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Interpretative Phenomenological Analysis of the Lived Experiences of Older Adults Regarding Their Functional Activities in Ghana


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Abstract

Introduction: Research on disability largely draws on epidemiological data, often conducted in more developed countries. To date, there is little research related to older adults in Ghana, Africa. The purpose of this study was to strengthen understanding of how older adults in Ghana perform functional activities, referenced against the World Health Organization's International Classification of Functioning, Disability and Health (WHO-ICF) framework. **Methods:** Interpretative phenomenological analysis (IPA) of semistructured interview data was employed as the methodological approach. Using purposive criterion sampling, 8 older adults admitted to Komfo Anokye Teaching Hospital in Ghana, presenting with any identified health condition and/or frailty were recruited. **Results:** Analysis of interview data identified 5 interrelated themes: (1) feeling anxious, (2) feeling restricted, (3) understanding and admitting difficulty, (4) striving to be healthy and being productive, and (5) managing functional difficulty. These concerns were classified and related to the WHO-ICF, particularly the contextual factors. **Discussion:** This study examined in detail experiences of older adults performing functional activities. Our study highlights the relevance of the WHO-ICF framework for understanding the health needs of older adults, emphasizing the functional, social, and environmental factors influencing the functional status of older adults. The findings offer unique insight into the health needs of older adults, drawing attention to the implications for policy and care.

Keywords

interpretative phenomenological analysis, older adults, functional difficulty, WHO-ICF, Ghana, Africa

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Introduction

The population of adults aged 60 years or older in Ghana is growing rapidly due to decreasing birth rates and delayed mortality.¹ The number of older adults in Ghana increased more than 7-fold from 213 477 (4.5%) in 1960 to 1 643 381 (6.7%) in 2010.² The percentage of older adults in Ghana is further expected to increase to 9.8% by 2050.² Although the percentage of older adults in Ghana is below that of developed countries, it is worthy of note because the pace of ageing is faster than in developed countries.³ Population ageing is associated with increases in service need and requires updated policies and programs to respond to the current and future health needs of older adults in Ghana,⁴ particularly those who may be living with functional difficulties. Functional difficulties, in this article, refer to the difficulties experienced in engaging in everyday life activities.

As individuals age, they may experience increasing functional difficulties, often as a result of poor health, intrinsic incapability, body impairment or environmental impediments.^{5,6} For instance, older adults may experience difficulties in engaging in self-care, including toileting,⁷ in activities needed to live independently like preparing meals, and participation activities, including attending social meetings.⁸ Whether Ghana can meet the functional difficulties associated with population aging that older adults experience currently remains unknown.

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Many cross-sectional studies have examined functional difficulties among older adults, particularly in high-income countries.^{9,10} However, less attention has been given to functional difficulties among older adults in low- and middle-income countries (LMICs) and even less research into the functional difficulties among older adults in Africa. The World Health Organization's (WHO) Study on global AGEing and adult health (SAGE) project was designed to address this lack of information on aging in LMICs.¹¹ One analysis from WHO-SAGE compared scores for functional difficulty on activities of daily living (ADLs) and instrumental activities of daily living (IADLs) across the 6 SAGE countries (Ghana, Mexico, South Africa, the Russian Federation, India, and China).¹² Across all countries, functional difficulty scores increased with age and were higher for women. Age-specific functional difficulty scores were lowest in China, indicating lower functional difficulty among older adults, and the highest in India, with South Africa and Ghana having the next highest scores. Approximately 90% of people aged 60 years and older in Ghana had functional difficulties across the ADL and IADL items assessing cognition, mobility, self-care, getting along with people, engagement in household responsibilities, and participation in society.¹²

In Ghana, few studies exist regarding functional difficulties among older adults.¹²⁻¹⁵ For instance, one quantitative study reported that older women experience more functional difficulties than older men.¹⁶ Furthermore, in the same study, it was reported that people aged 90 years or older are more likely to report poor health.¹⁶ Similarly, a mixed-method study conducted in Ghana reported that participants, mostly those aged 60 years or older, experience participation restrictions in voluntary work, including childcare. Older adult participants admit having difficulties moving around inside their home and managing work.¹³ These studies are important in estimating the prevalence of functional difficulties among older adults in Ghana; however, they do not acknowledge older adults' experiences of functional difficulties and their care needs. The effort to maximize strategies to reduce functional difficulties in older age should not exclude the contributions of qualitative evidence on how older adults manage everyday activities with functional difficulties.

