eliciting ample responses. The in-depth interviews lasted between 35 minutes and 1 hour. Consent was sought from the participants before the interviews commenced. The qualitative interviews were conducted at Wedokum and some parts of Matekye at Dodowa.

For the quantitative aspect of the data collection, four research assistants were recruited and trained to assist the researcher with data collection. The participants were interviewed in their homes. Interviews lasted for approximately 40 minutes although some interviews went beyond an hour because the participants engaged interviewers in conversations on the topic. The quantitative aspect of the study was conducted at Bletu, Matekye (excludes the area used for the qualitative study), Numesi, Salam, Manya, and Tadonya electoral areas of Dodowa. The total number of participants interviewed were 175.

3.11 Measures

3.11.1 Dependent variable

The dependent variable is conceptualization of ageing and disability. Subjective perception of ageing, medical factors, and contextual factors scales were used as proxy measure for the

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dependent variable. The direction of the relationship between the independent variables and the scales determined whether ageing was conceptualized as being with a disability or without a disability. A positive direction was theorized as conceptualization of ageing as being with disability while a negative direction was theorized as conceptualization of ageing as being without disability for subjective perception of ageing and medical factors. However, a positive direction was theorized as influenced by contextual factors while a negative direction was regarded as not influenced by contextual factors in the participants conceptualization of ageing and disability.

3.11.2 Subjective perception of ageing

Twenty-six (26) items were extracted from the qualitative data which were tested at the quantitative phase. Questions required the participants to determine if the 26 items showed that an older adult is ageing with a disability or not. Reliability analysis of the items from the quantitative data yielded a Cronbach's Alpha of 0.803. Cronbach's alpha tests internal reliability of multiple items to determine if they are related (Bryman, 2012). The computed Cronbach's alpha coefficient ranges between 0 and 1 where '1' shows a perfect internal reliability while '0' shows there is no internal reliability (Bryman, 2012). A Cronbach's alpha of '0.80' is employed as a principle for an acceptable level of reliability although a slightly lower figure is acceptable by others (Bryman, 2012). The inter-item correlation matrix of multiple items was negative. Four (4) items (hearing and vision impairment not related to ageing and disability, disability in ageing is not possible, everyone gets disability during ageing, if not from birth it is not a disability) were removed initially to determine if the negative correlations will be resolved. A reliability test on 22 items yielded a Cronbach's Alpha of 0.856. Seven (7) items that is blindness, any eye defect is a disability,

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deafness, amputated limb, ageing is with disability, any change in ageing is a disability, and short and smallish people age without disability were further removed because they had negative correlation with other variables. A total of 11 items did not measure the 'subjective perception of ageing' and were deleted.

An exploratory factor analysis (EFA) on the remaining 15 items were done using the stand-alone program 'FACTOR' version 12.02.01 (Lorenzo-Seva & Ferrando, 2006; Baglin, 2014). FACTOR was used because 14 of the variables were ordinal and one was binary. FACTOR was appropriate because it has an option of using Polychoric correlation apart from Pearson correlation and uses multiple imputations for EFA (Lorenzo-Seva & Ferrando, 2006). Polychoric correlation is appropriate for variables that are not on an equal interval scale and has no linear relationship between the variables as required by Pearson correlation (Baglin, 2014). Pearson correlation is suggested to give a false multidimensionality and biased factor loadings for such variables (Baglin, 2014).

The EFA result on the 15 items showed that the variable 'curse' must be removed because it did not measure the same domain as the remaining items in the pool. The Bootstrap 95 percent confidence of 'curse' was 0.203 and this is less than the required 0.5. Seven (7) more variables were deleted from the pool, and these include 'mind turns into a child,' 'rate of thinking slows,' 'pain,' 'memory loss,' 'white hair,' 'hair loss,' and 'hearing difficulty.' A reliability analysis on the seven remaining variables produced a Cronbach's alpha of 0.846.

Procedures applied in the EFA by FACTOR on the 175 participants include Parallel Analysis which was used to determine number of dimensions and factors to be extracted. Polychoric correlation analysis was used for the dispersion matrix and Unweighted Least Squares was used

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for factor extraction for the first 15 variables and Promin for factor rotation to achieve factor simplicity. However, for factor extraction for the 7 variables Diagonally weighted least squares was used and Promax was used for factor rotation. Two factors were rotated, and Factor 1 had five factor loadings while Factor 2 had two factor loadings. Tables 3.0, 3.1, 3.2, and 3.3 presents the results.

Table 3.1: Rotated loading matrix

Variable	Factor 1	Factor 2	Communality
Strange behaviour	0.619		0.492
Shouts		0.698	0.779
Rude		0.951	0.795
Talks to self	0.850		0.846
Quarrelsome	0.491		0.516
Gets lost	0.675		0.487
Returns to old issues	0.886		0.761

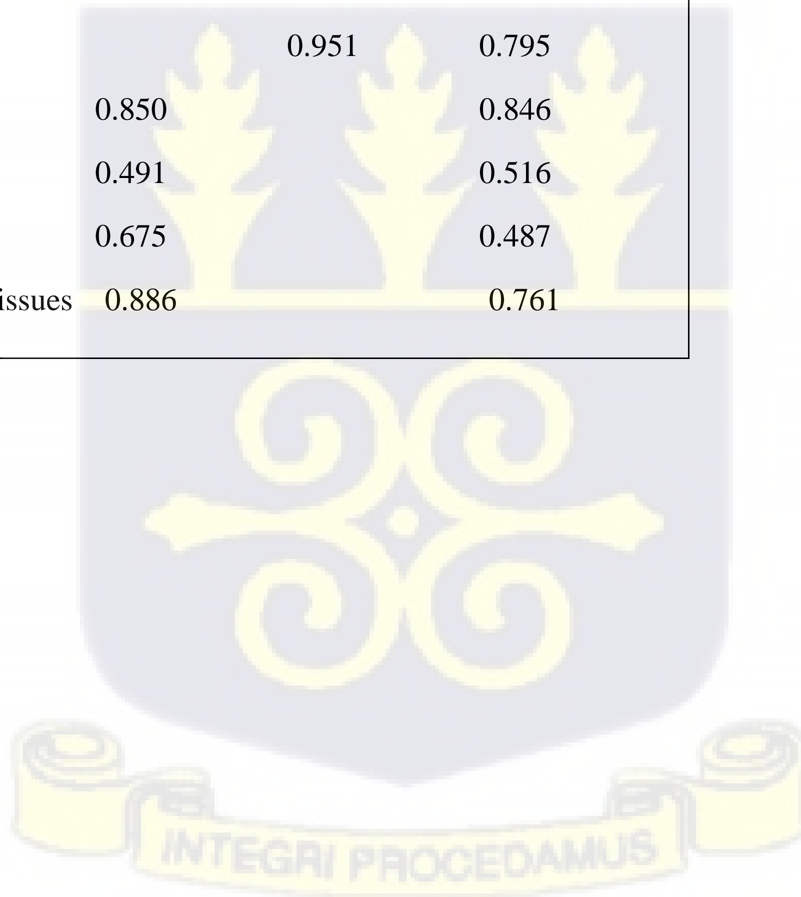

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Table 3.2: Explained variance of rotated factors and reliability of Phi-information oblique EAP scores

Factor Index	Variance	Factor Determinacy	Dimensions
1	2.919	0.960	1
2	1.757	0.943	

A scale, 'subjective perception of ageing' was created from the 2 factors through weighting. The variables that made up the two factors were standardized to zero their means. This was required for computation of the factor scores. Factor 1 and Factor 2 scores were computed separately by a sum of the product of the standardized variables with their corresponding loadings ((Standardized Variable 1 x loading on variable one) + (Standardized Variable 4 x loading on variable 4) + etc. A composite score was formed from the sum of Factors 1 and 2 with the square root function (sqrt) of their corresponding proportion of variances {(Factor 1 x sqrt (Factor 1 variance)) + (Factor 2 x sqrt (Factor 2 variance))}. Where the weight applied is the sqrt of their corresponding proportion variances. The composite variable 'Subjective perception of ageing' was used in the interpretation of analysis. It is suggested that "once a composite variable has been created and used in analyses, results involving the composite variable should be interpreted at the level of the composite variable, not at the level of the individual original variables" (Song et al., 2013).

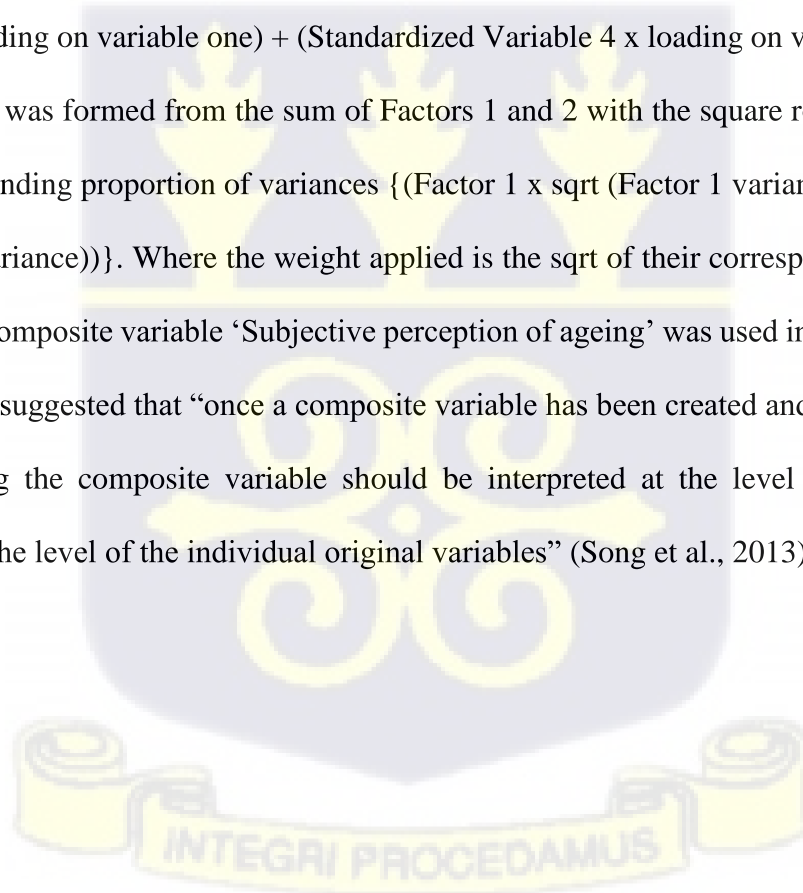

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Table 3.3: Items for subjective perception of ageing

Items- 26 **Cronbach's Alpha- 0.803**	**Items- 18** **Cronbach's Alpha- 0.904**	**Reliability test after EFA** **Items- 7** **Cronbach's Alpha- 0.846**
Blindness	Any eye defect	Strange behaviour
Any eye defect	Difficulty in hearing	Shouts
Difficulty in hearing Deafness	Strange behaviour Curses	Rude Talks to self
Hearing and vision impairment not related to ageing and disability	Shouts	Quarrelsome Gets lost Returns to old issues
Short and smallish people age without disability	Rude Talks to self Quarrelsome	
People ageing without disability give advice	Mind turns into a child Rate of thinking slows	
Strange `behaviour	Memory loss	
Curses	Gets lost	
Shouts	Pains	
Rude	White hair	
Talks to self	Hair loss	
Quarrelsome	Returns to old issues	
Mind turns into a child	Any change during old age	
Rate of thinking slows	Short and smallish people	
Memory loss	age without a disability	
Gets lost		
Pains		
White hair		
Hair loss		
Amputated limb		
Returns to old issues		
Disability in ageing is not possible		
Everyone gets disability during ageing		
Any change during ageing is a disability		
If not from birth not disability		

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3.11.3 Medical factors

The variables that made up medical factors were obtained from the qualitative study and comprised of 33 items. Medical factors represents body functions (includes psychological functions), body structures such as organs, limbs, and their components, life activities, and participation (Üstün et al., 2010; World Health Organization, 2007). Medical factors therefore is made up of Cognition-understanding and communicating, Mobility- moving and getting around, self-care, Getting along-interacting with other people, Life activities- domestic responsibilities, leisure, school, and work, and Participation- joining community activities and participating in society (Üstün et al., 2010). This definition was adopted from Üstün et al. (2010) and World Health Organization (2007) although the WHODAS 2.0 was meant to evaluate/assess disability presence and not conceptualization as it is used in this study.

The variables were tested at the quantitative phase of this study. A reliability test on the 33 items in the quantitative data yielded a Cronbach's Alpha of 0.927. The items covered diseases, self-care, life activities, mobility impairment, and capacity changes. Seven (7) items were removed because of negative inter-item correlations matrix. These items include recovered from disease, cannot brush teeth, has to be carried, uses wheelchair, measles, leprosy, and paralysis. The 26 remaining items had a Cronbach's Alpha of 0.935.

Items were grouped based on the concepts such as items related to self-care were put together and EFA run on them, and others were added gradually. Items that yielded negative results when added or are suggested by MSA to be removed were taken out. Consequently 11 items were removed from the 26 and EFA was run on 15 items.

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Procedures applied in the EFA by FACTOR on the 175 participants include Parallel Analysis, Polychoric correlation analysis for dispersion matrix, diagonally weighted least squares was used for factor extraction, and Promax was used for factor rotation. Two factors were rotated, and Factor 1 had three factor loadings while Factor 2 had twelve factor loadings. Tables 3.4, 3.5, 3.6, and 3.7 displays the results.

Table 3.4: Adequacy of the polychoric correlation matrix

Components	Value
Determinant of the matrix	< 0.000001
Bartlett's statistic	1936.1
Degree of freedom	105
P value	0.000010
Kaiser-Meyer-Olkin (KMO) test	0.93880 (very good)
Bootstrap 95 percent confidence interval of KMO	(0.941 0.949)

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Table 3.5: Rotated loading matrix

Variable	Factor 1	Factor 2	Communality
Sits to bath		0.869	0.574
Cannot bath		0.703	0.600
Cannot feed		0.854	0.792
Being cared for		0.946	0.872
Assisted to washroom		0.898	0.916
Inability to do laundry		0.846	0.706
Cannot cook		0.879	0.859
Cannot sweep		0.804	0.692
Cannot farm		0.986	0.919
Cannot fetch water		0.988	0.966
Being assisted		0.915	0.865
Rests between walks		0.683	0.530
Cannot lift hand	1.007		0.884
Limps	0.780		0.720
Has to be carried	0.508		0.373

Table 3.6: Explained variance of rotated factors and reliability of Phi-information oblique EAP scores

Factor	Variance	Factor Determinacy Index	Dimensions
1	2.065	0.961	1
2	9.203	0.994	

A scale, 'medical factors' was created from the 14 of the 15 variables through weighting. 'Cannot lift hand' was excluded from Factor 1 due to its factor loading of 1.007 which is greater than the acceptable loading of '1.' This error could not be rectified so the variable was omitted. The same

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method for the computation of the composite variable 'Subjective perception of ageing' previously described was used to compute the composite variable 'medical factors.' The composite variable 'medical factors' was used in the interpretation of analysis. It is suggested that "once a composite variable has been created and used in analyses, results involving the composite variable should be interpreted at the level of the composite variable, not at the level of the individual original variables" (Song et al., 2013). The Cronbach's alpha for the 14 variables that make up the scale was 0.948.

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Table 3.7: Items for medical factors

Items- 33 Cronbach's Alpha- 0.927	Items- 26 Cronbach's Alpha- 0.935	Reliability test after EFA Items- 15 Cronbach's Alpha- 0.946
Hypertension (cause)	Hypertension (cause)	Sits to bath
Stroke (cause)	Stroke (cause)	Cannot bath
Eye disease (cause)	Eye disease (cause)	Cannot drink or feed self
Diabetes (cause)	Diabetes (cause)	Being cared for
Has a disease	Has a disease	Assisted to washroom
Recovered from disease	Limps	Inability to do laundry
Cannot brush teeth	Uses stick	Inability to cook
Sits to bath	Sits to bath	Cannot sweep
Cannot bath	Cannot bath	Inability to farm
Cannot drink or feed self	Cannot drink or feed self	Inability to fetch water
Being cared for	Being cared for	Being assisted
Assisted to washroom	Assisted to washroom	Rests between walks
Inability to do laundry	Inability to do laundry	Limps
Inability to cook	Inability to cook	Has to be carried
Sits to cook	Sits to cook	Cannot lift hand
Inability to sweep	Inability to sweep	
Inability to farm	Inability to farm	
Inability to fetch water	Inability to fetch water	
Being assisted	Being assisted	
Speed in activities reduces	Speed in activities reduces	
Cannot do previous activities	Cannot do previous activities	
Stuck at one place	Stuck at one place	
Has to be carried	Cannot lift hand	
Rests between walks	Rests between walks	
Uses stick	Inability to perform social function	
Cannot lift hand	Inability to engage in social	
Limps	activities	
Uses wheelchair		
Inability to engage in social activities		
Inability to perform social function		
Measles (cause)		
Paralysis (cause)		
Leprosy (cause)		

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3.11.4 Contextual factors

Contextual factors are made up of personal and environmental components (Üstün et al., 2010). The environmental aspect is the physical, social, and attitudinal environment in which the individual resides and carries his/her life (WHO, 2001a; Üstün et al., 2010; World Health Organization, 2007). Environmental factors include other people in different relationships and roles, attitudes and values, social systems and services, and physical world and structures (WHO, 2001a). Personal factors constitute the background of a person's life and living such as gender, age, coping styles, past and current life experiences, individual psychological assets, social status, habits, and overall behaviour pattern (WHO, 2001a).

Contextual factors in this study covered religious beliefs, cultural beliefs, influence of media, school, personal experience, experience with others, expectation of ageing, fear, lineage (hereditary), and witchcraft accusation and how it influences conceptualization of ageing and disability. Items under expectation of future ageing, why there is no fear of ageing, why older adults are accused of witchcraft, and why witchcraft accusation causes ageing with disability were excluded in the analysis.

Forty-six items were extracted from the qualitative data and tested at the quantitative phase of the study. A reliability test was done on 46 items in the quantitative data that yielded a Cronbach's Alpha of -0.029. The value was negative due to a negative average covariance among the items, and this is said to violate reliability model assumptions. A total of 23 items that caused negative inter-item correlation matrix were removed. A reliability test on the remaining 23 items resulted in a Cronbach's Alpha of 0.782. Seven (7) items that had negative inter-item correlation matrices

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were deleted and the 16 remaining items had a Cronbach's Alpha of 0.851. Thirteen items were retained after the EFA, and this yielded a Cronbach's alpha of 0.863.

Procedures applied in the EFA by FACTOR on the 175 participants include Parallel Analysis, Polychoric correlation analysis for dispersion matrix, diagonally weighted least squares which was used for factor extraction, and Promax which was used for factor rotation. Two factors were rotated, and Factor 1 had three factor loadings while Factor 2 had twelve factor loadings. Tables 3.8, 3.9, 3.10, and 3.11 displays the results.

Table 3.8: Adequacy of the polychoric correlation matrix

Components	Value
Determinant of the matrix	< 0.000001
Bartlett's statistic	1943.8
Degree of freedom	78
P value	0.000010
Kaiser-Meyer-Olkin (KMO) test	0.88917 (good)
Bootstrap 95 percent confidence interval of KMO	(0.868 0.940)

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Table 3.9: Rotated loading matrix

Variable	Factor 1	Factor 2	Communality
Fear of witchcraft accusations		0.646	0.496
God ordained ageing with disability		0.591	0.276
Lived with older adults	0.901		0.664
Parents			0.250
Other family members		0.479	0.419
Personal experience	0.619		0.441
Personal growth		0.911	0.615
Fear of inability to perform life activities		0.986	0.905
Fear of mobility challenges		0.929	0.802
Fear of diseases	0.400	0.583	0.775
Fear of inability to perform self-care		0.887	0.751
Fear of excessive talking		0.638	0.541
Fear of disability		0.690	0.702

Table 3.10 Explained variance of rotated factors and reliability of Phi-information oblique EAP scores

Factor	Variance	Factor Determinacy Index	Dimensions
1	1.748	0.913	1
2	5.889	0.981	

A scale, 'Contextual factors' was created from the 11 variables through a weighted sum. The variables 'Parents' and 'fear of diseases' was excluded from the composite variable due to no factor loading and cross loading of more than 0.3 on both factors respectively. Other procedures were used to attempt to rectify 'parents' but yielded results that produced multiple cross loadings

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on both Factors 1 and 2. 'Parents' was therefore omitted from the composite analysis. The same procedure used for computation of the composite variable 'Subjective perception of ageing' was used to compute the composite variable 'Contextual factors.' The composite variable 'Contextual factors' was used in the interpretation of analysis. It is suggested that "once a composite variable has been created and used in analyses, results involving the composite variable should be interpreted at the level of the composite variable, not at the level of the individual original variables" (Song et al., 2013). The reliability analysis of the 11-item scale yielded a Cronbach's alpha of 0.848.

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Table 3.11: Items for Contextual Factors

Items- 23 **Cronbach's Alpha- 0.782**	**Items- 16** **Cronbach's Alpha- 0.851**	**Reliability test after EFA** **Items- 13** **Cronbach's Alpha- 0.863**
Religious teaching	Lived with older adults	Lived with older adults
Influenced by God	Took care of older adults	Fear of disability
Radio	Parents	Parents
Social media	Grandparents	Fear of diseases
Some cases run in families	Other members of the family	Other members of the family
Lived with older adults	God ordained ageing with disability	God ordained ageing with disability
Informed by older adults	Fear of disability	Fear of excessive talking
Took care of older adults	Personal experience	Personal experience
From parents	Through growth	Through growth
From grandparents	Fear of diseases	Fear of witchcraft accusations
From other members of the family	Fear of mobility challenges	Fear of mobility challenges
God ordained ageing with disability	Fear of inability to perform life activities	Fear of inability to perform life activities
Ageing with disability is related to morality/works/acts	Ageing with disability is related to orality/works/acts Fear of inability to perform selfcare	Fear of inability to perform self-care
Personal experience	Fear of excessive talking	
Through growth	Fear of witchcraft accusations	
Fear of inability to perform life activities		
Fear of mobility challenges		
Fear of diseases		
Fear of inability to perform self-care		
Fear of excessive talking		
Fear of disability		
Fear of witchcraft accusations		
Fear of death		

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3.11.5 Independent variable

The key independent variable is 'Age' and was measured as 20-39 = 1 (young), 40-59 = 2 (middle-aged), and 60 and above = 3 (older adults).

3.11.6 Other independent variables

Other independent variables include sex, ethnic group, religious affiliation, marital status, school attendance, highest level of schooling, and engagement in economic activity. These variables were measured using the Ghana Statistical Service 2021 Census Questionnaire and Manual (Ghana Statistical Service, 2021; Ghana Statistical Service, 2021). The remaining independent variables comprise of children ever born alive, perceived wealth status, ever lived with older adult, and whether the older adult had a disability or not. The sociodemographic variables and their respective categories are presented in Table 3.12.

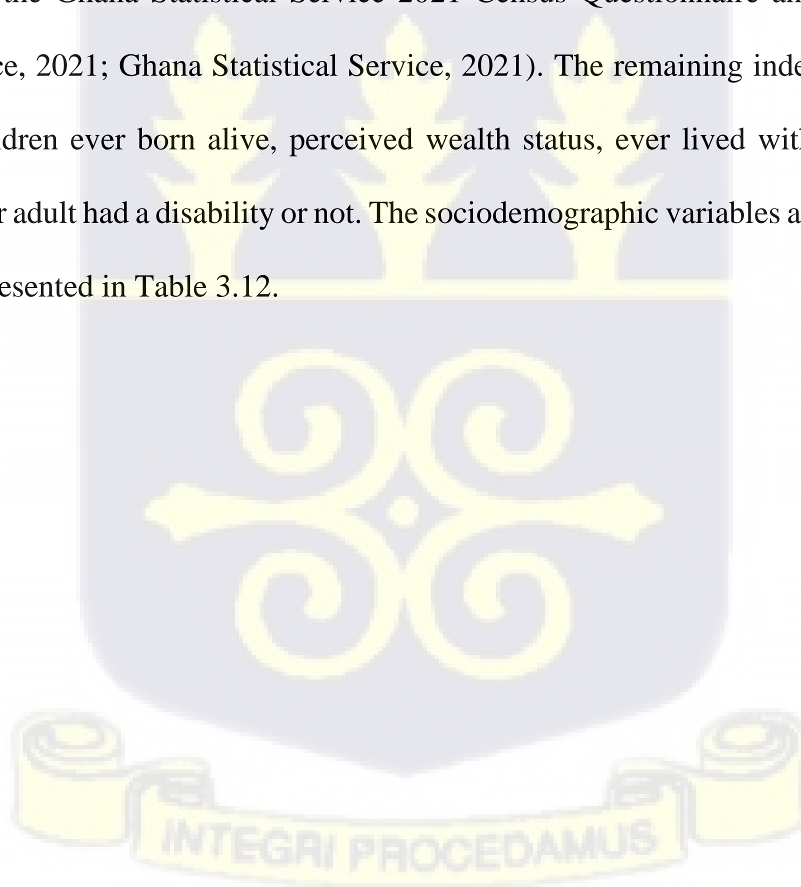

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Table 3.12: Socio-demographic variables

Variable	Categories
Sex	Male, Female
Ethnic group	Akan, Ga-Dangme, Ewe, Guan, Gurma, Mole-Dagbani, Grusi, Made, All others.
Religious affiliation	Catholic, Protestant (Anglican, Lutheran, Presbyterian, Methodist, Adventist, Baptist), Pentecostal/Charismatic, Other Christian, Islam, Ahmadi, Traditionalist, No religion, Other.
Marital Status	Informal/living together, Married (Civil/Ordinance), Married (Customary/Traditional), Married (Islamic), Married (other type), Separated, Divorced, Widowed, Never married.
Education	Never attended, Attending now, Attended in the past.
Highest level of education	Nursery, Kindergarten, Primary, JSS/JHS, Middle, SSS/SHS, Secondary, Vocational/technical/commercial, Post middle/secondary certificate, Post middle/secondary diploma, Tertiary – HND, Tertiary – Bachelor's Degree, Tertiary – Postgraduate Certificate/Diploma, Tertiary – Master's Degree, Tertiary – PhD, Other.
Economic activity engagement	No, Yes, work for profit on own/family business, Yes, engaged in economic activity but receives no pay/profit, Yes, works in agricultural activity, Yes, Wage/salary/profit work, Paid apprentice work, Unpaid apprentice work, Voluntary work without pay, Voluntary work with pay, Own production/service work.
Children ever born alive	None, 1, 2, 3, 4, 5 or more.
Perceived wealth status	Poorest, Poorer, Middle, Richer, Richest.
Ever live with older adult	1= Yes, 2= No.
Older adult lived with had disability	1= Yes, 2= No.
Respondent has disability	1= Yes, 2= No.

3.12 Data management

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The researcher is the only person who has access to the qualitative interviews, transcripts, and the survey responses. The quantitative data on the responses of the participants were extracted from Kobo Toolbox in SPSS Statistics Syntax and Excel format and imported to SPSS. The responses of each respondent were examined for completeness. Data cleaning was completed in 6 weeks.

3.12.1 Coding and recoding

Coding of socio-demographic variables followed the format of the Ghana Statistical Service 2021 Census Questionnaire and Manual (Ghana statistical service, 2021; Ghana statistical service, 2021). The coding of the remaining variables was done in relation to statistical reasons. Ethnic group, Religious affiliation, Marital status, Highest educational level, Engagement in economic activity, Children ever born alive, and Perceived wealth status were recoded before analysis. This was done because the sample counts were too small for analysis. The ordinal categories that had 5 levels were collapsed to 3 levels. These include variables under cognition, variables under possibility of ageing with disability, and causes of ageing with disability. The 5 levels were collapsed to 3 levels because they were sparse and to improve on unidimensionality. Strongly agreed was collapsed to agree and strongly disagree to disagree and reverse coded whereby '1' for Agree was recoded to '3' and '3' for disagree recoded to '1.' According to a study by Distefano et al. (2021) it was observed that collapsing categories (from Likert scales) were advantageous for unweighted least squares (ULSMV) and weighted least squares (WLSMV). It generated higher convergence rates that were more precise estimation of parameters and standard errors, and chi-square test rejection rates was close to the nominal level (Distefano et al., 2021). Analysis of items was done in the EFA using both unweighted and weighted least squares. For the multiple-choice

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questions selected items were coded as '1' while those not selected were coded as '0.' Recoding was done whereby '1' was recoded to '3' and '0' recoded to '1' to take on the highest and lowest level codes of the ordinal variables. This was also necessary for unidimensionality and to improve the Cronbach's Alpha results of each scale. Table 3.13 presents the coded and recoded variables.

