Subjective Well-Being among Older Adults in Addis Ababa, Ethiopia: Conceptualization and Instrument Development

By

Teshome Kondale Gurara

Addis Ababa University

College of Education and Language Studies

School of Psychology

July 2025

Addis Ababa, Ethiopia

Subjective Well-Being among Older Adults in Addis Ababa, Ethiopia:

Conceptualization and Instrument Development

By
Teshome Kondale Gurara

Advisor

Yekoyealem Desie (PhD, Associate Professor)

Dissertation Study Report Submitted to the School of Psychology of Addis Ababa University in Partial Fulfillment of the Requirements for the Doctor of Philosophy Degree in Applied Developmental Psychology

July 2025

Addis Ababa, Ethiopia

Declaration

I, the undersigned, declare that the work contained in this PhD dissertation has not been previously submitted to meet requirements for an award at this or any higher education institutions. To the best of my knowledge and belief, the dissertation contains no material previously published or written by another person except where due reference is made.

Teshome Kondale Gurara _____ _____

Name **Signature** **Date**

School of Psychology

College of Education and Language Studies

Addis Ababa University

The Dissertation work entitled *"Subjective Well-Being among Older Adults in Addis Ababa, Ethiopia: Conceptualization and Instrument Development"* has been prepared under my supervision as a university advisor and I recommend that it is accepted as it fulfils the necessary requirements.

Yekoyealem Desie (PhD, Associate Professor)	_____	_____
Advisor's Name	**Signature**	**Date**

Addis Ababa University

College of Education and Language Studies

School of Psychology

Approved by Board of Examiners

This is to certify that the dissertation prepared by Mr. Teshome Kondale Gurara entitled: Subjective Well-Being among Older Adults in Addis Ababa, Ethiopia: Conceptualization and Instrument Development and submitted in partial fulfillment of the requirements for the Degree of Philosophy in Applied Developmental Psychology complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by the members of the Examining Board

_____	_____	_____
Chairperson	Signature	Date
_____	_____	_____
Internal Examiner	Signature	Date
_____	_____	_____
External Examiner	Signature	Date
_____	_____	_____
Head, School of Psychology	Signature	Date

Acknowledgements

Firstly, a heartfelt thank you to my supervisor, Dr. Yekoyealem Desie, Associate Professor of Applied Developmental Psychology at Addis Ababa University, School of Psychology, for his unreserved support and direction during my dissertation work and publication processes. Without his unwavering support, priceless contributions, and helpful criticism, this dissertation work would have never been completed. I also want to acknowledge and extend my sincere gratitude to Prof. Margaret Adamek (Professor at Indiana University, School of Social Work), my co-supervisor, for her professional advice and support throughout the publication process.

Thank you to Addis Ababa University School of Psychology for allowing me to embark on this amazing journey. I am grateful to the all-course staff for their unwavering support, especially through the more difficult times, which has been invaluable. I wish to thank all older adult participants who consented to participate in this study. This study would not have been feasible without your contribution. Thank you for letting me glimpse into your lives and helping us further understand matters crucial to subjective well-being. For their all-around support during my research work, I am especially appreciative of the Ethiopian Elderly and Pensioners National Association (EEPNA).

Finally, my dearest gratitude goes to my wife, W/ro Nardos Fikermariam, and my children (Nathan, Milkeyas, and Selihot) for their patience, heartfelt support, encouragement, and love during my studies. My special thanks also go to my sisters and brothers for supporting and motivating me to accomplish this study.

Mr. Teshome Kondale Gurara
July 2025
Addis Ababa, Ethiopia

Table of Contents

Acknowledgements i
Table of Contents ii
List of Tables v
List of Figures vi
Acronyms vii
List of Published Articles viii
Abstract ix
Chapter 1: Introduction 1
1.1. Background of the Study 1
1.2. Statement of the Problem 10
1.3. Objectives of the Study 15
1.4. Rationale and Significance of the Study 15
1.5. Delimitation of the Study 17
1.6. Limitation of the Study 18
Chapter 2: Review of Related Literature 19
2.1. The Essence of Aging 19
2.1.1. Biological Perspective 19
2.1.2. Psychological Perspective 19
2.1.3. Social Perspective 20
2.2. Conceptualization of Subjective Well-Being 20
2.3. Theories and Models on Subjective Well-Being 24
2.3.1. Psychosocial Theories 24
2.3.2. Social Exchange Theory 28
2.3.3. Modernization Theory 29
2.3.4. Rowe and Kahn's Model of Successful Aging 29
2.3.5. Model of Psychological Well-Being 31
2.3.6. Model of Selective Optimisation with Compensation 31
2.3.7. Lifespan Model of Successful Ageing 32
2.4. Implications of the Various Theories and Models of Subjective Well-Being 39
2.5. Determinants of Subjective Well-Being 40
2.6. Research on the Older Adults in Ethiopia 42
2.7. Measurement of Subjective Well-Being 46
2.7.1. Eight Measures of Subjective Well-Being 46
2.7.2. Description of Subjective Well-Being Measures 48
2.7.3. Systematic Evaluation of Subjective Well-Being Measurements 58
2.8. Development and Validation of Scales 62
2.8.1. Scale Development and Validation Models 63
2.8.2. Major Procedures in Scale Development and Validation Process 64
2.9. Summary 80

Chapter 3: Methods of the Study 83
3.1. Study Setting 83
3.2. Study Design 85
3.3. Target Population 86
3.4. Data Sources 87
3.4.1. Primary Source of Data 87
3.4.2. Secondary Data of Sources 87
3.5. Inclusion Criteria 87
3.6. Ethical Considerations 88
3.7. Phase 1: Study One and Two 89
3.7.1. Philosophical Assumptions of the Research 89
3.7.2. Rationale for Using Qualitative Research Method 90
3.7.3. Participants and Sampling Technique 91
3.7.4. Methods of Data Collection Tools 92
3.7.5. Procedures of Data Collection 93
3.7.6. Strategies to Ensure Research Quality 95
3.7.7. Data Storage and Retrieval of the Study 97
3.7.8. Methods of Data Analysis 98
3.8. Phase 2: Study Three 102
3.8.1. Sample and Sampling Techniques 102
3.8.2. Sample Size 103
3.8.3. Method of Data Collection 104
3.8.4. Procedure of Data Collection 105
3.8.5. Methods of Data Analysis 110
Chapter 4: Results 114
4.1. Socio-Demographic Characteristics of the Participants in Study One and Two 114
4.2. Phase 1: Study One 116
4.2.1. The Living Situation of Retired Pensioners 116
Theme 1: Unattended health issues and unaffordable health care 116
Theme 2: Absence of recreational places 121
Theme 3: Lack of respect and feeling disengaged 125
Theme 4: Vulnerable livelihood and precarious life 129
Theme 5: The overlooked value and contribution of older adults 134
4.3. Phase 1: Study Two 137
4.3.1. Conceptualization of Subjective Well-Being 137
Theme 1: Physical and mental health 139
Theme 2: Family and social interactions 143
Theme 3: Financial stability and security 148
Theme 4: Optimism and autonomy 150
Theme 5: Religious faith and practices 153

Theme 6: Opportunity to work and contribute to the community 156
4.4. Phase 2: Study Three 161
4.4.1. Specifying the Construct (Older Adults' SWB) 161
4.4.2. Content Validity Assessment 163
4.4.3. Scale Purification 164
4.4.4. Validity Analysis 177
4.4.5. Norms of the Scale 179
Chapter 5: Discussion 181
5.1. The Living Situation of Retired Pensioners 181
5.2. Conceptualization of Subjective Well-Being 187
5.3. Development and Validation of an Instrument to Measure Subjective Well-Being among Retired Older Adults 191
Chapter 6: Conclusion 196
6.1. Conclusion 196
6.2. Implication 198
References 201
Appendices 243
Appendix A: Interview Guide 243
Appendix B: Focus Group Discussions Guide 251
Appendix C: Initial Draft Items 255
Appendix D: The Selected 46 Items 260
Appendix E: The Selected 46 Items 263
Appendix F: The Final Version of Older Adults SWBS 266
Appendix G: The Final Version of Older Adults SWBS 268

List of Tables

Table 1: Types of SWB measures 47

Table 2: Critical CVR values based on the number of panelists 67

Table 3: The two distinct phases of the study.....86

Table 4: Interview participant characteristics 115

Table 5: FGD participant characteristics 115

Table 6: Dimensions of SWB and their definition.....162

Table 7: Socio-demographic characteristics of participants (n=272) 165

Table 8: Descriptive statistics and reliability of variables (n= 272) 166

Table 9: The distribution of the SWB scale data used for EFA (n= 272).....167

Table 10: The eigenvalues, total percentage of variance, and the cumulative percentage of variance accounted for by the five factors 168

Table 11: Rotated component matrix of older adult SWB (n=272) 171

Table 12: Items and reliability coefficients of the five SWB subscales (n=272) 173

Table 13: Socio-demographic characteristics of participants (n= 259) 174

Table 14: The distribution of the SWB data used for CFA (n= 259) 175

Table 15: Convergent and discriminate validity analysis 178

Table 16: Items, mean, standard deviation, minimum score, and maximum score of the five SWB subscales (n= 259) 179

Table 17: The norms of SWB subscales in terms of percentile rank (n =259) 180

List of Figures

Figure 1: Sub-cities of Addis Ababa and their geographical locations 84

Figure 2: Flow diagram for the procedures followed to develop and validate the SWB scale....113

Figure 3: The SWB conceptual framework emerged from qualitative phase.....138

Figure 4: Scree plot of items and their eigenvalue 167

Figure 5: Initial standardized CFA of the older adults SWB scale with 27 Items.....176

Figure 6: Final standardized CFA of the SWB scale with 27 Items.....177

Acronyms

AAC	Assimilative and Accommodative Coping
CFA	Confirmatory Factor Analysis
CSA	Central Statistics Agency
CVR	Content Validity Ratio
DSWP	Developmental Social Welfare Policy
EEPNA	Ethiopian Elderly and Pensioners National Association
EFA	Exploratory Factor Analysis
ESA	East and Southern Africa
FGD	Focus Group Discussion
HAI	HelpAge International
MoWSA	Ministry of Women and Social Affairs
MTLD	Motivational Theory of Lifespan Development
NPAOP	National Plan of Action on Older Persons
NSSP	National Social Protection Policy
PANAS	Positive and Negative Affect Schedule
SAVI	Strength and Vulnerability Integration
SOC	Selective Optimization with Compensation
SPWB	Scales of Psychological Well-Being
SSA	Sub-Saharan African
SEST	Socio-Emotional Selectivity Theory
SWB	Subjective Well-Being
SWLS	Satisfaction with Life Scale
UN	United Nations
WHO	World Health Organization

List of Published Articles

- Kondale Gurara, T., Desie, Y., & Adamek, M. E. (2025). 'Age should never be a barrier to pursuing our passions': older adults' conceptualization of subjective well-being in Ethiopia. *Journal of Aging & Mental Health*, 1-10. https://doi.org/10.1080/13607863.2025.2464711
- Kondale Gurara, T., Desie, Y., & Adamek, M. E. (2025). "Old age is like a curse: "Perspectives of retired pensioners on late life precarity in Addis Ababa, Ethiopia. *Journal of Aging & Social Policy* (accepted for publication).
- Development and Validation of an Instrument to Measure Subjective Well-Being among Older Adults in Ethiopia *(under review)*.

Abstract

Conceptualization and measurement of Subjective Well-Being (SWB) among retired older adults is insufficiently studied area in Ethiopia but of growing importance. The purpose of this study was to explore the perspectives of retired pensioners on late life precarity, examine how SWB is conceptualized among retired older adults, and develop and validate locally relevant instrument for measuring retired older adults' SWB in Addis Ababa. Sequential exploratory mixed-methods research design was employed through two distinct phases where qualitative methods precede the quantitative approach. The first phase of the study was aimed to explore the perspectives of retired pensioners on late life precarity and examine how SWB is conceptualized among retired older adults in Addis Ababa. For this study, six woredas from three sub-cities were chosen purposively, and 31 retired pensioners (20 men and 11 women) aged 60 and older participated. In-depth interviews and focus group discussions were used to gather qualitative data from the study participants and a thematic analysis was employed to analyze the data. The qualitative analysis generated five overarching themes: unattended health issues and unaffordable health care; absence of recreational places; lack of respect and feeling disengaged; vulnerable livelihoods and precarious lives; and the overlooked value and contributions of retired older adults to Ethiopian society. Concerning participants' perspectives on their well-being, the six themes identified were physical and mental health, family and social interactions, financial stability and security, optimism and autonomy, religious faith and practice, and opportunity to work and contribute to the community. The second phase of the study was designed to develop and validate locally relevant instrument for measuring retired older adults SWB. For this purpose, an exploratory sequential mixed methods research design was employed initially to explore the conceptualization of SWB and its indicators qualitatively, then followed by a quantitative method to examine the validity of the scale. Both qualitative and quantitative data were collected. Data for qualitative analysis were gathered from retired older adults using in-depth interviews and focus group discussions, whereas data for quantitative analysis were gathered from expert judges and retired older adults. A multistage random sampling method was employed to choose woredas, and twelve woredas from four sub-cities with better documentation were selected. To develop and validate instrument for measuring older adults' SWB, data were collected twice, one for preliminary analyses such as item analysis, exploratory factor analysis, and reliability analysis based on the responses of 272 participants (men=176; women=96), and the other for examining confirmatory factor analysis as well as convergent and discriminant validity analysis using the responses of 259 participants (men=168 and women=91) from the four sub-cities, were randomly selected. The collected data was analyzed using IBM SPSS with AMOS 23.0. The final results revealed that a 5-factor solution (physical and mental health, family and social interactions, financial stability and security, optimism and autonomy, religious faith and practice) with a 27-item was identified, and then confirmed with good fit indices. Moreover, acceptable convergent and discriminant validity evidence was found. Thus, it would be sufficient to say that the SWB scale measures what it purports to measure. Overall, the results underscore the importance of comprehensive and contextually relevant psychosocial and economic interventions aimed at improving the SWB of retired older adults. The results suggest the need for national aging policies with a strong political will and gender sensitivity for their implementation. Additionally, it also indicates the need for further research to examine the concurrent validity of the newly developed SWB scale.

Keywords: subjective well-being, older adults, pensioners, conceptualization, precarity, aging in Ethiopia, challenges of retired older adults, instrument development, Addis Ababa

Chapter 1: Introduction

1.1. Background of the Study

Older adults' demographic changes have become one of the most significant factors affecting families and societies worldwide. Currently, approximately 63% of the population aged 60 years and older lives in developing countries, and this figure is expected to rise to nearly 73% in the next 25 years (United Nations [UN], 2019). The proportion of older adults in Sub-Saharan African (SSA) total population is expected to rise from 4.8% today to around 7% by 2050, while their number will triple from 52 million to 158 million a more rapid rise than anywhere else or for any other age group (UN, 2019). Ethiopia is the largest country in East and Southern Africa (ESA) in terms of population size, with a total projected population of almost 115 million in 2020 (UN, 2022). Of this population, approximately 5.3 percent or around 6.1 million people are over the age of 60 years, making it the country in ESA with the largest population of older people. Inline with demographic trends elsewhere in the region, this proportion is projected to rise to 9.1 percent by 2050. The average life expectancy has risen significantly in Ethiopia, from low of 45 years in 1990 to 66 years in 2022 (UN, 2022). However, the aging phenomenon and the situation of the elderly in Ethiopia have so far attracted limited attention (Seid & Babbel, 2023).

A study conducted by HelpAge International (HAI, 2018) shows that Ethiopia is experiencing a steady increase in the aging population, while the coverage of pension schemes is low compared to Sub-Saharan African countries, leaving citizens defenseless in their old age. According to the Ministry of Women and Social Affairs (MoWSA, 2012) report, most older people have suffered from poverty, exclusion from the public pension, and economic exclusion,

hampered their access to basic services. The current social security schemes are extremely marginal in terms of the percentage of the covered labor force and the size of pensions received in Ethiopia (Kotecho et al., 2021). Furthermore, studies conducted in Ethiopia (e.g, HAI, 2018; MoWSA, 2012) reported that pension, the only formal social security in place, is not received on time or at all; it also has very limited coverage and is inadequate. Unlike in the more industrialized nations where support such as transport concession, health care, housing, income support, mature age allowance, rent assistance, disability payments, and pharmaceutical benefits are given (World Health Organization [WHO], 2018), these are absent for the elderly in Ethiopia. There is also an inadequate provision of funding for nursing homes and community care services for the elderly in Ethiopia (Adamek et al., 2024). The very few institutional homes for the aged are relatively not funded adequately (HAI, 2023).

Moreover, the impact of this demographic reality in Ethiopia is yet to receive adequate governmental attention as there is a lack of political will to implement aging welfare policy (Kotecho et al., 2021). The Ethiopian government has developed several social welfare services to improve the living condition of older adults. For example, the social policy framework involving the elderly in Ethiopia includes the Developmental Social Welfare Policy (DSWP, 1996), National Plan of Action on Older Persons (NPAOP, 2016-2025), and National Social Protection Policy (NSSP, 2012). However, since the action plan was not adequately budgeted and implemented, satisfactory services were not delivered to address the issues and needs of older adults in Ethiopia.

Along with the demographic changes in older adults, the well-being of older adults has been recognized as one of the most pressing health and social issues (Westerhof et al., 2012).

Two major categories of well-being that derive from Western, particularly Greek, traditions are hedonic and eudaimonic well-being (Ryan & Deci, 2001). The first category is the hedonic well-being, it involves a focus on pleasure and happiness, such as experiencing joy and the second category is the eudaimonic well-being, it involves a focus on human flourishing, such as achieving one's potential and having good relationships (Ryan & Deci, 2001). Although there is overlap between hedonic and eudaimonic well-being, scholars have proposed several models of well-being that measure components of both hedonic and/or eudaimonic well-being. For example, Subjective Well-Being (SWB) is perhaps the most popular model of hedonic well-being and, arguably, the most widely used index of overall well-being in psychological research (Ryan & Deci, 2001).