Qualitative studies on the experience of people with chronic conditions, such as heart failure and hemodialysis, exist for the Thai population aged between 18 and 80 years.^{17,18} In these studies, older adult participants living with chronic conditions experience feelings of the lost self and isolation because they feel restricted in their functional abilities. They express an opinion of not knowing what will happen next in their lives and having to depend solely on others for medical assistance.¹⁷ Moreover, another study conducted in Thailand revealed that older adults feel overwhelmed but also accept who they are and learn to live with their health conditions.¹⁸ In England, Borley and Hardy¹⁹ reported on the experiences of women living with Alzheimer's disease and

their perceptions of becoming dependent on others for care. They reported that women are concerned about their loss of identity, feel unhappy but continue to fight to remain themselves. In Botswana, a southern African country, Hondras et al²⁰ examined the lived experiences of participants aged between 20 and 97 years living with musculoskeletal disorders. In this study, participants, including older adults, attached importance to their loss of independence and social identity from fulfilling their traditional roles. However, identifying qualitative studies on older adults' functional abilities in Africa, particularly Ghana, remains a challenge.

Accordingly, this study explored the lived experiences of older adults regarding their functional abilities, referenced against the WHO's International Classification of Functioning, Disability and Health (WHO-ICF) to understand health and care needs of older adults in Ghana. The present study employs interpretative phenomenological analysis (IPA) to make sense of how older adults in Ghana experience these difficulties.

Analytical Framework

The WHO-ICF framework offers a common language that can be used to describe and understand a person's health in terms of function and disability.²¹ Function, as defined by the WHO-ICF, relates to all body functions, activities and participation, while disability encompasses impairments, activity and participation restrictions.⁶ In this current study, the term functional difficulty is used in place of disability to reflect the impairment, activity and participation restrictions as per the WHO-ICF. The WHO-ICF acknowledges the interaction between body structures and function, activities, participation and how they are influenced by personal (including coping strategies) and environmental factors (including social relationships).²¹ Per the WHO-ICF, the "personal" domain is a contextual factor intrinsic to the individual that can influence health statuses, such as gender, marital status, and coping strategies. Body function and structure refers to the impairment or function level of older adults' body parts. Health condition refers to illnesses or chronic conditions that may affect older adults' function. Activity refers to the level of difficulty older adults may experience in engaging in activities necessary for daily life. Environmental factors encompass the physical, social, and attitudinal settings in which older adults go about their everyday life activities. Finally, participation refers to the level of restrictions older adults may experience engaging in meaningful activities.^{6,22} In this study, we assume that older adults' lived experiences of their functional difficulties may relate to the components of the WHO-ICF, enhancing our understanding of factors that may influence the health or care needs of older adults. The findings of this study will be necessary for program developers in Ghana to target factors that may potentially increase the health or care needs of older adults.

Design and Methods

Design

This qualitative study is part of a larger concurrent mixed-method program of research employing the WHO-ICF framework to examine functioning among older adults in a hospital setting of the Ashanti Region of Ghana. This research used IPA to analyze the interview data to provide insights into how older adults make sense of their lived experiences of their functioning. The findings were then referenced against the WHO-ICF to see how the various components relate to the experiences of older adults. In this study, research question construction, sampling, data collection methods, interviewing, and analysis followed IPA procedures,²³ which allowed for a unique exploration and analysis of an individual's experiences of the phenomena of interest through reflexivity and engagement.²³ In IPA, interpretation begins from the first interview through to the analysis of each transcript. In this study, interpretations of participants' interview data follow 3 recommended stages. First, interpretation of meaning recollection, that is, authors offered interpretations of how participants understood their phenomenon. Second is hermeneutics (interpretation) of suspicion where authors contrasted interpretations of participants' experiences against the WHO-ICF framework. Third, in some cases, authors raised questions to make meaning of participants' experiences.^{24,25}

Site and Participant Sample

The researchers used purposive criterion sampling²³ to recruit potential participants from the wards of Komfo Anokye Teaching Hospital in Ghana. Participants were eligible to take part in the study if they were aged 60 years or older, were admitted for experiencing difficulties engaging in daily activities due to any illness and/or frailty, were receiving care from a caregiver, and provided informed consent. These criteria were used in order to recruit participants who may experience difficulties in engaging in daily life activities, and who needed help from another person. For this study, nurses were used as a point of contact to help identify admitted older adults who were physically and cognitively able to take part in the study based on the shared inclusion criteria similar as elsewhere.²³ A trained research assistant then explained the study to potential participants and provided them with the information and consent forms. Each person had at least 72 hours to consider whether to participate. Out of 26 eligible participants, 8 individuals provided informed consent. Despite the research assistant's recruitment efforts, 18 potential participants could not make time for the interview because of either early discharge from hospital or change of decision to participate. According to IPA methodology, a sample size between 5 and 10 is enough to discover the nuances and complexities of people's lived experiences.²⁶