Table 3.13: Coded and recoded variables

Variables	Measures	Categories Recoded
Highest level of education	1= Nursery 2= Kindergarten 3= Primary 4= JSS/JHS 5= Middle 6= SSS/SHS 7= Secondary 8= Vo/technical/commercial 9= Post middle/secondary certificate 10= Post middle/secondary diploma 11= Tertiary-HND 12=Tertiary-Postgraduate ertificate/Diploma 13= Tertiary-Master's degree 14= Tertiary-PhD 15= Other	0 = Never attended 1 = JHS/Middle or lower 2 = SHS or higher
Ethnic group	1= Akan 2= Ga-Dangme 3= Ewe 4= Guan 5= Gurma 6= Mole-Dagbani 7= Grusi 8= Made 9= All Others	1= Ga-Dangme 2= All others
Religious Affiliation	1= Catholic 2= Protestant (Anglican, Lutheran, Presbyterian, Methodist, Adventist, Baptist) 3= Pentecostal/Charismatic 4= Other Christian 5= Islam 6= Ahmadi	1= Christianity 2= Islam 3= No religion

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	7= Traditionalist 8= No religion 9= Other	
Variables	**Measures**	**Categories Recoded**
Marital Status	1= Informal/living together 2= Married (Civil/Ordinance) 3=Married (Customary/Traditional) 4= Married (Islamic) 5= Married (other type) 6= Separated 7= Divorced 8= Widowed 9= Never married	1= In union/currently married 2=Separated/Divorced/Widowed 3= Never married
Economic activity engagement	1= No 2= Yes, work for profit on own/family business 3= Yes, engaged in economic activity but receives no pay/profit 4= Yes, works in agricultural activity 5= Yes, Wage/salary/profit work 6= Paid apprentice work 7= Unpaid apprentice work 8= Voluntary work without pay 9= Voluntary work with pay 10= Own production/service work	1= Not engaged in any economic activity 2= Engaged in economic activity with pay 3= Engaged in economic activity with no pay
Children ever born	1= None 2= 1 3= 2 4= 3 5= 4 6= 5 or more	1= None 2= 1 or more children
Perceived wealth status	1= Poorest 2= Poorer 3= Middle 4= Richer 5= Richest	1= Poor 2= Middle 3= Rich

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3.13 Data Analysis

3.13.1 Qualitative data analysis

For the qualitative case study data analysis was ongoing with data collection. ATLAS.ti 9 was used in the organization of data and analysis. A case study database was created with interview recordings, transcripts, field notes, reports, and the researcher's reflective memos. These were brought together to make data ready for analysis. The researcher familiarized herself with the interviews and transcripts throughout the process of analysis. Recorded audio interviews mostly in Dangme with a few in Twi and English were transcribed. Confirmation of transcription was done with another person whose native language is Dangme for validation.

Constant comparative analysis (Glaser, 1965) was used to analyse the data. Constant comparison was carried out with the interviews and transcripts. Memos were written on patterns observed. The first stage of constant comparative analysis involved open coding. Information in the transcripts were broken into incidents. Codes were applied inductively by comparing incidents applicable to each category. In vivo coding was also done at this stage whereby participants statements were used as codes to represent true meaning of the codes. The codes were re-examined with quotations anytime new ones are added to see similarities and differences. New codes therefore were compared with previous ones before further coding was done. Codes that were previously applied that did not represent the statements were deleted. Some codes that had close or the same meaning were merged into one. Codes that had many elements were split and recategorized to create subcodes. Axial coding was done at the second stage by creating categories to connect the codes. Comparing similarities and differences helped to create theoretical features of the categories.

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The third stage entailed integrating categories and their properties. This was done through comparing properties of the categories that had the same meaning and putting them under specific themes. Categories under those themes were constantly or continuously examined to ensure they reflect or align to the meaning of the theme. Categories that had different meaning to the theme or did not represent it were removed or reviewed. New categories were also added which applied to the themes. Some of the themes were split into sub-themes. Some other themes were split or renamed when re-examination showed it had different meaning from the categories or did not fully represent their core meaning. Diverse properties of the themes were also integrated with other themes through constant comparison. Relations between themes were made. Broader themes were created from the various themes through integration. How conceptualization is done by the participants was demonstrated as the themes were integrated with others. The next stage involved fewer major modifications of the themes. Modifications were based on logical clarity where non-relevant properties were paired off and interrelated themes were put under major ones. The final stage involved writing out the findings. Discussions in memo and researcher journal guided the process. This helped in understanding how various concepts make up conceptualization and how to use the results generated to develop an instrument for the quantitative study. The case analysis was done holistically instead of reporting on individual participants. Case themes were generated, and descriptions made based on the case.

3.13.2 Quantitative data analysis

Statistical Package for Social Science (SPSS version 22) was used for the quantitative data analysis and FACTOR 12.02.01 for the Exploratory Factor Analysis. Univariate analysis was done using

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descriptive statistics such as frequencies, percentages, sample mean, and standard deviation. Descriptive statistics were used to present the socio-demographic variables. At the bivariate level, One-way ANOVA and independent samples t-test were used to test the differences in the scales (composite variables) and the mean scores of the socio-demographic variables. Linear regression was used at the multivariate level to examine the relationships between the socio-demographic variables and the three scales.

3.14 Ethical consideration

Ethical clearance for the study was sought from the Ethics Committee for the Humanities, University of Ghana. Permission was also obtained from the Shai Osudoku district office to conduct the study in the district. Consent was obtained from the respondents aged 20 years and above. Participants were also informed about anonymity and their right to withdraw from the study at any point. The data on the participants does not have identifications that could reveal who they are. The researcher wore face mask and gave same to the participants to prevent the transmission of the COVID-19 virus since this study was conducted during the period of the COVID-19 pandemic. Social distancing was also ensured.

3.15 Limitations of the study

This study was conducted at an urban community whose characteristics may be different from that of people who live in rural communities. Rural-urban differentials have been identified in experiences, perceptions, and self-perceptions in ageing and health-related quality for instance

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(Hou et al., 2020; Fast & de Jong Gierveld, 2008; Chow & Bai, 2011). This suggests that the findings in this study may be different from that from a rural community and may not reflect the conceptualization of ageing and disability by rural residents. Hence generalizations cannot be extended to rural communities.

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CHAPTER FOUR

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

4.0 Introduction

This chapter justifies the need to describe the socio-demographic characteristics to provide context for the data analysis and ensure the representativeness of the sample. The objective is to present a detailed overview of the participants' socio-demographic profiles and the results of the data collection. By providing this information, the chapter aims to set the stage for the subsequent analysis and discussion of the research findings.

4.1 Socio-demographic characteristics of the qualitative study participants

The participants for the qualitative study were 14, with 10 females and 4 males. Four (28.6 percent) of the participants were young adults (20-39 years), 7 (50 percent) were middle-aged adults (40-59 years), and the remaining 3 (21.4 percent) were older adults (60 years and above).

Regarding the highest educational level attained by the participants, only 1 (7.1 percent) had never attended school and 1 (7.1 percent) had primary education. Most (57.1 percent) of the respondents had Junior High School (JHS) education, while few (28.6 percent) had secondary school or higher education.

Half of the participants (50 percent) were married or in union, while the other half were separated, divorced, or widowed (28.6 percent) and have never married (21.4 percent). For religious affiliation, all the participants were affiliated with Christianity. Three (21.4 percent) of the participants had no children while the remaining 11 (78.6 percent) had one or more children.

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In relation to ethnic group, 13 of the respondents (93 percent) were Ga-Dangme while only 1 (7.1 percent) respondent was Akan. The majority of the respondents (64.3 percent) were engaged in an economic activity with pay while the remaining (35.7 percent) were not engaged in any economic activity. Also, most of the participants (78.6 percent) perceived their wealth status as middle while a few of them (21.4 percent) described their wealth status as poor. Twelve (85.7 percent) of the participants had ever lived with an older adult while 2 (14.3 percent) participants have never lived with an older adult. For those who lived with an older adult, 8 (57.1 percent) of the older adults they lived with had no disability while 4 (28.6 percent) of the older adults they lived with had a disability.

Respondents were also required to tell whether they had a disability or not. Two (14.3 percent) of the respondents had a disability while most (85.7 percent) of them had no disability. Table 4.1 presents the results.

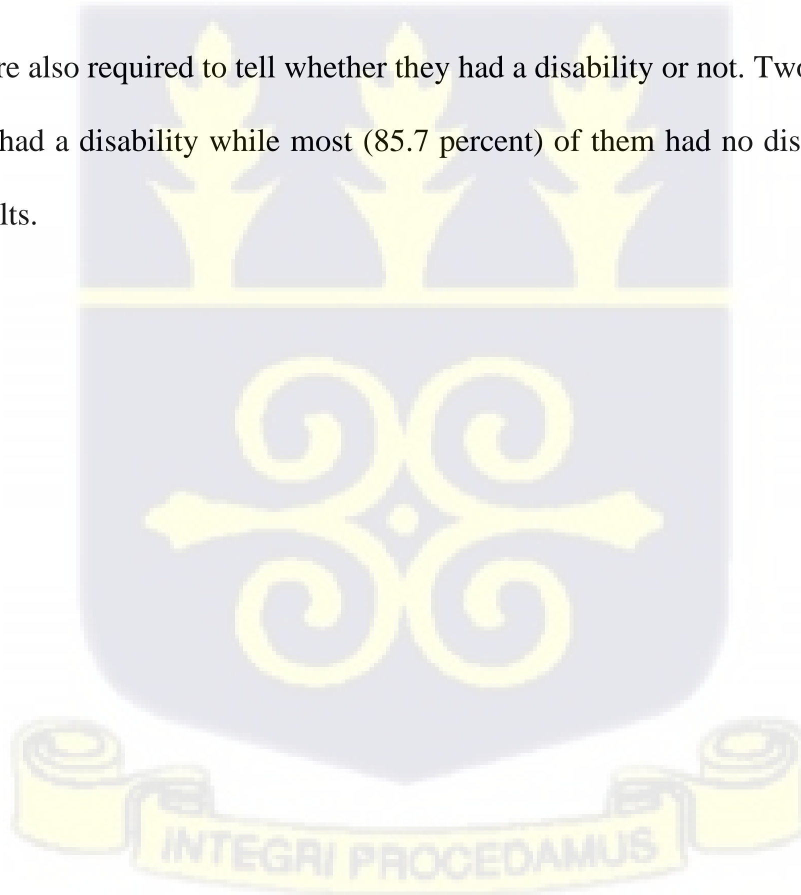

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Table 4.1: Percentage distribution of the socio-demographic characteristics of the participants in the qualitative study

Characteristics	N = 14, % = 100	Characteristics	N = 14, % = 100
Age		**Economic activity**	
20-39	28.6	No economic activity	35.7
40-59	50	Economic activity with pay	64.3
60 and above	21.4	Economic activity with no pay	-
Sex		**Ethic group**	
Male	28.6	Ga-Dangme	93
Female	71.4	All others	7
Educational level		**Perceived wealth status**	
Never attended school	7	Poor	21.4
JHS/Middle or lower	64	Middle	78.6
SHS or lower	29	Rich	-
Marital status		**Religious affiliation**	
In union/currently married	50	Christianity	100
Previously married	28.6	Islam	-
Never married	21.4	No religion	-
Lived with older adult		**Older adult had disability**	
Yes	85.7	Yes	28.6
No	14.3	No	57.1
Children ever born alive		**Respondent has disability**	
No children	21.4	No disability	85.7
1 or more children	78.6	Has disability	14.3

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4.2 Socio-demographic characteristics of the quantitative study participants

The total number of participants for the survey was 175. More than half (56.6 percent) of the respondents were females while the remaining (43.4 percent) of them were males. A little over 37 percent (37.7 percent) of the respondents were 20 to 39 years, 32.6 percent were ages 40 to 59 years, and the remaining 29.7 percent were 60 years and above.

The majority (86.3 percent) of the respondents attended school in the past while a few of them (11.4 percent) never attended school. Very few (2.3 percent) of the respondents are attending school now. Of the participants who attended school in the past or are currently attending, more than half of them (53.7 percent) had an educational level of Junior high school or below while the remaining (34.9 percent) had an educational level of Senior high school and above.

Thirty-two (32.0) percent of the respondents were married, 24.6 percent were never married, while 11.4 percent of them were in an informal union or living together. For participants who were previously married most of them (18.9 percent) were widowed, while the remaining were either divorced (7.4 percent) or separated (5.7 percent).

Most of the respondents (93.7 percent) were affiliated with Christianity, while only a few (4 percent) were affiliated to Islam and 2.3 percent had no religion. Regarding children ever born alive, 13.1 percent of the participants had no children, 15.4 percent had a child, 16.6 percent had 2 children, 14.3 percent had 3 children, 12.6 percent had 4 children, and 28.0 percent of the participants had 5 or more children. In all, 86.9 percent of them had 1 or more children while 13.1 percent of them had no children.

The majority (73.7 percent) of the respondents were Ga-Dangme while all other ethnic groups comprising of Akan, Ewe, Guan, Mole-Dagbani, Grusi, and all others were 26.3 percent. For

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economic activity engagement, 69.7 percent of the respondents were engaged in an economic activity with pay, 26.3 percent were not engaged in any economic activity, while the remaining 4.0 percent were engaged in an economic activity with no pay.

The results showed that more than half (59.4 percent) of the respondents perceived their wealth status to be middle, 36.6 percent of them perceived their wealth status to be poor, and 4.0 percent regarded their wealth status to be rich. Only a few (14.9 percent) of the participants have never lived with an older adult but the majority of them (85.1 percent) have lived with an older adult.

For the respondents who have ever lived with an older adult, most (64.0 percent) of them mentioned that the older adult they lived with did not have a disability while those who lived with an older adult with a disability were 20.0 percent. Out of the 175 respondents, the majority (84.6 percent) of them had no form of disability while the remaining 15.4 percent had a disability. Figure 4.1 displays the results.

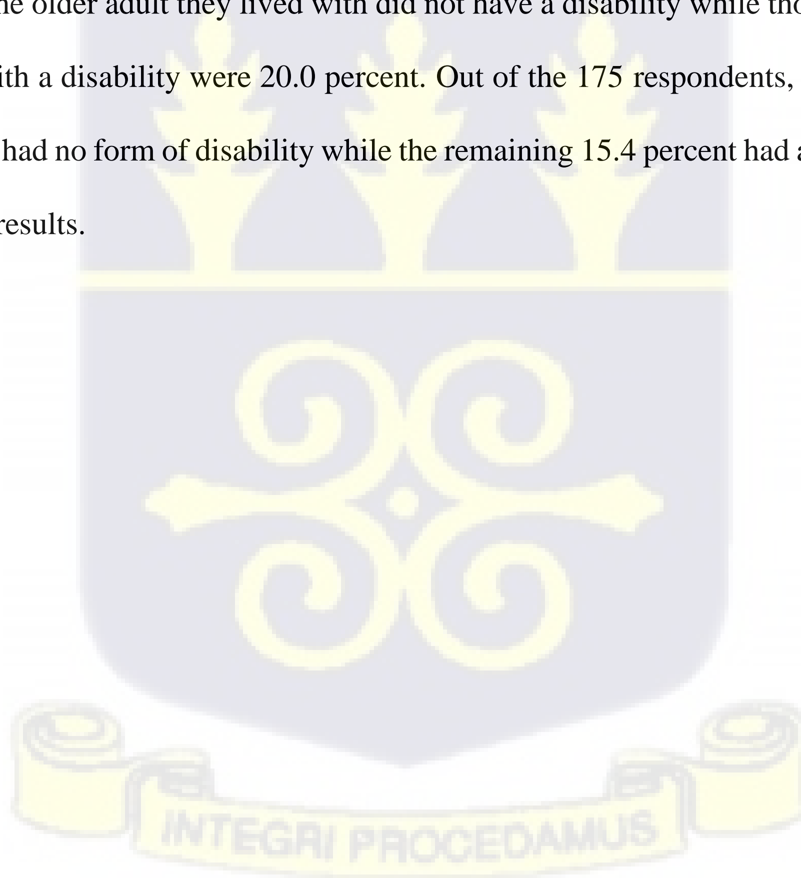

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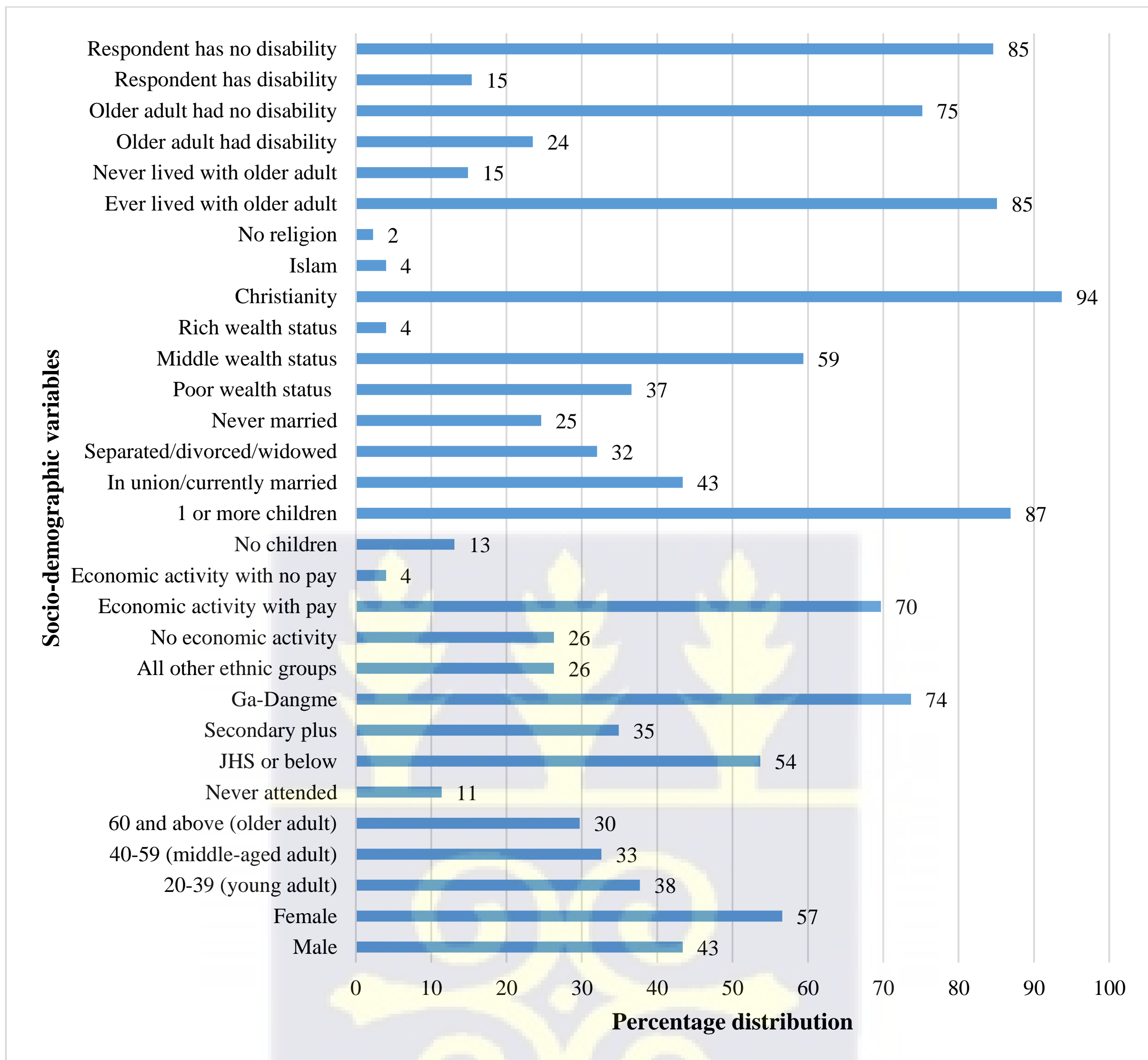
Figure 4.1: Socio-demographic characteristics of the quantitative study participants



4.3 Summary

This chapter described the socio-demographic characteristics of the respondents. It was observed from the findings of the study that most of the respondents were females. This finding is in consonance with the population characteristics of Shai Osudoku district. The district has more females (51.3 percent) than males (48.7). Young adults were slightly more than middle-aged adults

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and older adults. This reflects the population of the Shai Osudoku district (Ghana Statistical Service, 2014).

Most of the respondents in this study attained some level of education while only a few have never attended school. For the highest level of education, the majority of the respondents have Junior high school or below while the minority have Secondary or higher. This mirrors that of the educational level of people living in the Shai Osudoku district although the 2010 census results include people who are below 20 years. Only 9 percent of the population in the district have a secondary school or higher education while the majority have Junior high school and below (Ghana Statistical Service, 2014).

Regarding marriage, the majority of the respondents were married/in union or have been previously married while very few were never married. This also reflects the results of the 2010 Population and Housing Census where more than 50 percent of the population (25 to 64 years) were married. For religious affiliation and children ever born alive, an overwhelming majority were affiliated with Christianity and most of them had 1 or more children. The religious affiliation of people living in the Shai Osudoku district was mostly Christianity (89.6 percent) while a few are affiliated with Islam (7.6 percent). The religious background of the qualitative study participants, all being Christians, likely influenced their perceptions of ageing and disability through values of care giving, community support, and acceptance of ageing as part of a divine plan.

The majority of the respondents were Ga-Dangmes' while the remaining belonged to other ethnic groups. This was expected because the indigens of Dodowa are Ga-Dangmes'. A majority of the study participants were economically active. According to the 2010 population and Housing

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Census report, most people (69.2 percent) in Shai Osudoku district were economically active (Ghana Statistical Service, 2014). The majority of the respondents lived with an older adult, and this is reflective of the demographics of Dodowa and Shai Osudoku. The district has a high older adult population among its total population (Ghana Statistical Service, 2014). Of the older adults the respondents lived with, only a few of them had a disability and only a few of the respondents also had a disability. This is comparable to that of the district whereby only 2.6 percent of the entire population of the Shai Osudoku district have a form of disability (Ghana Statistical Service, 2014).

These sociodemographic variables are important in determining how these variables influence the conceptualization of ageing and disability by the respondents.

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CHAPTER FIVE

CONCEPTUALIZATION OF AGEING AND DISABILITY BASED ON SUBJECTIVE PERCEPTION OF AGEING

5.0 Introduction

Understanding how ageing and disability are conceptualized based on subjective perceptions is crucial for addressing the needs of different age groups. This chapter examines these perceptions to provide insights into how socio-demographic factors influence views on ageing and disability. The objective is to integrate the qualitative and quantitative study findings, highlighting themes from the qualitative data that informed the quantitative analysis.

This chapter covers the following key areas: Presentation of how study participants perceive ageing and disability based on their subjective perceptions; Integration of qualitative and quantitative findings; Use of constant comparative analysis to identify themes relevant to the quantitative study; Development of the subjective perception of ageing scale based on Cronbach's alpha analysis and EFA of the quantitative data; and Application of independent samples t-test and one-way ANOVA to explore differences in subjective perception of ageing by socio-demographic variables. The Games-Howell post hoc test was used for ANOVA to control Type I error for unequal group sizes (Sauder & Demars, 2019). The chapter also presents the use of linear regression to examine relationships between socio-demographic variables and the subjective perception of ageing scale.

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5.1 Subjective perception of ageing

The qualitative study explored factors that made up subjective perception of ageing among the participants. Themes that emerged from the data include cognition, physical attributes, sensory impairment, and possibility of disability during ageing. Figure 5.0 presents the themes and linkages with subjective perception of ageing and conceptualization of ageing and disability. The participants described issues in relation to the themes as either ageing with or without disability. The views of the participants amongst the three age groups showed more similarities than differences. Differences were mostly observed within age groups. For instance, touching on possibility of disability during ageing, one of the older adults believed that disability in ageing was not possible. However, the other two believed that disability in ageing was possible. Some young adults associated negative communication with ageing with disability, while others did not. While some middle-aged adults regarded cognitive decline as ageing with disability, others did not.

The findings suggested patterns related to the ageing process and process of ageing (WHO, 2001b). Some participants linked disability to non-ageing factors, like bad communication. The participants equated the ageing process to the process of ageing. Psychological ageing was also evident on how the participants described issues related to the mind of the older adult.

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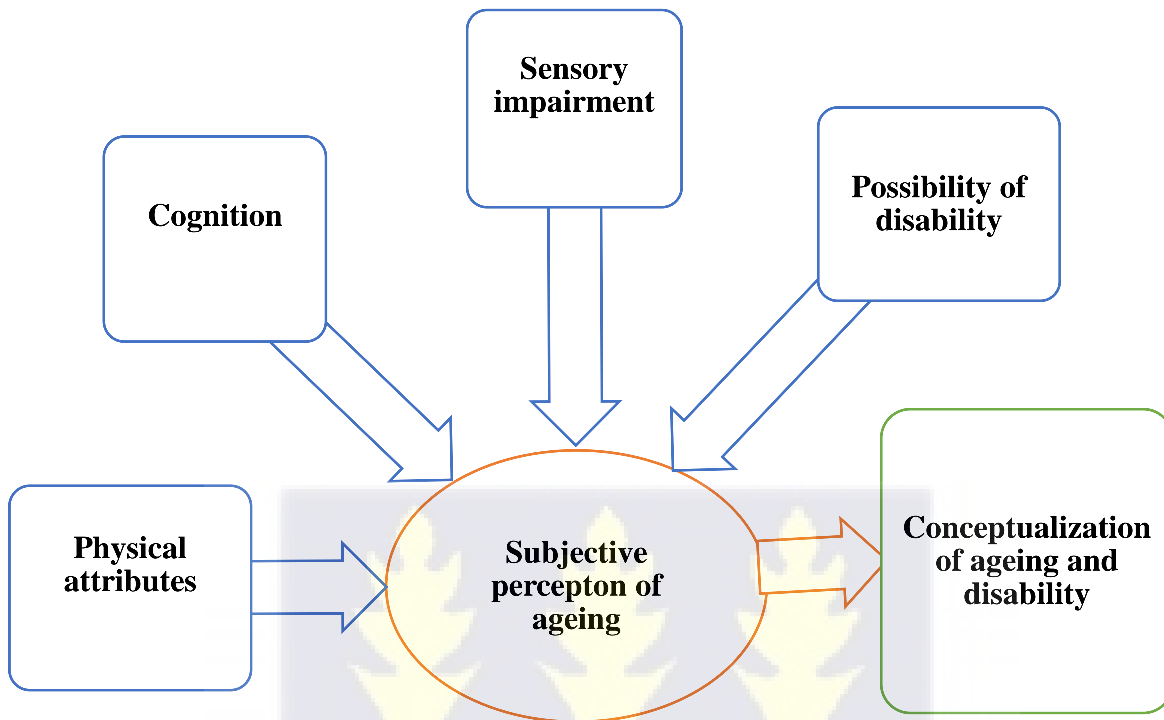
Figure 5.0: Thematic representation of conceptualization of ageing and disability based on subjective perception of ageing



5.2 Cognition

Cognition had two categories namely communication and cognitive attributes. Table 5.1 presents the theme with its associated categories and corresponding codes. Communication comprises both verbal and non-verbal behavioural characteristics while cognitive attributes relate to the mind. Negative communication was associated with both disability and without disability while positive communication was associated with ageing without disability. These patterns were similar among young, middle-aged, and older adults. Some differences were observed within age groups, such as that among the middle-aged adults. Talking excessively was viewed as disability in ageing by some middle-aged adults, but not by others. Being worrisome or quarrelsome were also viewed as typical in ageing individuals.

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Table 5.1: Conceptualization of ageing and disability based on cognition

Theme	Category	Sub-category	Codes	Conceptualization
Cognition	Communication	Negative communication	Cursing, insults, rudeness, strange behaviour, inability to speak, ignoring known faces, shouting, talks to self, talks like a child, unsound conversation, and excessive talking.	Ageing is with disability
			Repetition of issues, excessive talking, talks to self, unsound conversation, untoward behaviour, and inability to speak.	Ageing is without disability
		Positive communication	Expresses gratitude, gives advice, talks nicely, and admits faults	Ageing is without disability
	Cognitive attributes		Memory loss, gets lost, untoward things, unpleasant talk, thinks about bad things, engages in conversation uninvited, deny things done for them, rate of thinking slows, and mind turns into child.	Ageing is with disability
			Unyielding, talks to self, pick things from ground, excessive thinking, insults, accuse people of insulting them, memory loss, defect in behaviour, returns to old issues, upsets others, mind turns into child, sobs often, and repeats the same things.	Ageing is without disability

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Cognitive attributes were conceptualized as ageing with or without disability. These are displayed in Table 5.1. Some attributes, such as mind turns into a child, were viewed as ageing with or without disability by different participants. Another pattern under cognitive attributes was the incidence of cognitive decline during ageing. Cognitive decline was viewed differently by different individuals. Some felt it affects everyone, while others did not think so. The cause of cognitive decline or changes in ageing were regarded as being from God, poverty, lineage, and excessive thinking, for instance. While some participants viewed cognitive changes as ageing with disability, others did not. Different views in cognitive attributes were not observed for different age groups, but within age groups. Some middle-aged and older adults believe cognitive decline is a disability that comes with ageing, while others did not see it that way. Here are some statements from participants who did not see communication problems as ageing with a disability:

Case 1

> *For communication there is someone who from childhood speaks little and she grew old with it and there are others who talk a lot and grow with it. My grandmother shouts when she is speaking to you. It is nothing bad, but it is because of her being old. Someone also speaks slowly. Every ageing and what it comes with. Some is dependent on how her mother trained her from childhood and it becomes a part of her. You see a Christian will be trained as a Christian and will grow as a Christian. That is the same way. That is how she was trained. No, it is not a disability. For disability we have one from the earth and one from God. If you were born with it, then it is from God but if you got it from the earth then it is from you.* (30 years male young adult).