Various researches have examined SWB as an indicator of successful adaptation during old and very old age (e.g., Ryan & Deci, 2001; Vanhoutte, 2014). The pursuit of SWB is a common rationale behind international and local policies as well as research agendas (Van Hoorn, 2007). As a result of the worldwide rise in the proportion of older age, SWB in later life has gained substantial attention in research agendas as well as in economic, health, and social policies (Diener et al., 2009; Forgeard et al., 2011). This huge attention given to SWB had important contributions to physical, psychological, and social well-being of the older population (Diener et al., 2009). This makes SWB as a popular and interesting construct in many of the gerontological and applied developmental science studies since it is highly correlated with several positive life outcomes in old age (Bowling & Dieppe, 2005). Moreover, SWB is considered as one of the important life goals of older adults.

SWB has been considered as an indicator of psychological adaptation and successful aging (Baltes & Baltes, 1990). Related to this notion, Socio-Emotional Selectivity Theory (SEST) proposes that with life experience, older adults have found ways to successfully control and avoid potentially negative experiences, by selecting social partners (e.g., family, friends) who provide positive emotional feedback and support (Carstensen et al., 1999). According to the life span development perspective (Baltes & Baltes, 1990), older adults age successfully if they can manage their sense of well-being using flexible, adaptive strategies that optimize their functioning and well-being despite constraints in personal competencies and external resources. Literature on gerontology illustrated that well-being contributes immensely to health in old age and longevity (Hassan et al., 2018). Accordingly, in late adulthood, identifying the alternative pathways to well-being that involves such components as quality social relations, happiness, positive self-regard, purpose in life, and mastery over one's environment is reported to be the central developmental task of older adults (Ryff & Singer, 1998). Moreover, well-being works as a protective agent against maladaptive functioning and is considered as an important ingredient for a happy life in old age (Myers & Diener, 1995).

The researcher has reviewed several theories of aging from the gerontology and lifespan development literatures related to SWB. First, the theories that the researcher reviewed differ in how they define well-being in the context of aging. Although early gerontology theories such as activity theory (Havighurst, 1963), continuity theory (Atchley, 1989), and disengagement theory (Cumming & Henry, 1961) focus on SWB, later theories focused on more objective outcomes such as the probability of diseases and disability (Rowe & Kahn, 1997) or both subjective and objective criteria (e.g., Selective Optimization with Compensation (SOC) (Baltes & Baltes, 1990); Motivational Theory of Lifespan Development (MTLD) (Heckhausen & Schulz, 1995).

Second, the theories also differ with regard to how they incorporate and conceptualize the "aging" part of successful aging. Whereas early gerontology theories focused exclusively on older and very old adults and largely neglected earlier phases in the lifespan, later lifespan developmental approaches (i.e., SOC, MTLD) focus on the entire adult lifespan. Third, the theories differ with regard to the mechanisms that lead to SWB, including the active maintenance of social relationships (activity theory), withdrawal from society (disengagement theory), continuance of previous activities and relationships (continuity theory), personal resources (resource approach), and action regulation strategies (SOC, MTLD).

Even though there has been a substantial theoretical and methodological advancement in the field of SWB, the concept mainly faces competing interpretations (e.g., Conceicao & Bandura, 2012; Diener et al., 2009; Muzindutsi & Sekhu, 2014; Ryan & Deci, 2001; Vanhoutte, 2014); conceptualizations of SWB are still incomplete. Some scholars have even concluded that the question on how SWB should be defined is unresolved research agenda in the literature (e.g., Dodge et al., 2012; McGillivray & Clarke, 2006). Conceição and Bandura (2012) view SWB as a general description of the state of people's life situation, while other authors including Muzindutsi and Sekhampu (2014) view it as people's satisfaction with life as a whole. SWB refers to a person's evaluations of their quality of life, including self-acceptance, environmental mastery, autonomy, positive relationships with others, personal growth and a sense of the meaning of life (Ryff & Keyes, 1995). According to Dodge et al. (2012), SWB has been described as a good quality of life. It is also seen as means of developing as a person, being fulfilled, and making a contributions to the community. Others consider SWB as a state or a condition of a system in which the essential qualities are relatively stable (Atchley, 1989). Dodge

et al. (2012) also proposed that SWB is a balance point between an individual's resource pool and the challenges faced.

As per SWB theoretical models and measures, however, the concept of SWB stems from researchers' predefined conceptions (Goodwill, 2009). Nevertheless, it is unclear to what extent these views correspond to the personal conceptions of the individuals concerned (Bowling & Gabriel, 2007; Cosco et al., 2013). Thus, the level of SWB of older adults is affected by their personal conceptions (Sastre, 1999), which are in turn based on their individual characteristics, value, motivational systems, personal experiences, socio-cultural factors, and socio-spatial circumstances (Diener et al., 2009; Diener & Suh, 2000). Therefore, future research needs to clearly define and justify the indicator used to investigate SWB among older adults in a different cultural context. Scholars recommended employing a "lay-view approach" to minimize the risk of researchers' bias and improve the relevance of SWB measurements to older adults (Borglin et al., 2005; Bowling & Gabriel, 2007). The 'lay-view approach' takes into account the older adults' own views concerning their well-being which mainly embedded in the complexity of their individual characteristics, lived experiences, perspectives, and circumstances, without imposing preconceived concepts (Bowling et al., 2003; Cosco et al., 2013).

Previous research shows that older adults personal conceptions of SWB often include a much wider variety of dimensions than are considered in most researcher driven theoretical models (Bowling et al., 2003; Cho et al., 2015; Cosco et al., 2013). This indicates that though the pursuit of well-being is universal, SWB is chiefly a subjective and individual level experience. Based on the available literature, the concept of SWB is multidimensional that researchers should strive to conceptualize it and vigorously come up with a comprehensive conceptualization

so that they can measure it properly. A comprehensive conceptualization also enables policy makers and development actors to design appropriate interventions to improve SWB of older adults. Thus, this study is aimed to explore how Ethiopian older adults conceptualize their WB by taking account their subjective views.

In addition, the factor structure underlying SWB remains under debate. While some studies have demonstrated that SWB has a multifactorial structure (Ryff & Singer, 2008), others have suggested that it can be represented by either a single-factor (Diener et al., 2009) or a bifactor structure. Recent research underscores the complexity of well-being as a construct, comprising multiple factors (Diener et al., 2017). Consequently, important aspects of this construct are dispersed across a variety of instruments. While researchers have developed important, valid, and reliable instruments to assess different aspects of well-being (e.g., Cummins, 2010; Diener et al., 1999; Chen & Davey, 2009; Ryff & Keyes, 1995), the researcher believe that the various models have not yet been integrated into a single, coherent scale covering well-being overall and in the most important domains of life. As a multidimensional construct, it makes sense to integrate overall satisfaction (Diener et al., 1999) with psychological (Ryff & Keyes, 1995) and social (Keyes, 2006) aspects of well-being, along with facet theories (Chen & Davey, 2009), into one survey that assesses crucial domains of well-being. This lack of consensus on the factor structure of SWB makes it challenging to compare findings across studies and limits our ability to develop a comprehensive understanding of this construct.

Various instruments have emerged over the years to capture facets of SWB (Goodwill, 2009). Noteworthy among these are the Satisfaction with Life Scale (SWLS, Diener et al., 1985), which assesses general life satisfaction, and the Positive and Negative Affect Schedule (PNAS,

Watson et al., 1988), which gauges emotional states. Further augmenting the repertoire are the Scales of Positive and Negative Experience (SPANE) (Diener et al., 2010), which delve into diverse emotional experiences, and the Perceived Stress Scale (PSS, Cohen et al., 1983) to understand experienced stress levels. Branching beyond generic measures, Keyes' (2006) SWB scale and the PERMA Profiler (Butler & Kern, 2016) offer a broader perspective on well-being by emphasizing factors like positive relationships and accomplishment. Consequently, Steverink (2014) asserted that objective measures of function are not the most appropriate indicators of successful ageing and, instead, subjective measures of well-being would better represent success. Additionally, Steverink (2014) described how an individual with reduced physical, cognitive, or social function may rate their well-being as high, whereas an individual who is considered high functioning in these areas may be low in SWB.

Furthermore, the existing measures of SWB often neglect aspects associated with contentment in social connectedness, financial security, and religious well-being (Keyes, 2006). This oversight likely stems from a reliance on an individualistic cultural framework that places greater value on intrapsychic elements of SWB, with less emphasis on domains of SWB that are particularly salient to collectivistic cultures (Cooke et al., 2016). Besides, much of the research on SWB measures has been conducted in Western cultures, and the existing measures developed thus far have been criticized by cultural researchers (e.g., Oishi & Westgate, 2022; Kubzansky et al., 2023). According to Kubzansky et al. (2023), the measures of SWB were developed from a universal approach, which might fail to detect cultural variations and neglect to consider the dimensions of SWB in different cultural contexts. There is a need to strengthen evidence gathering using reliable measurements and instruments that can enable monitoring and evaluation of the health and well-being of older adults 65 years or older in different cultural

contexts (Angelini et al., 2022; Macia, 2016). While these instruments are valuable, not all are universally applicable as comprehensive measures of SWB, especially in the older adults context. All measures consider several important aspects of well-being, no measure captured the entire range of factors highlighted by older people as paramount to well-being (Oishi & Westgate, 2022).

While various studies conducted to assess the SWB of older adults, empirical investigations into the conceptualization and measurement of SWB continue to advance. However, a unifying theoretical model that comprehensively incorporates different dimensions of SWB for older adults remains elusive. Furthermore, systematic investigations on the impact of culture on SWB among older adults are lacking. Consequently, to effectively assess older adults' SWB, there is a need for reliable and valid instruments containing appropriate items that capture the overall dimensions of older adults' well-being. These could be ascertained by adapting and integrating various models for scale development and validation.

Notably, studies focusing on the impact of the basic income benefits on retired pensioners' current living situation, conceptualization, development and validation of SWB measures among retired older adults in resource-poor, low-income countries like Ethiopia are nearly non-existent. Hence, the current study attempted to fill this gap by exploring the perspectives of retired pensioners on late life precarity, examining how SWB is conceptualized, developing a locally validated instrument for assessing SWB among retired older adults and examining the psychometric properties of this newly developed SWB instrument.

1.2. Statement of the Problem

In today's aging societies, assessing the living situations and conceptualization of SWB in later life has gained substantial attention among researchers, as well as among policymakers in the areas of social policies (Sutipan et al., 2017). Moreover, in this fast aging world, older adult will increasingly play a critical role in society and its development (WHO, 2018). In recent years, different countries have been giving more attention to the issues of older adults; in Ethiopia, however, it is still a neglected segment and it is very obvious that little attention is being paid to the older adults. Additionally, research on the aging processes in Africa in general, and in Ethiopia in particular, is very limited, and available studies have stressed the need for research in this context (HAI, 2023).

Despite efforts by few local elderly instituations and associations, higher government officials are largely uninformed about the interests and needs of older adults (Zerihun et al., 2024). The culture of benefiting from the accumulated experience and wisdom of older adult has been declining in Ethiopian culture over time (Adamek et al., 2024). And, indeed, elderly in Ethiopia will "continue to make critical contributions to the welfare of their families, communities, and societies". But such contributions to development can only be ensured if older adults enjoy adequate levels of health and life quality. In Ethiopia, little is known about how retired older adults conceptualize their well-being and how these concepts can measure. The present study tried to fill this gap in an exploratory study of the SWB of retired older adults of different socio-economic statuses. Below are the major gaps that this study was tried to address.

First, the challenges faced by retired older adult in Ethiopia regarding their living standards are significant and need to be addressed urgently. The high cost of living, inflation, and

lack of permanent income are severely affecting their lives (Kotecho & Adamek, 2017). Even those who are considered better off economically are struggling to maintain a decent level of subsistence. The lack of financial and material resources is making it difficult for retired older adult to meet their basic needs, and they are relying on their children and grandchildren for support. The low pension payments and the challenges associated with accessing them are making the situation worse. The economic burden starts at retirement, and even if older adults want to work, opportunities to do so are limited, and no one is creating opportunities for them. The increasing cost of living is impacting their lives unpredictably, and the situation is worsening over time. Because of these changes, attention to retired older adults' quality of life and SWB is warranted. Therefore, conceptualizing and understanding of SWB among Ethiopian retired older adults is unambiguously important because it helps to determine major indicators of SWB that can be given high priority in intervention and policy making to improve SWB of retired older adults in Ethiopia.

Second, despite the overall dearth of studies in Ethiopia, most of studies conducted on issues of older adult hitherto excluded how older adults' conceptualize their SWB. The existing body of research on older adults in Ethiopia has mainly focused on issues' such as quality of life (e.g., Belay & Teshome, 2014; Hamren et al., 2015; Kotecho & Adamek, 2017); psychological well-being (e.g., Girum, 2012; Kassahun, 2015); aging and retirement (e.g., Getinet, 2015); old age and social change (e.g., Kifle, 2002); socio-economic situation (e.g., Baru et al., 2018); living arrangements (e.g., Hailu, 2020; Zelalem et al., 2021) and experiences and practices of old age home care and support (e.g., Abebe, 2020; Ayana, 2012; Lemma, 2014; Zikarge, 2017) among others. In some of the previous studies in Ethiopia, elderly serve as the custodians of information about history, traditional customs, and other elements of culture (e.g., Alambo &

Yimam, 2019). Others examine the role of elderly in dispute resolution (e.g., Unruh, 2005) and challenges of older people (e.g., HAI, 2018; Kifle, 2002; Zelalem & Kotecho, 2020). Still others analyzed the livelihoods and general living and working conditions of the elderly in various parts of Ethiopia (e.g., HAI, 2018; Adamek et al., 2024). The majority of these studies, however, examine the conditions of older persons in rural areas who are already “captured" by a formal or informal social support. Yet, retired older adults who live in the cities have either been taken for granted or completely entrusted to informal or formal social support systems. The paucity of gerontological studies in Ethiopia is another huge gap that needs due attention to combat the challenges faced by the older adults (Adamek et al., 2024).

Furthermore, there is a notable misconception among scholars in the area about the situations of retired older adults in the cities. However, urban areas in Ethiopia are experiencing noticeable demographic, cultural and socio-economic changes which detrimentally affect the living conditions and well-being of retired older adults. Relatively little is known about the living conditions of older adults in urban Ethiopia. Beyond these, inadequate attention has been paid to studies on the situations of older adults in Ethiopia, thereby, creating gaps in the body of knowledge. Based on these, the following research questions are raised: (i) what are the current situations of retired older adults in Ethiopia? (ii) What are the major indicators of retired older adults living conditions?

Third, the conceptualization and measures of psychological phenomena like SWB were developed from a universal approach where one might not detect cultural variations (Henrich et al., 2010). Likewise, most of these studies failed to consider the indigenous understanding of the psychological phenomena in a different cultural context (Berry, 1989; Fry et al., 2011).

Therefore, psychological phenomena and their instruments which are culture sensitive need to be developed to investigate the personal conceptions of older adults' psychological phenomena in a different cultural context (Klar & Kasser, 2009). Important factors that could contribute to conceptualizations of SWB have been provided, and appropriate conceptualizations of SWB now needs to be developed and validated by gathering empirical data from older adults. Here, a participatory approach that aims to have older adults elaborate on what makes life better or worse in later years will likely be important in developing an accurate conceptualizations of SWB. It is worth noting that, without a clear understanding of what contributes to SWB, government policies might not actually help people age well. Recent attention given to well-being in the elderly, has argued for the importance of narrative-driven rather then theory-driven approaches (Gabriel & Bowling, 2004). Several recent studies have interviewed older adults to more directly ascertain older adults' own definitions of well-being and aspects associated with it (e.g., Borglin et al., 2005; Gabriel & Bowling, 2004; Wilhelmson et al., 2005).

Several authors have argued that older adults' personal conceptions of well-being, specifically SWB are likely to change over time and can be adjusted to a given personal and contextual circumstances (e.g., Borglin et al., 2005; Douma et al., 2017). Thus, treating older adults as a homogenous group masks potential variations in personal conceptions of individual older adults. This might result in a set of domains that are unlikely to have equal significance to different individuals (Bowling et al., 2003). However, as the interest in understanding and measuring SWB grows in the world, it is crucial to know clearly what is measured when one is dealing with this concept (Borglin et al., 2005). In light of the literature review, the researcher indicated that the conceptualization of SWB in older adults is controversial and unresolved. The meaning of SWB and the factors that facilitate it are particularly at issue in cultural studies.

Christopher (2018) instructively argued that definitions of well-being are inherently culturally rooted and, further, that there can be no such thing as a value-free assessment of well-being. According to Christopher (2018), all understandings of well-being are essentially moral visions based on individuals' judgments about what it means to be well. So to understand what is measured requires proper understanding and conceptualization of SWB.

Moreover, conceptualization of SWB can be potentially affected by culture. Because meanings and concepts are molded by culture (Bruner, 1990; Fry et al., 2011), it seems necessary to explore what older adults think about SWB as embedded in the world of meanings construed by a unique cultural tradition. This is because the meaning and measures developed so far are criticized from cultural researchers. Specifically, in Ethiopia, the fact on the ground is that conceptualization which are applicable to the investigation of the view of Ethiopian older adults about their SWB are not yet addressed as far, as the researcher's knowledge is concerned. Hence, it is believed that exploration of the conceptualization of Ethiopian older adults SWB needed to be understood through qualitative methods.

Finally and most importantly, the researcher felt that it is worthwhile to explore retired older adults' current living conditions, conceptualization of SWB and also develop and validate locally made SWB instrument. Therefore, the present study was designed to answer the following basic research questions.

- How do retired pensioners view their late-life precarity in Addis Ababa?
- How do retired older adults conceptualize their subjective well-being in Addis Ababa?
- What are the dimensions of subjective well-being among retired older adults in Addis Ababa?

- What is the validity of the newly developed measure of subjective well-being scale?

1.3. Objectives of the Study

The general objectives of this study were to explore how SWB is conceptualized among retired older adults and then to develop and validate instrument for measuring retired older adults SWB in the context of Ethiopia:

Specifically, the study intended to:

- Explore the perspectives of retired pensioners on late-life precarity in Addis Ababa.
- Explore retired older adults' conceptualization of their SWB in Addis Ababa.
- Identify the core dimensions of retired older adults' SWB.
- Develop an instrument to measure the SWB of retired older adults.
- Examine the validity of the newly developed SWB scale.