Semistructured Interviews

The primary researcher, who is experienced and trained in qualitative research, including IPA, interviewed each participant. Respect, concerns for privacy, a nonjudgmental attitude together with a genuine interest in the participants were always maintained. Moreover, the primary researcher speaks the same language as the participants (Twi, the main Akan dialect in Ghana), which helped facilitate the interactions. Participants were asked to reflect upon their experiences concerning functioning. The interview guide was devised to encourage discussion by participants of how they experience everyday functioning. Questions and prompts explored broad domains of general health, activities that required assistance, how the person felt about receiving assistance, their social engagement, and what helped them to manage.

Each participant was interviewed once only, with interviews lasting an average of 1 hour (48-90 minutes). Each of the interviews was conducted outside of the ward in a place and at a time of the participant's choosing, such as under a tree in the hospital grounds.

Interviews were transcribed immediately following each interview. As part of the design, codes, categories, and themes identified from the interview data were contrasted against the WHO-ICF to see how they relate to this framework. The classification, therefore, informed the discussion of the study to see how WHO-ICF relates to the lived experiences of older adults regarding their functioning.

Quality of the Research

Consistent with Yardley,²⁷ the current study was designed to ensure (1) sensitivity to context, (2) commitment to the study and rigor, (3) transparency and coherence, and (4) importance.

In establishing sensitivity to context, older adult inpatients, who were all admitted to the hospital for health or frailty reasons, were purposively recruited. The adoption of IPA was relevant due to its effectiveness in facilitating an understanding of the experiences of older adults living with functional difficulties.²³ Ghanaian society, including Akans, is characterized by social dependence²⁸ and so participants' responses may have been influenced by their cultural beliefs. In this case, the primary author shares similar beliefs and therefore understood their social interactions concerning their cultural beliefs and ideologies. However, this prior cultural understanding was bracketed.²⁹ In establishing a commitment to the study and rigor, the primary author was attentive to participants' information during data collection and careful in analyzing each participants' transcript. Before conducting the research, the primary author acquired an understanding of IPA and gained skills from previous qualitative studies, which increased the author's

Table 1. Demographic Information of Participants.

Names ^a	Gender	Age, y	Reason for admission	Marital status	Care provider
Afia	Female	60	Diabetes, leg injury	Married	Grandson
Blessings	Female	64	Hypertension, malaria	Widowed	Daughters
Esme	Female	61	Hip fracture and pains	Divorced	Granddaughters
John	Male	80	Kidney disease	Widowed	Daughter
Mavis	Female	70	Breast cancer, a broken leg	Widowed	Daughters
Michael	Male	73	Leg injury, diabetes	Separated	Brother
Ouansah	Male	79	Leg injury	Married	Daughter and wife
Sampson	Male	81	Fall	Widowed	Daughter

^aPseudonyms were used.

commitment to conduct a good IPA study. Also, existing literature was used to provide further context to the research.²³ Commitment to the research and rigor ensured sufficient data from participants and effective interpretation (both induction and deduction). The third principle is transparency and coherence. For transparency, a thorough description of participants' recruitment, the analytical approach, and the researcher's awareness of his relationship with participants have been provided in this study. To ensure coherence, authors were empathetic toward potential readers when writing and proofreading the final write-up. The last principle, impact and importance, was ensured by demonstrating how useful this research is to policy, practice, and research, which will be used by health care and social care professionals.

Ethical Considerations

Ethics approval for this research was received from The University of Newcastle (H-2018-0149) in Australia and Kwame Nkrumah University of Science and Technology (CHRPE/AP/112/18) in Ghana research ethics committees.

Data Analysis

Data were analyzed using IPA, following the 6 recommended steps.²³ NVivo version 12 was used to manage the data. First, each interview transcript was read several times in succession. Second, after gaining an understanding of the first interview transcript, codes about participants' experiences were made. Third, these initial codes were then translated into themes using abstraction. In developing the initial themes, descriptive, in vivo, and process first cycle coding methods were employed.³⁰ Fourth, the identified themes were reflected upon to find connections between them through abstraction and subsumption.²³ As for the fifth step, steps 1 through 4 were repeated for each one of the remaining seven interview transcripts. After this, the last step was to look for patterns of themes across all eight final transcripts combined, leading to 5 overarching themes. The 5

themes were then reported in the form of a narrative account, supported by participant quotes.²³

Results

Details of participants' characteristics are provided in Table 1.