Case 2

> *No, you cannot have a disability with communication. For communication there is someone who talks excessively. And there is another who does so because of menopause. She talks to herself when no one is talking to her. She talks while walking. If she gets a hold an issue, she will keep talking about it till after three days before she stops talking about it.* (51 years female middle-aged adult).

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Case 1 felt communication does not change in ageing, while case 2 believed communication cannot be linked to disability. Communication, a category of cognition, is embedded in medical factors in the conceptual framework. Such cognition feature is conceptualized as ageing without disability. This is how some participants who perceived communication issues as ageing with disability described it.

Case 1

> *Yes, if it affects your speech and you can't even say meaningful things then there is a problem with your talking* (22 years female young adult).

Case 2

> *As for that before you can tell that this one has a disability or not, it is just like our character. Like this child is disrespectful or this child is respectful so you can tell this is a disability and this is not a disability. One person talks a lot and curses, insults people badly. But another likes to advise them like her children* (65 years old female old adult).

Cases 1 and 2 considered changes in communication as ageing with disability. They strike a difference between ageing with disability and ageing without disability. They connected negative and positive characteristics with disability and without disability, respectively. These participants' views reflect that of the medical model of disability.

Views of the participants on cognitive attributes are demonstrated in the following quotations:

Case 1

> *It gets to a stage that the person is ageing when his mind turns to that of a child. It turns into a child's mind. It could be that the person is old, you put food in this bowl for her to*

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> *eat. In attempt to wash her hands before eating she will pour the food into a chamber pot/pail and start eating from it"* (51 years old female middle-aged adult).

Case 2

> *Disability as I know is someone who has had an accident like my aunt. That is also one type. You know someone may be sick and it affects his mind. For such people they can do things that are unnecessary. Excuse me to say as I used my grandmother as an example. Someone may be there you may be having a conversation that does not involve her, but she will involve herself in the conversation and say things she is not supposed to say. She takes over an issue that does not concern her. When she wakes up in the morning she will talk and say things she is not supposed to say. Or talk about unnecessary things. That is also another type. For another it is said that she was born with it. When she was born, she was like that. She was a sick person. That type can bring a lot of problems. For all the types what I will say is that the person living with her need patience for such people"* (54 years female middle-aged adult).

These statements reflect changes that most of them perceived as changes that people experience during ageing. These cognitive attributes were mostly related to ageing with disability by most of them. This study's findings are comparable to the findings of previous studies. A study by Reichstadt et al. (2010) revealed that having a positive attitude was related to successful ageing among older adults. It may explain why some older adults in this study related a negative behaviour, such as 'rude' to ageing with disability. Stordal et al. (2012) in a study observed that decline in cognition especially in episodic memory functions were regarded as normal ageing while a good cognitive function was viewed as successful ageing. In this study 'memory loss' and 'gets lost' which may be related to decline in episodic memory function were viewed as ageing with disability. Perceived disability by older adults was related to cognitive impairment (Kelley-Moore et al., 2006). In a study by Laditka et al. (2009) ageing well was related to no cognitive malfunction and good memory. Older adults in a study by Iwamasa & Iwasaki (2011) considered good cognitive function as ageing successfully. These are patterns that were observed in this study.

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This demonstrates that cognition features such as communication and cognitive decline are important factors that determine how the participants conceptualized ageing and disability.

5.3 Physical attributes

Physical attributes were related to ageing with or without disability. These views were not different among the young, middle-aged, and older adults in the study. Table 5.2 displays the findings.

Table 5.2: Conceptualization of ageing and disability based on physical attributes

Theme	Category	Codes	Conceptualization
Physical Attributes	Physical attributes Related to ageing with disability	Pains, weakness, white hair, loss of hair, broken limb, amputated limb, loss of limb, old with deformity, head shaking, waist problem, and back and knee problem.	Ageing is with disability
	Physical attributes Related to ageing without disability	Strong, reduced strength, goes and comes, short and small, and weakness.	Ageing is without disability

The perception of physical change influenced how the participants regarded such during ageing. A young adult aptly noted:

Case 1

> *Disability is when you age a little, your knees, your side, and your entire body starts hurting. And while your hair used to be fresh, you start losing your hair and it turns white* (30 years old female young adult).

Another explained:

Case 2

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> *Okay let's assume I take two older adults and at the age of 45, at the age of 50 for both of them. One person gets a waist problem at 50 and takes that waist problem from there. The person tries taking drugs, but it doesn't still work, and the waist starts going down and down and down and he or she attain the age of 80, the person is ageing with a disability* (22 years old female young adult).

The views of others indicate that ageing may not be with disability under some circumstances such as body structure:

Case 3

> *Those who age without a disability are the short and smallish people. For them as they age, they can still walk but if you are big and tall you can deform at any time. They do not have a disability because their bodies are very smallish, and they are very short. They are able to do everything* (30 years female young adult).

While case 1 linked pains to disability, case 2 linked inability to recover from ill health to disability. Case 3 attributed a huge body physique to ageing with disability. Ageing with disability, thus according to the participant, is related to how big or small the older adult is. These conceptualizations reflect that of the medical model of disability. The presence of physical impairment (under impairment) thus, in the conceptual framework, is conceptualized as ageing with disability.

An ageing body has been associated with pains (Wainwright & Turner, 2006). Teems (2016) also observed that among older adults' conceptualization of ageing was dependent on pains. In another study by Burke et al. (2014) middle-aged adults associated ageing with pains. Nantomah (2019) also showed that people perceived that older adults with disability have pains. For grey hair (white hair), most respondents in all the age groups considered it as ageing without disability. van der Geest (1998) showed that grey hair was not considered as a sign of ageing although according to Dosu (2014) and Lifshitz (2002) participants related old age with white hair. Burke et al. (2014) also observed that middle-aged adults associated grey hair to ageing. The participants in a study

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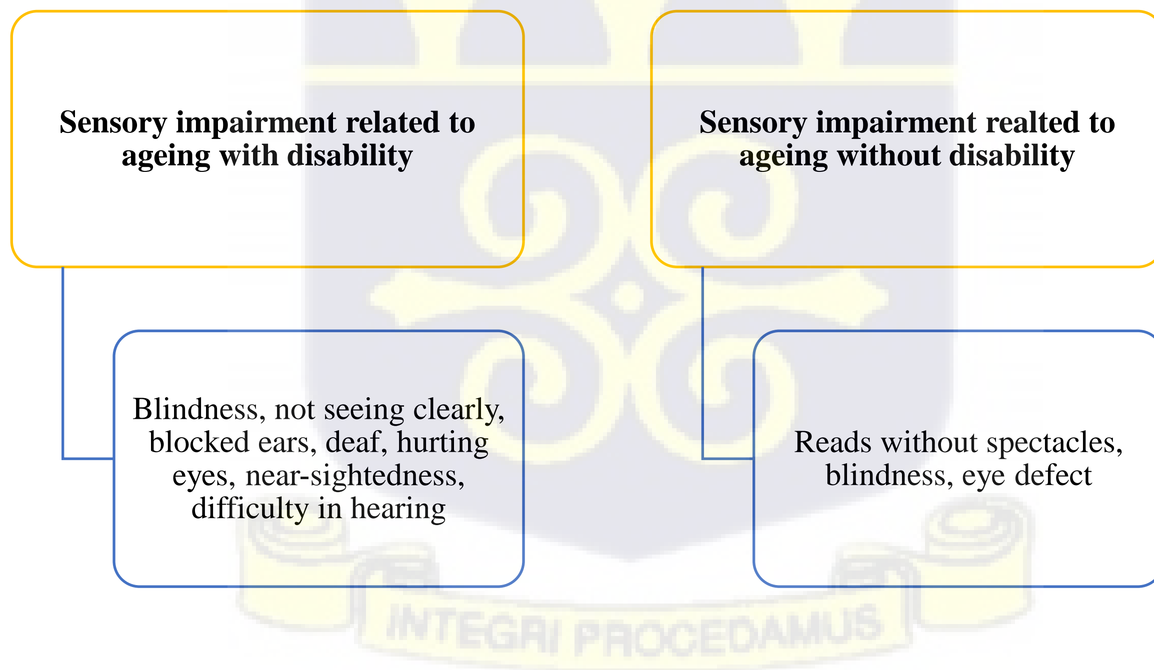
by Bourke & Waite (2013) also described disability as physical limitations and physical function. Having a broken leg was considered as a disability in a study by Robinson et al. (2007).

5.4 Sensory impairment

Sensory impairment was categorized as ageing with or without disability. These results, together with the codes, are displayed in Figure 5.2. Vision and hearing impairment was described as ageing with disability by most of the participants of all the 3 age groups. Hence, there were little variations between age groups. The differences were mostly within age groups. Some participants' views have been described to reflect the theme of sensory impairment.

Figure 5.2: Conceptualization of ageing and disability based on Sensory impairment



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Case 1, for instance, described ageing with an eye problem as a disability. She also mentioned that it is possible to age without a disability in relation to sensory impairment. Case 1 thus described her view about both phenomena by comparing herself with an older adult she was acquainted with.

Case 1

> *One of our deaconesses, she is old and over 80 years. She doesn't wear spectacles to read. She reads Dangme and reads English, but she is old. If you see her, old lady she has reached 80 years. She celebrated her birthday this year. She reads the Bible without spectacles. She does not wear anything but for me when I read my eyes hurts. Someone can grow without a disability* (58 years old female middle-aged adult).

Case 2 described having an eye defect as ageing without disability. He attributed such problem to a disease:

Case 2

> *Having an eye problem is a disease and not disability. It is a disease not disability. Disability is different* (61 years male older adult).

A young adult who attributed vision issues to ageing with disability describes it this way:

Case 3

> *Some old people don't see well. I don't know why it happens. I can't tell. It is a disability. As you grow most of your parts will start to expire. Some people start from as I said 45 going. You will not be able to see from far. You have to use a stick to be able to walk* (28 years old female young adult).

Apart from Case 2, the other cases described eye issues as ageing with disability. These views were expressed by most participants in the study who are young, middle-aged, and older adults. From the conceptual framework impairment (under medical factors) is conceptualized as ageing with disability based on the 3 cases. This conceptualization can be ascribed to the medical model of disability. Case 2, however, relates an eye defect as ageing without disability.

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Blindness has been linked to features of ageing in a study by van der Geest (1998). According to a study by Kelley-Moore et al. (2006) older participants related vision impairment to disability. Most respondents in a study by Robinson et al. (2007) also regarded blindness as a disability while less than half considered an older person with a hearing aid as being disabled. In Bourke & Waite (2013) participants with hearing difficulties for instance described such condition as an impairment and not a disability unlike in this study where such was described as a disability.

5.5 Possibility of disability

The participants ascribed various views on the possibility of disability in ageing. Some participants felt ageing with disability is experienced by everyone. Others also felt disability is not peculiar to age since this could occur at younger ages. Figure 5.3 displays the codes under this category. Differences in this category were observed to be different within age groups. For instance, among the three older adults, one of them felt ageing does not cause disability, hence disability is not possible in ageing. The other two perceived that ageing could either come with or without disability. Only a few of the middle-aged adults perceived that disability in ageing was not possible, however, most of them felt ageing could be with disability.

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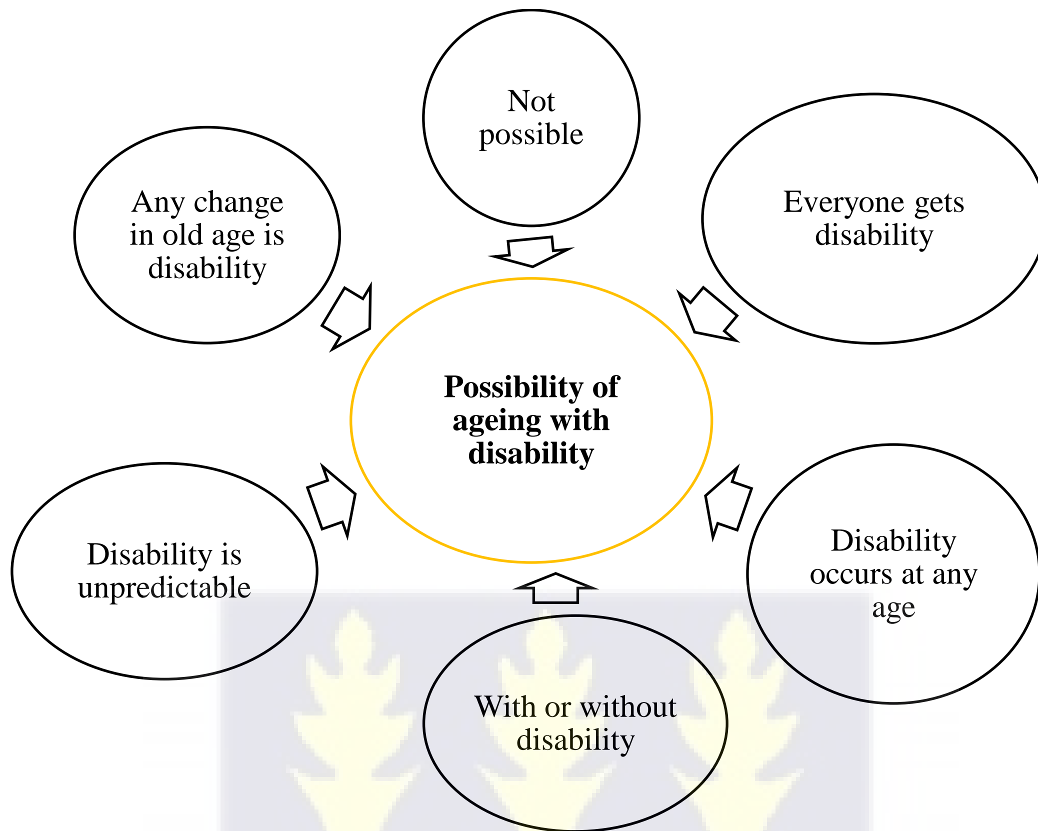
Figure 5.3: Codes associated with Possibility of ageing with disability



Some participants statements have been described to reflect how most of the participants perceived the phenomenon. For 'everyone gets disability,' Case 1's view reflects the perception that disability is a part of ageing:

Case 1

> *Oh, disability is part of it. Maybe you are not the one who went for the disability. Maybe it's God. You don't know. I don't know if it will happen to me. You also don't know* (41 years old female middle-aged adult).

Reflecting the views of those who felt ageing does not bring disability, case 2 believed that one has to get a disability early in life before the person can age with a disability:

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Case 2

> *For disability it is with you before ageing. Because if it is on you, it is on you. If it is not on you, it is not on you. As I am here now there is nothing on me and I am 46 years and above so if nothing is on me it is the same way I will age.* (46 years old male middle-aged adult).

Case 3, a young adult notes that disability could occur either during ageing or earlier years in life. According to her disability could come with ageing or not:

Case 3

> *Ageing, sometimes disability comes with ageing. People age with disability and there are a lot of young people that have disability too* (28 years old female young adult).

These participants' statements reflect contrasting views on how ageing and disability is conceptualized. While a participant perceived that ageing is with disability, others felt that ageing can either be with disability or not. Two of the participants perceived that disability occurs in earlier years but not during ageing. The biopsychosocial model of disability situates disability in context. The views that suggest that ageing could be with or without disability could be attributed to the biopsychosocial model. This is because they contextualized the phenomenon.

For those who ascribe ageing as being with disability, their views could be associated with the medical model. The participants who suggest that ageing cannot be with a disability could be related to the social model who reject the medical model of disability. Another view the participants reflected was on the ageing process and process of ageing (WHO, 2001b). These participants separated the ageing process from the process of ageing. They suggested that what an individual had during earlier years must not be associated with the ageing process. However, the

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process of ageing could be affected by other factors that could expose the older adult to disability. The disability that happened in old age cannot be associated with ageing or regarded as brought by ageing.

5.6 Distribution of subjective perception of ageing scale

Table 5.3 displays the quartile distribution of the composite scores in the data among 175 respondents. The mean is '0' with a standard deviation of 5.96411. This suggests a moderate variability from the mean (Interquartile range 10.2739). Half (50 percent) of the respondents had scores that were below 0.7619, while 25 percent of the scores were below -5.1497, and 75 percent of the scores were below 5.1242. This suggests that a large portion of the scores were within positive values suggesting a perception of ageing with disability.

Table 5.3: Distribution of 'subjective perception of ageing scale' in quartiles

Number of respondents	175
Mean	0.0000
Standard deviation	5.96411
Percentiles 25 50 75	 -5.1497 0.7619 5.1242

5.6.1 Age

Table 5.4 shows the ANOVA test results that compare the mean scores of subjective perception of ageing among the three age groups. This aspect of the study tests the first hypothesis that there is

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no significant difference in conceptualization of ageing and disability based on subjective perception of ageing among young and middle-aged adults. The results showed that there was a statistically significant difference in the means of the 3 groups with p-value of 0.025 and F ratio of 3.756.

Table 5.4: Mean difference in subjective perception by age group

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	258.985	2	129.492	3.756	0.025
Within Groups	5930.311	172	34.479		
Total	6189.295	174			

However, multiple comparisons in the Post hoc test showed no statistically significant difference between the means of young and middle-aged adults (p value 0.996); and between middle-aged and older adults (p value 0.051). However, there was a statistically significant difference in subjective perception of ageing between young and older adults (p value 0.039, mean difference -2.70478, 2.70478). The results of the post hoc test are presented in Table 5.5. The mean difference between young and older adults (I-J) is -2.70478. While the difference between older adults and young adults (J-I) is 2.70478. Young adults did not associate subjective perception of ageing with disability, but the older adults did. This suggests that older adults perceived ageing to be with disability. The first hypothesis of this study is thus accepted because the post hoc test showed that there is no significant difference in conceptualization of ageing and disability based on subjective perception of ageing among young and middle-aged adults.

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Table 5.5: Post hoc test results for age and subjective perception of ageing

(I) Age group of participants	(J) Age group of participants	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
20-39	40-59	-.09549	1.06680	.996	-2.6272	2.4362
	60 and above	-2.70478*	1.09237	.039	-5.2994	-.1101
40-59	20-39	.09549	1.06680	.996	-2.4362	2.6272
	60 and above	-2.60929	1.10253	.051	-5.2301	.0115
60 and above	20-39	2.70478*	1.09237	.039	.1101	5.2994
	40-59	2.60929	1.10253	.051	-.0115	5.2301

* The mean difference is significant at the 0.05 level.

Age is an important factor to conceptualization of ageing based on subjective perception of ageing. It also supports the findings of Kelley-Moore et al. (2006) and Teems (2016) that some older adults perceive ageing as being with disability. Although some studies, such as Chonody (2019) described that younger adults have a negative attitude toward ageing than older adults. Significant associations were also observed for age and ageing perceptions in a study by Chow & Bai (2011).

5.6.2 Sex and subjective perception of ageing

Table 5.6 displays results for the independent samples t-test that compares the mean scores of subjective perception of ageing by sex. The Levene's test for equality of variances showed that males and females had unequal variances (p value 0.006, F-statistic 0.941). No significant difference was observed among males and females (p value 0.679 and mean difference 0.37751). Though insignificant, males associated disability with subjective perception of ageing while females did not. Males in this study therefore, perceived ageing to be with disability. This perception though varied among them (at 95 percent confidence interval, the difference in mean scores for males and females is between -1.42208 and 2.17710).

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Table 5.6: Independent samples t-test results in subjective perception of ageing

Socio-demographic variable		N	Mean	Std. Deviation	P-value
Sex	Male	76	0.2136	5.91796	0.679
	Female	99	-0.1639	6.02419	
Ethnic group	Ga-Dangme	129	-0.1024	5.75045	0.705
	All other ethnic groups	46	0.2872	6.58532	
Children ever born alive	None	27	-0.9786	5.82178	0.355
	One or more	148	0.1785	5.99177	
Ever lived with an older adult	Yes	149	-0.2199	5.99567	0.238
	No	26	1.2599	5.72892	
Older adult had disability	Yes	35	1.5010	5.22719	0.040
	No	112	-0.7183	6.14031	
Respondent has disability	Yes	27	2.3559	5.91315	0.025
	No	148	-0.4298	5.89188	

Although construction of ageing is found to be gendered (Russell, 2007; van der Geest, 2001; Kelley-Moore et al., 2006) the findings of this study did not show any significant differences between subjective perception of ageing among males and females. Another study by Cramm & Nieboer (2017) on ageing perceptions showed a significant difference in some aspects of male and female perceptions. Significant differences were also found between males and females in a study by Chow & Bai (2011).

5.6.3 Ethnic group

Table 5.6 presents the results of the independent samples t-test that compared the means of subjective perception of ageing by ethnic group. The Levene's test for equality of variances showed that the two groups had unequal variances (p value 0.056, F ratio 3.704). No significant

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difference was observed in subjective perception of ageing among the two groups (p value 0.705, mean difference of -0.38963). Those who were Ga-Dangme perceived ageing to be without disability while those of all other ethnic groups associated disability with ageing. The perceptions though varied among Ga-Dangme participants (at 95 percent confidence interval, the difference in the mean scores for Ga-Dangme and all other ethnic groups is between -2.41619 and 1.63692).

Most studies on ethnicity and ageing perceptions are on racial variations such as by Menkin et al. (2017), Cramm & Nieboer (2017), and Zubair & Norris (2015). In a study among Turkish and Dutch ethnicities for instance, Cramm & Nieboer (2017) found significant differences in ageing perceptions. This was however not so in this study. The findings of this study reflect that of a study by van der Geest (1998) among Akan participants at Kwahu-Tafo in Ghana. The findings by van der Geest (1998) suggest that medical factors were attributed to ageing as confirmed by this study. Although this study has the component of disability. It can be assumed that most of the respondents who are Ga-Dangme and those in other ethnic groups did not conceptualize ageing differently from the Akan participants in Kwahu-Tafo (van der Geest, 1998). Although this is inferred it cannot be established concretely because not having significant differences may not mean that they conceptualized the phenomenon similarly.

5.6.4 Children ever born alive

Independent samples t-test explored the differences in mean scores of subjective perception of ageing by children ever born alive. The variances of the two groups were equal with a p value of 0.942 and F statistic of 0.005. Table 5.6 shows that there was no statistically significant difference between the mean scores of the two groups (p value 0.355, mean difference of -1.15715). Those

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with no children perceived ageing to be without disability but those with 1 or more children perceived ageing to be with disability. The views among those with no children varied (at 95 percent confidence the difference of those who have no children and the respondents who have 1 or more children is between -3.62163 and 1.30733).

Having children, a social resource, is purported to influence perceptions of ageing (Cramm & Nieboer, 2017). This is because of the help children may give parents during ageing. People with children may expect less difficulty and disability during ageing than those without children. There were, however, no significant differences in subjective perception of ageing by children ever born alive.

5.6.5 Ever lived with an older adult

Table 5.6 presents the findings of the independent samples t-test results of the difference in subjective perception by ever lived with an older adult. The two groups had approximately equal variances with a p value of 0.751 and F ratio of 0.101. No significant differences in the means were observed (p value 0.244, mean difference of -1.47978). Although not statistically significant those who lived with an older adult perceived ageing to be without disability while those who never lived an older adult perceived ageing to be with disability. The views among them varied (at 95 percent confidence interval the difference in subjective perception of ageing between the two groups is -3.97913 and 1.01956).

5.6.6 Older adult lived with had disability

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Independent samples t-test was further used to compare the difference in subjective perception of ageing by older adult lived with had disability. The variances of the two groups were significantly different. The F ratio from the Levene's test for quality of variance was 5.501 and significant at a p value of 0.020. There was a statistically significant difference between the mean scores of the two groups (p value 0.040, mean difference 2.21928). Those who lived with an older adult with disability viewed ageing to be with disability but those who lived with an older adult with no disability did not. The difference of the mean scores between the two groups at 95 percent confidence interval is 0.10879 and 4.32977. The results are displayed in Table 5.6.

5.6.7 Respondent disability

Table 5.6 displays the difference in subjective perception of ageing by respondents' disability status. The independent samples t-test results showed that the variance of the two groups were approximately equal (F ratio 0.636, p value 0.426). There was a statistically significant difference between the mean scores of the respondents with a disability and those who had no disability (p value 0.025, mean difference of 2.78573). Those with a disability perceived ageing to be with disability while those with no disability perceived ageing to be without disability. The difference in mean scores between the two groups at 95 percent confidence interval was 0.35076 and 5.22070.

Warmoth et al. (2016) suggest that conceptualization of disability among older adults is impacted by living with a disability. Knight & Ricciardelli (2003) also showed that older adults with limited physical abilities had worse expectations of ageing. Perceptions were also influenced by relationships with older adults during younger years (Knight & Ricciardelli, 2003). The findings of those studies are relevant in why 'whether a respondent had a disability' and 'whether a

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respondents lived with an older adult with a disability' produced significant differences. The experiences of the respondents influenced their conceptualization of ageing and disability.

It is also observed that experiences of younger people is influenced by their life interaction with older people (Burke et al., 2014). When young people have less experience with older people they are more likely to believe negative stereotypes about ageing (Chonody & Teater, 2018). This study though did not yield significant differences in people who lived with older adults and those who did not.

5.6.8 Marital status

One way ANOVA compare the mean scores of subjective perception of ageing by marital status. A statistically significant difference was observed among the three groups. Table 5.7 (F 5.730, p value 0.004).

Post hoc test showed a statistically significant difference in subjective perception of ageing among those in union/currently married and those who were separated/divorced/widowed (p value 0.034, mean difference I-J is -2.53245, J-I is 2.53245). A significant difference was also observed among those who were previously married and those who were never married (p value 0.005, mean difference I-J is 3.81263, J-I is -3.81263). Compared to the previously married respondents, those who were never married and in union/currently married did not associate subjective perception of ageing with disability. Previously married participants thus, perceived ageing to be with disability. No significant difference existed among those who were in union/currently married and those who were never married (p value 0.503). The results are presented in Table 5.8.

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Marital status has been observed to be important in some dimensions of ageing perceptions, such as self-perception of ageing. Spousal strain, for instance, is associated with less positive self-perception of ageing (Kim et al., 2021). People who experienced marital loss had lower positive self-perception of ageing compared to those who remained married (Turner et al., 2022). Turner et al. (2022) suggests that it is not marital status, but the transition in and out of marriage that influences how participants perceived their ageing. Although this study is a broader scope than self-perception of ageing, the differences in marital status were among those who were never married and those who were previously married (either separated, divorced, or widowed). Marital status was significant in ageing perceptions among older adult Chinese participants who were never married, widowed/divorced, or currently married in a study by Chow & Bai (2011). Significant differences were also found among married and single women (Chow & Bai, 2011). Chow & Bai (2011) observed that marital status was a significant predictor of positive and negative perceptions of ageing. The findings by Chow & Bai (2011) confirm the results of this study and illustrate that marital status is an important variable in subjective perception of ageing.

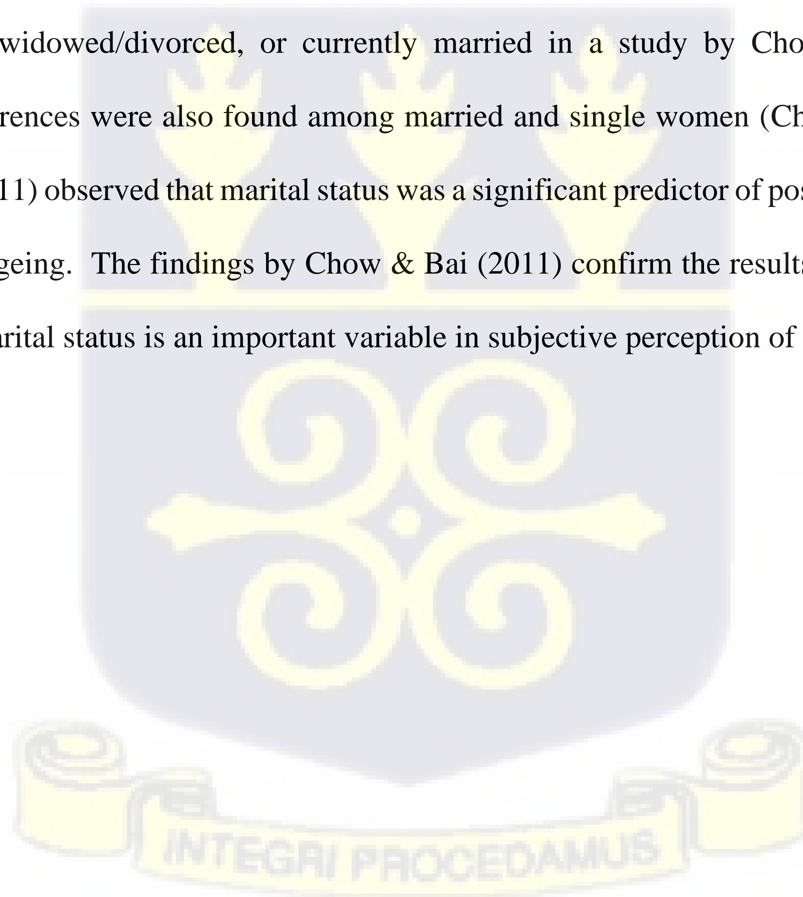

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Table 5.7: ANOVA results in subjective perception of ageing

Socio-demographic variables		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Marital status	Between Groups	386.593	2	193.296	5.730	0.004
	Within Groups	5802.702	172	33.737		
	Total	6189.295	174			
Highest level of education	Between Groups	153.193	2	76.596	2.183	0.116
	Within Groups	6036.103	172	35.094		
	Total	6189.295	174			
Economic activity engagement	Between Groups	122.608	2	61.304	1.738	0.179
	Within Groups	6066.687	172	35.271		
	Total	6189.295	174			
Perceived wealth status	Between Groups	71.448	2	35.724	1.004	0.368
	Within Groups	6117.847	172	35.569		
	Total	6189.295	174			
Religious affiliation	Between Groups	41.543	2	20.772	0.581	0.560
	Within Groups	6147.752	172	35.743		
	Total	6189.295	174			

Table 5.8: Post hoc test results for marital status and subjective perception of ageing

(I) marriage recategorized	(J) marriage recategorized	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
In union/currently married	Separated/divorced /widowed	-2.53245*	1.00067	.034	-4.9066	-.1583
	Never married	1.28017	1.14016	.503	-1.4393	3.9996
Separated/divorced/ widowed	In union/currently married	2.53245*	1.00067	.034	.1583	4.9066
	Never married	3.81263*	1.17908	.005	1.0007	6.6245
Never married	In union/currently married	-1.28017	1.14016	.503	-3.9996	1.4393
	Separated/divorced /widowed	-3.81263*	1.17908	.005	-6.6245	-1.0007

*. The mean difference is significant at the 0.05 level.