1.4. Rationale and Significance of the Study

As the number of older adult in Ethiopia is rising progressively, this study would contribute a lot to addressing the SWB of this age group in the country. As the debate concerning whether SWB should be studied continues, extensive gaps in our knowledge of the SWB persist. At least three critical challenges for the study of SWB have been recognized within the literature of well-being. The first challenge is little agreement over what SWB means or how it should be conceptualized (Veenhoven, 2009). Secondly, there is similar uncertainty regarding how SWB should be measured (Layard, 2010). Finally, researchers have been unable to provide widely

accepted insight into the determinants of SWB (Dolan et al., 2008). These three broad challenges provide the primary rationale for the present study.

As the aging population increasing with the dynamic needs of older adults, the pivotal role of SWB has become indisputable (Teka & Adamek, 2014). Amidst the extensive body of research, there remains a persistent need for both theoretical clarity and methodological excellence in SWB. By bridging gaps, introducing novel methodologies, and enhancing the depth of theoretical discourse, the present study aim to chart a paradigm shift in our understanding and measurement of older adults SWB. The implications drawn herein detail our salient contributions to the theoretical scaffolding and methodological robustness surrounding the SWB construct.

The current study has both theoretical as well as practical significance about retired older adults SWB. Theoretically, this study would add to the existing body of knowledge related to conceptualization and its measurement of SWB among retired older adults in Africa in general and in Ethiopia in particular. It is noteworthy that the study also tackled the deficit in contemporary research on SWB by focusing on cultural and contextual factors. Additionally, it contributes an original, locally relevant, and valid measurement of older adults' SWB. This study could also inspire other researchers to conduct additional studies in the area.

Practically, this study would have important policy implications because of the growing aging population pushing the government to establish an older adult service infrastructure to suit the needs of contemporary older adults for years to come. The results from this study also would be useful for governmental and non-governmental organizations to introduce more services that focus on old adults' positive psychological outcomes. Generally, the current research would

create awareness and urge policymakers to look into this social issue and provide better long-term care to retired pensioners. It is helpful for those involved in therapy and counseling to identify older adults who are at a low level of SWB and to develop and improve prevention and intervention methods for older adults.

1.5. Delimitation of the Study

According to the UN definition older persons are those people whose age is 60 years and over (UN DESA, 2020). The definition has gained acceptance in Ethiopia as it coincides with the country's official retirement age (MoWSA, 2006). In this study, the researcher followed this trend when referring to older adults. Therefore, the participants of this study were adults aged 60 years or older. The present study focused on understanding conceptualization of SWB among retired older adults. Among other psychological construct, SWB was chosen for this research because they have not yet been thoroughly investigated in Ethiopian context, and as evidenced in the previous research findings, these variables were influenced by contextual factors and subjective experiences.

This study was also delimited to retired pensioners' in the Addis Ababa city. The reason why retired pensioners' was chosen for this study is because as a distinct group of the aging population in Ethiopia, retired pensioners themselves can provide unique insights and perspectives on the living situation and challenges of older adults, and conceptualization of well-being. The reason why Addis Ababa city was chosen for this study is because older adults in Ethiopia, particularly those in urban areas, experience unprecedented political, technological, and socio-cultural changes in recent times that affect their life situation in an uncharted manner. In addition, older adults in urban areas in Ethiopia, particularly in Addis Ababa, are experiencing

very high inflation and continued rises in the cost of living, displacement and relocation, and significant disturbance of family and social ties that ultimately affect their well-being. Therefore, in order to understand the current living conditions of retired older adults in Addis Ababa, the city was chosen. The research would have been more meaningful if it had been conducted using a nationwide sample. However, within the limit of time and financial constraints, the study is delimited to be conducted in Addis Ababa.

1.6. Limitation of the Study

The results of this study should be understood taking the following limitations into consideration: The study focused on retired older adults in urban settings. Thus, the living situations of urban and rural older adults who are not beneficiaries of formal pensions might be different, and further studies are encouraged to explore their experiences. Furthermore, by expanding the study to include a more diverse sample from different regions within the country, it would be possible to capture a broader range of experiences and better understand the aging well among older adults in the entire regions. This would provide a more comprehensive and representative picture of the SWB and allow for more targeted interventions and support tailored to the specific needs of retired older adults in various regions of the country.

Chapter 2: Review of Related Literature

In this section, the available literature related to the issue of conceptualization and measurement of SWB among older adults is reviewed. The review is organized by sub-sections in line with the research questions and objectives.

2.1. The Essence of Aging

Aging embraces three major perspectives: biological, psychological and social aspects. So, the definition of aging is also approached from these three different perspectives.

2.1.1. Biological Perspective

The definition of biological aging is based on the vivid physical changes that accompany advancing age (Giddens et al., 2006). Aging is viewed as an involuntary phase in the development of the organism that brings about a decrease in adaptive capacities and ultimately death (Schaie & Willis, 2010). Universality, internality, progressiveness, and inevitable death are characteristics of aging that distinguish it from disease (Strehler, 1962). Nevertheless, the exact chronological age at which this deterioration sets on greatly varies from individual to individual (Giddens et al., 2006; Schaie & Willis, 2010). The common effects of biological aging include declining vision, hearing loss, wrinkles, reduction of muscle mass and fat, and decrease in cardiovascular efficiency among others (Schaie & Willis, 2010).

2.1.2. Psychological Perspective

The psychological perspective of aging is concerned with issues such as personality, memory, self, and self-identity (Birren et al., 2001). Unlike effects of biological aging, changes

that are associated with psychological aging are not markedly noticeable. Decline in memory, learning, skill, and motivation to learn is believed to be associated with psychological aging (Schaie & Willis, 2010).

2.1.3. Social Perspective

Aging is a socially constructed phenomenon and how it is perceived and experienced is influenced by culture, societal expectation, and individuals lived experiences (Teater & Chonody, 2020). It is interwoven with a particular societal values, role expectations, norms, and traditions of the society are very important in defining social aging (Binstock et al., 2011). The social role expectations that are anticipated of old age could be negative or positive. Positive role expectations that are attached to old age tend to boost the well-being of older people whereas the negative role expectations of old age are more likely to give rise to diminished self-esteem and social network of older people. They often comprise stereotypes of older people that tend to discriminate against older people (Schaie & Willis, 2010).

2.2. Conceptualization of Subjective Well-Being

Well-being is a concept with different interpretations. The following review takes a closer look at how prominent researchers have defined well-being. One of the most cited reviews in the literature compares two of the most widely referenced theoretical approaches (Ryan & Deci, 2001). The ‘hedonic’ theory of SWB (Diener, 1984) is contrasted with the ‘eudaimonic’ theories of Psychological Well-being (Ryff, 1989) and Self Determination (Ryan & Deci, 2001). Hedonic well-being or SWB is typically conceptualized with Diener’s tripartite model, in which SWB is posited as a multidimensional construct capturing cognitive (i.e., life satisfaction) and

affective (i.e., positive affect and negative affect) components (Diener et al., 1999). Life satisfaction describes the cognitive and relatively stable evaluations that people make about their lives overall. Positive and negative affect are the emotional evaluations that fluctuate overtime and encompass experiences like happiness and anxiety. Diener's efforts to highlight the importance of the individual's own perspective on well-being have been highly influential to developments in the measurement of well-being (Diener, 1994).

Several theories of SWB have been developed in response to Diener's work. SWB homeostasis- proposes that a person's level of SWB is regulated around an optimal 'set point', enabling people to adapt to the demands of most environments (Cummins et al., 2004). Kahneman's hedonic psychology claims that researchers are better able to understand whether a person is objectively happy by taking an average of multiple responses to happiness questionnaires over time (Kahneman et al., 2003). Another approach called the Intentional model of emotional well-being, suggests that discussions of SWB should focus primarily on satisfaction about something, as opposed to satisfaction in general (Simsek, 2011). It has also been proposed that a person's past, present and future SWB can be taken together to represent their 'ontological well-being' (Simsek, 2011).

Conversely, eudaimonic well-being offers a more profound perspective, emphasizing a meaningful life enriched by purpose, personal growth, autonomy, positive relations, environmental mastery, and self-acceptance (Ryff, 1989). Ryff identified six major dimensions of well-being; s*elf-acceptance*, which was the most recurrent dimension in Ryff's review, concerned positive attitudes towards oneself and one's life. *Positive relations to others*, including trust, love, and empathy, was concluded to consistently relate to positive mental health.

Autonomy was described as the ability to evaluate one's life based on internal standards and to live an independent life. *Environmental mastery* describes the way an individual takes advantage of, and is able to adjust to changes in, their environment. *Purpose in life* was determined by an individual's sense of meaning and the extent to which they were directed by some sense of goals or intentions. Finally, *personal growth* was concerned with an individual's openness to experiences and an active pursuit of reaching one's full potential. This distinction establishes hedonic well-being as the pursuit of happiness, while eudaimonic well-being pivots toward a life of significance. Further broadening this spectrum, Keyes (2006) introduced social well-being, underscoring our interactions and responsibilities within societal structures. Contrasting with the intrapersonal lens of eudaimonic well-being, social well-being sheds light on the interpersonal dynamics of our existence.

Rowe and Kahn (1987), defining successful ageing as an absence of disease and disability, high levels of physical and cognitive functioning, and engagement in interpersonal relationships and productive activities. Additionally, Pruchno et al. (2015) proposed that the ability to age successfully is a product of resilience in response to experiencing hardship across the lifespan. According to Pruchno et al. (2015), individuals can age successfully by developing resilience. This conceptual evolution dovetails with the rise of 'positive psychology,' which challenges us to ponder "what makes life worth living" (Seligman & Csikszentmihalyi, 2014). The approaches disagree on the nature of well-being and have typically studied the determinants of well-being from their own perspectives. Furthermore, SWB is defined by Magyar and Keyes (2019) as "A person's cognitive and affective evaluations of his or her life. These evaluations include emotional reactions to events as well as cognitive judgements of satisfaction and fulfillment". In agreement with Snyder and Lopez's view that SWB includes both cognitive and

affective components, Carr (2004) defines SWB as “A positive psychological state characterized by a high level of satisfaction with life, a high level of positive affect and a low level of negative affect”. According to Vleioras and Bosma (2005) SWB refers to feeling well, which is highly parallel to the characteristics of a healthy personality set forth by Erikson. Some researchers claim that SWB need not be constructed so narrowly (Russell et al., 2013). Meister (1991) suggests that SWB is a comprehensive and flexible concept that is broader than health.

In 2013 Diener has added specific domain satisfactions: work satisfaction, marital satisfaction, or satisfaction with other relationships. However, there are alternative conceptualizations, such as happiness, morale and satisfaction. Therefore, SWB incorporates life satisfaction, happiness, affective experiences, quality of life which tend to be used interchangeably in the research of subjective well-being. The literature suggests that the measures of these concepts are highly correlated among each other and with relevant personal and social characteristics (George, 2010).

Different researchers often treated SWB as a multidimensional concept that consists of a number of distinct interpretations. Here the rest on the subjective position, meaning that people lived experiences and evaluations are the basis for well-being (Keyes, 2006). This subjective perspective, in its present form, comprises, among others, so called hedonic theories, where well-being is understood as a feeling of pleasure and satisfaction, and a non-existence of discomfort (Angner, 2012). Theories focusing on life satisfaction assume that well-being comes from an informed evaluation of, or attitude to, circumstances in life (Soukiazis & Ramos, 2016). To what extent does the individual feel satisfied and content with person’s life and life circumstances? Basically, it is the person’s own experience or understanding that decides whether well-being is

present or not (Linley et al., 2006). Summarized, it is the description of the state of the individual's life situation. A hallmark of SWB is that it centers on the individual's personal judgements and not upon some criterion judged by the researcher as important (Diener & Emmons, 1984). The term SWB includes affective states, the self- evaluations of quality of life and individual events and circumstances, including residence type (Steptoe et al., 2015). SWB was often used to assess overall quality of life (Cummins et al., 2004). Sociopsychological factors that are important to ageing well, including access to social and recreation opportunities, and access to community-based services and support (Nguyen & Lin, 2025). Within the United Kingdom, "Ageing Well in Wales" focused on (a) age-friendly communities, (b) prevention of falls, (c) dementia-supportive communities, (d) providing learning and employment opportunities, and (e) addressing loneliness and isolation (Square, 2014).

Many researchers have defined well-being, but as Gasper (2007) points out, the term well-being is a concept or idea referring to whatever is assessed in an evaluation of a person's life situation or 'being'. The lack of agreed-upon conceptualizations of ageing well is clearly illustrated in the literatures.

2.3. Theories and Models on Subjective Well-Being

In this section, signifcant theories and models on successful aging and agine well that have informed definition and conceptualizations were discussed.

2.3.1. Psychosocial Theories

These are three major historically significant theories of psychosocial development in old age and successful aging (Bengtson et al., 2009). These theories were developed by

gerontologists between the 1950s and 1980s and thus represent early conceptualization of successful aging.

2.3.1.1. Disengagement Theory

Disengagement theory postulates that people gradually disengage from social life as they grow older, which was originally proposed by social scientist Elaine Cumming and colleagues in 1960, and later in 1961, Cumming and Henry systematize this theory into the book – *Growing Old* – arguing that aging is an inevitable, mutual withdrawal. Disengagement theory more controversially suggests that aging is inevitably associated with reduced social interactions and the mutual withdrawal of older adults, along with others in his or her social environment, and society as a whole; the withdrawal of older adults is seen as natural, voluntary, and acceptable (Cumming & Henry, 1961). Moreover, in a set of propositions, Cumming and Henry (1961) argued that individuals' knowledge, skills, and abilities decline with age; due to fewer social interactions, older people are less influenced by social norms.

Underlying disengagement theory is that older people willfully initiate the disengagement process and it is part of the natural aging process and normal course of life when older people prepare themselves for death (Harmell et al., 2014). Nevertheless, scholars points out that against the will of older people there might exist occasions when society may oblige them to disengage from social activities and roles totally or partially (Amalia, 2019). In the light of this theory, aging is believed to be associated with powerlessness, loneliness, loss of role, sense of greater dependency and loss of sense of purpose. Consequently, as to this theory, older people are perceived to be unproductive and a daunting burden on the society (Harmell et al., 2014).

According to disengagement theory, successful aging occurs when older people willfully withdraw from social activities.

2.3.1.2. Activity Theory

Activity theory was developed by Robert J. Havighurst in 1961 proposing that successful aging occurs when older adults staying active, particularly with regard to social interactions, and engaged with in society. According to this theory, a positive aging implies preserving, for as much as possible, the activities and attitudes of middle age (Havighurst, 1963). More specifically, activity theory suggests that by maintaining personal relationships and by staying socially active, older adults can slow down or even avoid age-related losses and improve their subjective well-being (particularly life satisfaction) (Hackert et al., 2019; Havighurst et al., 1963). Moreover, activity theory proposes that, to maintain their subjective well-being, older adults should substitute previous life roles, relationships, and activities from the mid-life phase (e.g., work, caring for own children) with new life roles, relationships, and activities (e.g., volunteering, grand-parenting).

Consistent with propositions of activity theory, a longitudinal study showed that engagement in volunteering activities, providing help to others, and being a member of sports or social clubs positively predicted quality of life among retirees over a time period of two years (Potocnik & Sonnentag, 2013). Therefore, activity theory asserts that older people should try to assume new and meaningful roles or activities when they incur loss of the previous roles due to old age to maintain their well-being and sense of purpose and meaning. Successful aging, therefore, leans on active aging that defies challenges of old age (Harmell et al., 2014). According to Havighurst, Neugarten, and Tobin (1963), as activity decreases, the sense of well-

being associated with it decreases during the years after 60, and that, those older people who continue the greatest amounts of activity generally have greater psychological well-being than those who have lower levels of activity.

2.3.1.3. Continuity Theory

Continuity theory was formerly developed in 1989 by Robert Atchley in his article "*A continuity theory of normal aging."* The theory is based on the central assumption that there is a basic structure that remains over time and which guarantees considerable consistency of the thinking patterns, behavior, activity profiles, and social relationships particularly in middle-aged and older adults. In these life stages, adults profit from the weight of the past experience to use continuity as a primary adaptive strategy in order to face normal aging-associated changes (Atchley, 1989).

The continuity theory dictates that older people can sustain patterns of life that they developed prior to the onset of old age. Hinging on their accumulated youthful experience and knowledge, older people adjust their life style to changes that appear with aging (Minhat et al., 2013). As to continuity theory, old age is, therefore, simply an extension of the former part of life: the values, belief and style of life that older people accumulated as younger people will be cushion against challenges that appear with aging (Harmell et al., 2014). Thus, according to continuity theory, aging is regarded as a process of adaptation where personality of older people is believed to be a decisive component. Older people adapt to both biological and social changes that accompany old age by actively engaging in activities and creating life style that render them life satisfaction. In general, successful aging is characterized by how much coyinuity the elder has with activities.

2.3.2. Social Exchange Theory

According to this theory with regard to aging, the more people get older, the more they become powerless and dependent on their caregivers. Their powerlessness and dependency expose them to various problems such as abuse (McDonald, 2007). It also argues that interaction among family members is based on reciprocal exchange of goods and services aimed at beefing up their own well-being. Thus, older parents attain the care and support of their children by giving them resource transfers (Bernheim et al., 1985, as cited in Bianchi et al., 2007). Transfers are not necessarily made at the same time but can be made in the future for the services received in the past or at current moment (Bianchi et al., 2007). Exchanges may include overarching "commodities, resources, or skills" (Rank & LeCroy, 1983).

In the process of reciprocal exchange, the less powerful actors are always at a disadvantaged position, because he/she benefits less compared to the powerful actor. In the light of this, older people are at a disadvantaged position in the exchange process at both familial and societal level (John, 1984). "…there is often deterioration in their bargaining position and decreasing power resources, resulting in increasing their vulnerability to a multitude of psychosocial factors" (Varshney, 2007, p. 6). But, "family member receiving assistance may want to avoid feeling dependent on the support provider and may seek to reciprocate with other forms of assistance, such as emotional support or advice, thus "balancing" the support exchange in an effort to reciprocate" (Parrott & Bengtson 1999 as cited in Lowenstein et al., 2001, p.14).

2.3.3. Modernization Theory

Modernization theory argues that modernization has diminished the status of older people (e.g., Hammond, 2010; Chatrungrueangchai, 2016). Modernization has eroded all the privileged roles of older people that were recognized and respected in pre-modern societies. Older people have now been deprived off their earlier valued status as sources of knowledge, skill and experience. The erosion of older people's prestigious status is partly attributed to education because it has made older people inferior to younger people in terms of knowledge (Amalia, 2009). Plus, modern economic and social systems have excluded older people from participation and engagement (Hammond, 2010).