From the experiences of older adults, a total of 351 codes were identified and grouped into 20 categories, which were then summarized as 5 overarching themes (see Table 2).

The 5 themes are reported below.

Theme 1: Feeling Anxious

This theme reflected participants' expressions of anxiety when engaging in functional activities. Feelings of anxiety were emotional responses, often manifested in the form of fear, worry, surprise and safety concerns among participants. Feelings of anxiety seem to vary in relation to the specific function restriction. In the following extract, Esme, who has no difficulty toileting, expressed anxiety about not being able to perform other functional activities:

I don't have any problem going to the toilet because it's in my house. It's fufu (food prepared from cassava) I cannot pound. Pounding fufu is very difficult for me. And because of my waist pains, I cannot sweep a larger portion maybe my small apartment, and that worries me a lot.

Central to Esme's account was the assumption by the researchers that her attachment to the sick bed at the hospital obscured her ability to perceive her future ability to engage in functional activities:

When I wake up, and I can move to and from, then I'm okay, but like today I have slept here, yesterday I was here. I do not know when I would leave here (hospital).

The space between the hope to regain ability and the total reliance on others in completing personal care and household activities was occupied by worry. It is in relation to their inherent desire for full independence and their concerns

Table 2. Themes, Categories, and Codes From the Experiences of Older Adults Regarding Functional Activities.

Themes (N = 5)	Categories (N = 20)	Codes (N = 351)
Feeling anxious	Fear of unknown future	3
	Surprised feeling and safety concerns	7
	Worry about the health state	14
Feeling restricted	Loneliness	15
	Restrictions (eg, self-care, household work, social gathering)	29
Understanding and admitting difficulty	Poor health (eg, stroke, injury, breast cancer)	35
	Attributing difficulty to a cause	14
	Normalizing difficulty	26
Striving to be healthy and productive	Being productive	26
	Striving for social acceptance	18
	Yearning to regain the ability	13
Managing functional difficulty	Acceptance and comparison	5
	Suppressing the intensity of functional difficulty	3
	Environmental friendliness	22
	Feeling of welcomeness	3
	Faith, hope, and God	35
	Social support and relationships	54
	Being cared for	29

about incapacity that participants' anxiety manifested. Reflecting on her intrinsic desire to be independent in undertaking household duties and personal care created much anxiety for Mavis:

It is only small things like cooking or washing the dirty clothes that I do. But for now, I don't know what will happen, whether I will be able to live with it (broken legs and hips) to do small things for myself or I will be dependent on others. That worries me a lot.

Anxiety was also driven by a perceived lack of social support in completing functional activities, including household chores. Reflecting on the uncooperative attitudes of children appeared to give Mavis more reason to be anxious:

Taking these modern children, for instance, sometimes when I see that children are not able to do (household responsibilities). It worries me that I cannot do those myself, and I have instead asked children to do it for me.

Blessing's comments illustrated how the onset of poor health could become a shock in participants' lives and the existence of anxiety related to their difficulty in admitting poor health. Blessing used a rhetorical question to describe how unexpected her change in health circumstances felt:

I became very worried because I was not expecting any sickness like that. Why should it happen this way?

The occurrence of poor health impeding functional activities, to Afia, was a period of transformation of behavior and attitude in ensuring safety in life:

This is because I don't do many things that will be more than my strength.

Theme 2: Feeling Restricted

This theme embodies what participants expressed regarding the restrictions in functional abilities. It appears that the restrictions in social participation contributed a great deal to participants' feelings of a loss of humanity. To be a human is to be free to participate in all aspects of life, and to be visited by and to visit others without any hesitation. In the following extract, Sampson used a rhetorical question to describe the extent of his social restriction:

And now that I am alive, do you think I can go to church, wedding ceremony or some gathering? No, I cannot do due to my poor health.

As described by Ouansah, restrictions were likened to imprisonment, where one is deprived of freedom. He demonstrates his struggle for freedom in life to self-care:

Since then (broken legs), I have not been able to be free in life. If I want to go to the toilet, I will need someone to carry me, and if I want to bath, someone bathes me.

Michael extended the understanding of his experience of restrictions in functioning, as he demonstrated how his broken legs had confined him to a stationary place, making him depend totally on others for help with daily activities:

Now, I'm not able to do any of those things anymore. All I do is to stay in my room because of my condition. Even walking is a problem for me now.

The extent and impact of restriction seem to become more tangible when the present is compared with the past. Blessing highlighted the extent of restriction by referring to “fufu pounding” and how this represented her comparison of the present with the past:

I used to do things with much strength, but now I find it difficult to do certain things. Those times I was able to pound fufu, but now I am not able to pound. And even sweeping it is difficult for me.