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5.6.9 Highest level of education

The ANOVA test compared the mean scores in subjective perception of ageing by the respondents' highest level of education. The p value of the F ratio (2.183) was 0.116. No significant differences were observed in subjective perception of ageing by highest level of education. Those who never attended school associated subjective perception of ageing with disability but those with JHS/Middle or lower and SHS or higher did not. This suggests that those who never attended school perceived ageing to be with disability. The results are displayed in Table 5.7. In contrast with this study the associations between educational level and ageing perceptions was significant in a study by Cramm & Nieboer (2017) among migrant Turkish and native Dutch elders in Rotterdam.

5.6.10 Economic activity engagement

Table 5.7 displays the one-way ANOVA test results that compares the mean scores in subjective perception of ageing by economic activity type. There was no statistically significant difference between the mean scores of the three groups (F ratio 1.738, p value 0.179). Those who were not engaged in any economic activity perceived ageing to be with disability while those engaged in an economic activity did not.

5.6.11 Perceived wealth status

Differences in the mean scores of subjective perception of ageing by perceived wealth status is presented in Table 5.7. The ANOVA test results showed no statistically significant difference between the means of those who regarded themselves as poor, middle, or rich (F ratio 1.004, p

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value 0.368). Those with poor perceived wealth status viewed ageing to be with disability while those with middle and rich perceived wealth status did not.

Other studies on economic activity and wealth, show that perceived age discrimination is associated with lower levels of household wealth, being retired, or not in an employment (Rippon et al., 2014). Although this study is not on age discrimination, relating factors of subjective perception of ageing may be related to age discrimination in older ages. Poor perceived wealth status and no economic activity engagement associated subjective perception of ageing with disability. This was, however, not statistically significant. Contrary to the findings of this study, Cramm & Nieboer (2017) observed a significant association between income and perceptions of ageing. Comparable to this study people of low income in the study by Cramm & Nieboer (2017) had negative perceptions. Working status which is akin to economic activity was found to be significant for ageing perceptions (Chow & Bai, 2011). This, however, is in contrast with the findings of this study.

5.6.12 Religious affiliation

As presented in Table 5.7 the ANOVA results showed that there is no statistically significant difference in subjective perception of ageing by religious affiliation. The p value was 0.560 with an F ratio of 0.581. Compared to those affiliated to Islam and no religious association, those affiliated to Christianity perceived ageing to be with disability. This, however, was not statistically significant. The sample variation for the 3 religious affiliations were minimal with small numbers for Islam and no religion. This could have influenced the direction of the results.

Religious beliefs influence ageing perceptions whereby most of these is biomedical (Ewen et al., 2020; Sagner, 1999). The findings of this study showed that, compared to those affiliated with

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Christianity and Islam, those who had no religious affiliation did not associate subjective perception of ageing with disability. This suggest that being affiliated with a religious body was associated with conceptualization of ageing as being with disability. This is in consonance with the medical model of disability.

5.6.13 Multivariate analysis

Table 5.9 presents the model from the backward stepwise linear regression. Backward stepwise linear regression was employed to identify the most significant predictors of the conceptualization of ageing and disability. Given the exploratory nature of the study, backward stepwise regression allowed for the inclusion of a broad range of potential predictors. This approach helped to identify which variables have the most substantial impact on the dependent variable, even when there is limited prior knowledge about the relative importance of each predictor. By allowing the data to guide the selection of predictors, this method uncovered relationships that may not have been anticipated based on theoretical considerations alone. While the initial inclusion of variables were broad, the stepwise approach helped validate the models by empirically testing which variables were indeed significant predictors.

The model includes the key independent variable, 'age' and all the other socio-demographic variables as control variables. The omnibus model was not statistically significant with a p value of 0.051, F statistic of 1.651, R of 0.410, and R square of 0.168. The model explains 16.8 percent of the variations in subjective perception of ageing.

Age was not a significant predictor of subjective perception of ageing. For the categories of 'age' a negative relationship was observed for middle-aged adults and subjective perception of ageing while a positive weak relationship was observed for older adults and subjective perception of

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ageing. The relationships though were not statistically significant. The results suggest that compared to young adults middle-age adults associated subjective perception of ageing with disability. However, when young adults are compared with older adults, young adults did not associate subjective perception of ageing with disability. These relationships were not statistically significant. The findings imply that other variables had more impact on subjective perception of ageing than the key independent variable, 'age.'

Older adults in studies by (Kelley-Moore et al., 2006) and Teems (2016) also associated ageing with disability. Contrary to the findings of this study, significant associations were observed between age and ageing perceptions in a study by Cramm & Nieboer (2017) whereby older adults had negative perceptions. Older adults in this study ascribed to the medical model of disability.

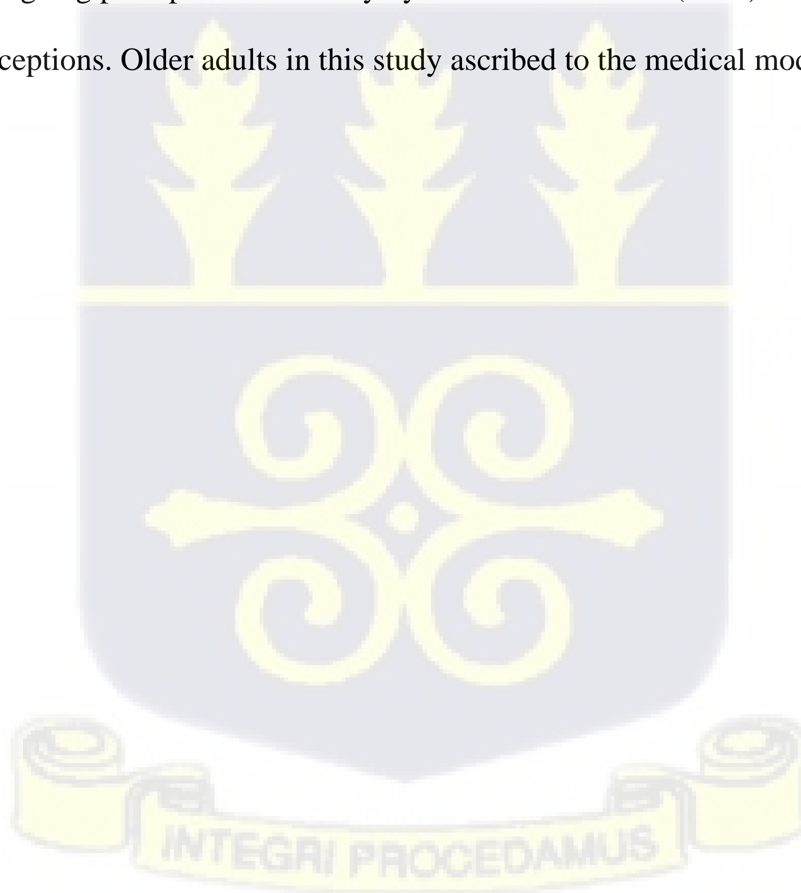

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Table: 5.9 Predictors of subjective perception of ageing

Socio-demographic Variables	Standardized Coefficients	t Statistic	Sig.	95 % Confidence Interval for B	
	Beta			Lower Bound	Upper Bound
Age					
40-59	-.036	-.375	.708	-2.854	1.943
60 and above	.053	.437	.663	-2.414	3.786
20-39 (RC)	-	-	-	-	-
Sex					
Female	-.083	1.005	.317	-2.945	.959
Male (RC)	-	-	-	-	-
Education					
Never attended school	.118	1.424	.157	-.855	5.268
SHS or higher	-.072	-.829	.408	-3.048	1.245
JHS/Middle or lower (RC)	-	-	-	-	-
Ethic group					
All other ethnic groups	.099	1.247	.214	-.782	3.458
Ga-Dangme (RC)	-	-	-	-	-
Economic activity engagement					
No economic activity	-.018	-.198	.843	-2.729	2.231
Economic activity with no pay	-.037	-.474	.636	-5.876	3.603
Economic activity with pay (RC)	-	-	-	-	-
Children ever born alive					
None	.115	1.030	.305	-1.738	5.524
1 or more children (RC)	-	-	-	-	-
Marital Status					
In union/currently married	-.152	-1.536	.127	-4.157	.520
Never married	-.299	-2.393	**.018**	-7.549	-.722
Separated/Divorced/Widowed (RC)	-	-	-	-	-
Perceived wealth status					
Poor	.084	1.047	.297	-.918	2.987
Rich	-.024	-.304	.762	-5.386	3.950
Middle (RC)	-	-	-	-	-
Religion					
Islam	-.108	-1.360	.176	-8.029	1.482
No religion	-.110	-1.408	.161	-10.550	1.769
Christianity (RC)	-	-	-	-	-
Ever lived with older adult					
No	.436	1.595	.113	-1.741	16.324
Yes (RC)	-	-	-	-	-
Older adult had disability					
Yes	.173	2.163	**.032**	.223	4.908
No (RC)	-	-	-	-	-
Respondent has disability					
No	-.086	-.909	.365	-4.499	1.663
Yes (RC)	-	-	-	-	-

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Sex, highest educational level, ethnic group, economic activity engagement, children ever born alive, perceived wealth status, religious affiliation, ever lived with older adult, and respondent's disability status were not significant predictors of subjective perception of ageing. This is in contrast with the findings of a study by Chow & Bai (2011). Chow & Bai (2011) identified a significant association between age, working status (economic activity), and ageing perceptions. Ethnicity, sex, and age was significantly associated with ageing perceptions in a study by Cramm & Nieboer (2017). Contrary to the findings of this study Cramm & Nieboer (2017) in their study observed a significant association between educational level and ageing perceptions. People with low educational level had more negative perceptions towards ageing (Cramm & Nieboer, 2017). In this study however, significant relationships were not observed for higher educational level and subjective perception of ageing. Although those who never attended school associated subjective perception of ageing with disability while those who have JHS/Middle or lower education (the reference category) did not. Furthermore, compared to the respondents with SHS or higher education, those with JHS/Middle or lower education associated subjective perception of ageing with disability.

The only significant predictors of subjective perception of ageing in the model, were marital status and older adult lived with had a disability. For marital status, those in union/currently married had a negative relationship with subjective perception of ageing. This relationship was not statistically significant. The statistically significant relationship was observed for the respondents who were never married and subjective perception of ageing. The relationship was negative and slightly strong. Compared with those who were previously married, those who were never married did not associate subjective perception of ageing with disability. Marital status has been related to conceptualization of ageing although focus was on strain and loss (Kim et al., 2021; Turner et al.,

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2022). Chow & Bai (2011) also observed a significant association for marital status and ageing perceptions.

A positive but weak relationship was observed for the respondents who lived with an older adult with a disability and subjective perception of ageing. This relationship was statistically significant. Compared with those who lived with an older adult with no disability, those who lived with an older adult with disability associated subjective perception of ageing with disability. This suggests that living with an older adult with disability is associated with conceptualization of ageing as being with disability. This may be because people who live with an older adult with a disability may think that is how they will also be in the future.

5.7 Summary

The aim of this chapter was to reveal whether people associate ageing with disability or not. The qualitative study explored factors that constitute subjective perception of ageing. The intention was to explore which themes were relevant to subjective perception of ageing by the participants. The themes generated include cognition, physical and sensory impairment, and possibility of disability during ageing. The items under these themes were used to develop an instrument for the quantitative phase.

Cronbach's alpha analysis and EFA on those variables in the quantitative data resulted in the removal of items under physical attributes, possibility of ageing, and sensory impairment. Cognition was the only theme which had some variables retained after the EFA. These variables were used to develop a scale for further analysis with one-way ANOVA, independent samples t-test, and linear regression.

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Older adults perceived ageing to be with disability while middle-aged and young adults did not. There was no significant difference in subjective perception of ageing among young and middle-aged adults. The study hypothesis was therefore accepted.

Being previously married, ever lived with an older adult with disability, and having a disability was associated with conceptualization of ageing as being with disability. At the multivariate level, only marital status and older adult lived with had a disability were significant predictors of subjective perception of ageing. Unlike the other socio-demographic variables, marital status and older adult lived with had disability had a stronger effect of subjective perception of ageing.

The study finding suggest that ageing was mostly conceptualized as being with disability. The medical model of disability was prominent in the participant's conceptualization. This is because subjective perception of ageing was related to medical factors and these factors were mostly associated with disability. Some concepts of ageing such as the ageing process, process of ageing, and psychological ageing were also observed.

Findings from this study were contrary to some previous studies and agreed with other studies. Some studies were not entirely similar but had relevant results for this study. The qualitative and quantitative research designs revealed how the participants conceptualized ageing and disability based on a subjective perception of ageing.

The Madrid International Plan of Action on Ageing (MIPAA) adopted in 2002 aimed to 'build a society for all ages' where ageing influences every facet of individual, community, national, and international life (United Nations, 2002). The policy aimed to remove disparities in ageing so that people in developing countries will age with security and dignity and have full right as citizens in society like in developed countries (United Nations, 2002). The findings of this study suggests that

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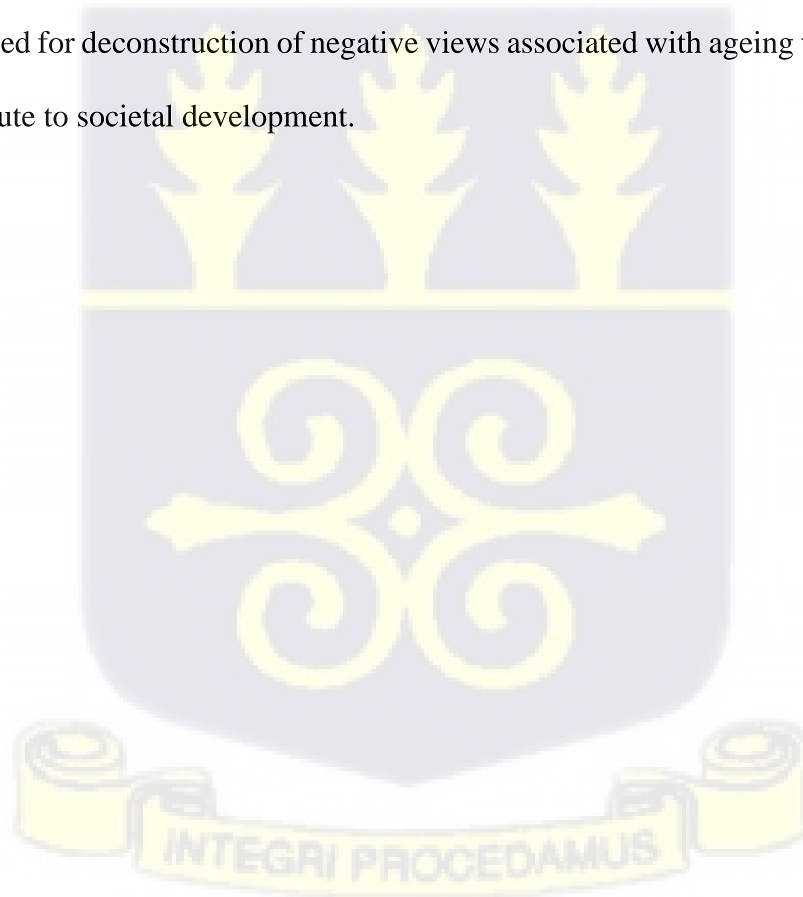
this goal is far from being reached. Older adults would not be able to age in dignity when their ageing process is equated with disability. In MIPAA, older adults are also expected to be active in society and development (United Nations, 2002). However, negative views associated with ageing such as disability is likely to prevent older adults participation in society. This is because a reduction in strength due to age equated with disability is likely to deter older adults from being engaged in society. Hence making it difficult from contributing to the development of society. The objectives of MIPAA are in line with the concept of the second demographic dividend. Gaining from the second demographic dividend is possible when older ages are not tagged as being with disability. This would allow for their inclusion in the work force aiding economic development. This reveals a need for deconstruction of negative views associated with ageing to encourage older adults to contribute to societal development.



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CHAPTER SIX

CONCEPTUALIZATION OF AGEING AND DISABILITY BASED ON MEDICAL FACTORS

6.0 Introduction

Understanding how ageing and disability are conceptualized based on medical factors is crucial for developing effective health interventions and policies. This chapter justifies the examination of medical factors to provide insights into their impact on perceptions of ageing and disability. The objective is to integrate qualitative and quantitative findings to present a comprehensive analysis. This chapter covers conceptualization based on medical factors; Integration of qualitative and quantitative findings; Initial presentation of results from the qualitative data analysis, identifying key themes related to medical factors; Presentation of findings from the quantitative data analysis, including the creation of a medical factors scale based on Cronbach's alpha analysis and EFA; Application of independent samples t-test and one-way Analysis of Variance (ANOVA) to explore differences in socio-demographic variables by the medical factors scale; Use of linear regression to examine relationships between socio-demographic variables and medical factors scale; Discussion of the results in comparison with findings from previous studies, highlighting similarities and differences; and a summary of the key findings and their implications for understanding the role of medical factors in the conceptualization of ageing and disability.

By addressing these areas, the chapter aims to provide a detailed and nuanced understanding of how medical factors influence perceptions of ageing and disability, informed by both qualitative and quantitative data.

6.1 Medical factors

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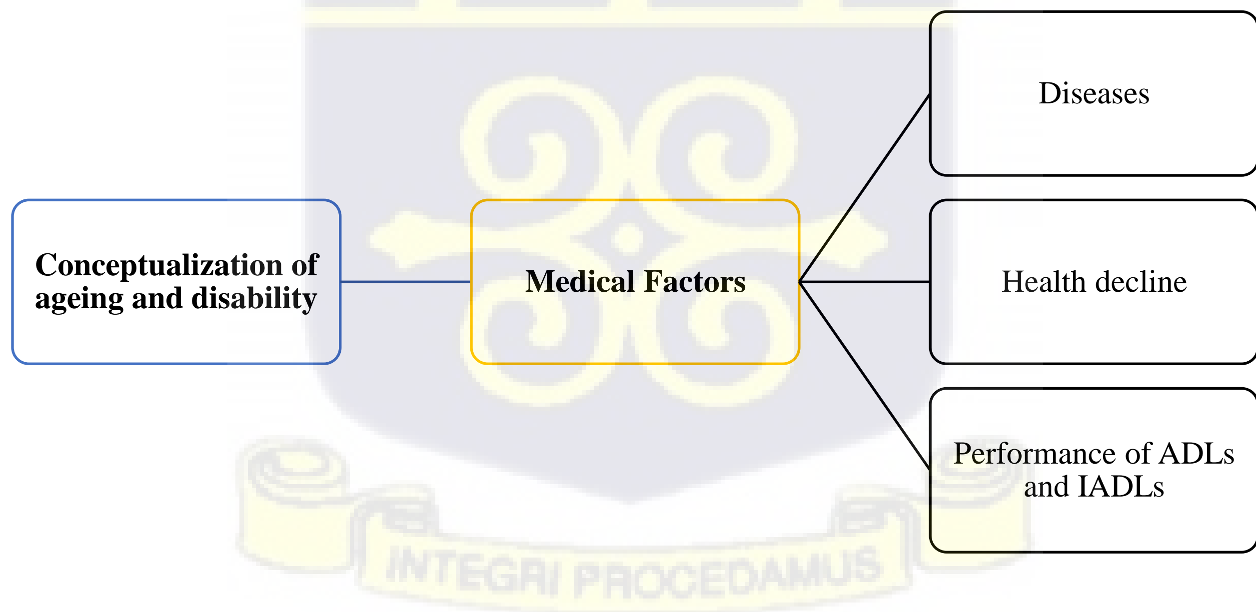
The qualitative aspect of this study explored the constituents of medical factors. Constant comparison analysis was used for the data analysis. Most young, middle-aged, and older adults associated medical factors with ageing with disability. Themes that emerged include diseases, health decline, performance of ADLs and IADLs (life activities, self-care activities, mobility). These themes were associated with ageing with or without disability. The themes were consistently observed across the different age groups, though the emphasis and experiences varied. For instance, younger adults often focused on the potential future impact of medical factors on ageing, middle-aged adults highlighted current health challenges and their implications for ageing, and older adults discussed their lived experiences with health decline and disability. Figure 6.0 displays how conceptualization of ageing and disability is linked to the themes.

Figure 6.0: Thematic representation of conceptualization of ageing and disability based on medical factors



6.1.1 Diseases

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The categories forming this theme comprise diseases as a disability, diseases that cause ageing with disability, and the reasons why diseases are associated with disability. Table 6.0 presents the theme with its categories and associated codes.

Most young, middle-aged, and older adults considered disease as ageing with disability. The presence of a disease during ageing, according to some participants, prevents the older adult from performing life activities and self-care activities. They also felt that diseases also restrict their mobility. Diseases therefore were described as a disability, cause ageing with disability or its presence is ageing with disability. A few middle-aged adults, though perceived an older adult with a disease, is ageing without disability. One older adult also felt diseases differ from disability.

Table 6.0: Conceptualization of ageing and disability based on diseases

Theme	Category	Codes	Conceptualization

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Diseases	Disease as a disability	Having a disease, disease before old age, growing with a disease, being old and sick.	Ageing with disability
		Never had a disease, growing with a disease, and recovering from a disease	Ageing without disability
	Diseases that cause ageing with disability	Hypertension, measles, stroke, paralysis, leprosy, eye disease, and diabetes were described as diseases that cause ageing with disability.	Ageing is with disability
	Reasons diseases are associated with disability	Has to be carried, cannot drink by self, cannot eat by self, can do nothing, keeps at one place, unable to lift things, cannot bath by self, cannot move, causes weakness, disease disables, affects mind, changes person, worsens disability, paralyses, cause communication problems, cause mental instability, inability to work, dependency, and health decline.	Ageing is with disability

Associating diseases to ageing with disability reflects the medical model of disability. The medical model of disability links disease to disability (Verbrugge & Jette, 1994). Some middle-aged adults, for instance, who ascribed diseases to ageing without disability, felt diseases differ from disability. Their arguments reject the medical model. Berridge & Martinson (2018) also suggested that older adults who age with a small risk of disease and disease related disability are excluded from successful ageing. It could be deduced from Berridge & Martinson (2018) that older adults with no disease risks are regarded as ageing without disability. Minkler & Fadem (2002) and Rowe & Kahn (1997) however, suggested that normal process of ageing or usual ageing is one with high risk of disease. This is in consonance with the views of the participants who related presence of

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disease to ageing without disability. Minkler & Fadem (2002) and Rowe & Kahn (1997) however, did not associate disease with ageing without disability.

Some respondents' statements that express their views on the presence of diseases as ageing with disability include the following.

Case 1

> *Do you see, someone who is sick grows with it. Someone also would be healthy until he dies. And someone too has nothing on him at all. Someone too as you grow a little you will be troubled with diseases. That is, you have aged with disability* (58 years old female middle-aged).

Case 2

> *Me, you see the first I used my father as he has the stroke. So, from beginning you don't have that sickness so when you get to the old age you have that sickness you can't do anything anymore. Is a disability* (43 years male middle-aged).

Cases 1 and 2, from their statements, perceived disease during ageing as ageing with disability. However, Case 3, below distinguished diseases from disability. This participant felt having a disease is not a disability. Hence, an older adult with a disease is not ageing with a disability. This reflects the social model of disability. The social model rejects the individualization of any impaired function as a disability.

Case 3

> *Ageing with disease is not a disability. That is why I explained to you that there are diseases and there is disability. If the person is growing old and she has malaria, and this makes her weak or unable to do anything, that is not a disability. Disability is someone whose spine is curved. The person got a spinal problem and that affected the alignment such that it is curved, and she is unable to walk if she has no stick* (40 years female middle-age).

Regarding diseases that cause disability cases 1, 2, and 3 amply states:

Case 1

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> *Diseases that cause disability are very many. Like stroke. Diabetes can affect you in such a way that you are afraid to go somewhere and get injured for it to become a problem. With that too you cannot go anywhere. Those are the troubles* (58 years female middle-aged).

Case 2

> *Paralysis cripples you. You cannot go anywhere. Someone will have to carry and bath you and this makes you age more. Once you are not dead and you are walking you are perfect* (30 years male young adult).

Case 3

> *There are many. Like measles can keep a person at one place. This brother of mine sitting here usually gets it. It's a disease he usually gets. His body itches. It stops after he is given a medication. So, ageing and those things. It is a lot of things. Many things cause disability such that a person is unable to do anything* (51 years female middle-aged).

The participants listed both communicable and non-communicable diseases as a cause of disability. Leprosy, stroke, and diabetes were regarded as a disability instead of a cause of disability by some participants. Those 3 conditions were regarded as a disability because leprosy and diabetes took away body parts while stroke was paralysis. Case 3 associated measles to disability because of the restrictions it causes, such that an individual cannot move about freely. Kennedy & Minkler (1998) however, suggests that although chronic diseases are referred to as causes of disability, they are not sufficient or necessary causes. Reasons diseases were associated with disability by the participants are reflected in the statements by cases 1, 2, and 3.

Case 1

> *You know heart disease, someone may be there, or for what I know because of heart disease the person is unable to do things she has to do. Due to the heart disease, she is unable to do what she is supposed to do. It is a disability because the heart disease is not allowing her to do what...like at first, she used to farm. However, because of the disease she cannot do that. Someone may say as for this thing if not for this heart disease I would have done this in the past. Like she could have pound fufu with a hand but because of the disease I can't. This small food I could have done it by myself but if I do my heart. It worries her so*

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she is unable to do things she is supposed to. Things have gone down for her (54 years female middle-aged).

Case 2

Diseases can cause disability in old age. There is a disease that affects you and you do not lose your leg but there is another disease that could affect you which will impede your movement and you cannot do anything unless you are carried. There could be an instance where you cannot drink, eat, and you remain at one place unless someone carries, baths you, and does things for you (61 years male older adult).

Case 3

An example is if someone has hypertension, it can grow into diabetes eventually you will be getting stroke. So, when you get the stroke automatically you can't do anything. You can't do things for yourself because as the body, the tissues are dead so you can't do things for yourself. So, I think diseases can play a part in disability in ageing (22 years female young adult).

Diseases were associated with disability because of the repercussions it brings to the individual. Although this concept was not considered in the conceptual framework, the participants linked diseases to impairment and self-care restrictions. Once there is a restriction, then diseases are associated with disability.

6.1.2 Health decline

Health decline was regarded by the participants as ageing with or without disability. The perception of health decline among the young, middle-aged, and older adults was similar. Health decline was mostly linked to body weakness. It was suggested by almost all the participants that health decline is experienced by everyone during ageing. Body weakness, reduction in strength, a dip in health, and inability to do previous things were attributed to health decline and consequently to ageing with disability. Older adults with their youthful health intact and cannot perform some activities because of health decline were perceived by a few as ageing without disability.

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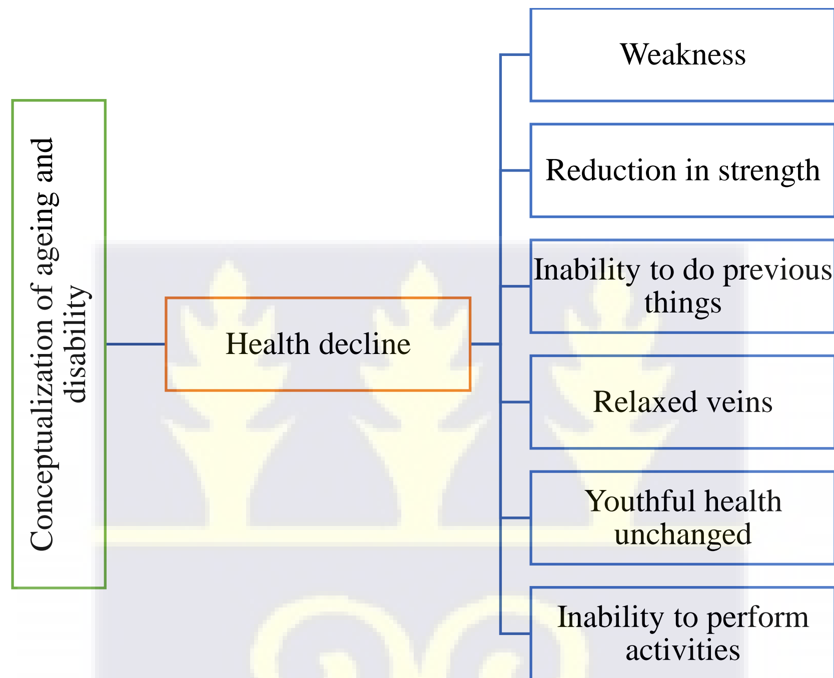
Associating health decline to ageing with disability reflects the medical model of disability. Most of the young, middle-aged, and older adults ascribed to this view. Figure 6.1 presents the theme and its associated codes.