On the other hand, it is believed that modernization has brought about the diminished familial and community respect and support for older people (Goldstein & Beall, 1981). Also, the erosion of the traditional veneration of older people is attributed to modernization wherein older people are treated as useless (Nelson, 2005; Cuddy, Norton & Fiske, 2005 as cited in Holmes, 2006). Due to requirements of modern economic system and impacts of urbanization, children are obliged to move to urban areas hampering proximity to their parents thereby weakening familial ties. This intern impinges on the care and support for their older parents (Chatrungrueangchai, 2016).

2.3.4. Rowe and Kahn's Model of Successful Aging

Rowe and Kahn (1987) coined the term "successful ageing" to highlight the difference between typical and successful ageing. To age successfully, according to Rowe and Khan's (1997) model, one must be in good health (i.e., lack disease or disability) and be physically and

socially active, cognitively adept, and contributing to society. This model of successful ageing was praised by Whitley et al. (2016) as being an appropriate and objective measure of successful ageing, but they suggested successful ageing should be considered a spectrum, rather than a dichotomy. A spectrum would be more representative of ageing experiences and would allow age-related decline and compensation strategies to coexist. In their initial attempt to define successful aging, Rowe and Kahn (1997) distinguished the concept from "normal" and "usual aging." They defined normal aging as being free from physical and mental pathology and further categorized individuals aging normally into those following an average or normative age-related trend in an objective life outcome ("usual aging"), those following a more positive than average age-related trend ("successful aging"), and those following a less favorable than average age-related trend ("unsuccessful aging").

Based on the observation that considerable heterogeneity exists in objective life outcomes among older adults, Rowe and Kahn (1987) argued that these age-related developmental trends in life outcomes are influenced by individual differences in genetics and lifestyle factors, as well as by contextual factors such as social support. In short, successful aging is dependent upon individual choices and behaviors and can be attained through individual choice and effort (Rowe & Kahn, 1997). Rowe and Kahn (1997) later specified successful aging as the simultaneous presence of three objective outcomes, including a low probability of disease and disability, maintenance of high physical and cognitive functioning, and continued engagement in social and productive activities. Additionally, Rowe and Kahn (1997) argue that the key to aging successfully lies in "keeping active" in four ways: active social engagement, active exercise, proactive diet, and avoiding disease.

2.3.5. Model of Psychological Well-Being

Ryff (1989) criticized previous defnitions of successful ageing for focusing on perceived deficiencies (e.g., illness) and, consequently, proposed a six-domain model of psychological well-being that she applied to successful ageing. These domains include (1) self-acceptance (e.g., accepting one's positive and negative traits), (2) having satisfying interpersonal relationships involving trust, (3) autonomy such as being independent and able to self-regulate behavior, (4) environmental mastery (e.g., feeling competent about engaging in activities), (5) purpose in life (e.g., having goals), and (6) personal growth (e.g., having a desire to improve). In contrast to other models of successful ageing (e.g., Rowe & Kahn's [1997] model), Ryff's (1989) conceptualization of successful ageing does not explicitly incorporate disease, disability, or physical/cognitive functioning. Although the domain of "autonomy" (i.e., being independent) may infuence (or be infuenced by) disease, disability, or functioning— as there are plausible relationships between one's ability to be independent and their physical and cognitive health— Ryff (1989) focused primarily on psychological well-being.

2.3.6. Model of Selective Optimisation with Compensation

Baltes and Baltes' (1990) Selective Optimisation With Compensation (SOC) model outlines an adaptation strategy that can be applied throughout the lifespan but is of relevance to "older adults" given common age-related changes, such as reduced physical functioning, and diminished views of the self that stem from negative stereotypes associated with ageing. Selection refers to focusing on a reduced number of tasks based on, for example, the individual's interests, priorities, and abilities, and adjusting some expectations in response to age-related changes (Baltes & Baltes, 1990). Optimization refers to practicing and engaging in behaviors

that enhance the quality of life, whereas compensation refers to increasing effort or using other internal (e.g., mnemonics) and external (e.g., hearing aid) mechanisms to maintain functioning despite some reduction in ability (Freund & Baltes, 2002). Together, these three aspects form a model of adaptation to help achieve successful ageing, despite constraints associated with ageing. Implementation of SOC strategies can lead to positive outcomes for older adults including, but not limited to, increased happiness (Teshale & Lachman, 2016), positive emotions, low levels of agitation, contentment with ageing, and reduced loneliness (Freund & Baltes, 2002).

2.3.7. Lifespan Model of Successful Ageing

Similar to Baltes and Baltes' (1990) SOC model, Schulz and Heckhausen's (1996) model focuses on adaptation to mitigate age-related losses. In this context, successful ageing is associated with nurturing and promoting "primary control" across one's lifespan to facilitate personal growth, whereas mitigating challenges such as cognitive decline. Primary control is associated with outward processes (e.g., behaviors) designed to infuence one's immediate environment such that it better fits the individual's wants and needs (Heckhausen & Schulz, 1995). The model, in part, implies that individuals who maintain high levels of primary control across the lifespan are successful agers.

Although this implies a rigid defnition of success, Schulz and Heckhausen (1996) acknowledge that success must be considered relative to individual circumstances and resources. As such, and in contrast to Rowe and Kahn's (1997) view that physical functioning is essential for successful ageing, Schulz and Heckhausen's (1996) model posits that someone born with physical limitations, for example, can still achieve success. In this case, using assistive aids (e.g.,

wheelchairs) can be a way of achieving primary control that provides an individual with opportunities to achieve goals. This model, therefore, provides more inclusive criteria for successful ageing than do some other models (e.g., Rowe & Kahn, 1987, 1997). Life span developmental theorists generally agree that the broadest and most general criterion for successful aging is efficiently striking a balance between losses (e.g., decreased physical functioning, rapid processing of information, memory) and gains (e.g., increased experience, knowledge, and emotional competencies) associated with advancing age. The lifespan developmental perspective offered by Baltes (1987) offers seven organizing principles for understanding human development as a lifelong process that involves phases of stability as well as continuous and discontinuous changes over time. Two principles of the lifespan perspective immediately bear consideration here: Reflecting the most general criterion for successful aging, the third principle of Baltes' (1987) lifespan perspective suggests that with increasing age, losses progressively outweigh gains. Additionally, Baltes' (1987) fourth principle suggests that each individual's development is modifiable by both person and contextual influences, and that this plasticity can occur at any point in the lifespan.

In this section, the researcher tried to discus prominent theories of successful aging developed in the lifespan developmental literature.

Resource Approach

Resource perspectives on lifespan development (Neugarten, 1972) posit fundamental shifts in the allocation of personal resources in service of developmental goals. Broadly, there are three related classifications of developmental goals and associated actions that are considered by lifespan theorists: growth, maintaining resilience, and loss regulation (Ebner et al., 2006; Freund

& Ebner, 2005). Growth-related goals and their consequent actions correspond to desires or efforts that increase levels of functioning or adaptive capacities. Maintenance-related goals and their consequent actions correspond to desires or efforts that either maintain levels of functioning when faced with challenges or aid in re-attaining previous levels of functioning following the experience of loss. Finally, loss regulation goals and their consequent actions correspond to desires or efforts that optimally organize functioning when maintenance and/or growth are no longer possible (e.g., because of chronic resource decrements, the forfeiture of resources, or permanent loss of functional capacities).

Proponents of the resource approach to lifespan development generally adopt the idea that, with increasing age, the allocation of resources toward growth-related goals decreases, whereas there are generally age-graded patterns of increasing investment of resources toward maintaining resilience and regulating loss (Ebner et al., 2006). Neugarten (1972) suggested that a variety of personal resources may be allocated and invested to serve growth, maintenance, and loss-regulation goals across the lifespan (e.g., income, education, health, social networks, personal autonomy, personality traits, and cognitive functioning). With respect to successful aging, such personal resources may have positive influences on a variety of subjective success criteria, such as life and aging satisfaction (Baltes & Lang, 1997; Jopp & Smith, 2006).

Motivational Theory of Lifespan Development

The Motivational Theory of Lifespan Development (MTLD) is a lifespan theory of goal striving, control, and self-regulation. Generally, control theories of motivation suggest that people strive to maintain control over "behavior–event contingencies" (Heckhausen & Schulz, 1995). As a lifespan control perspective on motivation, MTLD posits how individuals maintain

such control capacity when faced with the potential for developmental losses (e.g., challenges, threats, and transitions) that threaten existing levels of control capacity, and how this process changes across the lifespan.

MTLD suggests that control-related actions (i.e., goal-relevant behaviors that augment the maintenance of control) can take either primary or secondary forms. Heckhausen and Schulz (1995) suggest that *primary control strategies* involve actions that bring the environment in line with one's goal-relevant needs. In contrast, *secondary control strategies* involve actions that bring oneself in line with the environment. Thus, primary control strategies entail outward-focused behavioral actions, where as secondary control strategies entail inward-focused cognitive (re) actions. By necessity, primary control strategies hold functional primacy over secondary control strategies, because engaging one's environment as a means of managing particular needs (i.e., primary control strategies) is more adaptive than passive strategies (i.e., secondary control strategies). In addition, the use of secondary control strategies supports control capacity when primary control strategies fail (i.e., secondary control strategies buffer against the loss of control capacity and can cyclically support future efforts at enacting primary control).

MTLD also makes several assumptions regarding trajectories of the use of primary and secondary control strategies across time. The use of primary control strategist ends to conform to an inverse U-shaped function over the lifespan (i.e., one's capacity for primary control strategy use increases to a point, plateaus, and then decreases with advancing age). Thus, according to MTLD, the onset of declining primary control strategy use maybe an important antecedent of successfully navigating losses in control capacity. As primary control strategy use decreases over time, people must invest additional resources (i.e., secondary control strategy use) to alleviate

losses of control. Therefore, secondary control strategy use tends to follow a general positive trajectory over time and can augment decreasing primary control strategy use through various compensatory means (Heckhausen et al., 2010).

Model of Assimilative and Accommodative Coping

A related lifespan control theory, the model of Assimilative and Accommodative Coping (AAC), has been advanced by Brandtstädter and Renner (1990). Similar to MTLD, AAC explains the management of developmental challenges though two corresponding modes of coping. *Assimilative coping* focuses effort on the alignment of one's goals with the context of their development and is characterized in terms of "tenacious goal pursuit." *Accommodative coping* characterizes the process of adjusting one's goals to match constraining circumstances within one's developmental context and is characterized by "flexible goal adjustment" (Brandtstadter & Renner, 1990).

MTLD and AAC make similar predictions about how people manage developmental change and focus on the development of adaptive coping mechanisms across the lifespan. Two lines of distinction can be drawn between MTLD and AAC. First, MTLD is considered by many to be a more nuanced treatment of the general dual-process coping framework (Flammer, 1995). Moreover, Heckhausen et al. (2010) suggests that AAC is conceptually different from MTLD in that the notion of accommodative coping is viewed as a consequential action rather than as a purposeful, intentional exercise of agency.

Socio-Emotional Selectivity Theory

Socio-Emotional Selectivity Theory (SEST) is a lifespan theory of motivation that is based on the notion that people possess the capacity to actively self-contextualize the passage of their lives (Carstensen et al., 1999). More specifically, humans have an essential consciousness of time, its meaning, and its limits. Consequently, we adjust our time horizons (i.e., the expansiveness/open-endedness or restrictiveness/closed-endedness of time) with advancing age. SST suggests that dynamic time horizons have implications for various motivational and psychosocial processes, such as goal setting, emotion regulation, and social interactions, because they provide context for these processes (Carstensen, 2006).

SEST was originally introduced to explain changes in social-interactive processes across the lifespan (Carstensen, 2006). Social interactions serve identity maintenance, emotional regulation, and self-regulation aspects of psychological functioning (Carstensen et al., 1999). Generally, there is decreasing utility in fostering new social relationships over time (i.e., as generally observed, there are age-graded patterns of increasing emotional closeness in familiar social relationships with a commensurate decrease in actively crafting new social relationships with advancing age). Moreover, there are dynamics in the costs and rewards associated with social interaction across the lifespan (i.e., investing in later-life social relationships may entaila higher cost-to-benefit ratio due to the investment of limited social and psychological resources).

To explain these observations, SEST posits that dynamic perceptions of time lead to changes in two broad categories of goals: knowledge acquisition goals and emotional regulation goals. SEST suggests that future time perspective is one important mechanism for understanding this process. In terms of time horizons, *future time perspective* can be classified as either open-

ended or constrained. When time horizons are perceived to be open-ended, the highest priority goals within one's goal hierarchy tend to be focused on long-term knowledge acquisition (e.g., gaining new experiences, learning skills). When time horizons are perceived to be constrained, the highest priority goals within one's goal hierarchy tend to be proximal, short-term emotional regulation goals (e.g., sustaining positive mood). Furthermore, SEST suggests that one's age (i.e., as a proxy for developmental changes) predicts the prioritization of different goals. This general pattern can explain shifts in social–interactive relationships over time. As people get older, they begin to perceive time as more finite, restricted, and constrained. Furthermore, older individuals are less likely to attach importance to long-term acquisition goals and therefore devote more energy toward goals from which emotional meaning can be derived.

Strength and Vulnerability Integration Model

Aligned with SEST, the Strength and Vulnerability Integration (SAVI) model describes age-related changes in emotional regulation capacity across the lifespan (Charles, 2010). The SAVI model posits that age-related differences in emotion regulation outcomes vary according to the timing of the emotion regulation process. For example, similar to SEST, SAVI acknowledges that aging is associated with increased capacities for the regulation of emotional experiences (i.e., increased emotion regulation skills such as attentional strategies, appraisals, and various behaviors). This idea follows from the general finding of overall higher levels of affective well-being with increasing age. Such emotion regulation strategies facilitate the mitigation of negative emotional experiences while correspondingly augmenting positive emotional experiences.

Like SEST, SAVI also posits that the increased use of emotion regulation strategies with age is based on shifts in time perspectives (i.e., perceived time remaining). However, it

additionally integrates a “time lived” principle. Specifically, knowledge and accrued experiences serve as important resources in service of successful emotional regulation. Therefore, SAVI is complementary to SEST in the recognition of the finitude of time, but also novel in the integration of experience as an important resource for successfully regulating emotions across the lifespan.

2.4. Implications of the Various Theories and Models of Subjective Well-Being

The various theories and models of subjective well-being among older adults provide a comprehensive framework for understanding the complex interplay of psychological, social, and biological factors that influence the aging experience.

The theoretical frameworks on subjective well-being among older adults offer significant implications for further research in gerontology, psychology, and public health. First, future research should aim to explore the interactions and integration among these theories, as individual models capture different dimensions of aging, and a more holistic understanding may emerge from interdisciplinary or multi-theoretical approaches. For example, combining psychosocial theories with psychological models like Ryff’s or the SOC model can provide deeper insights into how structural and personal factors jointly influence well-being. Additionally, researchers should investigate how culture, socioeconomic status, gender, and ethnicity mediate the applicability and outcomes of these models, as many were developed in Western contexts and may not universally apply. There is also a critical need to examine these theories in longitudinal and cross-cultural studies, which can clarify how subjective well-being evolves over time and across diverse populations.

Moreover, with increasing longevity and technological integration in older adults' lives, future studies should consider the impact of digital inclusion, lifelong learning, and virtual socialization on subjective well-being. Research should also focus on intervention development, using these models to design, implement, and evaluate programs that promote resilience, emotional regulation, and adaptive coping. Finally, more empirical work is needed to validate newer models such as the Strength and Vulnerability Integration (SAVI) Model or the Motivational Theory of Lifespan Development, particularly in real-world policy and healthcare settings. Overall, these theories not only guide current understanding but also open numerous avenues for innovative, inclusive, and practical research to enhance the quality of life in aging populations.

2.5. Determinants of Subjective Well-Being

Maintaining high levels of SWB is considered to be one aspect of successful aging (Baltes & Baltes, 1990). The increased risk for losses in health and competence, social networks, and income suggest that older people should have lower levels of SWB than younger people. Due to their age, older adults face problems such as declining physiological functions, which in turn lead to a diminished sense of well-being (Liu et al., 2023). This is problematic, as well-being especially among older adults is vital for improving quality of life, promoting mental health and coping with the needs of an aging population (Diener & Chan, 2011). Studies have shown that physical health status, mental health problems and SWB among older adults were negatively correlated (Wang & Kim, 2020). SWB was influenced not only by health but also by lifestyle factors unrelated to health (Lampropoulou, 2018). It was also been found that the level of SWB was influenced by other factors, such as personality (Abdullahi et al., 2020), culture

(Yamaguchi & Kim, 2015), interpersonal interaction (Nikitin & Freund, 2021), marital status (Becker et al., 2019), and economic factors (Zhou et al., 2015).

In recent years, there has been a growing recognition of the importance of SWB and its various determinants, particularly among the older adult population (Liu et al., 2023). As societies continue to age, the wellbeing of older individuals becomes a significant area of concern, demanding a shift in focus toward their holistic experiences. Recent studies have focused on factors affecting SWB among older adults, mainly demographic differences (Lee et al., 2016), rural residency (Liang et al., 2020), physical exercise (An et al., 2020), social support (Liu et al., 2022), and environmental conditions (Ram et al., 2020).

There is a growing body of research demonstrating the relationship between social capital and well-being, with social capital positively affecting SWB (Liu et al., 2023). Zhang (2022) showed that social capital is a favorable predictor of well-being. Furthermore, the connections, trust, and support derived from social relationships, were closely intertwined with the well-being of older adults (Pinquart & Sörensen, 2000). As social dynamics evolve over time, older adults can experience changes in their social networks, potentially affecting their health and well-being (Rook, 2015). Liu et al. (2023) found that the neighborhood environment had a significant impact on older adults' SWB. Participation in social activities (Helliwell & Putnam, 2004) and volunteering (Pavlova & Silbereisen, 2012) also had a positive impact on SWB. Recognizing the significance of social capital sheds light on the ways in which communities and institutions can foster an environment that nurtures positive interactions and meaningful relationships among older individuals.

Relationships between well-being and several aspects of current life circumstances, such as competence, SES, and social network, have been assessed in numerous studies (Helliwell & Putnam, 2004; Liu et al., 2023). However, differences in measurement and inconsistencies in the results make it very difficult to draw clear conclusions from these studies.