It appears that restriction in social participation is connected to feelings of isolation. When the most cherished activity, social participation, has been curtailed by poor health, the feelings of the unimportance of self and others arise. John demonstrated how his inability to attend gatherings with friends had made him feel isolated:

It makes me feel lonely. I am not able to go and visit others much due to my disability.

Moreover, when the feelings of restriction in functional abilities become pronounced, and there is a loss of a sense of value as a human, there is an accompanying lack of interest to live. Sampson expressed dissatisfaction in life:

I will even be happy to die. I am no longer a human being.

Theme 3: Understanding and Admitting Difficulty

This theme represents those aspects of participants’ experiences that connoted an understanding and admission of functional difficulties. It is when participants acknowledged, normalized, and attributed their difficulty to a cause. Inherent in Sampson’s extract was an assumption that functional difficulty is an inherent part of the course of human life:

Oh, it does not make me sad. As for humans, we grow, and when you grow to some point, I know you will fade out.

Participants’ understanding and admission of restrictions became explicit as they offered varying explanations of the cause of difficulties experienced. The attributions to the cause manifested itself as the participants pinpointed the cause of their functional difficulties. Participants compared their abilities in the present with the past to understand present difficulties. Afia expressed this idea when she described her satisfaction with her past abilities and participation in life activities and admitted her current restrictions in walking were due to old age:

I used to walk to marketplaces. But just that I am not able to walk like the way I used to walk in the past. I know I am growing old.

Esme drew attention to the effects of a lifetime of hard work on current functional difficulties:

It is our work baking of bread. It is about bending and arising. I have done it for long too since childhood. Therefore, as I’m growing, then I experience this waist pain.

The need to fulfil responsibilities as a parent also affected subsequent difficulties. A perceived inability to perform the roles may have created an emotional imbalance. For Michael, who had a broken leg, tension and pressures emanating from the requirement to meet the financial needs of his family further had an impact on his difficulty:

Our financial unstableness at home is also a part of it.

Participants acknowledged the importance of varying health problems that contributed to functional difficulties. Their statements connoted some level of admission of poor health. Afia indicated what worsened her poor health:

I fell down, and so that led to the brokerage of my hip. Although I have diabetes, it was when I fell that my strength went down.

Blessing demonstrated knowledge and awareness of her poor health:

My heart and all over under my breast was paining me. I find it very difficult to breathe, and I was restless.

Using several clauses, John acknowledged how living with poor health affected the social participation he cherished:

My health is not good. Things have gone down. I cannot even go to the Red Cross Society meetings for two years now. This is because I am weak.

It appeared that unexpected falls led to a loss of trust in oneself, and subsequently resulted in confinement or dependence on others. As Sampson talked about his poor health, his self-esteem seemed to have been diminished because he did not know when he would fall again:

I cannot even walk to church. Sometimes I can even fall. When it even began, I did not realise that it would lead to a devastating situation like this. Maybe when I am walking and then suddenly, I will fall.

Theme 4: Striving to Be Healthy and Being Productive

This theme includes the internalized desire for social acceptance and to be healthy and productive in functional activities. For some participants, the onset of functional difficulties represented a time when they were in search of a resolution of their difficulties, rather than an acceptance of

the change. Sampson talked about his diminishing status within society:

As I sit here and my functioning is decreasing, I don't want people to see my shrinking body. That is my worry now.

The inherent desire to be independent can also supersede the onset of poor health. Participants made themselves useful in other areas of life to maintain a sense of self-worth, despite their functional difficulties. They kept active by engaging in self-care, such as bathing, eating, and toileting. Blessing described how she managed to engage in activities that did not need much strength, despite her challenging poor health:

As for bathing, I can bath, and I am able to cook too.

When capacity was reduced, participants could not work beyond their available strengths. John, a retired photographer, made himself productive as far as his health allowed him. Central to John's narrative is the assumption that, when most of his strength was lost, it was not lost for making money from work that his strength allowed for:

After church, I take pictures of people, and I then get something in my pockets.

Contributing to the welfare of the immediate family served to restore the lost self-worth of participants. By improving the emotional and physical well-being of his family, Sampson restored his self-worth:

I need to be able to build so that my children can benefit if I am not alive. What I can do to help my children in the future is the most important thing.

Seeing attending social gatherings as a duty, Mavis illustrated how she made herself available for several gatherings despite her poor health:

Recently, three of my grandchildren got married, and so I was able to attend all of them. I am also able to go to the funeral.