Figure 6.1: Conceptualization of ageing and disability based on health decline



The findings are comparable to previous studies on physical functioning and its importance in the construction of ageing, and ageing with disability (Teems, 2016; Halaweh et al., 2018; Iwamasa & Iwasaki, 2011; Phelan et al., 2004; Bourke & Waite, 2013). Health decline was also equated with disability in Teems (2016) and Kelley-Moore et al. (2006). However, Plikuhn et al. (2014) suggest that such perceptions have declined. Although studies by Halaweh et al. (2018), Buys et al. (2008), Chong et al. (2006), and Troutman et al. (2011) did not include disability, they observed that good health was important in definition of active ageing by the participants. This supposes that health decline which is a reverse of good health could be seen as negative ageing. Older adults

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in Malaysia also regarded deteriorating health and chronic diseases as disabling in late life (Awang et al., 2018). Negative ageing perceptions were also linked with poor health outcomes in Andrew Achenbaum (2015) and Robertson et al. (2015). These findings confirm the findings of this study on the importance of health in conceptualization of ageing and disability by some people. Here are some respondents' statements that reflect their views.

Case 1

> *Excuse me to say, those who work at offices and all of them when it gets to a stage, that is why when they see that you grow weak, they tell you that you have to go on pension and rest. And you know yourself and if you do not notice it yourself, someone will see it. If no one sees it, your body will show you that how you were from the beginning, you are not the same again. When your health declines, that is the weakness. You weaken and that is disability* (65 years female older adult).

Case 2

> *As you are growing old your strength, your whole body weakens which results in your health declining. You see where I have reached, I am like a disabled person. Because I cannot perform as I used to in the past. It is ageing, disability, and diseases that brings the decline* (58 years middle-aged adult).

Cases 1 and 2, associated health decline with disability. Older adults, according to the participants are expected to have a health decline due to advanced age. This is portrayed in the comparison to retirement by Case 1. Ageing therefore according to these participants comes with disability due to health decline. Health decline is a feature under medical factors (in the conceptual framework), and this could be captured under impairment (physical impairment) which is characterized as ageing with disability by the participants. Case 3 for instance, did not relate health decline to ageing with disability. In her statement she hints on decrease in strength while ageing and this to her is not a disability. Her view rejects the medical model of disability although it cannot be related to the social or biopsychosocial model.

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Case 3

> *It means that after you were given birth to, and you grew up you were young. And there is a stage that you will reach that you would wish to do somethings that you cannot do. By that stage there is another old woman who has reached where you are and cannot do those things. Like this bowl. When I was young, I could carry a full bowl. However, as I have grown old, I cannot carry a full bowl but half of it. Another old woman may not be able to carry the half-filled bowl. She cannot carry a quarter filled bowl. So, at that stage you are coming down. So that is not a disability* (51 years female middle-aged).

6.1.3 Performance of ADLs and IADLs

Inability to perform ADLs and IADLs was associated with disability. While the ability to perform ADLs and IADLs was associated with ageing without disability. Some participants, though, did not associate the inability to perform ADLs and IADLs with disability. No particular differences were observed in the perceptions of young, middle-aged, and older adults. Assisted, dependent on others, and having a decline in ability or change in execution of activities were conceptualized as ageing with disability. Ageing without disability was related to the ability to perform activities and absence of capacity change. Table 6.1 displays the categories, sub-categories, and the codes connected to the theme.

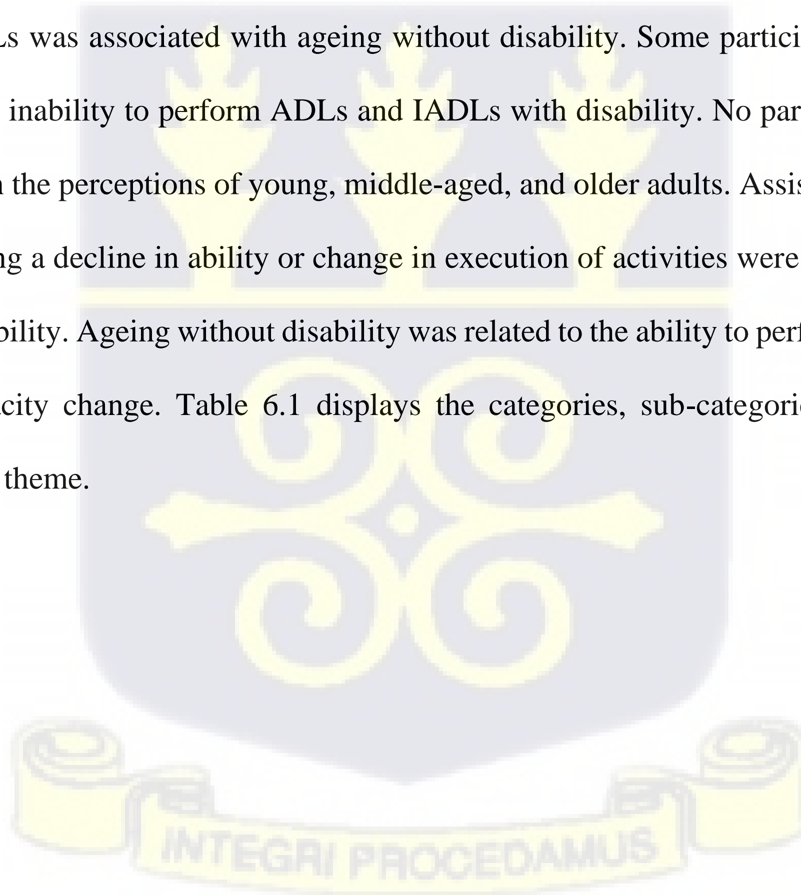

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Table 6.1: Conceptualization of ageing and disability based on performance of ADLs and IADLs

Theme	Category	Sub-category	Codes	Conceptualization
Performance of ADLs and IADLs	Inability related to ageing with disability	Assisted	Assisted to sit, assisted with laundry, and assisted to washroom.	Ageing with disability
		Dependent	Cannot drink water by self, cannot lift things, cannot carry heavy things, cannot do laundry, cannot cook, unable to move, has to be fed, cannot brush teeth by self, cannot bath, can do nothing, and cared for	
		Capacity change	Sitting to bath, sits to cook, speed in activities reduces, and cannot do previous things	
		Mobility challenge	Stuck at one place, carried, difficulty in movement, rest in-between walk, holds back to walk, cannot walk fast, cannot walk for long, walks with a stick, cannot lift hand, cannot sit for long, cannot stand for long, defect in walking, limps, cannot go outside, hold clutches, and sits in a wheelchair.	
	Ability related to ageing without disability		Assisted, inability to do things by self, fast with doing things, can sweep, can do everything, can walk, can fetch water, can farm, can help self, can eat by self, can do laundry, function as youth, up and about, and can cook	Ageing is without disability

The findings reflect the medical model of disability. Inability to perform activities that were regarded as normal function by the participants were conceptualized as ageing with disability. The

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social model contests that the availability of resources will reduce such difficulties. The findings in this study are in consonance with the findings of previous studies. For instance, van der Geest (1998) in a study in Ghana observed that inability to farm was associated with old age. Although the study was not focused on ageing and disability it gives an impression of how such inability is related to ageing. Partridge et al. (1996) in their study observed that the ability to carry out life activities like walking, performing tasks, and personal care were important in perception of disability. The participants in a study by Bourke & Waite (2013) also described being dependent on others as a disability. Using a wheel chair was associated with disability in a study by Robinson et al. (2007) although in the same research respondents who used wheel chair described themselves as not disabled. Bourke & Waite (2013) also showed that disability was described as inability to do particular things and needing a mobility apparatus.

Stordal et al. (2012), Rush et al. (2013), Laditka et al. (2009), Beyer et al. (2015), Jankowski et al. (2016), and Kelley-Moore et al. (2006) also suggested that disability in ageing was related to inability to perform life activities. Walking unassisted, walking distance, getting around inside, and overall levels of activity determined perception of disability (Partridge et al., 1996). Mobility was also strongly related to subjective perceptions and other factors such as personal hygiene and handiness (Partridge et al., 1996).

Contrary to the findings of this study Partridge et al. (1996) observed that the least related to perception was feeding and using the washroom which in this study were mostly related to ageing with disability. Some participants statements that reflect the theme and categories include that of the following cases.

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Cases 1, 2, and 3 linked disability to capacity change, dependence, mobility challenge, and being assisted. The ability of the person to perform self-care reduces hence the possibility of reliance on others. Mobility change was also equated to disability especially in relation to time span of walking.

Case 1

> *Hm. like bathing like this… the one with disability can bath alright but will take him time. It will take him time to do it. But he will bath alright. But the disability person when he gets old in that stage it will be difficult for him to do a lot of things* (43 years male middle-aged).

Case 2

> *Let me say as we age Um, you can walk for long but someone with a disability or someone ageing with disability you can't walk for that long period, and you will be okay. You have to rest before you continue. And some can bath themselves but there will be a type of disability that you can't even do anything for our own self. Unless someone does it for you. And then, um, so actually the performance of your daily activity will become it will not be like you used to do it, you need some assistance from people to help you do your daily activities* (22 years female young adult).

Case 3

> *You see those who are ageing with a disability their ability to do things is not like someone who is strong. Do you see? Especially those who have disability what you can do she cannot do it. Even at all if it comes to walking if you can use five minutes to walk a distance she will take about an hour* (40 years female middle-aged adult).

The statements of the participants demonstrates that ageing without disability is linked to ability to perform life activities, self-care, no capacity change, and no mobility challenge. On the other hand, the participants considered inability to perform such tasks as ageing with disability. Performance of life activities, self-care, and mobility impairment (impairment) are under medical factors in the conceptual framework. The participants conceptualize ageing as being with disability in the presence of a mobility challenge and inability to perform life activities and self-care.

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6.2 Distribution of medical factors

Table 6.2 shows the distribution of the composite scores of 'medical factors' among the 175 respondents. It presents the quartile distribution of the scale in the data among 175 respondents. The mean is '0' with a standard deviation of 26.63131 that suggests a moderate variability from the mean (Interquartile range 55.3524). Half (50 percent) of the respondents had scores that were below 11.4324, while 25 percent of the scores were below -31.0813, and 75 percent of the scores were beneath 24.2711. This suggests that a large portion of the scores were within positive values suggesting a perception of medical conditions in old age as ageing with disability.

Table 6.2: Distribution of 'medical factors' in quartiles

Number of respondents	175
Mean	0.0000
Standard deviation	26.63131
Percentiles	
25	-31.0813
50	11.4324
75	24.2711

6.2.1 Age

One-way ANOVA compared mean differences in medical factors by age group. This aspect tests the second hypothesis for the study that 'there is a significant difference in conceptualization of ageing and disability based on medical factors among young and older adults.' As displayed in Table 6.3 there was no statistically significant difference between the means of the 3 age groups (F 0.394, p value 0.675).

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Table 6.3: Mean difference in medical factors by Age

	Sum of Squares	df	Mean Square	F	Sig
Between Groups	563.347	2	281.674	0.394	0.675
Within Groups	122842.082	172	714.198		
Total	123405.429	174			

The Games-Howell post hoc analysis did not yield any statistically significant difference with multiple comparison as displayed in Table 6.4. It is inferred from the results that young adults associated medical factors with ageing with disability while middle-aged adults did not. Compared with older adults, young adults did not associate ageing with disability. These differences were not statistically significant. The second hypothesis for the study is therefore not accepted. Contrary to the hypothesis, the results demonstrates that there is no significant difference in conceptualization of ageing and disability based on medical factors among young and older adults.

Table 6.4: Post hoc test for age and medical factors

(I) Age group	(J) Age group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
20-39	40-59	1.10583	4.84981	.972	-10.4108	12.6225

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	60 and above	-3.28100	4.87234	.779	-14.8622	8.3002
40-59	20-39	-1.10583	4.84981	.972	-12.6225	10.4108
	60 and above	-4.38683	5.26367	.683	-16.8979	8.1242
60 and above	20-39	3.28100	4.87234	.779	-8.3002	14.8622
	40-59	4.38683	5.26367	.683	-8.1242	16.8979

The finding of this study is contrary to the finding of Robinson et al. (2007) who observed considerable differences in perceptions of medical factors by age group.

6.2.2 Sex

Results of the Independent samples t-test are presented in Table 6.5. The Levene's test for equality of variances yielded a p value of 0.179 and F statistic of 1.822. No statistically significant difference was observed for medical factors between males and females (p value 0.409, mean difference 3.36388). Although not statistically significant, males associated medical factors with disability, while females did not. This suggest that males view older adults who have a mobility challenge and are unable to perform self-care and life activities as ageing with a disability. The difference in the mean scores for males and females is between -4.65988 and 11.38764 at 95 percent confidence interval. This suggests the views among the males varied. Thus, other factors may have more influence on conceptualization of ageing and disability based on medical factors than sex.

Kelley-Moore et al. (2006) found significant differences in how males and females perceived disability. Their finding is contrary to the findings of this study. The results could be because of variation of age groups in the current study. The respondents in Kelley-Moore et al. (2006) were older adults while the respondents in this study include young, middle-aged, and older adults.

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Table 6.5: Independent samples t-test results in medical factors

Socio-demographic variable		N	Mean	Std. Deviation	P-value
Sex	Male	76	1.9030	25.90943	0.409
	Female	99	-1.4609	27.21260	
Ethnic group	Ga-Dangme	129	0.4720	26.29822	0.696
	All other ethnic groups	46	-1.3236	27.79760	
Children ever born alive	None	27	-5.1372	27.88229	0.277
	One or more	148	0.9372	26.38670	
Ever lived with an older adult	Yes	35	-0.3395	26.93155	0.688
	No	112	1.9454	25.25410	
Older adult had disability	Yes	149	6.8801	23.70633	0.054
	No	26	-2.4853	27.58808	
Respondent has disability	Yes	27	8.1024	25.00423	0.086
	No	148	-1.4781	26.73300	

6.2.3 Ethnic group

Table 6.5 displays the independent samples t-test results of the mean differences in medical factors by ethnic group. The Levene's test show that the two groups had equal variances with a p value of 0.367 and F statistic of 0.817. No significant difference was observed in medical factors among those who were Ga-Dangme and all other ethnic groups (p value 0.696, mean difference of 1.79556). Those who were Ga-Dangme perceived an older adult with a mobility challenge and unable to perform self-care and life activities as ageing with disability. This difference, however, was not statistically significant. The difference between the means of the two groups at 95 percent confidence interval is -7.25330 and 10.84441. It is inferred from the findings that being Ga-

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Dangme or not does not yield a significant difference in conceptualization of ageing and disability based on medical factors.

LoBianco & Sheppard-Jones (2007) also examined differences within different ethnic groups. The ethnic groups though were blacks and whites. However, it suggests how different ethnicities in a population may conceptualize disability. In consonance with the findings of this study, LoBianco & Sheppard-Jones (2007) also found no significant difference in self-perception of disability among them.

6.2.4 Children ever born alive

Independent samples t-test compared medical factors by children ever born alive. The variances of the two groups were approximately equal, with a p value of 0.370 and F statistic of 0.809. The difference in medical factors among those who had no children, and those who had 1 or more children, was not statistically significant (p value 0.277, mean difference of -6.07440). The mean difference at 95 percent confidence interval is -17.06850 and 4.91969. The respondents with no children did not associate medical factors with disability while those with 1 or more children did. Table 6.5 presents the finding.

Kelley-Moore et al. (2006) observed that older adults with more living children were significantly less likely to identify as having a disability. This portrayed a significant difference between those who have more children and those who did not. In this study, which is broader than self-perception of disability, no significant difference was observed between respondents who had 1 or more children alive and those who had no children. It is noted however, that Kelley-Moore et al. (2006)

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investigated older adults while this study included young and middle-aged adults. It cannot be determined whether the results would have been different or remain the same.

6.2.5 Ever lived with older adult

Table 6.5 presents the results of the independent samples t-test. It compared the differences in medical factors by ever lived with an older adult. The Levene's test for equality of variances showed that the variance of the two groups was equal (p value 0.160, F statistic 1.994). No significant differences were observed (P value of 0.688 with a mean difference of -2.28485). The difference between the means of the two groups at 95 percent confidence interval is -13.48378 and 8.91408. The respondents who lived with an older adult did not associate medical factors with ageing with disability but those who never lived with an older adult did.

6.2.6 Older adult lived with had disability

Independent samples t-test was used to examine the difference in medical factors by older adult lived with had a disability. The variances of the two groups were unequal (p value 0.015, F statistic 6.064). No significance difference was observed (p value 0.054, mean difference 9.36541). The difference between the means of the two groups at 95 percent confidence interval is -0.18095 and 18.91178. Though not significant, those who lived with an older adult with disability associated medical factors with disability while those who lived with an older adult with no disability did not. Table 6.5 displays the findings.

Robinson et al. (2007) in their study found that respondents who knew a person with disability were more likely to regard impairments (physical) as a disability as compared with those who

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knew no one with disability. Although their study include other age groups, it gives an idea of how living with someone with a disability influences perceptions of disability. Robbins et al. (2022) also observed significant differences between those who had contact experience with people with physical disability and those who did not have contact experience. Those with no contact experience had negative attitudes compared to the regular contact experience group (Robbins et al., 2022). Another study by Costea-Bărluţiu & Rusu (2015) also observed significant differences in the level of contact a person has with someone with a disability. Significant differences were found between those who lived with a family member with disability and those who did not live with a family member with a disability (Leutar & Raič, 2008). These studies indicate that contact experience influence perceptions of disability. The findings of this study however, are contrary to the findings of Robinson et al. (2007) and Robbins et al. (2022).

6.2.7 Respondent disability

Independent sample t-test explored the mean differences in medical factors by respondent disability status. The variances of the two groups were approximately equal with a F statistic of 2.038 and p value of 0.155. No statistically significant difference was observed (p value 0.086 and mean difference 9.58055). The difference between the means of the two group at 95 percent confidence interval are -1.35718 and 20.51829. Though not significant having a disability was associated with ageing with disability while having no disability was not. Table 6.5 presents the findings.

In a study by Robinson et al. (2007), respondents who had an impairment were more likely to view other people with a physical impairment (medical) as having a disability. Robinson et al. (2007)

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suggest the varied views among those with and without disability were not significant. The finding of Robinson et al. (2007) agrees with the finding of this study.

6.2.8 Highest educational level

One-way ANOVA compared the mean differences in medical factors by highest educational level. There was no statistically significant difference between the means of the groups. The p value of the F ratio (0.457) was 0.634. There was also no statistically significant difference in the means of the 3 groups at multiple comparison level. Compared to the respondents who have JHS/Middle or lower and SHS or higher educational level, those who never attended school associated medical factors with disability. The respondents with JHS or lower education associated medical factors with disability when compared to those who had SHS or higher educational level. The observed differences were not statistically significant. The findings suggest that educational level did not result in a considerable difference in conceptualization of ageing and disability based on medical factors. Table 6.6 shows the results.

Education was observed to be significant in explaining the differences in perceptions of disability in a study by Robinson et al. (2007). Most of the highly educated respondents in Robinson et al. (2007) considered medical factors as a disability as compared to those with lower educational level. This is contrary to the findings of this study whereby significant differences were not observed. This difference may be because only few of the respondents in this study had a tertiary level education as compared to the respondents in Robinson et al. (2007).

6.2.9 Economic activity engagement

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The ANOVA results in Table 6.6 presents a comparison in medical factors by economic activity engagement. There was no statistically significant difference in the mean scores of the 3 groups (F ratio 1.163, p value 0.315). A post hoc analysis of multiple comparisons showed no statistically significant differences in the means. The findings of this study illustrate that engagement in an economic activity or not does not yield a significant difference in conceptualization of ageing and disability based on medical factors.

A study by LoBianco & Sheppard-Jones (2007) identified significant differences between people who were employed (assumed to be akin to those engaged in an economic activity with pay) and the unemployed (assumed to be akin to those not engaged in an economic activity/economic activity without pay). This is contrary to the finding of this study.

6.2.10 Marital status

Results of the differences in the mean scores in medical factors by marital status are displayed in Table 6.6. The difference between the means of the 3 groups was statistically significant with a p value of 0.013 and F ratio of 4.464.

The Post hoc test of the multiple comparisons as displayed in Table 6.7 showed a statistically significant difference only between the respondents who were separated/divorced/widowed (I) and those who were never married (J) with a p value of 0.013 and mean difference I-J of 15.80983 and J-I of -15.80983. The results imply that the respondents who were previously married connected medical factors to ageing with disability while those who were never married did not. There was, however, no statistically significant difference in medical factors among those who were in union or currently married and those who were previously married.

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LoBianco & Sheppard-Jones (2007) observed a significant difference between married and unmarried people's self-perception of disability. It is assumed that unmarried could mean previously married or never married because the distinction was not made in LoBianco & Sheppard-Jones (2007). This confirms the omnibus result in this study which showed significant differences among the 3 groups although a significant difference was found only between previously married and never married.

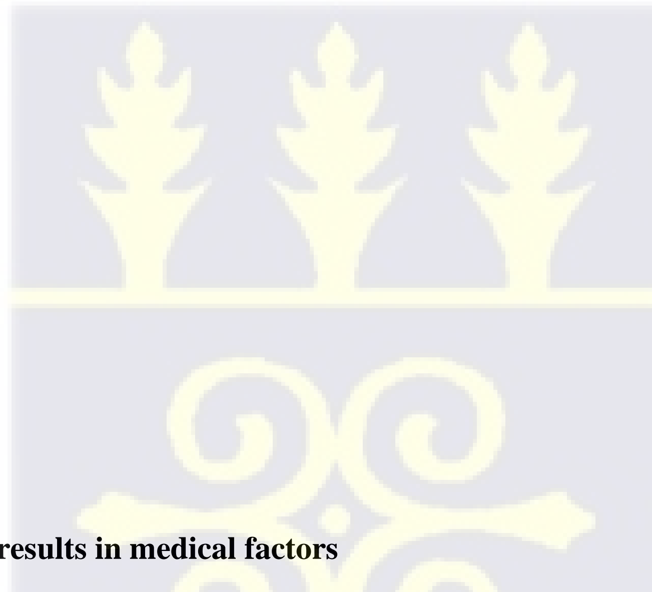

Table 6.6: ANOVA results in medical factors

Socio-demographic variables		Sum of Squares	df	Mean Square	F	Sig.
Marital status	Between Groups	6089.195	2	3044.597	4.464	0.013
	Within Groups	117316.235	172	682.071		
	Total	123405.429	174			
Highest level of education	Between Groups	651.762	2	325.881	0.457	0.634
	Within Groups	122753.667	172	713.684		
	Total	123405.429	174			
Economic activity engagement	Between Groups	1646.005	2	823.002	1.163	0.315
	Within Groups	121759.425	172	707.904		

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	Total	123405.429	174			
Perceived wealth status	Between Groups	4671.703	2	2335.852	3.384	0.036
	Within Groups	118733.726	172	690.312		
	Total	123405.429	174			
Religious affiliation	Between Groups	1938.912	2	969.456	1.373	0.256
	Within Groups	121466.517	172	706.201		
	Total	123405.429	174			

Table 6.7: Post hoc test result for marital status and medical factors

(I) marital status	(J) marital status	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
In union/currently married	separated/divorced/ widowed	-7.33910	4.49680	.236	-18.0118	3.3336
	never married	8.47073	5.15620	.234	-3.8385	20.7800
separated/divorced/widowed	In union/currently married	7.33910	4.49680	.236	-3.3336	18.0118
	never married	15.80983*	5.43684	.013	2.8439	28.7758
never married	In union/currently married	-8.47073	5.15620	.234	-20.7800	3.8385
	separated/divorced/ widowed	-15.80983*	5.43684	.013	-28.7758	-2.8439

*. The mean difference is significant at the 0.05 level.

6.2.11 Perceived wealth status

One-way ANOVA examined the differences in the means of medical factors by perceived wealth status. Table 6.6 presents the results. There was a statistically significant difference between the mean scores of the 3 groups based on the omnibus results (p value 0.036 and F ratio 3.384).

The results of the post hoc test are presented in Table 6.8. Only those who perceived their wealth status as poor (I) and those who were middle status (J) (p value 0.030, mean difference I-J is 10.58508, J-I -10.58508) had significant difference in medical factors. Those who perceived their

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wealth status as poor associated medical factors with ageing with disability, while those in the middle wealth status did not. Although not statistically significant, the respondents who perceived their wealth status as rich also associated medical factors with ageing with disability, while those in the middle did not.

Table 6.8: Post hoc test result for perceived wealth status and medical factors

(I) marital status	(J) marital status	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Poor	Middle	10.58508*	4.11296	.030	.8421	20.3280
	Rich	.66901	10.08229	.998	-28.6724	30.0104
Middle	Poor	-10.58508*	4.11296	.030	-20.3280	-.8421
	Rich	-9.91607	9.93531	.601	-39.2310	19.3988
Rich	Poor	-.66901	10.08229	.998	-30.0104	28.6724
	Middle	9.91607	9.93531	.601	-19.3988	39.2310

*. The mean difference is significant at the 0.05 level.

6.2.12 Religious affiliation

One-way ANOVA compared the means in medical factors by religious affiliation. The omnibus showed no statistically significant difference between the means of the three groups (p value 0.256, F ratio 1.373). However, post hoc test showed a significance difference in medical factors between those affiliated with Christianity (I) and no religion (J) with a p value of 0.000 and a mean difference of I-J is -22.27935, J-I is 22.27935. Table 6.6 shows the omnibus results while Table 6.9 displays the post hoc test.

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The respondents affiliated with Christianity did not associate medical factors with ageing with disability, but those with no religious affiliation did. No significant difference was observed for affiliation with Christianity and Islam, and affiliation with Islam and no religion. It is noted though that the respondents affiliated with Islam and no religion were minimal, and this could have influenced the results.

Table 6.9: Post hoc test results of religious affiliation and medical factors

(I) Religious affiliation	(J) Religious affiliation	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Christian	Islam	-.20585	12.37417	1.000	-37.5703	37.1586
	No religion	-22.27935*	2.87019	.000	-29.8653	-14.6934
Islam	Christian	.20585	12.37417	1.000	-37.1586	37.5703
	No religion	-22.07350	12.35887	.249	-59.4560	15.3090
No religion	Christian	22.27935*	2.87019	.000	14.6934	29.8653
	Islam	22.07350	12.35887	.249	-15.3090	59.4560

Although LoBianco & Sheppard-Jones (2007) studied engagement in religious activities and not religious affiliation, they observed a significant difference among respondents who attended religious services and those who did not.

6.3 Multivariate analysis

Linear regression was used to explore the relationships between 'age,' the other socio-demographic variables, and medical factors. Table 6.10 presents the model. The omnibus model

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was not statistically significant, with a p value of 0.088, F statistic of 1.511, R square of 0.156, and R of 0.395. The model explains 15.6 percent of the variations in conceptualization of ageing and disability based on medical factors. From the model, it was observed that the key independent variable 'age' was not a significant predictor of medical factors. The categories 40-59 years (middle-aged adults) and 60 years and above had a negative relationship with medical factors. These relationships were not statistically significant. Compared to young adults, both middle-aged and older adults did not associate medical factors with ageing with disability. This implies that young adults conceptualized ageing as being with disability based on medical factors. These observed associations were not statistically significant. The findings is contrary to that of Robinson et al. (2007). Robinson et al. (2007) indicated that middle-aged adults regarded medical conditions (factors) as a disability as compared to other age groups.

The study found no significant relationship between medical factors and the respondents' sex, education, ethnicity, economic activity engagement, children ever born alive, religious affiliation, and ever lived with an older adult, older adult lived with had disability, and respondent's disability. Hence, these variables were not significant predictors of medical factors. LoBianco & Sheppard-Jones (2007) studied perceptions of disability based on self-perception. Contrary to the finding of this study, LoBianco & Sheppard-Jones (2007) observed that employed people were less likely to perceive themselves as having a disability than unemployed people (LoBianco & Sheppard-Jones, 2007). Although their study is on self-perception it sheds some light on how disability is conceptualized. In this study no significant relationships were observed for the respondents engaged in an economic activity with pay (mostly employed) and those who were not engaged in any economic activity (mostly unemployed). However, in this study it was observed that compared with those engaged in an economic activity with pay (employed), both those engaged in an

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economic activity with no pay and those engaged in no economic activity (unemployed) associated medical factors with ageing with disability.

Regarding sex, the males in the study by LoBianco & Sheppard-Jones (2007) were more likely to perceive themselves as having a disability than females. This study showed that males associated medical factors with ageing with disability, while females did not. The association, though, was not statistically significant.