2.6. Research on the Older Adults in Ethiopia

There are few research reports that provide a glimpse of information about older adults' psychological phenomena in Ethiopia (e.g., Belay & Teshome, 2014). The scholarly literature addressing older adults issues in Ethiopia is minimal and focuses on the socioeconomic problems of older adults, problems facing the families in providing care and support to older adults, and factors influencing the traditional values and functions of the family (e.g., Assefa, 2010; Jember, 2007; Kassahun, 2007). Here are some the studies conducted on the issues of older adults in the Ethiopian context.

Abedella (2005) explore the role, status and perceived social support of the elderly in Gedeo Culture. The findings showing that the elderly play various roles, receive social status and support from family members at large and others including in-laws, neighbors, friends, and the community (Abedella, 2005). On the other hand, Mahlet (2007) also examined the attitude of the Tehuledere Community of the Dessie ZureaWoreda towards Abegar members and non-members and its implication for successful aging. According to Mahlet, the Abegar members were more respected, favorably accepted, engaged far better in social activities like mediation of people in conflict, had better self-views and psychological wellbeing (Mahlet, 2007). Kifle's (2002) also examined old age and social change in the rural village of Goshwuha in the district of Ensaro, in Amhara Region. The study identified problems of elderly people including lack of proper care

and support, vulnerability to socio-economic problems, and various forms of abuse: emotional, physical, financial, abandonment and neglect (Kifle, 2002).

Mussie (2006) also studied the consequences of HIV/AIDS in the traditional support networks of the elderly in Arada Sub-City, Addis Ababa. The findings show that social exclusion, abuse, psychological stress and trauma are the problems of elderly people (Mussie, 2006). Setegn (2010) also studied community-based elder care in Awuramba, in Amhara Region. The findings show that support provided to elders under the community-based care system was encouraging (Setegn, 2010). Fasil (2010) studied the effects of institutional care on older persons in Kaliti Institutional Care Centre for the Elderly in Addis Ababa. This study revealed economic and health problems, weak ties with children and family members, and lack of support from children and other relatives forced elders to become institutional care recipients (Fasil, 2010). Solomon (2012) also examined the lived experiences of six abused elderly people in Bishoftu Town, Oromiya Region. The study found older adult related conditions that contributed to elders for the risk of elder abuse such as extreme aging, physical deterioration, chronic illness, dependence on others, poverty, and behavioral problems (Solomon, 2012).

Other studies focused rather on psychological profile of the elderly (e.g., Girum, 2012; Tilahun, 2010; Tomas, 2007) indifferent settings: Kaliti Home for the Aged (Tomas, 2007), Dangila Town (Tilahun, 2010), and Dessie Town (Girum, 2012). Tomas (2007) found out that the psychosocial profile of the elderly before admission into Kaliti Home for the Aged was much lower than their profile after admission showing that for the elderly considered in the research even life in institution is better than outside. On the other hand, Girum (2012) explored the psychological wellbeing as a function of religious involvement, spirituality and personal

meaning in life among community-residing elders. He found out that most elders had moderate score on self-esteem, autonomy and depression and males were consistently better in psychological well-being.

A more specific dimension of psychological profile that was closely examined among the elderly in Ethiopia was “self-esteem” (e.g., Belay, 2010; Belaynesh, 2007; Zeru, 2009). Some researchers investigated self-esteem of the elderly (Belay, 2010; Belaynesh, 2007; Zeru, 2009) along with such other variables as activity engagements (Belaynesh, 2007), depression, loneliness, and coping mechanisms (Zeru, 2009) and age, sex, income, education, and perceived adequacy of support (Belay, 2010) in Addis Ababa (Belaynesh, 2007), Dangila (Zeru, 2009), and DebreMarkos (Belay, 2010) Towns. According to Belaynesh (2007), the elderly with multiple roles had the highest self-esteem while engagement in a work role didn’t not make significant differences in self-esteem compared with socio-cultural roles, and when work engagement was important, it was in a manner that those engaged in work roles by choice had better self-esteem than those who engaged by necessity. Examining possible factors affecting self-esteem of the elderly, Belay (2010) reported a decrease in self-esteem with age, no difference in self-esteem by sex, but a positive relationship of self-esteem with income, education, and perceived adequacy of support. Zeru (2009) examined self-esteem along with such other variables as depression, loneliness, and coping mechanisms and reported a prevalence rate of 26%, 8.7%, and 2.7% respectively.

Belay (2010) examined the situation of the elderly affected by HIV/AIDS in Addis Ababa and Chilga, Gondar and indicated that nursing sick adult children, morning their loss, grand parenting children under limited resources and financial constraints were some of the added common problems of the elderly in most recent years. Samuel (2005) examined the abuse

and neglect of the elderly in the streets of Addis Ababa and in the homesteads and found there were serious abuses in both settings (Samuel, 2005). The lack of government attention to older adult issues is noted by Zelalem et al. (2021), who reported that factors contributing to food insecurity included a "lack of national guidelines on acute malnutrition management, data on older people not included in regular facility reporting, and older people not routinely included in needs assessments" (p. 3). Sadly, throughout Ethiopia, the needs of the older population are not prioritized. According to Teshome (2013), of the more than 100,000 beggars in the capital city of Addis Ababa, the majority are older adults. These days, however, that sort of courtesy toward older adults is becoming much less common (Chane & Adamek, 2015). People not only show a lack of support, but sometimes abuse older adults when assertiveness or agility is required to get any service (Zelalem & Kotecho, 2020; Zelalem et al., 2021). Older adults have difficulty securing support services from government and nongovernment institutions. Currently, no national policy addresses the older population in Ethiopia. Although a previous administration in Ethiopia endorsed a National Action Plan on Aging (MoLSA, 2006), there has been little action and no financial commitment of the central government to older citizens. Instead of an institutional approach to ensure older adults' well-being, the Ethiopian government has taken a minimalist residual approach, addressing only the most severe needs of vulnerable older adults.

The above mentioned studies are useful to illuminate the conditions of older adults but they are not enough. There is little literature and research on older adults issues in Ethiopia. Specifically, there is a research gap in the area of older adults' conceptualization SWB and its measurements, which necessitates further study.

2.7. Measurement of Subjective Well-Being

Despite extensive study the measurement of SWB remains a contentious topic (Deci & Ryan, 2008; Goodwill, 2009). Some critics have condemned the practice and argued that is impossible to measure SWB (Cho et al., 2015) while others have suggested that these critics have misunderstood the nature of the instruments in use (Christopher, 2018).

Most of the measures of SWB are obtained through self-reports (Goodwill, 2009). People are asked to evaluate their lives as a whole or some aspect of it (Van Hoorn, 2007). In the earlier research on SWB, researchers studying the facets of happiness usually relied on only a single self-report item. Recent measures of SWB contain multiple items. The Satisfaction with Life Scale (SWLS; Diener et al., 1985) and the Positive and Negative Affect Schedule (PANAS; Watson et al., 1988) are the much used ones. The literature suggests that the decision to use a single item scale or a multi-item scale for measuring SWB depends on the researchers' needs and the research feasibility. Despite the continued development of new instruments, no universally accepted measure has emerged (Layard, 2010). Instruments are scattered across disciplines, inconsistently labelled, and the differences between them are unclear (Gasper, 2010).

2.7.1. Eight Measures of Subjective Well-Being

Eight measures concerned with psychological and subjective well-being are identified in the literatures (Goodwill, 2009); the Positive and Negative Affect Schedule (PANAS; Watson et al., 1988), the Life Satisfaction Index (LSI; Neugarten et al, 1961), the Bradburn Affect Balance Scale (ABS; Bradburn, 1969), Satisfaction with Life Scale (SWLS; Diener et al., 1985), the Perceived Well-Being Scale (PWB; Reker & Wong, 1984), the Scales of Psychological Well-

Being (SPWB; Ryff, 1989), the Warwick Edinburgh Mental Well-Being Scale (WEMWBS, Tennant et al., 2007) and the Memorial University of Newfoundland Scale of Happiness (MUNSH, Kozma & Stones,1980).

Table 1

Types of SWB measures

Measures	Subscales	Items	Psychometric Properties
The Positive And Negative Affect Schedule (PANAS) (Watson et., 1988)	Positive affect Negative affect	20	Test-retest (r = 0.39 to 0.71) Internal consistency (α = 0.84 to 0.90) Inter-scale correlation (r = -0.12 to -0.23)
Life Satisfaction Index (LSI-A) (Neugarten et al., 1961)	Zest vs. apathy Resolution and fortitude Goal congruence Positive self-concept Mood tone	20	Test-retest (not available) Inter-scale correlation (r = 0.48 to 0.84) Internal consistency (not available)
Affect Balance Scale (ABS) (Bradburn, 1969)	Positive affect Negative affect	10	Test-retest (r = 0.76) Internal consistency (α = 0.55 to 0.73) Inter-scale correlation (r = 0.04 to 0.15)
The Warwick Edinburgh Mental WellBeing Scale (WEMWBS) (Tennant et al., 2007)	Positive mental health	14	Test-retest (r = 0.83) Internal consistency (α = 0.89 to 0.91)
Scales of Psychological Well-Being (SPWB) (Ryff, 1989)	Self-acceptance Positive relations with others Autonomy Environmental mastery Purpose in life Personal growth	120	Test-retest (r = 0.81 to 0.85) Internal consistency (α = 0.86 to 0.93) Inter-scale correlation (r = 0.32 to 0.76)
Satisfaction With Life Scale (SWLS) (Diener et al., 1985)	Life satisfaction	5	Test-retest (r = 0.82) Internal consistency (α = 0.57 to 0.67)
Perceived WellBeing Scale (PWB) (Reker & Wong, 1984)	Perceived psychological health Perceived physical health	14	Test-retest (r = 0.65 to 0.79) Internal consistency (not available) Inter-scale correlation (r = 0.32)
Memorial University of Newfoundland Scale of Happiness (MUNSH) (Kozma & Stones,1980)	Positive affect Negative affect General positive experiences General negative experiences	24	Test-retest (r = 0.70) Internal consistency (α = 0.86) Inter-scale correlation (not available)

2.7.2. Description of Subjective Well-Being Measures

The following are the existing literature within the psychological research and measurement of SWB in older adults.

The Affect Balance Scale

The Affect Balance Scale (ABS; Bradburn, 1969) requires participants to state their agreement or disagreement with 10 statements. It defines well-being as being concerned with positive affect (measured by the 5-item Positive Affect Scale, PAS), negative affect (measured by the 5-item Negative Affect Scale, NAS), and the balance between the two (ABS). Whilst the PAS looks at interests, pride, achievements, general happiness and contentedness with life, the NAS is concerned with feelings of restlessness, isolation, boredom, unhappiness, and feelings of being criticised by others. Bradburn (1969) argued that positive affect and negative affect are independent constructs which both separately relate to the overall psychological well-being of individuals. Although originally developed for use on a younger sample, the applicability of the ABS with older samples has been assessed (e.g. Maitland et al., 2001), hence making it relevant to the current review. Its applicability has also been assessed cross-culturally (e.g. Devins et al., 1997).

Concerning reliability and validity, Bradburn (1969) reported good test-retest reliability ($r = 0.76$) over a three-day period and concluded that the two scales showed an acceptable internal consistency ($\alpha = 0.55$-0.73). Further, a low association between the two scales ($r = 0.04$-0.15) supported the notion that the PAS and the NAS measure separate constructs. Harding (1982) found support for Bradburn's measure using a British sample, reporting acceptable

internal consistency (α = 0.59-0.65) and non-significant association between the two scales (r = 0.002).

Criticism of the ABS has pointed to the fact that ABS is derived by subtracting NAS from the PAS, thus implying that they are not separate concepts (van Schuur & Kruijtbosch, 1995). In fact, some studies have reported an association between the NAS and the PAS (e.g. Kammann et al., 1984), in particular when using an old age sample (Benin et al., 1988), indicating that the ABS may be better described as a unidimensional measure. Further, MacIntosh (1998) concluded that as many as four factors were required to explain the data in the World Values Survey, which incorporated more than 50,000 participants in 38 different countries.

Finally, several studies have argued that only limited domains of positive and negative affect are represented in the ABS, arguing that the ABS may lack validity due to poor content sampling (Diener & Emmons, 1985). Further, the utility of the ABS with older people has been questioned following the conclusion by Connidis (1984) that several items carried negative connotations and hence, due to the pressures of social desirability, were disagreed with, irrespective of the individual's actual feelings. For example, several of the elderly in Connidis' sample stated that they disagreed with the question "Proud because someone complimented you on something you have done?" because the notion of pride carried a negative meaning. This has resulted in some subsequent studies opting for a removal of items that might carry a negative meaning for some individuals or cultures (Devins et al., 1997), posing further challenges to its ability to fully capture all aspects influencing well-being.

The Warwick Edinburgh Mental Well-Being Scale

The Warwick Edinburgh Mental Well-Being Scale (WEMWBS; Tennant et al., 2007) was recently developed in the UK as a tool to assess public and individual mental wellbeing. As such, it was developed as part of The National Programme for improving awareness and mental well-being in Scotland (Smith-Merry, 2008). It incorporates 14 positively worded items concerned with a single-factor of positive mental health, including hedonic (i.e. pleasure attainment and happiness) and eudaimonic (i.e. the meaning people assign to experiences, self-realisation, and positive functioning) wellbeing. Participants are instructed to consider their situation over the previous two-weeks and indicate to what degree they agree with statements on a five-point scale. As the sample in Tennant et al. (2007) study incorporated a sub-group of individuals 55 years and over, the WEMWBS was included in the present review.

Concerning reliability and validity, Tennant et al. (2007) concluded that the WEMWBS had a high test-retest reliability ($r = 0.83$) and internal consistency ($\alpha = 0.89$-0.91). They also reported confirmatory factor analytical support for their proposed single-factor model. The authors evaluated convergent validity against four positive well-being measures and three physical and mental well-being measures. They concluded that the WEMWBS correlated to expected measures, ranging from 0.43 to 0.77. The high internal consistency values prompted the authors to suggest that some items might be redundant. To test this, they dropped items from the analyses to investigate the number of items needed to achieve a Cronbachs's alpha value of 0.80. They found that only six out of the original 14 items were needed to achieve this value (Tennant et al., 2007). Similarly, Stewart-Brown et al. (2009) found that only 7 of the 13 original 14 items were reliable under Rasch modelling and that several of the unreliable items were also biased by

gender. As a consequence, a shorter 7-item uni-dimensional version of the WEMWBS was developed (The Short Warwick Edinburgh Mental Wellbeing Scale, SWEMWBS).

Analysis indicated high association between the WEMWBS and the SWEMWBS (ρ = 0.95). However, the authors conclude that the SWEMWBS offers a more limited assessment of well-being, especially since several items concerned with hedonic well-being were removed. This is notable as several researchers have argued that hedonic and eudaimonic well-being are separate concepts (Kopperud & Vittersø, 2008; Ryan & Deci, 2001). Nevertheless, Stewart-Brown et al. (2009) suggest that the robust measurement properties of the SWEMWBS make it preferable to WEMWBS for monitoring well-being. Yet they do concede that "when face validity is an issue there remains arguments for continuing to collect data on the full 14 item WEMWBS" (p.1).

The Positive and Negative Affect Schedule

Watson, Clark, and Tellegen (1988) developed The Positive and Negative Affect Schedule (PANAS) following research which supported the notion of separate positive and negative affect scales. The PANAS comprises two 10-item mood scales, positive and negative affect, and respondents are requested to indicate on a five-point scale to what extent they have experienced each mood or emotion during a specified time period. The PA scale focuses on items relating to alertness, enthusiasm, interest, strength, and attentiveness, whilst the NA scale focuses on items relating to fear, distress, nervousness, shame and irritability. Watson et al. (1988) derived these specific items by factor 14 analysing general population responses on lists of descriptors, or adjectives, and selecting the ones with strong primary loadings on either factor. The utility of the PANAS with old-age samples was established by Kercher (1992).

Concerning reliability and validity, Watson et al. (1988) reported test-retest values ranging from 0.39-0.71 depending on the time frame that participants were asked to consider (for example 'today' or 'last year'). Watson et al. (1988) further reported high internal consistency for both the PA (α = 0.86-0.90) and the NA (α = 0.84-0.87) scales. They also reported a quasi-interdependence between the two scales (r = -0.12 to -0.23). Further, Watson et al. reported moderate correlations to the Beck Depression Inventory (-0.35 for PA, 0.56 for NA) and the State-Trait Anxiety Inventory (-.035 for PA, 0.51 for NA). Kercher (1992) developed a short version of the PANAS by choosing items with the highest factor loadings, and assessed its utility with elderly populations. Kercher concluded that his two 5-item scales support the notion that PA and NA are separate constructs and that the short PANAS is a viable measure of well-being in older adults. Mackinnon et al. (1999) have argued that items in the NA scale of Kercher's short form display high intercorrelations. When examining these items, they concluded that four of the five items are pairs with intrinsically similar meanings (e.g. scared and afraid, distressed and upset). Hence, their utility for adding meaning to the concept of NA, they argue, must be questioned.

Scales of Psychological Well-Being

Ryff (1989) reviewed the literature on well-being and concluded that a multi-dimensional approach to well-being is needed to capture its full meaning. By integrating ideas and 15 theories from the mental health, clinical, and life span literature, Ryff concluded that well-being is comprised of six separate concepts: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. Using these concepts as a framework, Ryff developed the Scales of Psychological Well-Being (SPWB). The original

SPWB incorporates 20 items per construct and utilises a six-point Likert scale. Ryff included a sub-group of older adults in the development of the SPWB. Shorter versions of the original scale have later been proposed, including 14 (Ryff et al., 1994) and 3 items per scale (Ryff & Keyes, 1995).

Concerning reliability and validity, Ryff (1989) reported good test-retest reliability for all six dimensions (ranging from 0.81-0.85) over a six week period. Internal consistency for all scales was also high (α= 0.86-0.93). Ryff further reported correlations of the SPWB to six measures of related concepts, ranging from 0.32 to 0.72. Intercorrelations between scales were reported to range from 0.32 to 0.76, with high intercorrelations between self-acceptance and environmental mastery (0.76) self-acceptance and purpose in life (0.72), and purpose in life and personal growth (0.72), indicating an overlap between these scales. Ryff et al. (1994) reported similar values for the 14-item-per subscale version, which was also reported to be highly associated with the original 20-item-per-subscale version (ρ = 0.97). Van Dierendonck (2005) concluded that whilst the 3-item-persubscale version revealed the best factorial validity (i.e. least overlap between scales), the internal consistency of this measure was below acceptable levels (α = 0.17-0.68) and should therefore not be used.