Although they appreciated getting help, participants wanted to maximize their level of functioning to reduce the burden on others. Afia described how she craves to fulfil her lost functioning:

It makes you sometimes compare yourself to your youth and wish you could go back.

The desire to regain functioning was vivid in Quansah's willingness to amputate his leg. He expressed the desire to reduce his dependence on others for assistance:

I will amputate one of my legs, and I think that will help me a lot to walk small. Even here, if I want to go to the toilet, somebody needs to carry me.

Theme 5: Managing Functional Difficulty

This theme expresses the intrinsic and extrinsic means participants use to cope with functional difficulties. To them, these strategies are like a lubricant that reduces friction. The relevance of comparison and acceptance became evident as coping strategies. The assumption was that the moment participants resigned themselves to their difficulties, anxiety seemed to lessen. Sampson reported how he allowed his poor health to become part of his life:

What is going on in my life does not make me sad at all. As I sit here for me to be sad because I am weak, or even knowing I can die soon, it's not part of my plans.

Comparing one's condition with the conditions of others put things into perspective. It was a form of consolation when participants learned that their situation was relatively better than that of others. Sampson compared his poor health to his brother's, and this lessened the effect of his condition on his well-being:

Yesterday, one of my brothers came here. What is happening to my brother, when I even look at myself, I will realise that my brother is also experiencing worse disability than I am.

As an extension of this comparison, Blessing used examples from the Bible to console herself. It was when she compared that she accepted and gave her functional difficulties a place in her life:

I read the bible. Then I use examples in the bible to comfort myself.

It appeared that environmental factors also affected participants' coping methods, with an inverse relationship between the level of environmental support and how people coped with their difficulties. Participants were concerned about the safety and comfort of their physical environments as well as the social ambience surrounding it. Blessing referred to the ambience of her physical environment:

Where we live is a new site, and so it is much cool place to live.

Availability and accessibility of amenities were of concern to John. He illustrated how happy he was to have access to the bathroom:

I have a bathroom and bathroom is combined at the same place I live, so I just walk there.

According to Mavis, the security of the nation was a means for her to cope:

When I wake up in the morning, I don't hear that there is war nationwide. I feel like I am in a peaceful nation. I can eat, sleep without any panic.

Spirituality was at the forefront of participants' narratives. It appeared that faith in God, expressed in the form of praying, was their daily ritual. It was tantamount to life and air; it was rooted in their daily lives.

In the following extract, Afia illustrated her reliance on God for good health:

All my hope is on God. I have hope that God will protect me and give me peace and good health.

Esme alluded to God as a car manufacturer who repairs his car when it breaks down to show the extent of her faith in God to provide regained functioning:

God will help me to be healthy again because he created the human and so if there is something wrong with the body, he can fix it.

Another aspect of participants' management strategy was social support and relationships. Participants demonstrated swiftness in tapping into available resources to cope with present difficulties. The church was a source of relief for most participants. Afia explained how she received support through church members:

About that, they (church members) sometimes visit me when I get hurt.

Pension pay appeared to have given some participants the power to cope with difficulties. Despite how small the pension appeared to Ouansah, receiving the money in the face of poor health always created happiness:

I receive small money (pension) from the government every month, although it is not enough, but I can manage until the next months.

It was evident in the study how participants demonstrated feelings of wellness when they talked about the support they received from family members. Afia's usage of the expression 'my grandson' demonstrates how she feels good receiving support:

I have a little boy, my grandson, who helps me. He prepares food for us to eat.

Congruency With the WHO-ICF

In our study, we used the WHO-ICF as a framework against which we contrasted the lived experiences of older adults to see how they relate to the components of the WHO-ICF. All categories under the 5 themes were congruent with the various components of the WHO-ICF. Ten of the 20 categories identified were congruent with personal factors. Five categories were congruent with environmental factors, and 2

categories were congruent with participation. Of the remaining 3 categories, 1 was congruent with health conditions, 1 with body function and structure, and 1 with activity limitation. The contextual factors (personal and environmental factors) related to the majority of the lived experiences of older adults regarding their functioning (see Table 3).

Contrasting the lived experiences against the WHO-ICF framework, we realized that there was no explicit information on some personal factors such as information on the demographic characteristics, including gender, marital status, education, and others. Their lived experiences could not convey information on these significant variables. However, in deciding on improving functional abilities among older adults, these variables are important.