Only marital status and perceived wealth status were significant predictors of medical factors. For marital status, those in union/currently married had a negative but fairly weak relationship with medical factors. Those who were never married had a slightly strong but negative relationship with medical factors. These relationships were statistically significant. People who were never married or in union/currently married did not link medical issues with ageing and disability, unlike previously married people. These suggest that being married or not influenced conceptualization of ageing and disability among the participants. LoBianco & Sheppard-Jones (2007) in their study discovered that unmarried people were more likely to perceive themselves as having a disability than their married counterparts. Although this study is related to a phenomenon that is not self-perception, most unmarried people regarded the phenomenon as ageing without disability.

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Table 6.10: Predictors of conceptualization of ageing and disability based on medical factors

Socio-demographic Variables	Standardized Coefficients Beta	t Statistic	Sig.	95 % Confidence Interval for B Lower Bound	Upper Bound
Age					
40-59	-.132	-1.365	.174	-18.243	3.332
60 and above	-.189	-1.555	.122	-24.917	2.968
20-39 (RC)	-	-	-	-	-
Sex					
Female	-.115	-1.384	.168	-14.931	2.630
Male (RC)	-	-	-	-	-
Education					
Never attended school	.059	.708	.480	-8.837	18.702
SHS or higher	.028	.317	.752	-8.104	11.205
JHS and below (RC)	-	-	-	-	-
Ethic group					
All other ethnic groups	-.037	-.466	.642	-11.785	7.287
Ga-Dangme (RC)	-	-	-	-	-
Economic activity engagement					
No economic activity	-.029	-.311	.756	-12.909	9.395
Economic activity with no pay	-.055	-.685	.494	-28.710	13.925
Economic activity with pay (RC)	-	-	-	-	-
Children ever born alive					
None	.045	.397	.692	-13.053	19.610
1 or more children (RC)	-	-	-	-	-
Marital Status					
In union/currently married	-.197	-1.979	**.050**	-21.056	-.021
Never married	-.395	-3.132	**.002**	-39.690	-8.986
Separated/Divorced/Widowed (RC)	-	-	-	-	-
Perceived wealth status					
Poor	.188	2.334	**.021**	1.593	19.158
Rich	.064	.817	.415	-12.314	29.672
Middle (RC)	-	-	-	-	-
Religion					
Islam	-.014	-.179	.858	-23.330	19.444
No religion	.063	.802	.424	-16.460	38.943
Christianity (RC)	-	-	-	-	-
Ever lived with older adult					
No	.333	1.211	.228	-15.728	65.516
Yes (RC)	-	-	-	-	-
Older adult had disability					
Yes	.115	1.432	.154	-2.900	18.173
No (RC)	-	-	-	-	-
Respondent has disability					
No	-.090	-.946	.346	-20.496	7.221
Yes (RC)	-	-	-	-	-

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It was also observed from the model that poor perceived wealth status had a positive fairly weak relationship with medical factors. This relationship was statistically significant. Rich perceived wealth status also had a positive but weak relationship with medical factors. The relationship between rich perceived wealth status and medical factors was not statistically significant. Those with poor perceived wealth status associated medical factors with ageing with disability those with middle wealth status did not. This association was statistically significant. No significant differences were observed for those with rich perceived wealth status and middle perceived wealth status.

6.4 Summary

This aspect of the study sought to explore how medical factors are used to conceptualize ageing and disability by the respondents. The qualitative study explored factors that made up medical factors. Themes from the qualitative study include diseases, health decline, and performance of ADLs and IADLs (life activities, self-care, and mobility). Following Cronbach's alpha analysis and EFA of the quantitative data, variables related to ADLs and IADLs, including life activities, self-care, and mobility, were retained for further analysis. The items under these themes were used to develop an instrument for the quantitativ aspect of the study.

The quantitative study examined how medical factors determined the conceptualization of ageing and disability. The findings from the survey showed no significant differences in medical factors among young, middle-aged, and older adults. Young and older adults did not have a significant difference in medical factors. The study hypothesis was therefore not accepted. Significant differences were only observed for marital status, perceived wealth status, and religious affiliation.

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Significant predictors for medical factors include marital status and perceived wealth status. Poor perceived wealth status and previously married were associated with conceptualization of ageing as being with disability. All the other socio-demographic variables, including age, had no significant associations with medical factors.

The medical model of disability was prominent in the findings of this study (both qualitative and quantitative). Mobility challenge and inability to perform life and self-care activities were perceived as ageing with disability. This mode of conceptualization was mainly related to bodily changes. The finding contrasts the assertion of Sagner (1999, p2) that African construction of ageing is more on social/relational factors than biological processes in individualized bodies. The biopsychosocial and social model were also relevant in the qualitative study. The methods employed helped in answering the research question.

The National Policy on Ageing stipulates that 'poor health and nutritional status inhibits older person's participation in income generating activities' (Ministry Of Employment and Social Welfare, 2010 p23). However, apart from physical ability older adults can contribute to society by sharing the knowledge gained through the years. This can serve as an income generating activity. However, when focus is placed on their health status and physical ability which in this study is perceived as a disability, such income generation would be difficult. Hence the tendency of older adults being perceived as burdensome to families and society.

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CHAPTER SEVEN

CONCEPTUALIZATION OF AGEING AND DISABILITY BASED ON CONTEXTUAL FACTORS

7.0 Introduction

Understanding the impact of contextual factors on participants' conceptualization of ageing and disability is crucial for this study. This chapter aims to explore these contextual factors, which include both environmental and personal elements, to provide a comprehensive understanding of their influence. The necessity of this chapter lies in its potential to uncover how these factors shape perceptions and experiences, which is essential for developing targeted interventions and policies. The chapter begins with a qualitative analysis, presenting themes, categories, and codes supported by quotes from participants. This qualitative insight is foundational for forming a proxy for the dependent variable using quantitative data. The variables retained after Cronbach's alpha analysis and Exploratory Factor Analysis (EFA) were used to create the 'contextual factors scale.' At the bivariate analysis level, independent samples t-test and one-way Analysis of Variance (ANOVA) were employed to examine differences in the means of contextual factors across various socio-demographic characteristics. The Games-Howell post hoc test was chosen for the ANOVA due to its reliability in controlling Type I error across unequal group sizes (Sauder & Demars, 2019). Furthermore, linear regression was utilized to explore the relationships between socio-demographic variables and contextual factors. The chapter concludes with a summary of the findings.

7.1 Contextual factors

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The qualitative phase explored constituents of contextual factors in the participants' conceptualization of ageing and disability. Contextual factors were factors that influenced the participants' knowledge formation on ageing and disability. Themes that emerged include fear, social participation, beliefs, and experience. Figure 7.0 presents the themes with their corresponding categories. Both personal and environmental factors were observed. Sociological ageing was evident in the patterns that emerged. Social role changes were described as a part of the process of ageing by most young, middle-aged, and older adults. The way people viewed these role changes varied. Some thought of it as a disability (reflects the medical model), while others saw it as a typical part of ageing. The social model describes disability as a social construct. This can be inferred from the themes that emerged. Participants' views on ageing and disability were shaped by their beliefs and experience.

Figure 7.0: Thematic representation of themes that constitute contextual factors

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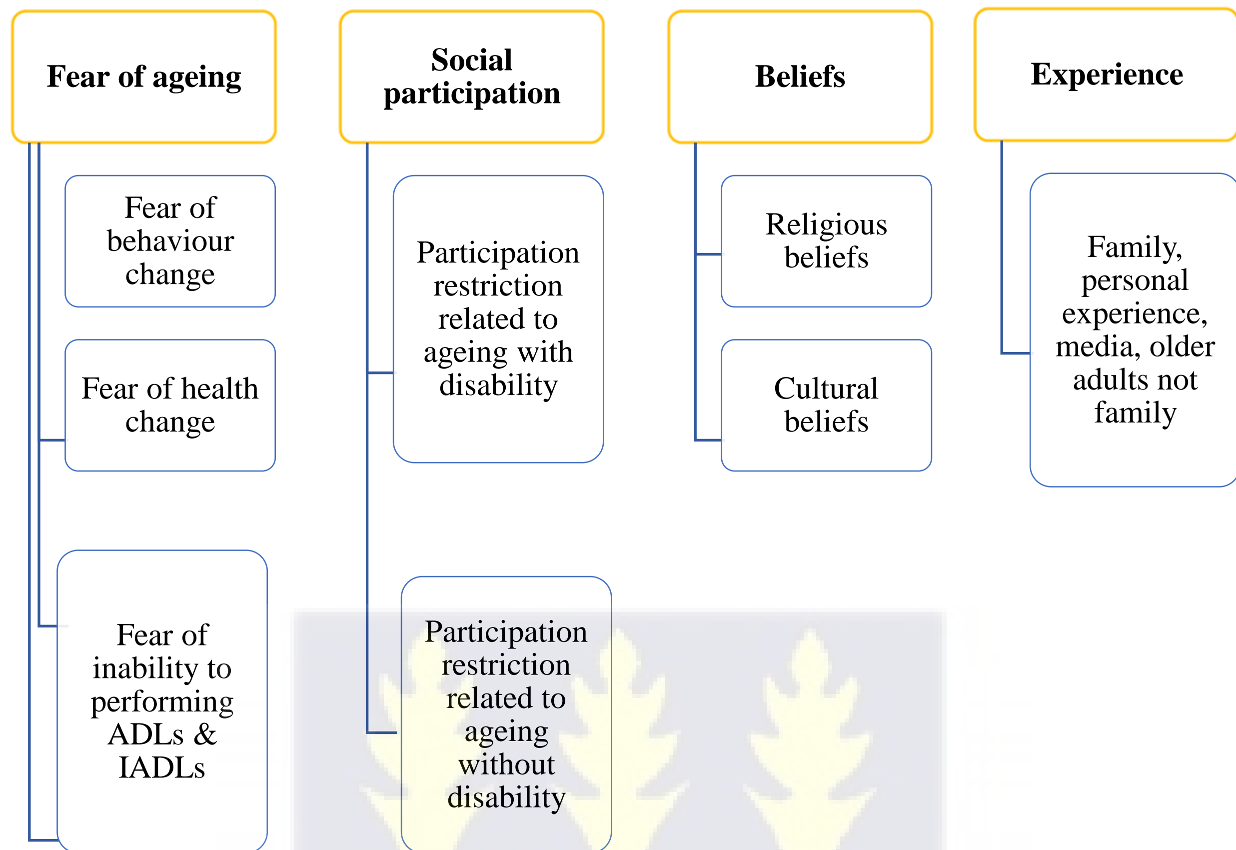

7.1.1 Fear

Fear was one theme that influenced how the participants conceptualized ageing and disability. Fear was related to performance of ADLs and IADLs, disease and disability, behaviour change, and fear of witchcraft accusations. These fears were mostly among young and middle-aged adults except for one older adult who had a fear of the inability to perform self-care activities. The fears of the participants were related to what they perceived to be a disability during ageing, and this reflects the medical model of disability. Young adults feared older adults' experiences with health, daily tasks, and behaviour changes. They envisaged themselves experiencing such diseases and disability during old age. These fears emanated from negative experiences.

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The fears associated ageing with disability and are likely to be experienced by everyone. Some discussions in the study found that participants believed ageing with disability is hereditary. This suggests that if the participant's family is noted to have a disability in old age, then that participant would also have a disability. Table 7.1 displays the theme 'fear' with its associated categories and the corresponding codes.

Table 7.1: Categories and codes associated with fear

Theme	Category	Codes
Fear	Fear related to performance of ADLs and IADLs	Being stuck at one place, unable to carry out activities, inability to bath, inability to lift things, room confinement, not having help, inability to walk, inability to carry out activities, difficulties, and inability to go to washroom by self.
	Fear of behaviour change	Excessive talking, menopause, and witchcraft accusations.
	Fear of health change	Fear of diseases, stroke, injury due to diabetes, and disability

The findings of the study are comparable to some previous studies. Fear of ageing is mostly prevalent among young adults (Brunton & Scott, 2015). Poorer health was also associated with a greater fear of ageing (Brunton & Scott, 2015). Chonody et al. (2014) showed that fear of ageing predicted the attitude of people toward ageism. In Stein (1995), the respondents had fear of changes in physical appearance, lack of control over changes in appearance, and fear of death. In this study, however, the participants did not mention fears in relation to changes in physical appearance, although some of them had a fear of death. Similar to the findings in this study, some people in Stein (1995) also had a fear of the inability of the body to perform and function.

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Some participants expressed fears that influenced how they thought about ageing and disability.

Case 1

> *For ageing what you are afraid of is reaching an age where you are unable to lift things as you used to in the past. The things you do that your strength does not allow you. You pray to that you do not experience that* (46 years male middle-aged).

Case 2

> *For me the only thing I am afraid of that I plead God for is that like I said that I don't want to be stuck at one place. That something will happen to me for me to remain at one place such that I cannot bath, excuse me to say that I cannot go to the washroom to pass urine or do something. That is the only thing I plead God for that he should take it away* (65 years female older adult).

Cases 1 and 2 were both afraid of the inability to perform life activities such as lifting and mobility challenges. These are some fears they had about ageing, and it influenced their conceptualization of ageing and disability. It could be inferred that these fears are perceived as a disability by the participants. Case 2, for instance, in an earlier conversation attributed inability to perform the activities she was afraid of as ageing with disability. Another participant described her fear in this statement.

Case 3

> *Ageing too as we were saying most of them you start having menopause, talking, saying things that don't even concern you. Then they start calling 'you witch…' and a lot of things* (28 years female young adult).

This statement by the participant described the fear some participants had. The participants related behavioural change in ageing as a basis for witchcraft accusations. Witchcraft accusations were claimed to result in abandonment and maltreatment of the older adult. This leads to disability. Some participants did not link behavioural changes to disability. Although behavioural changes were perceived as ageing with disability by some participants.

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For participants who were afraid of change in health, a few participant quotations that describe their fears include:

Case 1

> *That's when you start experiencing disability. Things you used to do you can't do it and you and if you are not lucky enough to have people around you, you will be facing difficulties. As at now when you send someone or even your child they frown. So, when you start ageing and maybe you can't walk, and you are inside. If you age with disabilities too that is my fear* (28 years female young adult).

Case 2

> *Um, so yeah, at times we fear what is happening to them will also happen to me. Maybe with the kind of things they go through with the process at times it's scary you will also not like to go through that, but it is a must you will go through that. With the kind of sicknesses, we have been seeing like stroke so at times you fear when you get there you will also get them, so you ask yourself questions* (22 years female young adult).

7.1.2 Social participation

Social participation was linked to an older adult's activeness in society and social roles. Similar views on social roles were observed among young, middle-aged, and older adults. It was noted, however, that very few middle-aged adults considered such inability as ageing with disability. Most participants accorded an inability to engage in social activities as unrelated to a disability. They connected such phenomenon to the ageing process. This reflects an admittance of the ageing process and biological ageing. This can be associated with the social model of disability, which purports that an individual's limitation is not a disability. Inability to perform social roles, however, was associated with disability among only few participants.

Participation restriction, therefore, was perceived as ageing with or without disability. The codes include cannot perform social roles, social roles changes, cannot engage in social activities, can

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engage in social activities, can perform social roles, social roles depend on the condition of the older adult. These quotes describe the views of some participants who did not associate participation restriction with disability.

Case 1

> *So, things will change. So, when you get old a lot of things that you have to hand over to someone beside you know that he also can do like the way you are, the time you are young the person can. Hand over. Because when I come in position as a chairman, we have an old man who was doing it but he is not performing very well so I think now we the young guys have to take on to do it. So, we also when me also I get to some age somebody has to continue. So, you can't do at old age. In that way I cannot say eh is a disability you know, because like as I explain from the beginning when I said when somebody is a disability you could see that the person is someone that he cannot do anything. You can't do anything on your own. People have to help you to do it. So maybe when you see yourself that you are going around and all over the things that you used to do you can't do them* (43 years male middle-aged).

Case 1 narrates that social roles changes during ageing. Although he did not regard such an inability to be disability. Case 2 connects behavioural change to social roles. She describes in her statement that the older adult does not speak a lot. A decrease in strength prevents him from sitting in a meeting for long. This, she said, is not a disability. It is inferred from her statement that the ability to perform roles changes during ageing.

Case 2

> *Let us say I am the head of the family, and something happens I will call the people but if I look at my age and the way I am growing old, and my strength is declining and growing weak. As we are sitting here, I will say this and that. If they do it fine. If they don't fine. You get up and leave them. It does not mean you have a disability* (61 years male older adult).

Case 3 also touches on engagement in social activities and the ability to perform them. She ascribed the inability to engage in activities to ageing without disability.

Case 3

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> *It can be that where you have reached you cannot go places. The way you used to do things quickly you cannot do them again. That is not a disability but ageing* (51 years female middle-aged).

The following participants perceived the inability to engage in social activities as a disability. Case 1, for instance, related changes in social participation as accompanying ageing. She accorded the change to disability. In an earlier part of the conversation, Case 2 recounted that she used to attend funerals or prepare meals for occasions in the past. However, she cannot do that currently. She related her inability to perform such roles in the family as a disability.

Case 1

> *It can change. It has to change. It can change in the sense that when you were young and a lady you go out and come back. But it will get to a time when you cannot go again. Yes. You cannot go again. If something comes up, you go and come back. You cannot do it again. When they go to a funeral and they are doing something they will say that if this person was with us, she would have helped with this, but now that she is old, she cannot. Yes* (65 years female older adult).

Case 2

> *It is a disability. Yes. Now I am a disabled person. I am unable to go anywhere so I am disabled (58 years, female middle-aged adult).*

The findings of this study are in consonance with the findings of previous studies. Kalyanpur (1999) for example, suggests that disability is defined by the community's understanding of individuals roles and their physical ability to perform them. Sagner (1999) asserts that 'older' in Africa is usually based on standard roles. Elderliness is thus based on social relationality of the older adult (Sagner, 1999). Hence, social functioning was important in conceptualization of ageing and disability by the participants. Attributing inability to perform such roles as a disability ascribes to the medical model. The medical model individualizes the phenomenon. This notion is what the social model rejects. Some participants though regarded such inabilities as ageing without disability. Their view agrees with the social model of disability.

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7.1.3 Beliefs

Beliefs was a theme that emerged from the data, and it had two categories, namely cultural and religious beliefs. Figure 7.1 displays beliefs and its associated categories and the codes that formed the category. The participants' beliefs influenced their knowledge formation on ageing and disability. Most of the participants ascribed their knowledge to religious books, such as the Bible. They described that whatever is expected of man is written in the Bible and that is how they formed their knowledge. Some participants attributed their knowledge directly to God. The participants' beliefs were also revolved around what they considered as the source of ageing with disability. Many of them believed that ageing with disability is from God. They perceived some people age with disability because of punishment for their sins. This bothers on morality whereby people who lead good lives age without disability while those who were evil age with disability.

For cultural beliefs, some participants believed that ageing with disability is a curse. This, they suggested, may stem from the actions of forefathers that have been passed on to the descendants. Some participants also attributed ageing with disability to a curse from a spiritual altar rooted in offense. Most young, middle-aged, and older adults ascribed to such views. Beliefs thus were important variables that influenced the participants' conceptualization of ageing and disability.

Figure 7.1: Beliefs and its associated categories and codes

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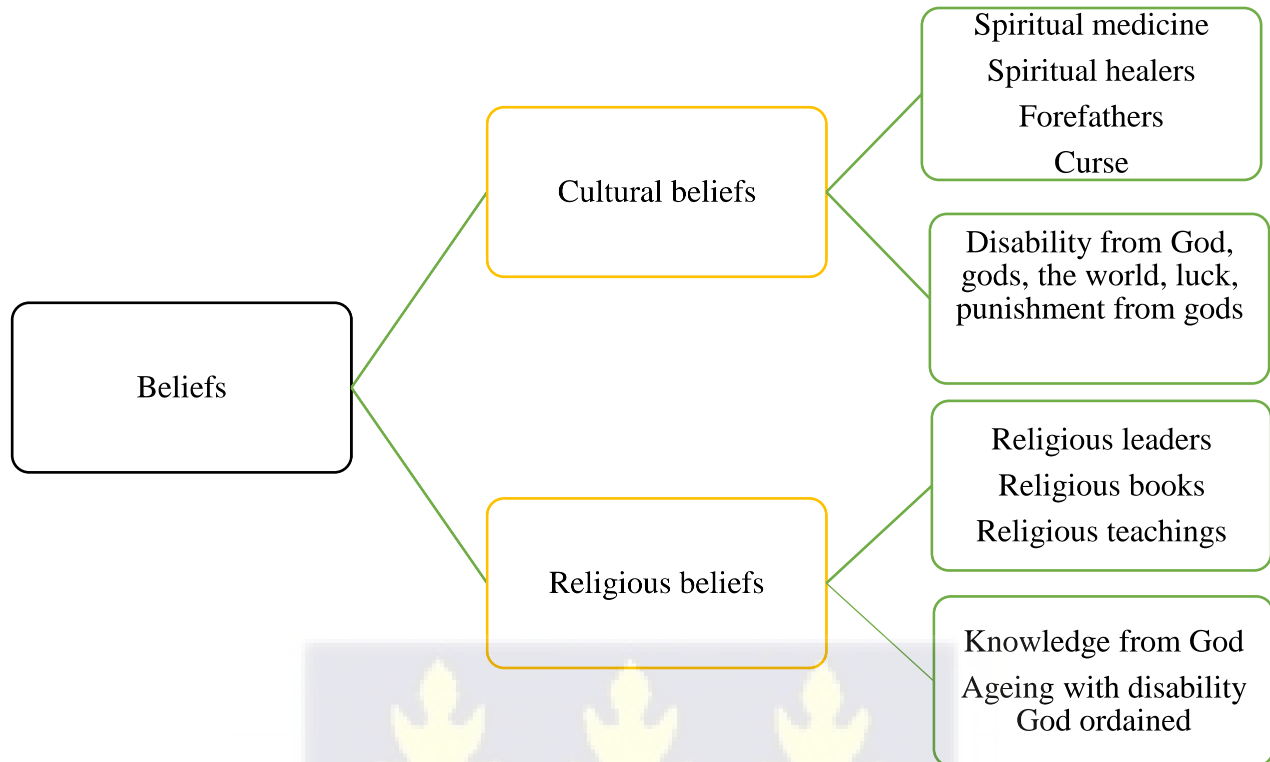

The following participants' statements portray how their beliefs influenced their perceptions. The first participant in her statement described that cognitive decline was instituted by God. Such cognitive decline was attributed to ageing with disability. The participant implied that ageing with disability was instituted by God, and it is something that is bound to happen to everyone.

Case 1

> *For that God said that when you grow old you will turn into a child again and your mind will even change. Whatever you do will change. It is God who gives it. Because whatever you do you will age* (30 years female young adult).

Case 2 attributed the cause of ageing with disability to the consequences of conduct of an individual. Such punishment is given by God.

Case 2

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> *It is your works that you brought on earth that God will reward you for. Do you see? Maybe when you came to the world you did not serve God, but you go to an idol to kill your brother. God will punish and reward you. Do you see?* (61 years male older adult).

Case 3 attributed her knowledge to the word of God and religious teachings.

Case 3

> *Yes, it is through the word of God. After studying the word of God, I know all this. As for that, God is the one taking care of us. There is a stage that will be reached. It is in the Bible and not human. You see. When you read the Bible, someone may have had a disability because of a sin she committed. It is from God. So, for this world that we are in, doing good and evil is what will give us a disability. You see how it is. If you live a good life nothing will happen to you. It depends on the way we live. Our good works. If God keeps you alive and you wake up, that is it. You are not afraid. Whatever you do you will go. It is useless to put such fears in you* (80+ years female older adult).

Some previous studies have outlined the influence of beliefs on perceptions. Abang (1988) suggests that some Nigerians perceived that disability was a curse from God and this is a reward of their deeds. Some Somali residents in a study by Greeson et al. (2001) ascribed the cause of disability to God. The same was observed in Jordan as an act of God, in a study by Turmusani (1999). In Kuwait, disability, according to participants in Raman et al. (2010) is from a divine intervention. These suggest that different societies are influenced by beliefs in their conceptualization of disability. This probably is a notion the social model of disability asserts. Disability is socially and culturally constructed (Lord et al., 2015; Bickenbach et al., 1999).

7.1.4 Experience

Another theme that emerged from the qualitative data is experience. Experience was an important factor in knowledge formation on ageing and disability. Experience was related to an older adult's personal experience and from other older adults or relatives. Some young adults also described

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peculiar experiences related to moving from a lower age to a higher one. Knowledge from older relatives was from living with their parents or grandparents. Knowledge was also formed based on experiences of older adults outside the home/family environment. These young adults never lived with an older adult, so their knowledge hinged on what they saw of older adults in the community. It was observed that whatever they saw of the older adults determined how they conceptualized ageing and disability. Apart from the young and middle-aged adults, two older adults ascribed their knowledge to what they had seen of their parents and grandparents. These experiences gave them expectations of how their ageing experience will be. Experience, whether personal or from others, influenced their perceptions. Negative experiences were mostly associated with conceptualization of ageing as being with disability. While positive experiences were mostly associated with conceptualization of ageing as being without disability.

The codes linked to experience include experience with older adults (does not include family members), experience with family, and personal experience (older adult respondent experience, growth).

Case 1 recounted that he learnt about ageing from his relatives. Case 2 described that she formed knowledge from her experience with her grandmothers.

Case 1

> *That is why I said I associated myself with older adults. Currently my father's younger brother. I will call him our father. If not at all he is 95 years old. He is alive currently* (46 years male middle-aged).

Case 2

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> *Oh, because I lived with my grandmothers, I saw all that and I was with them before they died. So, I saw it myself. If you did not live with your mother, then you would not know. If you did not live with your mother or grandmother, how will you see it? Like this woman with all her grandchildren around her then you will know* (80+ years female older adult).

For personal experience, Case 3 described how he formed knowledge on ageing and disability. He explained that such issues are not taught but are experienced by individuals while they advance in age.

Case 3

> *Eh, this knowledge is not a new thing that you will go to someone to teach you. But so far as you are born, and you get two years, three years, to some age like I said I am 43 now, you yourself have to sit down to think. So, it's something like someone will do, you come and will come and call you that you are growing ooo, so you will get fifty, this is what will this is what will, do this what now. You yourself have to sit down and think about it that you are growing so, when I get to this age maybe this is what I want to do so, this is not anything that someone will call you and tell you* (43 years male middle-aged).

Experience with an older adult was inherent in the participants' perceptions. They formed their knowledge from how the older adults they were involved with experienced or is experiencing ageing. The findings of this study are comparable to the findings of previous studies. Chonody et al. (2014) also suggested that contact (experience) is a predictor of ageism, for instance. Other studies that have shown that experience influences perceptions include studies by Robinson et al. (2007), Wise & Onol (2021), and Robbins et al. (2022). Experience thus, is an important factor that could influence conceptualization of ageing and disability.

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7.2 Distribution of contextual factors

Table 7.3 shows the distribution of the composite scores of 'contextual factors' among the 175 respondents. It presents the quartile distribution of the composite scores in the data among 175 respondents. The mean is '0' with a standard deviation of 12.34777 that suggests a moderate variability from the mean (Interquartile range 19.4312). Half (50 percent) of the respondents had scores that were below -5.7322, while 25 percent of the scores were below -9.4061, and 75 percent of the scores were beneath 10.0251. This suggests that a large portion of the scores were within negative values, indicating the influence of contextual factors on the views of the majority of the participants.

Table 7.2: Distribution of 'contextual factors' in quartiles

Number of respondents	175
Mean	0.0000
Standard deviation	12.34777
Percentiles 25 50 75	 -9.4061 -5.7322 10.0251

7.2.1 Age

One-way ANOVA compared the means of contextual factors by age group. The results as presented in Table 7.4 showed that there was no statistically significant difference between the means of the 3 groups with a p value of 0.560 and F ratio 0.582. Post hoc test of multiple comparisons also showed no statistically significant difference in the means. Table 7.4.1 displays the post hoc test of multiple comparisons. Compared to older adults, middle-aged adults were not

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influenced by contextual factors in their conceptualization of ageing and disability. The study hypothesized that there is a significant difference in conceptualization of ageing and disability based on contextual factors among middle-aged and older adults. The findings, however, showed that there is no significant difference between them. The hypothesis, therefore, was not accepted.

Table 7.3: Mean differences in contextual factors by age

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	178.197	2	89.098	0.582	0.560
Within Groups	26351.141	172	153.204		
Total	26529.338	174			

Table 7.4: Post hoc test of contextual factors by age

(I) Age group	(J) Age group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
20-39	40-59	-1.24923	2.15981	.832	-6.3841	3.8856
	60 and above	-2.46827	2.29224	.531	-7.9295	2.9930
40-59	20-39	1.24923	2.15981	.832	-3.8856	6.3841
	60 and above	-1.21904	2.59536	.886	-7.3892	4.9511
60 and above	20-39	2.46827	2.29224	.531	-2.9930	7.9295
	40-59	1.21904	2.59536	.886	-4.9511	7.3892

In a study by Robinson et al. (2007), significant differences were observed for age. It suggests that age influenced the perception of disability by the respondents in their study. In this study, there was no significant difference in contextual factors among the age groups. Although compared to young adults, middle-aged and older adults were influenced by contextual factors.

7.2.2 Sex

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Independent samples t-test compared the mean scores of contextual factors by sex. The Levene's test for equality of variance showed that the variance was approximately equal, with a P value of 0.617 and F statistic of 0.251. There was no significant difference in the means of males and females (P value = 0.666, mean difference = 0.81595). Contextual factors affected males' views on ageing and disability, but not females. The difference between the means of males and females at 95 percent confidence interval was -2.90966 and 4.54155. This suggests that the influence of contextual factors on the perceptions of males varied. Table 7.5 displays the results.