Criticism of the SPWB has focused on the high inter-correlations reported between different dimensions. Clarke, Marshall, Ryff, and Wheaton (2001) concluded that whilst there was an overlap between some of the dimensions their data still supported the multi-dimensionality proposed by Ryff (1989). Conversely, Kafka and Kozma (2002) concluded that their data indicated a three-factor solution, which did not tap the original dimensions. Springer and Hauser (2006a, 2006b) argue that until the issue of the seemingly high intercorrelations

between personal growth, purpose in life, self-acceptance, and environmental mastery has been solved, the validity of the SPWB is disputed.

The Life Satisfaction Index

One of the measures with has been widely cited in the literature assessing successful aging in older people is the Life Satisfaction Index (LSI; Neugarten et al., 1961). Neugarten et al. (1961) defined psychological well-being as a multi-dimensional concept involving zest, resolution and fortitude, congruence between desired and achieved goals, positive self concept, and mood tone. Based on this framework, they developed the Life Satisfaction Ratings (LSI-A and LSI-B), of which the LSI-A uses self-report and the LSI-B involves an interview. Hence, only the LSI-A was considered in the current review. The LSI-A incorporates 20 items, which are scored on a three-point scale.

Concerning reliability and validity, overall, limited psychometric information has been presented for the LSI. Neugarten et al. (1961) reported no test-retest, internal consistency, or convergent validity values. They did report high inter-correlations between their five factors (α = 0.48-0.84), particularly between self concept and resolution (0.83), zest and mood (0.84), and self concept and mood (0.82). Several papers have investigated the factor structure of the LSI and have failed to find five separate concepts (e.g., Adams, 1969; Hermes et al., 1998; Wilson, Elias, & Brownlee, 1985). As a result, several different versions of the LSI have been suggested, including the 13-item LSI-Z (Wood et al., 1969), the two-factor 8- item LSI-W, which was standardised on a British sample (Bigot, 1974), a three-factor version containing 7 items (Liang et al., 1988), a three-factor version containing 8 items (Hoyt & Creech, 1983), and a four-factor solution containing 18 items (Adams, 1969). In their review of the LSI, Wallace and Wheeler

(2002) conclude that most studies adopting the LSI have opted to report participants' overall questionnaire score rather than the individual scale scores. Until a homogenous framework has been agreed, it is argued that the results of the LSI are used cautiously with greater emphasis placed on overall questionnaire score (e.g. well-being) rather than on an individual's scores on the subscales or factors, since these may be contentious or misleading.

Satisfaction with Life Scale

Diener et al. (1985) developed a multi-item scale measuring life satisfaction. They named their five-item measure the Satisfaction with Life Scale (SWLS). Items cover issues around global satisfaction with life, conditions, and whether respondents would change life experiences if given the opportunity. Respondents are requested to state their agreement to items on a seven-point Likert scale. Whilst the SWLS was originally developed on a student population, its utility with an older sample has also been evaluated (Diener, et al., 1985).

Concerning reliability and validity, Diener et al. (1985) reported a test-retest correlation over a two-month period of 0.82. A single-factor solution (explaining 66% of the variance) supported the framework suggested. Inter-item correlations were in the acceptable range (α = 0.57-0.67). Pavot et al. (1991) reported similar values (α= 0.55-0.80). Pavot and Diener (1993) further reported a temporal stability over a four-year period of 0.54, which they argued support the scale's sensitivity to clinical change over time. Pavot et al. (1991) reported a significant correlation between the SWLS and the LSI-A of 0.81. The SWLS is a useful and psychometrically valid measure of life satisfaction. Critics argue that it only incorporates one aspect of life satisfaction, namely the cognitive component and thus fails to consider the affective element of well-being (Schiaffino, 2002).

Perceived Well-Being Scale

Reker and Wong (1984) argued that well-being in the elderly is best understood by considering people's perceptions of their psychological and physical status. They developed the Perceived Well-Being Scale (PWB) which measures these two components. The aggregate of the two is referred to as general well-being. The PWB consists of 14 items, and participants are asked to indicate their agreement to statements using a seven-point Likert scale. Items in the psychological well-being scale are concerned with boredom, excitement, apathy, and purposefulness whereas items in the physical health component regard ability to stand physical strain, tiredness, appetite, deterioration of health, and physical complaints.

Concerning reliability and validity, Test-retest correlations over a two-year period were reported at 0.65 for physical well-being and 0.79 for psychological well-being. A factorial solution supported the notion that psychological and physical well-being were distinct concepts, and these only inter-correlated moderately ($r = 0.32$; Reker & Wong, 1984). Further, Reker and Wong concluded that the PWB correlated significantly to the MUNSH (0.54-0.61) and the Beck Depression Inventory (-0.37 to -0.55). A revised version containing 16 items has since been developed, however no psychometrics for this version have been published (Reker & Wong, 1984).

The Memorial University of Newfoundland Scale of Happiness

Following criticism regarding the limited sampling of the ABS and questions regarding its applicability to older adults, Kozma and Stones (1980) developed the Memorial University of Newfoundland Scale of Happiness (MUNSH). They argued that whilst literature supported the

notion that positive and negative affect influence someone's perceived and reported well-being, aspects of a person's perceived positive and negative life experiences are equally influential in older adults. Subsequently, they utilised the theoretical underpinning of items from the ABS, which measure positive and negative affect, and the LSI-Z, which incorporates items concerned with positive and negative emotive experiences. The resulting scale includes four indices; positive affect (PA), negative affect (NA), general positive experiences (PE), and general negative experiences (NE). The MUNSH contains 24 items, to which respondents are instructed to indicate their agreement using a yes/no format.

Concerning reliability and validity, Kozma and Stones (1980) reported a test-retest reliability value of 0.70 over a six-month to a year interval. They reported good overall internal consistency ($\alpha = 0.86$). Stones and Kozma (1985) investigated the cross-validity of the MUNSH compared to the ABS and the LSI-Z using a single factor confirmatory analysis. They concluded that the combined scales accounted for 64% of the variance in determining positive well-being, with the MUNSH loading the highest (0.99) on to the single factor solution. However, in their study Stones and Kozma (1985) further analyzed seven additional datasets, yet did not report a comparison of the overall MUNSH scale in any other of the data sets analyzed. This may cast doubt over the generalisability of the factor loading and cross-validity results reported by Stones and Kozma (1985). Additionally, as mentioned previously, there may be problems with the validity of the ABS and the LSI-Z, thus also casting doubt over the utility of using these scales for cross-validation.

2.7.3. Systematic Evaluation of Subjective Well-Being Measurements

The results of the current review suggest that the concept of SWB in older adults is poorly defined. There is large variability in the way SWB is measured in terms of its: a) derivation from affect and/or cognitive evaluations, b) dimensionality and composition and c) psychometric properties.

A) Well-being as an affective state versus cognitive evaluation

The eight measures reviewed in the current paper focused on well-being as defined by either affective states, cognitive evaluations of one's life, or some combination of the two. This largely parallels present academic and clinical understanding of positive mental health in that it is a complex construct covering both mood and psychological functioning. In fact, well-being is widely recognised (e.g., Kopperud & Vittersø, 2008) as comprising two distinct perspectives: the hedonic perspective, focusing primarily on the experience of happiness and pleasure attainment (i.e. affective states), and the eudaimonic perspective, which focuses on psychological evaluation and self-realisation (i.e. cognitive evaluation) (Goodwill, 2009).

Measures primarily concerned with hedonic, or affective, mood are the ABS and the PANAS, which utilise the *presence* of *positive* emotions and *absence* of *negative* emotions as indicative of well-being (e.g., Goodwill, 2009). Common for these measures is the assumption that a preponderance of positive over negative affect results in subjective well-being. Hence, the more positive a person reports feeling, the better their well-being is concluded to be. Only one measure, the SWLS, focused solely on a eudaimonic, or cognitive, evaluation of well-being. The

SWLS focused primarily on an older person's global satisfaction with life in terms of its subjective measurement (e.g. "the conditions of my life are excellent").

More commonly SWB was conceptualised and defined as a mixture of affective and cognitive evaluations of a person's well-being. The PWB, SPWB, LSI, and the WEMWBS all theorised that well-being is an overall combination of hedonic and eudaimonic well-being. Although similar in its treatment of well-being, as it adopts a mixture of affective and cognitive elements, the MUNSH differed from the others in that it separated affect and cognitive experiences of well-being, treating them as independent constructs.

B) Dimensionality (number of dimensions) and composition (type of dimensions)

The systematic literature review identified that overall there is general disagreement among researchers on the number and type of dimensions comprising well-being in older adults. The measures in the present study were found to range from one to six dimensions in defining well-being. The WEMWBS used one dimension of positive mental health, although this dimension does in fact include both hedonic and eudaimonic well-being. The SWLS used one dimension of global life satisfaction, largely ignoring affective mood as a composite dimension of well-being. The ABS and the PANAS both used two dimensions: positive and negative affect. The PWB scale also utilised two dimensions, but these involved a person's perceived psychological and physical well-being. The MUNSH comprised four dimensions; positive and negative affect, and positive and negative experiences (e.g. cognitive evaluations). The LSI-A used five dimensions to define well-being; zest, fortitude, congruence between desired and achieved goals, positive self-concept, and mood tone. Finally, the SPWB used six dimensions; self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life,

and personal growth to define well-being. The range of dimensionality, interpretation of dimensions and the composition of those dimensions was markedly different between the measures identified in the review suggesting that well-being as a psychological concept is indeed difficult to define.

Differing interpretations of the definition of well-being not only exist across the various measures but are also evident in the composition of items within each individual measure, investigated in numerous validation studies. For example, the extent to which specific items in a measure have been found to consistently relate to specific dimensions of well-being have been questioned (e.g., Benin et al., 1988; Kafka & Kozma, 2002; Liang et al., 1988; Stewart-Brown et al., 2009). This has resulted in studies reporting low internal consistency, and/or cross-cultural validity (e.g., Bigot, 1974; Connidis, 1984; MacIntosh, 1998). Although studies generally have found contradictory evidence for the internal consistency of items, attempts to validate the LSI-A have resulted in a large number of alternative factorial solutions. Helmes et al. (1998) report that at least 10 studies testing the factorial solution of the LSI-A have found differing numbers of factors (e.g. dimensions) with differing composition. For example, Bigot (1974) concluded that data from the LSI-A could be best interpreted as simply a two-factor solution involving the concepts of acceptance-contentment and achievement-fulfilment.

At present, no alternative factorial solutions have been proposed for the WEMWBS, or SWLS, which perhaps is explained by them being uni-dimensional measures. Nevertheless, they have not escaped criticism within the academic literature. Both the WEMWBS and the SWLS have been criticised for not fully capturing the broad conceptualisation of well-being (e.g., Schiaffino, 2002; Stewart-Brown et al., 2009). The PWB has not had any published evaluations.

C) Psychometric properties of identified measures

All of the measures under study were found to have adequate reliability and validity in their original versions. However, numerous evaluative studies, as described above, have been conducted with the majority of these measures, with a vast number of studies reporting poor internal consistency of items, scales and factors. It is postulated that there may be several reasons why these subsequent studies have found little support for the initial psychometric properties reported by the authors in their original studies. Firstly, well-being has been reported to be dynamic in nature, with ratings of well being changing within individual subjects depending on current circumstances (e.g., Diener et al., 1998). Clearly, the dynamic aspect of well-being is likely to be more pronounced in affective items, such as "I feel happy", than in more cognitive, global items, such as "I think I am usually a happy person". Therefore, items relating to affective concepts of well-being may be influenced by short-term changes in affect, more so than items relating to more long-term cognitive and psychological aspects of well-being. Secondly, variations in findings across studies may relate to differences between the populations under scrutiny. Thus, even in evaluative studies where age has been kept a relative constant, additional demographics might have differed, such as socio-economic status (e.g., Larson, 1978), marital status (e.g., Wood et al., 1989), and cognitive or physical functioning (e.g., Pinquart & Sörensen, 2000), which have all been found to impact on subjective well-being. This might explain the differing results reported by some validation studies. Thirdly, methodological variations may have led to differing factorial solutions across studies: for example, elderly people are more likely to rate absence of negative affect as indicative of positive well-being compared to younger respondents (e.g., Zautra et al., 1988). Thus, bipolarity of dimensions of well-being might be

assumed by some respondents but not by others. This poses significant challenges for the way in which measures, and in particular response formats, are designed (e.g., Russell & Carroll, 1999)

Overall the measures collected from a systematic search of the literature suggest that there is a greatly varied opinion among researchers in how well-being in older adults should be defined in terms of its dimensionality, composition and psychometric structure. Attention will now be drawn to the question of whether measures capture aspects of well-being important to old people.

2.8. Development and Validation of Scales

A review of well-being measures unsurprisingly prompts the question "what makes a good measure of well-being?" (Tadesse, 2015). On one hand psychometric properties such as validity and reliability provide the main criteria used to determine the quality of a questionnaire (Cohen et al., 1996). Content validity and face validity for example concern the extent to which an instrument reflects the concepts it claims to measure, and the extent to which respondents agree with this (Rust et al., 2014).

Although a large number of studies (e.g., Hassad, 2010) have conducted on scale construction, most of them have focused on scale validation and over looked scale development. The possible reason why this happened is, perhaps, the enormity and the many extremely complex aspects the scale development process comprises. However, there are studies (e.g. Churchill, 1979; De Vellis, 2003; Hinkin, 1998; Slavec & Drnovsek, 2012) that combine those fragmented components together into a comprehensive model for scale development and validation. Without such a model, it is difficult to develop a new instrument (Tadesse, 2015).

2.8.1. Scale Development and Validation Models

There are four scale development and validation models (Tadesse, 2015). First, Churchill's (1979) scale development and validation model involves a series of eight steps beginning with specifying the domain of a construct and culminating in the development of norms for the scale. These eight steps include specifying the domain of a construct, generating a sample of items, collecting data, purifying the measure, collecting data, assessing reliability, assessing validity, and developing norms. Second, Hinkin's (1998) scale development model, on the other hand, comprises six steps. These are item generation, questionnaire development and administration, initial item reduction using item analysis and exploratory factor analysis, confirmatory factor analysis, convergent and discriminant validity, and replication. Third, DeVellis's (2003) scale development and validation model comprises eight steps. These are determining clearly what it is intended to measure, generating an item pool, determining scale format, expert review, inclusion of validating items, item administration, evaluating items, and optimizing scale length. Finally, Slavec and Drnovsek's (2012) scale development model contained ten steps and three phases. The first phase focuses on the theoretical importance and existence of the construct, the second phase deals with the representativeness and appropriateness of data collection, and the third phase focuses on the statistical analysis and statistical evidence of the construct (Tadesse, 2015).

As can be seen in the above four scale development and validation models, there are some sorts of variation, though they are comprehensive. This is so because the methods of their studies differ from one another, and thereby the methods used determine their study procedures

or steps. Cognizant of this, for the current study, the researcher used the proposed four scale development and validation models by adapting and integrating.

2.8.2. Major Procedures in Scale Development and Validation Process

2.8.2.1. Specifying a Construct

The first step in scale development and validation process involves specifying a construct. With regard to this, different authors (e.g., Churchill, 1979) underlined that a scale developer should identify the nature of a construct and its conceptual theme in the first stage of scale development process. Once a construct is clearly identified, it should be carefully defined in a clear and an unambiguous term to address what the construct is intended to conceptually represent or capture (e.g., Hinkin, 1995).

2.8.2.2. Generating Items for a Construct

After a construct has been specified and conceptually defined, items fully representing the conceptual definition of the construct should be generated (Nunnally, 1978). For this purpose, items can be derived from a variety of sources, including reviews of literature, deduction from a theoretical definition of a construct, examination of other measures of a construct that already existed, suggestions from experts in the field, and interviews or focus group discussions (Churchill, 1979). Following this, initial drafted items need to be written in the appropriate way. With regard to this, some authors (e.g., De Vellis, 1991; Nunnally, 1978) suggested the following criteria in the writing up of items: items must be unambiguous, use simple language, respondents must be competent to answer, the questions must be relevant to the respondents, and short items must be used.

2.8.2.3. Determining Scaling Format

There are different formats for scaling. Some of them are the following: (a) Thurstone scaling, each item comprises several statements that have been ranked in order of intensity (Dawis, 1998). The respondent then selects the responses that best describe how he or she feels (Fischer & Corcoran, 1994); (b) Guttman scale, like Thurstone scale, involves a series of statements that have been ranked in order of intensity. But unlike Thurstone scaling, Guttman scale involves selecting all the items with which one agrees until one's level of intensity on the construct is reached (Nunnally, 1978); (c) Semantic differential scale comprises pairs of words that represent the opposites of an attribute (e.g. presence and absence) separated by a set of several response categories. Then, the respondent marks the category along the continuum that best represents his or her position on the attribute (Abell et al., 2009); (d) Binary options, an item is presented in a statement or a question form, and respondents are asked to mark a dichotomous response, such as "yes" or "no", or "agree" or "disagree" (De Vellis, 1991); (e) Forced choice scale is often used in personality assessment. Items are presented with a pair of words or statements, and respondents are asked to select the one that they support most strongly (Hudson, 1994); (f) Likert scale is the most commonly used scale in research. Likert-type scale typically involves an item in the form of a statement, followed by response options that indicate varying degrees of agreement or frequency (Dawis, 1998). The response options of Likert-type scale do not exceed seven because writing meaningfully different labels become very difficult beyond this point (Abell et al., 2009).

In addition to scaling format, a scale should contain clear instructions to guide respondents through the process of completing the scale (Tadesse, 2015). If respondents do not understand how to answer the items, serious errors may be occurred. To minimize this kind of

error, Hudson (1994) suggested the following guidelines for instruction writing. That is, instructions for the respondent: (a) keep it simple, (b) explain what is being measured, (c) show a response key, (d) indicate where to put responses, (e) explain that there is no right or wrong answer.