Discussion

Older Adults' Lived Experiences

Our findings indicate that although participants experience numerous functional restrictions, they are more concerned about social participation restrictions, such as being able to attend church, weddings and visiting friends. This finding is consistent with studies that reported that the difficulties older adults experience included unintended dissociation from socialisation.³¹ It is also consistent with an ethnographic study conducted in Botswana, which found that participants are concerned about the loss of independence and social identity, resulting from their musculoskeletal disorders.²⁰ Participants' concerns about social participation difficulties found in this study could be a means of drawing attention to their internal desire to maintain relationships because as they age, they experience a decrease in their social network, increased loneliness and social isolation.^{32,33} In the Ghanaian context, older men are more susceptible to having a decrease in the social network compared with the older women because older men are often accused of abandoning their children, when their children were young,³⁴ and may thereby receive minimal emotional support. The health needs of older adults, particularly older men, should be addressed to be able to participate in things they value in Ghana. Currently, in Ghana, the built and social environments are not favorable for older adults,³⁵ which seemingly adds to the burdens of their lives. Despite that improving the health needs of older adults is relevant, making the social and built environment more accessible and adequate will improve the wellbeing of older adults.³⁶ For instance, if the roads are improved, and vehicles are made accessible to older adults, particularly older men in Ghana, they can maintain their relationships despite functional restrictions. Moreover, sensitizing individuals in the community about the needs and capabilities of older adults may reduce ageism, and strengthen older adults, particularly older men, and relationship with friends, family, and neighbors.

Table 3. Summary of Qualitative Themes and Categories Using the World Health Organization's International Classification of Functioning, Disability and Health (WHO-ICF) Framework.

Themes (N = 5)	Categories (N = 20)	Congruent WHO-ICF components
Feeling anxious	Fear of unknown future	Personal factor
	Surprised feeling and safety concerns	Personal factor
	Worrying about the health state	Personal factor
Feeling restricted	Loneliness	Personal factor
	Restrictions (eg, self-care, household work, social gathering)	Activities Participation
Understanding and admitting difficulty	Poor health (eg, stroke, injury, breast cancer)	Health conditions Body function and structure
	Attributing difficulty to a cause	Personal factor
	Normalizing difficulty	Personal factor
Striving to be healthy and productive	Being productive	Participation
	Striving for social acceptance	Personal factor
	Yearning to regain the ability	Personal factor
Managing functional difficulty	Acceptance and comparison	Personal factor
	Suppressing the intensity of functional difficulty	Personal factor
	Environmental friendliness	Environmental factor
	Feeling of welcomeness	Environmental factor
	Faith, hope, and God	Personal factor
	Social support	Environmental factor
	Relationship	Environmental factor
	Being cared for	Environmental factor

Previous research shows that when older adults experience restrictions in functioning, they become overwhelmed and manifest emotional and psychological instabilities.^{18,37,38} The restricted feelings could explain the reason why Ghanaian participants in this current study felt anxious, expressing worry and discomfort over their functional difficulties. With intensifying anxiety, older adults may feel more unable to engage in social and other activities, meant to enhance their health, which may lead to increasingly poor health, suicide, and premature mortality.³⁹ Appropriate and timely service provision could assist in reducing anxiety and assist older adults in regaining some functioning. In Ghana, social work practices can help improve the social needs of older adults. Since complete health includes a social aspect, effective policies and programs should be geared toward enhancing the emotional and psychological instabilities that population ageing presents among older adults in Ghana. These challenges social service professionals, including social workers, to become aware of the health and social needs of older adults and employ innovative approaches to meet the unique needs of older adults in Ghana. To be able to work with older adults, all educational curricula in Ghana should incorporate the knowledge of the unique needs of older adults to enhance understanding and appreciation in all sectors, including industry, services, and agriculture.

We identified that participants in the current study understood restrictions, which is similar to other studies.^{18,19} Even if older adults' understanding of present difficulties was unconscious, understanding tends to enhance their psychological well-being⁴⁰ and ensures management and restructuring of their perceptions in life.⁴¹ Counseling older adults is possible because their mind is already prepared for the change they are experiencing. This evidence also emphasizes that some older adults in Ghana, who were not participants may find it difficult accepting their change drawing attention to the need to create a platform for all older adults in Ghana to access health and social services.