Doncel-García et al. (2022) in their study observed no significant difference in negative stereotypes of ageing among males and females in one group of the respondents. However, significant differences were observed for another group of respondents based on residence. This study though did not examine differences in relation to place of residence. Doncel-García et al. (2022) suggests that perception varies by sex. Significant differences were also observed for males and females' perception of disability in Kelley-Moore et al. (2006). This is contrary to the findings of this study.

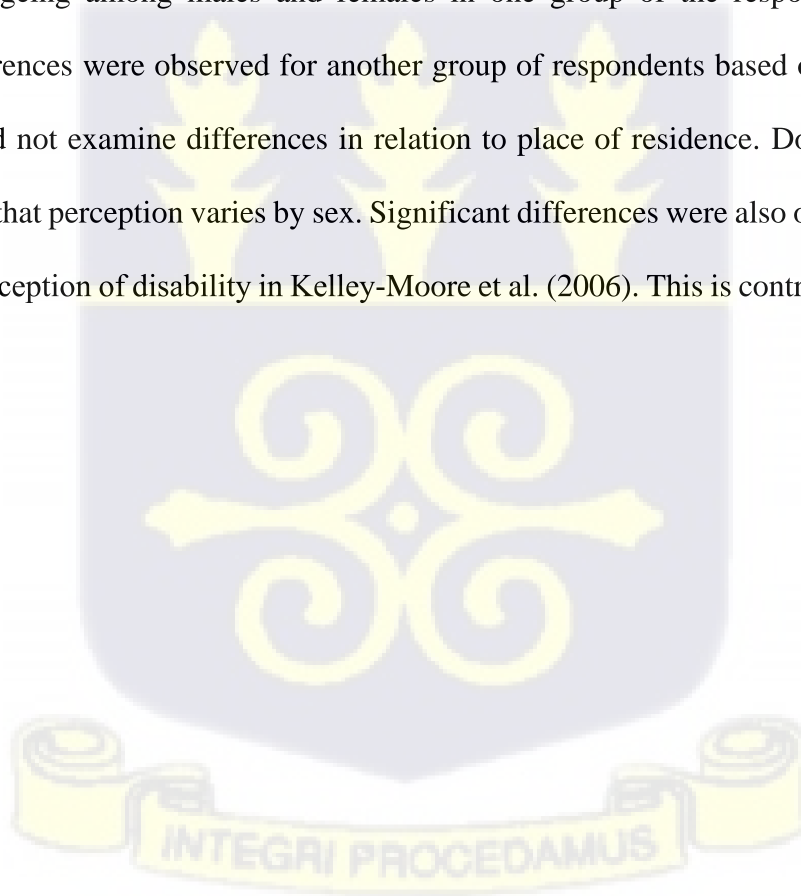

Table 7.5: Independent samples t-test results in contextual factors

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Socio-demographic variable		N	Mean	Std. Deviation	P-value
Sex	Male	76	0.4616	11.58662	0.666
	Female	99	-0.3544	12.94888	
Ethnic group	Ga-Dangme	129	-0.2182	12.22080	0.697
	All other ethnic groups	46	0.6119	12.81443	
Children ever born alive	None	27	-1.3075	9.89145	0.551
	One or more	148	0.2385	12.75912	
Ever lived with an older adult	Yes	149	0.6131	12.64981	0.116
	No	26	-3.5133	9.93942	
Older adult had disability	Yes	35	4.7520	13.53973	0.030
	No	112	-0.5663	12.23288	
Respondent has disability	Yes	27	3.4785	15.10313	0.112
	No	148	-0.6346	11.72599	

7.2.3 Ethnic group

The difference in the mean scores of contextual factors by ethnic group was compared using independent samples t-test. The Levene's test for equality of variances showed that the variances of the 2 groups were approximately equal with a p value of 0.779 and F statistic 0.079. There was no statistically significant difference in the means of the 2 groups with a p value of 0.697 and a mean difference of -0.83009. Compared with all other ethnic groups, the perceptions of those who were Ga-Dangme were not influenced by contextual factors. The means of the respondents who were Ga-Dangme and all other ethnic groups at 95 percent confidence interval was -5.02566 and 3.36548. This suggests that the impact of contextual factors on the views of ageing and disability among Ga-Dangme's varied. Table 7.5 displays the results.

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Cramm & Nieboer (2017) in their study observed significant differences in ageing perceptions among two ethnicities. In this study, ethnicity did not yield significant differences in the influence of contextual factors in how ageing and disability is perceived.

7.2.4 Children ever born alive

Independent samples t-test compared the mean scores in contextual factors by children ever born alive. The Levene's test for equality of variances showed that the variances of the two groups were approximately equal with a p value of 0.090 and F statistic 2.905. No significant difference was observed in the means of the 2 groups (p value of 0.551 and mean difference -1.54603). Compared with those with 1 or more children, the perceptions of those with no children were not influenced by contextual factors. The difference between the means of contextual factors between the two groups at 95 percent confidence interval was -6.65574 and 3.56368. This suggests that how contextual factors influenced the views of those with no children varied. Table 7.5 presents the findings. Contrary to the finding of this study, Kelley-Moore et al. (2006) observed a significant difference in self-perception of disability among those who had children and those who had no children.

7.2.5 Ever lived with an older adult

Independent samples t-test compared the mean scores in contextual factors by ever lived with an older adult. The Levene's test for equality of variances showed approximately equal variances among the two groups (F statistic = 3.050, p value = 0.083). No significant difference was observed in the means of the two groups (p value = 0.116, mean difference = 4.12641). The views of those

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who lived with an older adult were influenced by contextual factors. However, the perceptions of those who never lived with an older adult were not influenced by contextual factors. The influence of contextual factors on the views of ageing and disability among those who lived with an older adult varied (the difference between the means at 95 percent confidence interval is -1.03144 and 9.28426). Table 7.5 displays the results.

In a study by Wise & Onol (2021), a significant difference was observed in the perceptions of physical appearance and fear of losses among the respondents who had contact with grandparents (older adults). Their finding reveal that contact experience influences perceptions of ageing. This study, however, did not observe any significant difference among those who lived with an older adult (contact) and those who did not.

7.2.6 Older adult lived with had disability

Independent samples t-test compared the mean scores of contextual factors by ever lived with an older adult with disability. The Levene's test for equality of variance showed that the group means were equal with a p value of 0.071 and F statistic 3.316. A significant difference was observed in the two group means (p value of 0.030 and mean difference 5.31835). The difference between the means at 95 percent confidence interval is 0.51438 and 10.12232. Contextual factors influenced the views on ageing and disability among those who lived with an older adult with a disability. However, the perceptions of those who lived with an older adult with no disability were not impacted by contextual factors. Table 7.5 displays the results.

The findings of Robinson et al. (2007), Costea-Bărluţiu & Rusu (2015), and Leutar & Raič (2008) showed significant differences in perceptions of disability among people who had contact with older adults and others with a disability. Although not entirely related to contextual factors their

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findings reveal how experience influences perceptions of disability. Comparable with this study, significant differences were observed in the impact of contextual factors on the perceptions of ageing and disability among those who lived with an older adult with and with no disability.

7.2.7 Respondent disability

Independent samples t-test compared the differences in the means of contextual factors of the respondents who had a disability and those who did not have a disability. The Levene's test for equality of variances showed that the variances of the two groups were unequal with a p value of 0.001 and F statistic 10.851. No significance difference was observed in the means of the two groups (p value = 0.112, mean difference = 4.11308). The perceptions of ageing and disability was influenced by contextual factors among those with a disability but not those with no disability. The views of ageing and disability among those with a disability though, varied (at 95 percent confidence interval the difference in the means of the 2 groups was -0.96451 and 9.19068). In objective 1 (subjective perception of ageing), those with a disability perceived ageing to be with disability while those with no disability did not. Although not significant, the findings suggest that fear, beliefs, and experience contributed to why those with a disability perceived ageing to be with disability. The results are presented in Table 7.5.

7.2.8 Highest level of education

Comparison of the mean scores of contextual factors by highest educational level was done using ANOVA. No significant difference was observed in the mean scores of the three groups (p value = 0.945, F ratio = 0.057). Post hoc test yielded no significant differences with multiple

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comparisons. However, compared with those who never attended school, contextual factors, had no impact on how educated individuals viewed ageing and disability. Table 7.6 displays the results.

Doncel-García et al. (2022) found a significant difference between people with different levels of education. Hung et al. (2010) found that laypeople and academics have different ideas about healthy ageing. It is assumed from Hung et al. (2010) that academics are people with high education while lay people have a lower education or no education. This, though, is contestable. Robinson et al. (2007) also observed significant differences in perception of disability based on educational level. These significant differences may suggest that educational level influences perceptions of ageing and disability. Although there were differences in educational level in this study, these were not significant.

7.2.9 Economic activity engagement

Table 7.6 compares the mean scores in contextual factors by economic activity using ANOVA. No significant differences were observed in the means of the 3 groups (p value of 0.402 and F ratio 0.917). The Post hoc test of multiple comparisons showed no significant differences in the means of the 3 categories. However, compared with those engaged in an economic activity, contextual factors influenced the views held by those with no economic activity.

Economic activity did not yield a significant difference in subjective perception of ageing, medical, and contextual factors. This suggests that being economically active or not does not influence how ageing and disability is conceptualized. LoBianco & Sheppard-Jones (2007) observed significant differences in self-perception of disability among employed and unemployed respondents. This

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suggests that economic activity could influence perceptions of disability. This study suggests a contrary view.

7.2.10 Marital status

Table 7.6 compares the mean scores of contextual factors by marital status using ANOVA. No significant difference was observed in the means of the three groups in the omnibus model (P value = 0.071, F ratio = 2.687). Table 7.7 however, shows a significant difference only between those who were previously married and those who were never married. Compared with those who were never married, contextual factors influenced the views of those who were previously married. Those who were previously married perceived ageing to be with disability, in objectives 1 and 2. However, those who were never married did not associate disability with ageing in objectives 1 and 2. It suggests that fear, beliefs, and experience influenced why the previously married participants perceived ageing to be with disability in objectives 1 and 2. However, those who were never married had views that were not influenced by fear, beliefs, and experience.

Doncel-García et al. (2022) in their study found no significant difference in negative stereotypes of ageing between those who were single, married, separated, or widowed. LoBianco & Sheppard-Jones (2007) discovered that married and unmarried respondents had varying self-perceptions of disability. The three studies have varying categories for marital status, but they all reveal how it can affect how people perceive ageing and disability. In this study, the only significant differences were seen in those who were previously married and those who were never married.

Table 7.6: ANOVA results in contextual factors

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Socio-demographic variables		Sum of Squares	df	Mean Square	F	Sig.
Marital status	Between Groups	803.775	2	401.887	2.687	0.071
	Within Groups	25725.563	172	149.567		
	Total	26529.338	174			
Highest level of education	Between Groups	17.479	2	8.740	0.057	0.945
	Within Groups	26511.858	172	154.139		
	Total	26529.338	174			
Economic activity engagement	Between Groups	279.792	2	139.896	0.917	0.402
	Within Groups	26249.546	172	152.614		
	Total	26529.338	174			
Perceived wealth status	Between Groups	324.306	2	162.153	1.064	0.347
	Within Groups	26205.032	172	152.355		
	Total	26529.338	174			
Religious affiliation	Between Groups	83.441	2	41.720	0.271	0.763
	Within Groups	26445.897	172	153.755		
	Total	26529.338	174			

Table 7.7: Post hoc test of marital status and contextual factors

(I) Marital status	(J) Marital status	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
In union/currently married	Separated/divorced/widowed	-3.11672	2.30579	.370	-8.5925	2.3591
	Never married	2.56686	2.05987	.429	-2.3295	7.4632
Separated/divorced/widowed	In union/currently married	3.11672	2.30579	.370	-2.3591	8.5925
	Never married	5.68358*	2.32682	.043	.1449	11.2223
Never married	In union/currently married	-2.56686	2.05987	.429	-7.4632	2.3295
	Separated/divorced/widowed	-5.68358*	2.32682	.043	-11.2223	-.1449

*. The mean difference is significant at the 0.05 level.

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7.2.11 Perceived wealth status

ANOVA compared the mean scores of contextual factors by perceived wealth status. No significant differences were observed in the mean scores of the 3 groups (p value of 0.347 and F ratio 1.064). The post hoc test did not yield any significant differences among the means of the categories. However, the views on ageing and disability among those with poor perceived wealth status were influenced by contextual factors, while those with middle and rich perceived wealth status were not. Table 7.6 presents the results.

The findings of objective 2 (medical factors), showed that those with poor perceived wealth status perceived ageing to be with disability, but those with middle wealth status did not. The results show that people with poor perceived wealth status think ageing is associated with disability due to fear, beliefs, and experience, although this is not significant.

7.2.12 Religious affiliation

One-way ANOVA was used to compare the mean scores of contextual factors by religious affiliation. No significant differences were observed in the means of the 3 groups (p value = 0.271, F ratio = 0.182). Post hoc test showed no statistically significant differences. However, compared with those affiliated with Islam and no religion, fear, beliefs, and experience influenced the views on ageing and disability among those affiliated with Christianity. Table 7.6 presents the results.

Comparable to this study, Doncel-García et al. (2022) found no significant difference in negative stereotype of ageing among religious and non-religious respondents. Contrary to this study's finding, LoBianco & Sheppard-Jones (2007) found significant differences in religious activity

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engagement. Although different from religious affiliation, religiosity or being religious reveals the influence of religion on the perception of ageing and disability.

7.3 Multivariate Analysis

The relationship between socio-demographic variables and contextual factors was studied by using linear regression. The model analyses how "age" impacts contextual factors while keeping other socio-demographic variables as control variables. Table 7.8 presents the model. The omnibus model was not significant, with a p value of 0.210, F statistic of 1.271, R square of 0.135, and R 0.367. The model explains 13.5 percent of the differences in how respondents perceive ageing and disability based on contextual factors.

The key independent variable, 'age', was not a significant predictor of contextual factors. Both middle-aged (40-59 years) and older adults had a negative relationship with contextual factors. These relationships were not statistically significant. Contextual factors did not affect the views of middle-aged and older adults on ageing and disability, unlike young adults. These observed relationships, however, were not statistically significant.

The only significant predictors of contextual factors in the model were marital status and older adult lived with had a disability. Being in union/currently married was negatively associated with contextual factors. The relationship was weak and not significant. Those who were never married also had a negative relationship with contextual factors. The relationship was significant was slightly strong and significant. Compared with those who were previously married, the views on ageing and disability among those who were never married and those in union/currently married were not influenced by contextual factors. In objective 1, those who were previously married perceived ageing to be with disability, while those who were never married and in union/currently

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married did not. The study found that contextual factors played a role in why ageing was perceived as a disability by those who were previously married.

The study observed a positive but slightly strong relationship between ever lived with an older adult with a disability and contextual factors. The relationship was statistically significant. Contextual factors influenced the views on ageing and disability among those who lived with an older adult with disability. In objective 1, those who lived with an older adult with a disability viewed ageing to be with disability. The finding suggests that the views held by those who lived with an older adult with a disability were influenced by fear, beliefs, and experience.

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Table 7.8: Predictors of Contextual Factors

Socio-demographic Variables	Standardized Coefficients	t Statistic	Sig.	95 % Confidence Interval for B	
	Beta			Lower Bound	Upper Bound
Age					
40-59	-.011	-.116	.908	-5.362	4.768
60 and above	-.058	-.475	.635	-8.121	4.972
20-39 (RC)	-	-	-	-	-
Sex					
Female	-.050	-.591	.555	-5.356	2.889
Male (RC)	-	-	-	-	-
Education					
Never attended school	.047	.562	.575	-4.627	8.303
SHS or higher	.022	.246	.806	-3.968	5.098
JHS/Middle or lower (RC)	-	-	-	-	-
Ethic group					
All other ethnic groups	.073	.904	.367	-2.427	6.527
Ga-Dangme (RC)	-	-	-	-	-
Economic activity engagement					
No economic activity	-.042	-.442	.659	-6.408	4.064
Economic activity with no pay	-.088	-1.091	.277	-15.535	4.483
Economic activity with pay (RC)	-	-	-	-	-
Children ever born alive					
None	.116	1.017	.311	-3.719	11.617
1 or more children (RC)	-	-	-	-	-
Marital Status					
In union/currently married	-.158	-1.568	.119	-8.857	1.019
Never married	-.291	-2.282	**.024**	-15.536	-1.120
Separated/Divorced/Widowed (RC)	-	-	-	-	-
Perceived wealth status					
Poor	.095	1.160	.248	-1.703	6.544
Rich	-.041	-.512	.609	-12.412	7.302
Middle (RC)	-	-	-	-	-
Religion					
Islam	-.103	-1.276	.204	-16.528	3.556
No religion	-.078	-.978	.330	-19.447	6.566
Christianity (RC)	-	-	-	-	-
Ever lived with older adult					
No	.288	1.032	.304	-9.110	29.037
Yes (RC)	-	-	-	-	-
Older adult had disability					
Yes	.172	2.117	**.036**	.354	10.248
No (RC)	-	-	-	-	-
Respondent has disability					
No	-.130	-1.349	.179	-10.950	2.064
Yes (RC)	-	-	-	-	-

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The respondents' sex, highest educational level, ethnicity, economic activity, children ever born alive, perceived wealth status, religious affiliation, ever lived with an older adult, and respondent disability status were not significant predictors of contextual factors. Although these variables had varying relationships with contextual factors.

In objective 2, perceived wealth status was a significant predictor of medical factors. Those who perceived their wealth status as poor associated disability with medical factors but those with middle perceived wealth did not. Although not significant, the association of disability to ageing, based on inability to perform IADLs and ADLs (medical factors) by those with poor perceived wealth, was influenced by contextual factors.

Doncel-García et al. (2022) in their study observed that negative stereotypes towards ageing among older adults were significantly associated with age, sex, and higher levels of dependence on IADLs. The number of children the respondents had according to the findings of Doncel-García et al. (2022) was not significantly associated with negative stereotypes towards ageing. This suggests that age, being male or female, and being dependent influenced negative stereotypes towards ageing. In this study however, age and sex did not influence the respondents' conceptualization of ageing and disability based on contextual factors.

Doncel-García et al. (2022) discovered that the number of children the participants had was not connected to their perception, which agrees with our findings.

A study by Wise & Onol (2021) showed that frequency of contact with grandparents (akin with ever lived with an older adult) was not related to ageing anxiety, perceptions of physical appearance, and fear of losses. This may be closely related to the findings of this study, whereby ever lived with an older adult was not associated with fear, beliefs, experience (contextual factors). Contrary to the findings of this study, Marques et al. (2020) observed that quality contact with

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older adults (akin with ever lived with an older adult) is the strongest determinant while marital status was not associated with ageism. Apart from contact, Marques et al. (2020) suggested that age, sex, education, ethnicity, professional experience (akin to engagement in economic activity in this study), socio-economic status, and degree of religiosity were not significantly associated with ageism. These variables were not significantly associated with contextual factors. Ageism gives a negative view of older adults and a negative perception of age (Lima et al., 2018).

In a study by Kim et al. (2021) it was observed that married couples sex did not influence self-perceptions of ageing. Van der Geest (2001) in a study in Ghana, however, suggests that some constructs of ageing were based on the sex of the individual. In the findings by Kelley-Moore et al. (2006) females were more likely to view themselves as disabled. Chonody et al. (2014) in their study discovered that sex was a significant predictor for perceptions of ageing. The findings of this study are contrary to the findings of their studies.

7.4 Summary

This part of the study explored how contextual factors (personal and environmental) and its influence on the conceptualization of ageing and disability. The qualitative aspect explored what constitutes contextual factors. The quantitative study explored if contextual factors influenced why they associated or did not associate disability with subjective perception of ageing and medical factors. Themes from the qualitative study include fear, social participation, beliefs, and experience. The items from the themes were used to develop an instrument for the quantitative phase.

However, Cronbach's alpha analysis and EFA retained variables under fear, beliefs, and experience during the quantitative data analysis.

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Findings showed that age was not a significant predictor of contextual factors, but marital status and older adult lived with had disability were. Young adults views on ageing and disability were influenced by contextual factors while those of middle-aged and older adults were not. The third hypothesis for the study was not accepted because no significant difference was observed in contextual factors among middle-aged and older adults.

The study observed that views on ageing and disability were influenced by contextual factors among those who were previously married and those who lived with an older adult with a disability. However, the perceptions of those in union/currently married, never married, and lived with an older adult with no disability were not influenced by contextual factors. Furthermore, the findings of this study suggests that sex, ethnicity, religious affiliation, economic activity, highest educational level, children ever born alive, perceived wealth status, ever lived with an older adult, and respondent's disability were not significantly associated with contextual factors.

The methods employed and the findings revealed how contextual factors influenced the conceptualization of ageing and disability among the respondents.

Priority III aim of MIPAA is to create a supportive environment for older adults (United Nations, 2002). An issue of priority III is the promotion of a positive view on ageing in the public (United Nations, 2002). In this study it was observed that fear, experience, and beliefs influence people's perceptions on ageing and disability. These are from the social environment although fear is also from the personal environment. Priority III of MIPAA further encourages the mass media and educators to promote images of older adults that highlight their wisdom, contributions, courage, and resources (United Nations, 2002). This suggests that even though some people may have had negatives experiences with older adults they know, education on the contribution and wisdom of older adults for instance, would enable them focus on the positive traits. The promotion of positive

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views on ageing would reduce the likelihood of people associating inabilities with disability. This is because the focus would be on the contributions of the older adults.

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CHAPTER EIGHT

SUMMARY, CONCLUSION, AND RECOMMENDATION

8.0 Introduction

Young, middle-aged, and older adults perceive ageing and disability differently. This may be related to medical, personal, or environmental factors. Research exists on how some of these factors influence ageing perceptions in developed countries. However, knowledge on what these are and how they influence perceptions of ageing and disability in sub-Saharan Africa and Ghana is extinct.

This study explored how ageing and disability is conceptualized among young, middle-aged, and older adults based on subjective perception of ageing, medical, and contextual factors. The study was conducted at Dodowa in the Shai Osudoku district of the greater Accra region. The summary of the findings of the study, conclusion, theoretical implications of the findings, policy recommendations, and recommendations for future research are described in this chapter.

8.1 Summary of the findings

This study discovered that subjective perception of ageing was mostly made up of medical factors, such as cognition, physical attributes, and sensory impairment. These medical factors influenced the conceptualization of ageing and disability by the participants. Compared with young and middle-aged adults, ageing was perceived to be with disability among older adults. These differences were significant between young and older adults, but not young and middle-aged adults. The hypothesis that there is no significant difference in conceptualization of ageing and

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disability based on subjective perception of ageing among young and middle-aged adults was accepted.

Those who were previously married, lived with an older adult with a disability, and had a disability perceived ageing to be with disability. However, those who were never married, lived with an older adult with no disability, and had no disability perceived ageing to be without disability. These differences were significant. In the multivariate analysis, age and the other socio-demographic variables were not significant predictors of subjective perception of ageing. However, marital status and older adult lived with had disability were significant predictors of subjective perception of ageing.

For the second objective, the findings of this study showed that medical factors were mostly related to diseases, performance of ADLs and IADLs (self-care activities, life activities, mobility), and health decline. Compared with young adults, middle-aged adults associated disability with medical factors. Similar to young adults, older adults did not associate disability with medical factors. These differences were not significant. The hypothesis that there is a significant difference in conceptualization of ageing and disability based on medical factors among young and older adults was not accepted.

Those who were previously married, poor perceived wealth status, and affiliation with Christianity perceived ageing to be with disability based on medical factors. However, those who were never married, middle wealth status, and no religious affiliation did not associate disability with medical factors. These differences were significant. The linear regression model showed that significant predictors of medical factors include only marital status and perceived wealth status.

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Regarding the third objective, the results of the study revealed that contextual factors comprised fear, social participation, beliefs, and experience. Compared with young adults, contextual factors did not influence the views of ageing and disability among middle-aged and older adults. The hypothesis that there is a significant difference in conceptualization of ageing and disability based on contextual factors among middle-aged and older adults was not accepted. Significant differences were in contextual factors for previously married participants and those who were never married and also among the participants who lived with an older adult with a disability and those who lived with an older adult without a disability.

The linear regression model showed that age was not a significant predictor of contextual factors however, marital status and older adult lived with had disability were significant predictors of contextual factors. The medical model of disability was prominent in the participants' conceptualization of ageing and disability. Some concepts on ageing observed include the ageing process, process of ageing, sociological ageing, and psychological ageing.

8.2 Conclusion

The study highlights that socio-demographic factors such as marital status and personal experiences with disability significantly shape the conceptualization of ageing and disability. These findings underscore the importance of considering individual life circumstances and social contexts when addressing perceptions of ageing and disability. Programs aimed at changing perceptions should tailor their approaches to these socio-demographic nuances to be more effective.

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Medical factors, including health conditions and the ability to perform daily activities, play a crucial role in how ageing and disability are perceived. The study reveals that middle-aged adults are more likely to associate disability with medical factors compared to younger and older adults. This insight suggests that health interventions and educational campaigns should target middle-aged adults to address misconceptions and promote a more holistic understanding of ageing and disability.

Contextual factors such as fear, social participation, beliefs, and personal experiences also influence perceptions of ageing and disability. The study indicates that these factors are particularly significant among those who have lived with an older adult with a disability. This finding highlights the need for community-based initiatives that foster positive interactions and experiences with older adults, thereby reducing stigma and promoting a more inclusive view of ageing.

Overall, the study demonstrates that perceptions of ageing and disability are multifaceted, influenced by a combination of socio-demographic, medical, and contextual factors. The prominence of the medical model in participants' views suggests a need for broader education on the social and biopsychosocial models of disability. These insights can inform policies and programs aimed at improving the quality of life for older adults and those with disabilities.

8.3 Theoretical implication of the findings

This study was guided by the three models of disability, which include the medical (WHO, 1993), social (Oliver, 1976; Bickenbach et al., 1999; Lisicki, 2015), and biopsychosocial (WHO, 2001; WHO, 2013) models. It was also informed by concepts of ageing, such as biological ageing,

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sociological ageing, the ageing process, and the process of ageing, and theories such as the theory of planned behaviour and self-perception theory. An integration of these models and concepts explained how the participants conceptualized ageing and disability based on their subjective perception of ageing, medical, and contextual factors. It also moved beyond theories and integrated them with age-related concepts, revealing socio-demographic influences. The study also reveals how the inclusion of contextual factors impacts views on ageing and disability. The findings illustrate the models' applicability and expansion.

The findings of this study confirm both the medical and social models of disability, with little evidence of the biopsychosocial model in the qualitative phase. While views on ageing and disability by middle-aged adults reflected the social model, the views of young adults reflected the medical model. For older adults, both the medical and social models were evident.

On the concepts of ageing, middle-aged adults seem to have differentiated the ageing process from the process of ageing. While middle-aged adults did not associate disability with the ageing process, young adults did. Sociological and psychological ageing was also associated with their perceptions.

8.4 Recommendation

8.4.1 Policy recommendations

Some factors, such as personality (unrelated to ageing) and physical changes (like grey hair) were considered as signs of ageing with disability. It was observed that people formed knowledge on ageing and disability based on their age, experiences of older adults they lived with, the individual's disability, perceived wealth status, marital status, and religious affiliation. Although not significant, other socio-demographic variables were positively associated with the dependent

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variable, such as educational level. Those who never attended school perceived ageing to be with disability. These findings suggest a lack of knowledge on the phenomenon of ageing among people of varying socio-demographic characteristics.

The study recommends the Ministry of Education, Ministry of Health, Ministry of Gender Children Social Protection to work together to include a section on ageing in the curricular from the basic level to the tertiary level to increase awareness. This would help people to distinguish between ageing and disability and other factors unrelated to ageing, such as character/personality. To capture people who are outside school, educational campaigns through mass media, town hall meetings, social media, communities, and collaborations with Civil Service Organizations who focus on older adults and the National Communications Authority can help in sensitization and education on ageing and disability.

Implementing targeted economic support programs for older adults with low perceived wealth status. This could involve financial assistance, subsidies for healthcare, and support for daily living expenses to alleviate the economic burden associated with ageing and disability.

Enhancing access to affordable healthcare services for older adults, particularly those with low perceived wealth status. This could include expanding community health programs, providing mobile health clinics, and ensuring that healthcare facilities are equipped to address the needs of older adults with disabilities.

Developing comprehensive social support services that aid with daily activities, mobility, and self-care for older adults. This could involve training caregivers, establishing support groups, and creating community centres that offer resources and activities for older adults.