2.8.2.4. Assessing Content Validity

Once items that represent a construct of interest have been generated, the content validity of the generated items should be assessed (Tadesse, 2015). Straub et al. (2004, p. 424) defined content validity as "the degree to which items in an instrument reflect the content universe to which the instrument will be generalized." Content validity is often viewed as a minimum psychometric requirement for measurement adequacy and is the first step in construct validation of a new measure (Schriesheim et al., 1993). When assessing content validity, two related judgments should be made: (1) Is individual item representative of an aspect of the content domain of the construct? (2) Are items as a set collectively representative of the entire content domain of the construct? (DeVos et al., 2002). For this purpose, therefore, it is important to obtain experts who can judge the content validity of a scale. Expert reviewers should evaluate the extent to which each item measures a construct under study.

In line with this, researchers (e.g., Lawshe, 1975) have established different methods to assess the content adequacy of a new measure. For example, Lawshe (1975) specified a formula to determine a minimum Content Validity Ratio (CVR) for different expert judge sizes. In order to utilize Lawshe's formula, expert judges are expected to rate each item as (3) not necessary; (2) useful but not essential; (1) essential to quantify the content validity of individual items in a test or measurement instrument based on expert judgment.

The formula of content validity ratio is CVR= n_e – (N/2)/(N/2), in which the N_e is the number of panelists indicating "essential" and N is the total number of panelists. The numeric value of content validity ratio is determined by Lawshe Table.

Table 2: Critical CVR values based on the number of panelists

Number of Experts (N)	Minimum CVR for Significance (at p < 0.05)
5	0.99
10	0.62
15	0.49
20	0.42
25	0.37
30	0.33
40	0.29

Source: Lawshe's (1975) original table

2.8.2.5. Scale Purification

After assuring content validity of a new measure, it has to be administered to a large sample size that represents a population for which a measure is designed (Tadesse, 2015). Based on the data obtained from the samples, the researcher examines the psychometric properties of the scale. This is usually done using exploratory factor analysis, confirmatory factor analysis, and reliability analysis (Hinkin, 1998).

Factor Analysis

Exploratory Factor Analysis

There are two basic types of factor analysis: exploratory factor analysis and confirmatory factor analysis (Thompson, 2004). Exploratory Factor Analysis (EFA) is used to explore the underlying structure of a collection of observed variables or items, when there is no a priori hypothesis about the factor structure (Hurley et al., 1997). It is in this sense, it is "exploratory" in nature as it allows the researcher to determine the underlying dimensions or factors that exist in a set of data. Therefore, EFA is generally thought of as more of a model generating procedure, and it is usually manipulated through general purpose statistical software packages such as SPSS, SAS, and Stata (Hurley et al., 1997).

As noted by Hatcher and Stepanski (1994), the underlying assumptions of EFA are: (a) Interval-level of measurement. All analyzed variables should be assessed on an interval or ratio level of measurement (b) Random sampling. Each participant contributes one score on each observed variable and these sets of scores should represent a random sample drawn from a population of interest (c) Linearity. The relationship between all observed variables should be linear (d) Normal distributions. Each observed variable should be normally distributed. Whether the distribution is normal or non normal, it can be detected using skewness and kurtosis values. With this regard, Harrington (2009) stated that skewness is a measure of how asymmetric a distribution is. If most of the scores are below the mean, then the distribution is positively skewed, whereas if most of the scores are above the mean, then the distribution is negatively skewed. On the other, kurtosis is a measure of how well the shape of the bell conforms to that of a normal distribution. Positive kurtosis, or a leptokurtic distribution, occurs when the middle of the distribution has a higher peak than expected for a normal distribution, whereas negative

kurtosis, or a platykurtic distribution, occurs when the middle of the distribution is flatter than expected for a normal distribution.

In light of this, the recommended thresholds for the assumption of normality, skew and kurtosis values should be within ±2 for the data to be normally distributed (Garson, 2007). Other researcher (e.g. Kline, 2005) considers variables with an absolute value of skew > 3 as extremely skew. However, for the kurtosis value, much less consensus and more lenient rules have been suggested. For example, Garson uses a range within ±3, and others use a value no greater than 7, or a value no greater than 10 (Kline, 2005).

According to Williams et al. (2010), EFA is performed through five sequential steps. The first step is assuring whether or not the data is suitable for factor analysis. This could be determined by examining sample size and factorability of a correlation matrix. Sample size requirement is a key consideration in factor analysis. With regard to this, different authors set different rules, such as respondent-to-item ratio, respondent-to-item ratio together with sample size, item-factor ratio together with sample size and its factor pattern coefficient or communality, and sample size alone.

With regard to respondent-to-item ratio, for example, Hair et al. (2010) suggested that a minimum ratio of 5 to 1 is acceptable size. Moreover, Stevens (2002) noted that the number of participants per variable is the most appropriate way to determine sample size when it ranges from 5:1 to 20:1 participants per item. With respect to respondent-to-item ratio together with sample size, Kline (2005, p. 332) suggested, “An absolute minimum ratio is five individuals to each item, but not less than 100 individuals for any analysis.” In line with this, Tinsley and Tinsley (1987) indicated that 5:1 to 10:1 respondent per item and up to a maximum of 300 respondents are acceptable size. On the other hand, the most critical issue on the adequacy of

sample size for factor analysis is how saturated the factors are by the measured items. With this notion, Williams et al. (2010) indicated that replicable factors tend to be estimated if (a) factors are each defined by four or more measured items with factor loadings each greater than | .60 | regardless of sample size; or (b) factors are each defined with 10 or more measured items with factor loadings each around |.40 | if sample size is greater than 150; or (c) sample size is at least 300. Moreover, Worthington and Whittaker (2006) reported that (1) if communalities are greater than .50 or there are 10:1 items per factor with factor loadings of roughly | .40 |, then a sample size of 150 to 200 is likely to be adequate; or (2) if communalities are all at least .60 or there are a minimum of 4:1 items per factor with factor loadings above | .60 |, then even smaller sample sizes may suffice.

On top of the above sample size criteria, to determine if the data are likely to be factorability, Kaiser- Meyer-Olkin (KMO) Measure of Sampling Adequacy and Bartlett's Tests of Sphericity should be checked. KMO measure of sampling adequacy examines sample sufficiency (Kaiser, 1974), and its index ranging from 0 to 1. Therefore, if value of KMO is greater than .50, one can proceed with factor analysis (Malhotra, 2005). Regarding this, Kaiser also provided the following criteria for sample adequacy: .90 = marvelous, .80 = meritorious, .70 = middling, .60 = mediocre, .50 = miserable, below .50 = unacceptable.

Bartlett's Test of Sphericity measures the presence of correlations among the variables (Kaiser, 1974). It tests whether some significant correlations exist among the variables being studied. Thus, a significant Bartlett's Test of Sphericity (< .05) is required to proceed with factor analysis (Malhotra, 2005).

The second step in the EFA is identifying appropriate method of extraction. There are five basic extraction methods (1) Principal Component Analysis (PCA), (2) Maximum

Likelihood (ML), (3) Alpha Factoring (AF), (4) Image Factoring (IF), and (5) Principal Axis Factoring (PAF) (Tabachnick & Fidell, 2007). Without getting into the details, Gorsuch (1990) realized that these methods of extraction could have similar results with larger sample sizes. Moreover, Thompson (2004) noted that the practical differences among these extraction methods are often insignificant, particularly when variables have high reliability. Among the above extraction methods, PCA and PAF are, more often than not, used for factor analysis (Henson & Roberts, 2006). If the purpose is to reduce a large number of items into a set of factors or components, PCA is recommended, whereas the purpose is to identify the latent variables which are contributing to the common variance in a set of measured variables, PAF is advisable (Fabrigar et al., 1999).

The third step is identifying methods of factor rotation. The purpose of factor rotation is to simplify the factor structure of a group of items. In other words, it makes high item loadings on one factor and smaller item loadings on the remaining factor solutions (Thompson, 2004). Regarding this, there are two types of factor rotations: orthogonal rotation and oblique rotation. Orthogonal rotation method assumes that the factors in the analysis are uncorrelated, whereas oblique rotation method assumes that the factors are correlated (Fabrigar et al., 1999). In line with this, Tabachnick and Fiddell suggested that oblique rotation method is preferable if the factor correlation matrix for values over .32, whereas values below.32, orthogonal rotation method is appropriate.

The fourth step is determining factor extracting criteria. The aim of factor extraction is to reduce a large number of items into small factors or components. Therefore, given the choice and sometimes the confusing nature of factor analysis, no single criteria should be assumed to determine factor extraction (Thompson, 2004). In this view, Thompson and Daniel (1996) stated

that the simultaneous use of multiple decision rules is appropriate and often desirable to determine factors. With this intent, various authors (e.g., Tabachnick & Fidell, 2007; Thompson & Daniel, 1996) suggested the following factor extraction criteria or decision rules:

- Factors with eigenvalues > 1.0. The eigenvalue of a factor represents the amount of variance of the variables accounted for by that factor (Thompson & Daniel, 1996). The goal of factor analysis is to account for as much variance as possible in a set of observed variables or items, with a smaller number of factors. For this purpose, factors with eigenvalues > 1 rule is performed on the correlation matrix. Variables are standardized, therefore, each variable has a variance of 1, and the total variance is equal to the number of variables used in the analysis (Gorsuch, 1983).
- Factors above the elbow line in the Scree plot. The concept of scree is described as the rubble of loose rock which is not solidly attached to mountains and that is collected at the bottom of the mountains (Cattell, 1966). Therefore, the solid mountains are analogous to noteworthy factors that should be retained. Trivial factors, however, are analogous to scree. The scree plot is a two dimensional graph with factors or components on the Xaxis and eigenvalues on the Y-axis. The point at which the curve decreases and straightens out is the elbow of the graph that researchers include factors before that point (Fabrigar et al., 1999).
- The cumulative percent of variance extracted by the factor should account for at least 50 percent of the variance (Hair et al., 2006).

Interpreting a factor or giving that factor a name, a minimum of three items (Comrey, 1988); greater than .32 factor loadings; and communality (i.e., the amount of variance explained for each item in the factor solution) above .50 are required (Hair et al., 2006) though the choice

of a cutoff point for factor loading to be interpreted is a matter of a researcher preference. With regard to factor loading, Tabachnick and Fidell (2007) also suggested that loadings > .71 are considered excellent, > .63 are considered very good, > .55 are considered good, > .45 are considered fair, and less than .32 are considered poor.

Regarding the labeling of factors, Thompson and Daniel (1996) noted that once the number of factors and their indicators are identified, each cluster of items should be carefully examined to determine the underlying factor and its substantive meaning.

Confirmatory Factor Analysis

Although the underlying factors or dimensions of a scale are determined by EFA, the true test must come from Confirmatory Factor Analysis (CFA) approach. Unlike EFA, CFA (a) yields unique factor solution and define a testable model, (b) tests the extent to which a hypothesized model fits the data or suggests alternative parameterization for model improvement, (c) and adequately tests the factorial invariance (Bollen,1989). It is, therefore, a more powerful test of construct validity.

According to Stevens (1996), the major objective in CFA is determining if the relationships between the variables in the hypothesized model resemble the relationships between the variables in the observed data set. In other word, the analysis determines the extent to which the proposed covariance matches the observed covariance. In line with this, Abell et al. (2009) explaining that if the factor structure or the measurement model fits the data well, it is an indication that the responses of participants to the scale items are consistent with the hypothesized factor structure. If not, there is a need for possible revision of the scale configurations.

CFA like EFA should fulfill the underlying assumptions of interval or ratio level of measurement, random sampling, linearity, and normal distribution. On top of this, CFA also requires: (a) specification of a model a priori, (b) the number of factors, and (c) which items load on which factor (Schumacker & Lomax, 1996). In order to test how well the model fits the data, CFA demands special purpose software packages such as AMOS, CALIS, LISREL; Mplus just to name a few (Abell et al., 2009).

Using one of the above software packages, CFA can produce different fit indices to aid in the assessment of the degree to which a hypothesized model fits the observed data (Kline, 2005). Various authors (e.g., Hair et al., 1998) classified fit measures into three categories: measures of absolute fit, measures of relative fit, and measures of parsimonious fit.

Absolute fit measures indicate how well the correlation or covariance of the hypothesized model fits the correlation or covariance of the actual or observed data. The most common absolute fit measures assessing this general features are the chi square, the Goodness-of-Fit Index (GFI), and the Root Mean Square Error of Approximation (RMSEA).

Chi-square ($\chi 2$) test is a classic goodness-of-fit measure to determine overall model fit (Thompson, 2004). A chi-square statistic tests the null hypothesis that there is no statistically significant difference in the observed and hypothesized correlation or covariance matrices. Therefore, according to Hatcher (1994), if the model provides a good fit, the chi-square value should be relatively small, and the corresponding p-value should be relatively large ($> .05$ and preferably closer to 1.00). In other words, a statistically significant chi-square ($< .05$) and rejecting the null hypothesis indicates that the model does not fit the data. By contrast, a small chi-square and failure to reject the null hypothesis is an indication of good fit of the model to the data (Abell et al., 2009). However, the chi-square test is widely recognized to be problematic

(Bentler & Bonett, 1980; Stevens, 1996). It is because sensitive to sample size and it becomes more and more difficult to retain the null hypothesis as the sample size increases. To minimize this problem, the chi-square / degrees of freedom ratio is recommended. Therefore, an acceptable criterion for chi-square to degree of freedom ratio is < 2 (Hatcher, 1994).

GFI is conceptually similar to the R2 in multiple regressions (Kline, 2005). It is the proportion of variance in the sample correlation or covariance accounted for by the predicted model, with values ranging from zero (no fit) to one (perfect fit). By convention, GFI should be equal to or greater than .90 as indicative of an acceptable model (Hu & Bentler, 1999). RMSEA measures the discrepancy between the observed and estimated covariance matrices per degree of freedom. Values less than .08 deemed acceptable, whereas values greater than .10 are generally unacceptable (Hatcher, 1994).

Relative fit measures are measures of fit relative to the independence model, which assumes that there are no relationships in the data (thus a poor fit) and the saturated model, which assumes a perfect fit (Hu & Bentler, 1999). The most common relative fit measures are: Comparative Fit Index (CFI, Hatcher, 1994), Normed Fit Index (NFI, Bentler & Bonnett, 1980), Non-Normed Fit Index (NNFI, Bentler & Bonnett, 1980), and Incremental Fit Index (IFI, Bentler & Bonnett, 1980). Estimates for the CFI, NFI, NNFI, and IFI, ranged from 0 to 1, with values of .90 or above indicating acceptable values of fit (Byrne, 2001).

Parsimonious fit measures are sometimes called adjusted fit measures. These fit statistics are analogous to the adjusted R2 in the multiple regression analysis. Common parsimonious fit measures are Adjusted Goodness of Fit Index (AGFI) and the Parsimonious Goodness of Fit Index (PGFI). Ideally, AGFI and PGFI values greater than .90 indicated an acceptable model

(Byrne, 2001); however, typically parsimony based measures having .50 or greater is deemed acceptable (Hu & Bentler, 1999).

When examining the measurement model, fit indices should ideally correspond to the recommended values. However, it is important to note that all indices are not important. At the same time, it is not possible to achieve perfect values for all indices (Byrne, 2001). Thus, as suggested by Lindquist et al. (2001), the areas of greater focus were GFI and AGFI, Normed Fit NFI and NNFI, RMSEA, and chi-square/df ratio.

In addition to the above model fit indices, it is important to examine the significance tests for standardized factor loadings. The standardized loadings signify the correlation between each item and its corresponding factor, and the square of standardized loadings represents R-squared. With this regard, items with t- values above 2.0 being considered significant loadings (Hu & Bentler, 1999). Furthermore, Hatcher (1994) noted that t- values greater than 1.96 are significant at $p < .05$; those greater than 2.58 are significant at $p < .01$; and those greater than 3.29 are significant at $p < .001$.

Reliability Analysis

Reliability is defined as the extent to which a questionnaire, test, observation or any measurement procedure produces the same results on repeated trials. In short, it is the stability or consistency of scores over time or across raters (De Vos et al., 2002).

According to DeVellis (1991) and Nunnally and Bernstein (1994), there are three aspects of reliability, namely: equivalence, stability and internal consistency (homogeneity). The first aspect, equivalence, refers to the amount of agreement between two or more instruments that are administered at nearly the same point in time. Equivalence is measured through a parallel forms procedure in which one administers alternative forms of the same measure to either the same

group or different group of respondents. The second aspect of reliability, stability, is said to occur when the same or similar scores are obtained with repeated testing with the same group of respondents. In other words, the scores are consistent from one time to the next. Stability is assessed through a test-retest procedure that involves administering the same measurement instrument to the same individuals under the same conditions after some period of time. The third aspect of reliability is internal consistency. Internal consistency concerns the extent to which items on the test or instrument are measuring the same thing. Internal consistency is estimated via the split-half reliability, coefficient alpha or the Kuder-Richardson formula 20 (KR-20). Specifically, coefficient alpha is typically used during scale development with items that have several response options (De Vos et al., 2002).

Reliability estimates can range in value from 0 to 1, and it is important to know how high this estimate must be for the scale developer to claim that a reliable measurement tool has been developed. In other words, a satisfactory level of reliability depends on how a measure is used. For the social sciences, a reliability coefficient of .70 or greater is considered acceptable (Nunnally & Bernstein, 1994). In line with this, DeVellis (1991) recommended that coefficient alpha below .60 as unacceptable, .60 to .65 undesirable, .65 to .70 minimally acceptable, .70 to .80 acceptable, .80 to .90 very good; and if much above .90 excellent. In general, high reliability coefficient is desirable as it reflects that items are homogeneous and thereby measuring the same underlying property (Nunnally & Bernstein, 1994).

2.8.2.6. Scale Validation

Validity defined as the extent to which a scale measures what it claims to measure (Gregory, 1992). Validity and reliability are related to each other. According to Rubin and

Babbie (2005), it is impossible to have validity without reliability. For instance, if a measurement tool measures what it claims to measure, then, by definition, it must be reliable.

There are different types of validity. For example, face validity, content validity, criterion related validity, construct validity, convergent validity, and discriminant validity (Rubin & Babbie, 2005). Face validity refers to the extent to which items on an instrument appear to measure a particular construct as viewed by laypersons. This common sense approach to validity is often important in convincing laypersons to allow the use of an instrument regardless of the availability of more statistical evidences (Gregory, 1992).