Another finding is related to how participants strive to be healthy and productive despite difficulties. This feeling is a resource, especially currently when the desire for healthy and productive ageing is gaining the attention of researchers and policies worldwide, including Ghana. Participants' inherent desire to be productive infers that a caregiver adopting a reablement approach in Ghana to help older adults with a disability or frail to learn or relearn the skills needed for activities of daily living will be possible.⁴² This evidence should draw the attention of all health and social care professionals, including doctors, nurses, caregivers, and social workers, in how older adults desire to be productive and should be adopted that can enable older adults to have some autonomy in all areas of their lives. Older adults in Ghana should not be seen as passive recipients of care,

but as unique individuals who want to have control over their lives and therefore need assistance or support. Another possible argument is that participants' desire to regain their abilities, as found in this current study, can be a stressful experience; however, their hope to be active and healthy in times to come is itself valuable,⁴³ in that it connotes a feeling that older adults possess control over their lives.⁴⁴

Participants managed their functional difficulties in varying ways, making use of religious support, pensions, and family support to cope with their difficulties. Previous studies also identified family and friends as a great support system.^{45,46} Additionally, participants used comparison and acceptance to manage their difficulties. Possessing the ability to accept difficulties is a powerful coping strategy⁴⁷ because it gives older adults a tool to develop new perspectives on life and promotes psychological well-being.⁴⁰ Moreover, when participants compare their difficulties with others, they have a feeling of control over their current condition, especially when they realize that other people face enormous difficulties. Moreover, spirituality was a dominant coping strategy for participants, which is consistent with studies conducted with Thai older adults.¹⁸ As shown in this current study, a peaceful environment, availability of toilet facilities, and disability-friendly infrastructure can enhance participants' emotional and mental capacity to overcome their restrictions. Since older adults have coping strategies, what needs to be provided to older adults in Ghana is financial, health, physical, emotional, and social support.

We noticed that there were gender differences in how participants experienced functional difficulties. While female participants hoped the family or God would care for them, male participants discussed how they took action in the world to overcome their difficulties. This understanding of the variation in experience is particularly important because it is the first step to meeting the needs of older adults. This variation implies that an intervention to help older adults manage their difficulties should be structured according to gendered expectations. Intergeneration and spirituality can be promoted among older women since this can be easily accepted as a coping strategy. This highlights an opportunity for social workers to devise innovative approaches to work with older women. Older men can also be encouraged in communal activities or participate in group activities as far as their abilities may allow them to facilitate their coping strategies.

Our study findings have numerous implications. First, the contentment and happiness participants experience when support is available indicates the importance of caregiving relationships. Allied health professionals, such as social workers, should focus on enhancing caregiver relationships with older adults. Second, an in-depth understanding of older adults' perceptions and uptake of reablement approaches need to be explored. Third, for health

professionals, it offers an understanding of how older adults experience health conditions and their experiences of living with functional difficulties. The findings highlight the importance for researchers to explore the experiences of older adults experiencing specific health conditions in Ghana. Moreover, research is needed to understand the management strategies that can be effective in helping older adults improve their functional abilities. It draws attention to the need to explore the relationship between the built environment and older adults' management of their functional difficulties. More research needs to explore how the social and physical environment qualitatively impacts on older adults' functional difficulties in Ghana.

Applying the WHO-ICF Framework

Many older adults' lived experiences were endorsed by personal factors across all the five interrelated qualitative themes specified in this study, followed by environmental factors, and the third being participation. The health conditions, activities and body function and structure components of the WHO-ICF related to few of the lived experiences of older adults. The trend of endorsement shows that when the contextual factors are maximized, despite the presence of poor health or impairment, older adults may be able to engage in activities and increase their social participation. Examples of the contextual factors are the availability and accessibility of toilets and transport.

The contextual factors, which endorse most of the lived experiences of older adults engaging in functioning, reveal how relevant these factors could be in maximizing the capacity of older adults in later years to live independently. This study demonstrated how the WHO-ICF could be a useful guide for the analysis of qualitative data on the health and social care needs of older adults in Ghana, and beyond. We noticed that the demographic factors of the personal factors per the WHO-ICF could not be endorsed in participants' lived experiences. However, these variables are significant for health and social professionals to know what level of intervention should target which particular group of older adults. Quantitative studies employing the WHO-ICF to explore functional difficulties is relevant to complement what was found in this study.

Strengths and Limitations

The strength of this study is in its application of IPA, making it possible for each participant's experience be heard. Moreover, applying the WHO-ICF framework has identified both intrinsic and extrinsic factors affecting the functional difficulties of older adults. However, there were certain limitations that need to be recognized. Inherent in qualitative studies, the researchers may have interpreted participants' data subjectively; however, the researchers were reflexive

throughout the study and bracketed certain knowledge and beliefs. Furthermore, this study focused on hospitalized older adult inpatients engaging in functional activities without a specific interest in a specific chronic illness.

Conclusion

The lived experiences of older adults are interrelated with the various components of the WHO-ICF framework. This finding offers novel opportunities to meet the needs of older adults in Africa, particularly Ghana. The interventions that focus on older adults' personal and environmental factors, as per the WHO-ICF, need to be given much consideration by healthcare professionals and government agencies to help address the needs of older adults.

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