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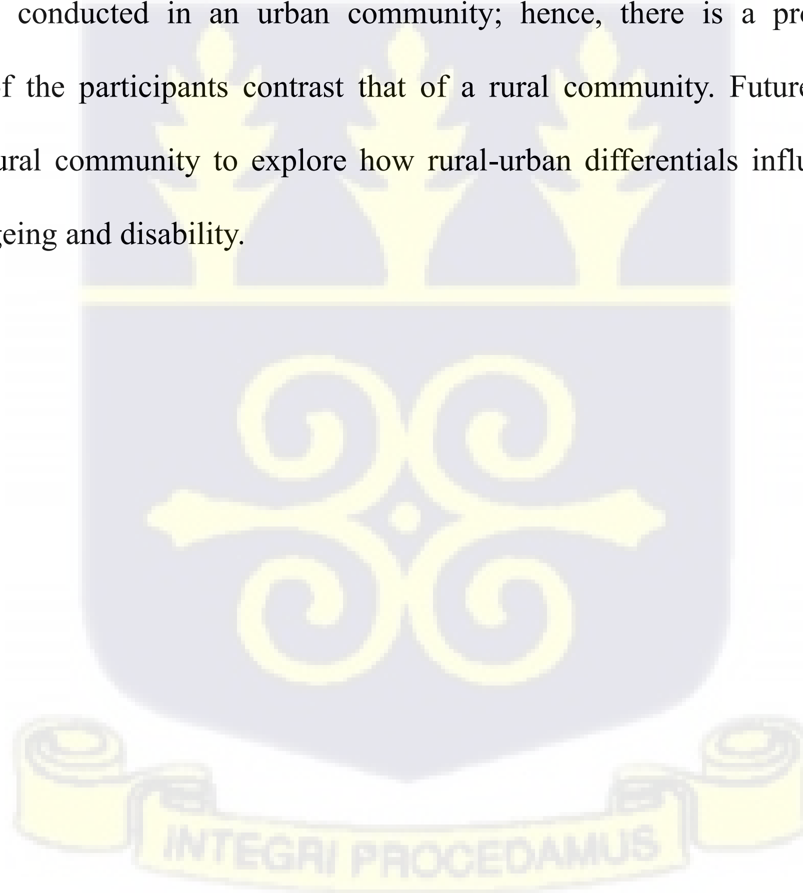
8.4.2 Recommendations for future research

This study has revealed results that would serve as a basis for future research. The study found that marital status is important in understanding ageing and disability. Previously married people associated disability with subjective perception of ageing and medical factors, while those who were never married did not. The views of the previously married were influenced by contextual factors, while those of the never married were not. Future research could expand on this finding and further investigate why differences exist in the conceptualization of ageing and disability by marital status.

This study was conducted in an urban community; hence, there is a probability that the characteristics of the participants contrast that of a rural community. Future research can be extended to a rural community to explore how rural-urban differentials influence how people conceptualize ageing and disability.



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APPENDICES

Appendix 1: Interview Guide

Title of the Study: Conceptualization of Ageing and Disability by Young, Middle-Aged, and Older Adults in the Greater Accra Region

Part One: Socio-demographic data

1. Can you tell me about yourself?

Probe: Respondent's age, highest level of education, employment status, religious affiliation, marital status, and place of residence.

If 60 years and above skip question 2.

Part Two: Screening for Case Units

2. Have you ever lived with an older person? Yes ( ) No ( ). If No skip questions 2, 3, 4 and 5.

3. Did/does the older person(s) have a disability? Yes ( ) No ( ). If No skip questions 3 and 4.

4. What type of disability did/does he/she have?

5. When did the disability develop?

Part Three: Subjective Perception of Ageing either with or without Disability

6. How would you describe ageing based on what you have seen, learnt, observed, heard, or experienced? When will you say old age starts and why do you think so?

Probe: What influenced your understanding of ageing?

7. How do you understand disability?

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8. What do you think causes disability?

Probe: What influenced your understanding of disability?

9. What is ageing with a disability?

10. How do you think people see persons who are old?

Probe: How does that influence how you perceive/understand ageing?

11. What have you heard about old people and disability?

Probe: How has that informed your view about old age and disability?

12. How are old people regarded in your community or society?

Probe: How does cultural beliefs, tradition and practices informed your view?

13. How does performance of ADLs and IADL affect your idea, knowledge or perception of ageing and disability?

Part Four: Differentiation between Disability and Normal Process of Ageing

14. How would you describe the differences between someone who is ageing with a disability and another who is not ageing with a disability?

Probe: How did you get this knowledge, idea, or perception?

15. What will you say is the normal process of ageing?

Probe: How did you develop such knowledge?

16. What are some things that you would use to distinguish someone who is ageing normally from another who is ageing with a disability?

17. How do you differentiate ageing from disability?

Probe: What informed your knowledge of the differences?

18. What cultural beliefs have influenced your knowledge of ageing and disability?

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Part Five: Conceptualization Based on Consequences of Disability on Social, Economic, Physical and Psychological Aspects of the Older adult and Family

19. How will you describe some consequences of the disability on you and your family? (If respondent is an older adult with a disability or has ever lived with older adult with disability).

Probe: How has that affected your understanding or view of ageing and disability?

20. What happens to family members who are taking care of old persons with disability? (If participant has never lived or observed an older person with disability).

Probe: How has that influenced your views of ageing and disability?

21. How does disability affect the life and well-being of the older adult?

22. How would you describe the difficulties family members face when caring for an older adult with disability?

23. How does disability on an older adult affect their relationship with others?

Probe: How has all you have spoken about influenced your perception of ageing and disability?

Part Six: Fears and expectations of Young, Middle-aged and Older Adults have of their Future Ageing Process

24. What would you say getting older brings?

25. What comes into your mind when you hear you are old, growing old or are going to be old?

26. What do you think getting old is like? (For young and middle-aged)

27. How is the experience of old age different from what you anticipated? (For older adult)

28. When you look at how people have aged and their experiences, how do you anticipate your own future ageing?

29. Can you describe some things that when you grow old you are unable to do any longer?

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30. What are some worries you have about growing old?

31. What fears did you have about growing old when you were younger that has materialized?

(Older adults)

32. What are fears you have of ageing?

33. Are you restricted in doing things for yourself? Yes ( ) No ( ).

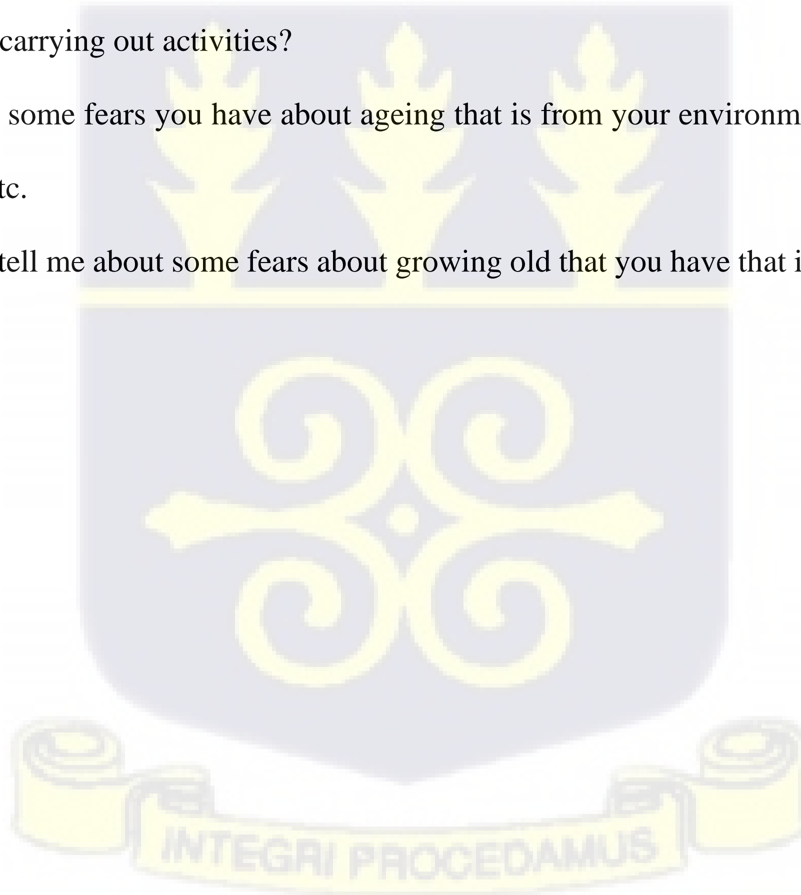
34. Do you have any medical condition that you think affects/affected the ageing process? Yes ( ) No ( )

35. How did it/ do you think it will affect you when you grow old?

36. How do you think the ageing process of someone will be if he/she has a medical condition or limitations in carrying out activities?

37. What are some fears you have about ageing that is from your environment that is society, culture family, etc.

38. Can you tell me about some fears about growing old that you have that is not from others?



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Appendix 2: Questionnaire

Title of the Study: Conceptualization of Ageing and Disability by Young, Middle-Aged, and Older Adults in the Greater Accra Region

Location of Interview…………………. **Respondent ID………..**

Date of Interview………………………. **Start time………………** **End time……………**

SECTION 1: SOCIODEMOGRAPHIC BACKGROUND

These questions will be about yourself.

1. Sex of the respondent?

Male	[1]
Female	[2]

2. What is your date of birth?

Day [ ] Month [ ] Year [ ]

3. How old were you at your last birthday? [ ]

4. Please enter age group of the respondent.

20-39	[1]
40-59	[2]
60 and above	[3]

5. To which ethnic group do you belong?

Akan	[1]
Ga-Dangme	[2]
Ewe	[3]
Guan	[4]
Gurma	[5]
Mole-Dagbani	[6]
Grusi	[7]
Made	[8]
All others	[9]

6. What is your religious affiliation?

Catholic	[1]
Protestant (Anglican, Lutheran, Presbyterian, Methodist, etc.)	[2]
Pentecostal/Charismatic	[3]
Other Christian	[4]
Islam	[5]
Ahmadi	[6]

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Traditionalist [7]
No religion [8]
Other (specify)………………………….. [9]

7. What is your marital status?
Informal/living together [1]
Married (Civil/Ordinance) [2]
Married (Customary/Traditional) [3]
Married (Islamic) [4]
Married (other type) [5]
Separated [6]
Divorced [7]
Widowed [8]
Never married [9]

8. Have you ever attended school or are you attending school now?
Never attended [1]
Attending now [2]
Attended in the past [3]

9. What is the highest level of school you are attending now /attended in the past?
Nursery [1]
Kindergarten [2]
Primary [3]
JSS/JHS [4]
Middle [5]
SSS/SHS [6]
Secondary [7]
Vo/technical/commercial [8]
Post middle/secondary certificate [9]
Post middle/secondary diploma [10]
Tertiary – HND [11]
Tertiary – Bachelor's Degree [12]
Tertiary – Postgraduate Certificate/Diploma [13]
Tertiary – Master's Degree [14]
Tertiary – PhD [15]
Other (specify)………………………….. [16]

10. ***For those currently attending school or attended in the past.*** What is the highest grade (form/class/level, etc.) you have completed at that level of schooling?……………..

11. Do you engage in any economic activity?
No [1]
Yes, work for profit on own/family business [2]
Yes, engaged in economic activity but receives no pay/profit [3]
Yes, works in own agricultural activity [4]
Yes, Wage/salary/profit work [5]

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Paid apprentice work [6]
Unpaid apprentice work [7]
Voluntary work without pay [8]
Non-voluntary work without pay [9]
Own production/service work [10]

12. What is the total number of children you have ever born alive?
None [1]
1 [2]
2 [3]
3 [4]
4 [5]
5 or more? [6]

13. What will you describe as your wealth status?
Poorest [1]
Poorer [2]
Middle [3]
Richer [4]
Richest [5]

14. Have you ever lived with an older adult? ***If 'no' skip questions 16 and 17.***
Yes [1]
No [2]

15. Did the person have a disability? ***If 'no' skip question 17.***
Yes [1]
No [2]

16. What type of disability did the person have?...

17. Do you have any form of disability?
Yes [1]
No [2]
If yes which type?...

SECTION 2: SUBJECTIVE MEANING OF AGEING WITH OR WITHOUT DISABILITY

Please, tell me if you agree the following communication features during ageing is ageing with disability?

18. Do you agree if the following communication features during ageing is ageing with disability?

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	Agree 01	Neutral 02	Disagree 03
Strange behaviour			
Curses			
Shouts			
Rude			
Talks to self			
Talks like a child			
Excessive talking			
Quarrelsome			

19. Please tell me if you think the following are displayed by an older adult who is ageing with disability?

	Strongly Disagree 01	Disagree 02	Neutral 03	Agree 04	Strongly Agree 05
Mind turns into a child					
Returns to old issues					
Rate of thinking slows					
Memory loss					
Gets lost					

20. Please tell me if the following physical attributes are ageing with disability.

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	Agree 01	Neutral 02	Disagree 03
Pains			
White hair			
Hair loss			
Amputated limb			

21. Please tell me if the following issues with hearing and seeing is ageing with disability.

Blindness [1]
Any eye defect [2]
Difficulty in hearing [3]
Deafness [4]
Other (specify)……………….. [5]
Hearing and vision impairment not related to ageing and disability [6]

22. Please tell me if you agree to the following statements about ageing and disability.

	Strongly Disagree 01	Disagree 02	Neutral 03	Agree 04	Strongly Agree 05
Disability from ageing is not possible					
Everyone gets disability in ageing					
Any change in old age is disability					
If the disability was not from birth, then it is not disability					
Short and smallish people experience normal ageing while hefty people age with disability					
Those who are ageing with no disability give advice					

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SECTION 3: MEDICAL FACTORS AND CONCEPTUALIZATION OF AGEING AND DISABILITY

Here I will ask you about diseases and performance of activities of daily living such as bathing or walking and how you think it is related to ageing and disability.

23. Which of these diseases do you think causes ageing with disability?

Hypertension [1]
Measles [2]
Stroke [3]
Paralysis [4]
Leprosy [5]
Eye disease [6]
Diabetes [7]
Diseases not related to ageing and disability [8]
Other (specify)……………. [9]

24. Please tell me if these are ageing with disability.

	Agree 01	Neutral 02	Disagree 03
Having a disease in old age			
Having a disease before old age			
Never had a disease in old age			
Recovering from a disease			

25. Which of the following inabilities in relation to selfcare is ageing with disability?

Cannot brush teeth [1]
Sits to bath [2]
Cannot bath [3]
Cannot drink water or feed self [4]
Cared for [5]
Assisted to use the washroom [6]
Self-care inability not related to ageing and disability [7]
Other (specify)………………… [8]

26. Can you tell me which of these life activities show that an older person is ageing with disability?

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Cannot do laundry [1]
Cannot cook [2]
Sits to cook [3]
Cannot sweep [4]
Cannot farm [5]
Cannot fetch water [6]
Assisted [7]
Life activities inabilities not related to ageing and disability [8]
Other (specify)……………….. [9]

27. These are some capacity changes that occurs during ageing. Do you agree that experiencing the following is ageing with disability?

	Agree 01	Neutral 02	Disagree 03
Speed in activities reduces			
Cannot do things done previously			

28. Do you agree that the following mobility challenges is ageing with disability?

	Agree 01	Neutral 02	Disagree 03
Stuck at one place			
Carried			
Rests in-between walks			
Walks with a stick/clutch			
Cannot lift hand			
Limps			
Uses wheelchair			

SECTION 4: ENVIRONMENTAL FACTORS AND CONCEPTUALIZATION OF AGEING AND DISABILITY

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Here I will ask you questions outside the individual like the community, family, and others and how they connect to ageing and disability.

29. Do you agree to the following statements about ageing with disability?

	Agree 01	Neutral 02	Disagree 03
Society is a cause of ageing with disability			
Inability to engage in social activities like parties, durbars, etc. is ageing with disability			
Inability to perform previous social functions like being a community leader, political party organizer is ageing with disability			

30. Which of the following statements do you agree to?

	Agree 01	Neutral 02	Disagree 03
Ageing with disability is from a curse			
Ageing with disability is from gods			
Ageing with disability is spiritual			
Ageing with disability is from forefathers			

31. Do you agree to these statements?

	Strongly Disagree 01	Disagree 02	Neutral 03	Agree 04	Strongly Agree 05
Ageing with or without disability is God ordained					
Ageing with disability is from personal works/acts/morality					

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32. Please tell me which of these religious factors influenced your knowledge on ageing with or without disability?

A religious book example a Bible or Quran	[1]
Religious teaching	[2]
God	[3]
Other (specify)…………….	[4]
Not influenced by religious factors	[5]

33. Which of the following have an influence on your knowledge on ageing with or without disability?

Radio	[1]
Television	[2]
Social media	[3]
Other (specify)……………….	[4]
Not influenced by media or educational institution	[5]

34. This part is about lineage and ageing and disability. Which of the following statements do you agree to?

Ageing with disability runs in families	[1]
Ageing with disability does not run in families	[2]
Some cases run in families, but others do not	[3]

35. The following options are about your experience with older adults and others. Which of them influenced your knowledge on ageing?

Lived with older adults	[1]
Observed older adults	[2]
Informed by older adults	[3]
Took care of older adults	[4]
Parents	[5]
Grandparents	[6]
Other family members	[7]
Observed changes in young people	[8]
Learnt from people	[9]
Other (specify)……………..	[10]
Not influenced by living with older adults or others	[11]

SECTION 5: PERSONAL FACTORS AND CONCEPTUALIZATION OF AGEING AND DISABILITY

Here I will ask you questions about some things that you think about and how it connects to ageing and disability.

36. Please tell me which of the following influenced your knowledge?

Personal experience	[1]
Mind	[2]

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Not taught but learnt through growth [3]
Other (specify) [4]

37. ***This question is for young and middle-aged adults.*** How do you expect your future ageing?
Age as family [1]
No disability [2]
Have ability to perform life activities e.g., household chores [3]
Have ability to perform self-care e.g., brush teeth [4]
Function as a young person [5]
Age with few diseases [6]
Be dependent [7]
Not a burden on family [8]
Not bedridden [9]
Age with no diseases [10]
Other (specify) [11]
Have no expectation of future ageing [12]

38. ***This question is for a participant 60 years old and above.*** Which of the following describes how you expected your ageing experience when you were young?
Prepared for ageing [1]
Ageing as expected [2]
Ageing against expectation [3]
Did not think of ageing when young [4]
Emulated parent's way of life [5]
Other (specify) [6]

39. Which of the following fear of ageing do you have?
Unable to perform life activities like work and domestic responsibilities [1]
Having mobility challenges like inability to move or walk with a stick [2]
Fear of diseases like diabetes and stroke [3]
Fear of inability to perform selfcare like bathing [4]
Fear of excessive talking [5]
Fear of menopause [6]
Fear of disability [7]
Fear of witchcraft accusations [8]
Fear of death [9]
No fear of ageing [10]
Other (specify)…………….. [11]

40. ***Do not ask this question if participant admitted to any fear of ageing.*** Which of the following describes why you have no fear of ageing?
Ageing is unavoidable [1]
Death comes anytime [2]
Does not think of ageing issues [3]
Sin causes fear [4]

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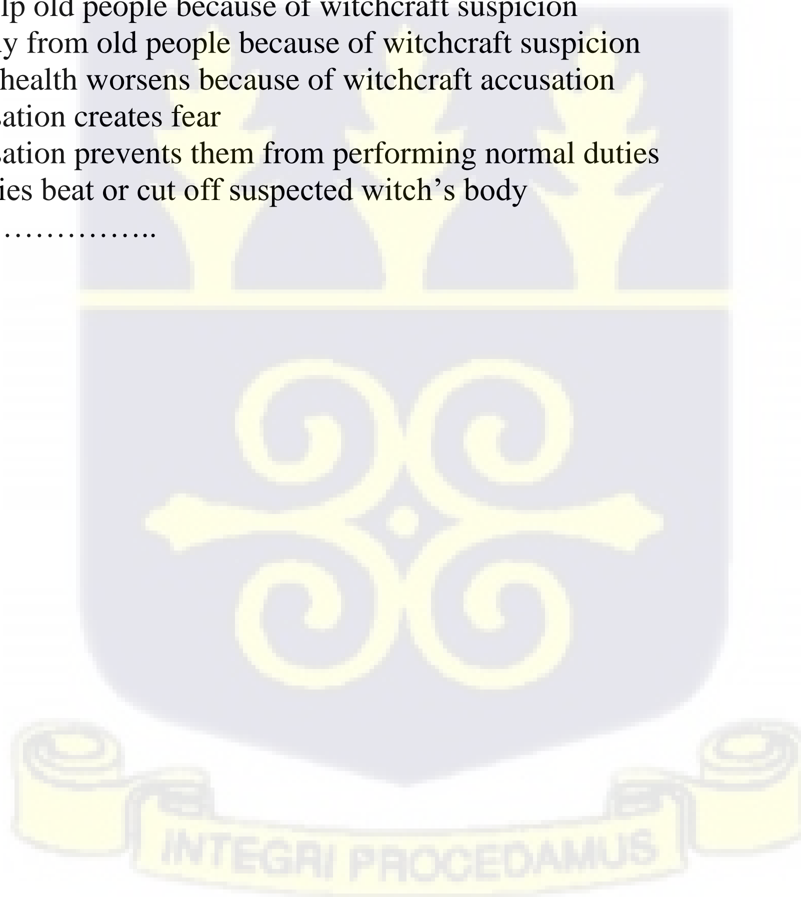
Trust in God [5]
Ageing is God ordained [6]
Fear is related to not living a moral life [7]
Other (specify)………….. [8]

41. This part is about witchcraft and ageing and disability. Which of the following do you think makes people accuse older adults of witchcraft?

Improper behaviour [1]
Wrinkled face [2]
Not dying [3]
Talks excessively [4]
Shouts [5]
Curses [6]
Other (specify)……………………. [7]

42. Which of the following explains why witchcraft accusations cause ageing with disability?

Witchcraft accusations cause abandonment of older adult [1]
People do not help old people because of witchcraft suspicion [2]
People do not buy from old people because of witchcraft suspicion [3]
Older adults' ill-health worsens because of witchcraft accusation [4]
Witchcraft accusation creates fear [5]
Witchcraft accusation prevents them from performing normal duties [6]
Some communities beat or cut off suspected witch's body [7]
Other (specify)…………….. [8]



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Appendix 3: Ethical Approval Letter

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No…ECH 128/ 20-21 …

May 9, 2021

Doris Akosua Tay
Regional Institute for Population Studies
University of Ghana
Legon

ETHICAL CLEARANCE
(ECH 128/ 20-21)

The protocol title below has been reviewed and approved by the ECH Committee.

TITLE OF PROTOCOL: **CONCEPTUALIZAION OF AGEING AND DISABILITY BY YOUNG, MIDDLE-AGED AND OLDER ADULTS IN GREATER ACCRA REGION**

PRINCIPAL INVESTIGATOR: **DORIS AKOSUA TAY**

Please note that the final review report must be submitted to the Committee at the completion of the study. Your research records may be audited at any time during or after the implementation. Any modification of this research project must be submitted to ECH for review and approval prior to implementation.

Please report all serious adverse events related to this study to ECH within seven (7) days verbally and in writing within fourteen (14) days.

This certificate is valid till May 8, 2022. You are to submit annual reports for continuing review.

Please accept my congratulations.

Yours Sincerely,

Professor C. Charles Mate-Kole
ECH Chair

Cc: Professor Margaret Delali Badasu, Regional Institute for Population Studies, UG

Tel: +233-303933866 Email: ech@ug.edu.gh

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Appendix 4: Ethical Approval Letter (Renewal)

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No: ECH 128/ 20-21

March 27, 2023

Doris Akosua Tay
Regional Institute for Population Studies
University of Ghana
Legon

RENEWAL
(ECH 128/ 20-21)

The Ethics Committee for the Humanities (ECH) conducted a full board review and approved the renewal of your protocol titled:

CONCEPTUALIZATION OF AGEING AND DISABILITY BY YOUNG, MIDDLE-AGED AND OLDER ADULTS IN GREATER ACCRA REGION

PRINCIPAL INVESTIGATOR: **DORIS AKOSUA TAY**

Please note that the final review report must be submitted to the Committee at the completion of the study. Your research records may be audited at any time during or after the implementation. Any modification of this research project must be submitted to ECH for review and approval prior to implementation.

Please report all serious adverse events related to this study to ECH within seven (7) days verbally and in writing within fourteen (14) days.

This certificate is valid until March 26, 2024. You are required to submit annual reports for continuing review.

Please accept my congratulations.

Yours Sincerely,

Professor C. Charles Mate-Kole
ECH Chair

Cc: Margaret Delali Badasu., Regional Institute for Population Studies, UG

Tel: +233-303933866 Email: ech@ug.edu.gh

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Appendix 5: Consent Form

UNIVERSITY OF GHANA

Ethics Committee for Humanities (ECH)

PROTOCOL CONSENT FORM

Section A- BACKGROUND INFORMATION

Title of Study:	Conceptualization of Ageing and Disability by Young, Middle-Aged and Older Adults in Greater Accra Region.
Principal Investigator:	Doris Akosua Tay
Certified Protocol Number	

Section B– CONSENT TO PARTICIPATE IN RESEARCH

General Information about Research

This study seeks to understand and describe how people specifically young, middle-aged, and older adults construct that is form ideas, develop perceptions and knowledge about ageing and disability. The interview is expected to last between 40 minutes to one hour and follow up will be done if clarifications are needed later. The interview will be recorded on a MP3 audio recorder and notes will also be recorded in a notebook.

Benefits/Risks of the study

The study will not benefit you directly but is expected to benefit the entire society and the nation. The findings of this study will help in policy interventions that will improve perception about ageing in society and help leaders understand why older people are treated in a way that may be inappropriate. Views that are brought up by this research will help in formulating, implementing, and strengthening of policies that already exist but are not enacted. There are no physical, social, and psychological risks associated with this study.

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Confidentiality

Your privacy and confidentiality will be assured. Your name will not be included in the research except the information given which will not be linked to you in anyway. The information that you give will be used solely for the purpose of this study. It will be accessed by the researcher, supervisors, and the university of Ghana. The information will also be stored on a computer which is pass-word protected so that other people cannot have access to it.

Compensation

There is no compensation that is associated in your participation in this study.

Withdrawal from Study

Your participation in the study is voluntary and you may withdraw at any time without any penalty. You will also not be affected adversely if you decline to participate or later withdraw from the study. Should you withdraw or decide to continue after withdrawal, you will be informed in a timely manner if information is available for you.

Contact for Additional Information

You can contact Doris Akosua Tay at the Regional Institute of Population Studies, University of Ghana about any issues related to this study.

Contact: 0249871003/0509688898. datay001@st.ug.edu.gh/doridily@gmail.com.

- If you have any questions about your rights as a research participant in this study you may contact the Administrator of the Ethics Committee for Humanities, ISSER, University of Ghana at ech@ug.edu.gh or 00233- 303-933-866.

Section C- PARTICIPANT AGREEMENT

"I have read or have had someone read all of the above, asked questions, received answers regarding participation in this study, and am willing to give consent for me, my child/ward to participate in this study. I will not have waived any of my rights by signing this consent form. Upon signing this consent form, I will receive a copy for my personal records."

____

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Name of Participant

____

____

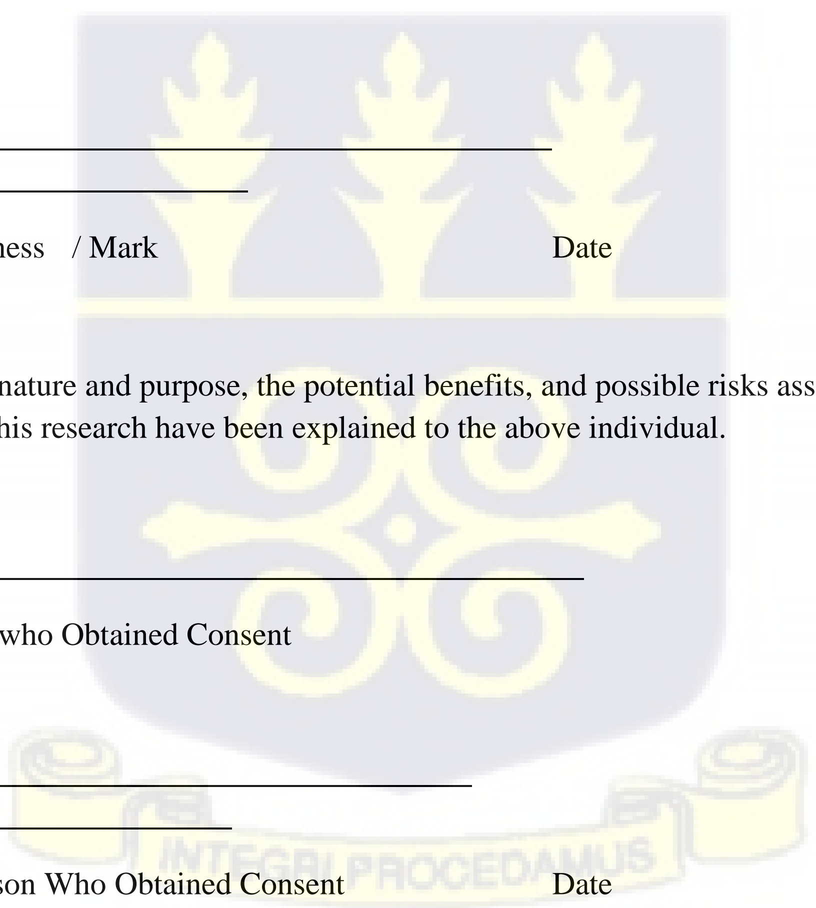
Signature or mark of Participant   Date

If participant cannot read and or understand the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered, and the volunteer has agreed to take part in the research.

____

Name of witness



____

____

Signature of witness   / Mark   Date

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

____

Name of Person who Obtained Consent

____

____

Signature of Person Who Obtained Consent   Date

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