Criterion validity involves multiple measurements and is established by comparing scores on an instrument with an external criterion known to or believed to measure the concept being studied. It is also apparent that the criterion used should itself be valid and reliable (DeVos et al., 2002). Construct validity is a scale`s ability to measure what it is supposed to measure (Hinkin, 1998). Construct validity is perhaps the most difficult of the other major approaches to validation. The difficulty arises in part from the highly abstract nature of a construct. As a construct cannot be measured directly, its existence must be inferred from the evidence at hand (Hudson, 1981).

Convergent validity is the extent to which items in a scale correlate positively and significantly with each other. A construct is said to possess convergent validity if items of a construct are highly correlated (e.g., Netemeyer et al., 2003). For a convergent validity check, (a) Bagozzi et al. (1991) suggested that all items should load on their hypothesized dimensions with values greater than .32 and the loadings should be positive and significant. (b) Green et al. (2006) recommended for assessing convergent validity using the BentlerBonett coefficients (i.e., NFI & NNFI) with values greater than .90 indicating strong convergent validity. (c) Netemeyer

et al. (2003) stated that convergent validity is assessed through t values for the factor loadings. If all t values are above two, then this is viewed as evidence supporting convergent validity exists. (d) Hair et al. (2010) also suggested that there is convergent validity if Composite Reliability (CR) is greater than Average Variance Extracted (AVE), where the values of composite reliability and average variance extracted are greater than .70 and .50 respectively. CR which assesses the variance extracted compared to the error in the model, whereas AVE is the average of the sum of the squared standardized factor loadings and is an indication of the amount of shared variance between the items compared to the error (Hair et al., 2006b; Netemeyer et al., 2003). On top of this, the convergent validity of a new measure can also be assessed by correlating with other theoretically similar construct. If the two theoretically similar instruments correlate positively and significantly, it is evidenced that there is convergent validity (Netemeyer et al., 2003).

Discriminant validity, on the other hand, is the extent to which items representing a factor discriminate that factor from other items representing other factors (Mentzer et al., 1999). A scale exhibits discriminant validity if its constituent items estimate only one factor (Bagozzi et al., 1991). For discriminant validity check, Garver and Mentzer (1999) suggested that items from one factor should not load on a different factor. Moreover, Hair et al. (2010) suggested that if the values of Maximum Shared Squared Variance (MSV) and Average Shared Square Variance (ASSV) are less than the value of AVE, indicating that there is strong discriminant validity. In addition, if the square root of the average variance extracted of each factor is greater than its correlation coefficients with other factors, signifying discriminant validity exists (Mentzer et al., 1999). Furthermore, the discriminant validity of a new instrument can also be assessed by correlating with other theoretically distinct construct. If the two theoretically different

instruments do not correlate significantly, it is evidenced that there is discriminant validity (Netemeyer et al., 2003).

2.8.2.7. Developing Norms for a Scale

An important component of complete scale validation is the establishment of scale norms or reference scores by which responses obtained from an individual or group can be compared to some known standard (Abell et al., 2009). Developing norm is to aid in the interpretation of scores of a scale. With this regard, Spector (1992) stated that

> In order to interpret the meaning of scores, it is helpful to know something about the distribution of scores in various populations. The scale of measurement for most constructs in the social sciences is arbitrary. The meaning of a score can only be determined in relation to some frame of reference. The normative approach, which forms the basis for much social science measurement, uses the distribution of scores as that frame of reference. Hence, the score for an individual is compared to the distribution of scores. The score is considered high if it is greater than most of the distribution and it is considered low if it is smaller than most of the distribution. (p. 67)

Therefore, to understand the norm of a scale, the mean and standard deviation scores need to be reported (Urbina, 2004). Moreover, one of the considerations in the development of scale norm is the size of the normative samples. As noted by Churchill (1979), the larger sample size and the more representative of the total group, the more stable will be the norms.

2.9. Summary

In summary, varied conceptualization and measurement models of SWB exist, and although there remains no universally accepted conceptualization and measurement. The lack of

agreement regarding the conceptualization is problematic and has implications for research, policy development, and some individuals' ability to age "successfully". Although several key conceptualizations of SWB have been reviewed here, each with its own merits, current conceptualizations do not adequately capture the factors contributing to SWB, particularly in response to inclusivity, diversity, and societal changes since the term was first coined (Goodwill, 2009).

Generally, the measures identified in this review all consider several important aspects of well-being, but it is unlikely, due to the problems identified above, that anyone one measure considers them all. Of significant importance for measures to assert validity is that they include dimensions identified by old people as paramount for well-being. A consideration of how well the measures under review capture these is therefore imperative.

Old people have identified relationships, health and functioning, access to interests and activities, financial security, safe and neighbourly home environment, and purposeful existence as important for successful aging (e.g., Borglin et al., 2005; Gabriel & Bowling, 2004; Wilhelmson et al., 2005). Noteworthy, is the range in dimensionality and composition of these aspects. Whilst health, opportunities for interesting and rewarding activities, and financial security can arguably be objectively assessed by others, relationships, neighbourly environment, and purposefulness are more subjective notions with each individual assigning their own meaning to what these constitute. Nevertheless, the more 'objective' aspects, such as health, available activities, and financial security can be interpreted subjectively by individuals in great contrast to a third-person's 'objective' viewpoint (Maddox & Douglass, 1973). An appraisal of these concepts also suggests that the way well-being is conceptualised by older people involves

some combination of happiness and pleasure attainment (e.g. affective states) and the eudaimonic perspective which focuses on psychological evaluation and self-realisation.

As already discussed, measures concerned with a combination of affective and cognitive evaluations of one's life included the PWB, SPWB, LSI-A, and the WEMWBS. Of these, the LSI-A and SPWB are multi-dimensional and cover a range of dimensions thought to be associated with well-being (Goodwill, 2009). All in all, both these measures capture a number of the dimensions identified in the literature as important to old people: the SPWB taps into relationships, health and functioning, access to interesting activities, independent living and purpose in life, while the LSI-A taps into health and functioning, access to interesting activities, and purposeful existence. Whilst all measures in this review to a degree tap into some of the concepts described above, the SPWB and the LSI-A offer the most diverse understanding of the complexity of well-being (Goodwill, 2009). However, as highlighted above, the structural composite of these measures have often been difficult to replicate. Hence, the debate on how well-being is defined, understood and measured continues.

Chapter 3: Methods of the Study

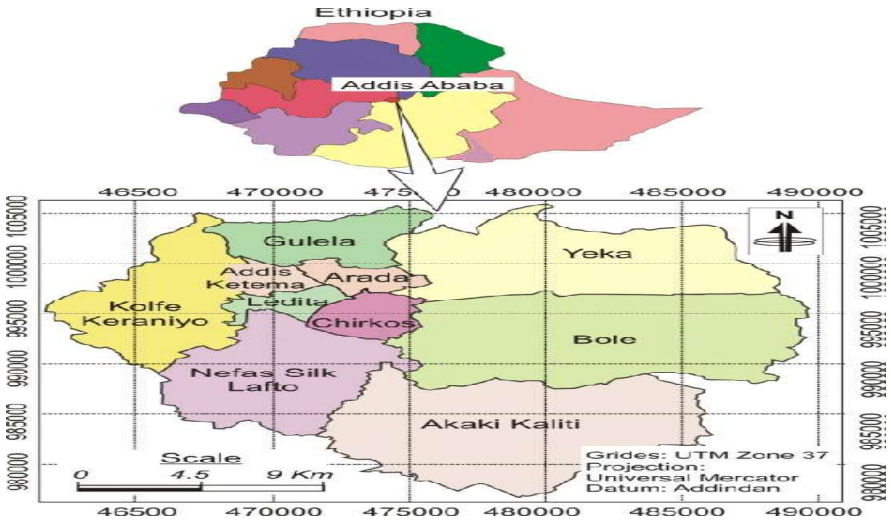
In this section, the research design, philosophical assumption of the research, the rationale for using the research design, description of the study area, data sources, sampling technique and sample size, inclusion criteria, procedures and methods of data collection, the trustworthiness of the study, data storage and retrieval, data analysis and reporting procedure, and finally ethical considerations are described.

3.1. Study Setting

The present study was conducted in Addis Ababa City Administration, Ethiopia. Addis Ababa City comprises 11 administrative sub-cities and 121 woredas. Astronomically, Addis Ababa is located at **9° 0' 19.4436" N and 39° 45' 48.999"E.** It is the capital city of Ethiopia since its emergency in 1886. It is also the home of the African Union, The Economic Commission for Africa, and other international and continental organizations. The city has an area of 540 km^2 and 2500 masl is its average elevation. The geographical map of the city is indicated as follows.

Figure 1

Sub-cities of Addis Ababa and Their Geographical Locations



According to the United Nations World Population Prospects (2024) data, the population of Addis Ababa in 2024 is 5.7 million, a 4.45% increase from 2023. Of the total population, 51.6% are females while 48.4% are males. Addis Ababa, with an estimated 420,000 older adults, has the highest concentration of older adults in the country. Estimates further indicate that the demographic share of older adults is increasing in the city (Central Statistical Agency [CSA], 2016).

The selection of Addis Ababa as the study site for this research has been erected because the area is a place where multicultural communities live together; the city can be considered a "little Ethiopia" because many retired older adults from different ethnicities and religions live in the area. Since the city holds a wide range of multicultural communities, studying the samples in Addis Ababa is believed to provide valuable information about the nature of retired older adults' SWB in the Ethiopian context, particularly in urban areas.

Specifically, this study was conducted at the Ethiopian Elderly and Pensioners National Association (EEPNA) in Addis Ababa. EEPNA is a national umbrella institution of older people in Ethiopia that works for the rights and well-being of over 6.8 million older women and men (Gebremichael et al., 2024). EEPNA has regional chapters in all regions and city administrations of the country, with its national hub in Addis Ababa. The organization was carefully selected to obtain a broad representation of retired pensioners with differing levels of functioning.

3.2. Study Design

The purpose of the present study was to explore the perspectives of retired pensioners on late life precarity, examine their conceptualization of well-being and develop and validate instrument that measures the SWB of retired older adults. Because it fits the purpose of the study, mixed-methods research design, both qualitative and quantitative approaches, were employed. The mixed methods research design, frequently referred to as the 'third methodological orientation', draws on the strengths of both qualitative and quantitative research (Creswell et al., 2011; Teddlie & Tashakkori, 2009). As mixed methods, research designs use qualitative and quantitative methods in either parallel or sequential phases (Teddlie & Tashakkori, 2009). In the present study, the sequential design was employed where qualitative methods precede quantitative methods. This type of design is Exploratory Sequential Design (Márquez & Delgado, 2017). Therefore, in this study, an exploratory sequential mixed-method research design was employed, initally to broadly explore and understand the perspectives of retired pensioners on late-life precarity and conceptualizations of subjective well-being, an exploratory qualitative method were used, and quantitative methods were used to develop and

validate instrument to measure the SWB of older adults. Thus, in this study, the sequential exploratory mixed methods design was employed through two distinct phases.

Table 3

The two distinct phases of the study

Phase	Study	Aim	Design
1	Study 1 and 2	- *Explore the current challenges of retired pensioners in Addis Ababa* - *Understand the conceptualization of subjective well-being among retired older adults in Addis Ababa*	An exploratory qualitative research approach (in-depth interview & focus group discussion)
2	Study 3	- *Development and validation of an instrument to assess retired older adults' subjective well-being*	Both qualitative and quantitative research approach (interview, FGD, pile sorting activities, and factorial analysis)

3.3. Target Population

The target population of this study was retired pensioners aged 60 years or older who were living in Addis Ababa. This is because retired older adults in Ethiopia, particularly those in urban areas, experience unprecedented political, technological, and socio-cultural changes in recent times that affect their life situation in an uncharted manner (Zerihun et al., 2024). Additionally, retired pensioners in urban areas in Ethiopia are experiencing very high inflation and continued rises in the cost of living, displacement and relocation, and significant disturbance of family and social ties that ultimately affect their well-being (Kotecho et al., 2021).

3.4. Data Sources

Primary and secondary sources of data were used to collect information pertaining to the psychological phenomena under inquiry (Dawson, 2019).

3.4.1. Primary Source of Data

Primary data for the study were collected from the participants of the study via in-depth interviews and Focus Group Discussions (FGDs) guided by open-ended questions. The kinds of questions that put the participants' encompassed throw- away questions, essential questions, and probing questions all aimed at eliciting rich data from the participants to answer the research questions amply.

3.4.2. Secondary Data of Sources

Any relevant secondary data were be exhaustively amassed from different relevant sources such as peer reviewed journals, book chapters, master's thesis, doctoral dissertations, and from different websites.

3.5. Inclusion Criteria

Rumsey and Marks (2004) point out that a meticulous decision should be made in order to set eligibility criteria for study participants. Creswell et al. (2007) states that participants who are selected for qualitative research should possess experience of the phenomenon under investigation. Additionally, the selection should be based on their goodwill and their ability to describe their experiences with the psychological phenomenon (Rumsey & Marks, 2004). For the present study, participants who met the following selection criteria were considered:

- Older adults who were resided in the community for at least six months
- Older adults who were retired
- Older adults who were registered pensioners
- Older adults who were aged 60 or older
- Older adults who were willing to participate in the study
- Older adults who were capable of describing themselves well.

3.6. Ethical Considerations

According to Arifin (2018), research ethics should serve to protect the rights and welfare of the participants at all times. Specific principles must be adhered to ensure the research is carried out according to ethical guidelines. First and foremost, the researcher was consider the regulations of the guidelines for a doctoral dissertation in Applied Developmental Psychology, and permission and ethical clearance for conducting the research was primarily obtained from the School of Psychology, Addis Ababa University. The Institutional Review Committee (IRC) of Addis Ababa University, College of Education and Behavioral Studies, approved all the research protocols (Reference No. CEBS_IRC/003/2022). After obtaining ethical approval from the Institutional Review Committee of CEBS an official letter of cooperation from Addis Ababa University, School of Psychology was sent to the respective selected EEPNA woredas offices. Furthermore, informed verbal consent was obtained from each personally contacted officer and key informants.

The research data obtained for this study is deemed private; consequently, oral informed consent is obtained from each participant after explaining the objective of the study and informing participants to keep all information discussed in the study confidential. The

participants were assured that their participation is free and they are free to withdraw at any time for any reason. Anonymity is an important ethical consideration. Hence, pseudonyms were used to protect the participants' identities. All data derived from the research process are stored safely and it will be removed after being used for the purpose at hand. As a researcher, the researcher of this study is ensured that the participants do not experience any emotional harm during the interview process and FGDs. Interviews and FGD were conducted in a safe space where participants would feel comfortable.

3.7. Phase 1: Study One and Two

- *Explore the current challenges of retired pensioners in Addis Ababa: Experience due to their meager income benefits and pensions*
- *Understand the conceptualization of subjective well-being among retired older adults in Addis Ababa, Ethiopia*

The purpose of this phase of the study was to explore the current challenges of retired pensioners in Addis Ababa and understand their conceptualization of SWB. The first phase of the study was an exploratory descriptive study with qualitative approach in nature.

3.7.1. Philosophical Assumptions of the Research

All research is founded on philosophical assumptions and paradigms concerning data collection and interpretation methods (Creswell et al., 2007). This research is based on the paradigm that acknowledges reality as subjective and contextual. The study was conducted based on the principles of a pragmatic approach to data collection and analysis. Specifically, in the present study, hermeneutical phenomenology was used to uncover the perspectives and personal

experiences of retired older adults in relation to their living situations and SWB. This approach requires a description or interpretation of the meanings of phenomena experienced by older adults in an investigation (Padilla-Díaz, 2015). In terms of ontological beliefs, the researcher assumed that a reality exists; however, believes that participants would attach different meanings to their well-being.

3.7.2. Rationale for Using Qualitative Research Method

Several researchers from the qualitative tradition agree that although no "recipe" for writing a qualitative research proposal exists, an organized rationale for the choice of a qualitative method is important (e.g., Marquez & Delgado, 2017). In the present study, the rationale for the use of qualitative methods is based on two elements. The first one is the nature of the research questions, writers from the qualitative tradition strongly suggest that the choice of qualitative methodology be made to fit the research question, since reversing this order can lead to gross mismatches. Similarly, Patton (2002) indicates that "certain purposes, questions, and situations are more consonant in qualitative methods than others" (p. 94). Patton specifies that research questions that ask "how" and "why" about a certain population or phenomenons lend themselves to qualitative inquiry. The major research question in this study is a "how" question: *How do retired older adults describe their living situations*? *How do retired older adults in Addis Ababa conceptualize their well-being?* Therefore, the exploratory nature of the inquiry in this area was well matched to qualitative methods. The second one is the nature of the population to be studied: older adults who are retired pensioner were the participants of the study.

3.7.3. Participants and Sampling Technique

The participants of the study were retired older adults aged 60 years or older who were living in Addis Ababa. In Addis Ababa city administration, there are eleven sub-cities administrations (namely: Addis Ketema, Akaky Kaliti, Arada, Bole, Gullele, Kirkos, Kolfe Keranio, Lideta, Nifas Silk-Lafto, Yeka, and Lemi Kura). Out of the total eleven sub-cities administrations, three sub-cities administrations (Addis Ketema, Yeka, and Kolfe Keranio sub-cities administrations) were selected using a purposive sampling technique. Then, two woredas from the respective three sub-cities administrations were chosen purposively with better documentation of retired pensioners. The selected woredas were woreda 11 and 9 from Yeka sub-city administration, woreda 5 and 9 from Addis Ketema sub-city administration, and woreda 1 and 7 from Kolfe Keranio sub-cities administration.

According to Chih-Pei and Chang (2017) recommendation, 3 – 15 participants for qualitative studies were adequate enough. For the present study, 13 participants (13 as a baseline) were considered an appropriate sample size for the interview as guided by the principle of "diminishing returns" (Anastas, 2004). For the Focus Group Discussion (FGDs), three FGDs were conducted with a total of 18 participants in the study area to collect relevant information about the issues. As it is recommended by Strauss and Corbin (2014), the final sample size was determined based on theoretical saturation until the living situations and conceptualization of SWB are fully explained. Thus, 31 participants were selected by purposive sampling and the researcher was try to ensure that the sample was broadly representative of the wider population in terms of religious affiliations, income level, gender, age, and education. The participants were selected for the study in collaboration with EEPNA since their coordinators had access to a pool

of potential participants and expertise in working with retired pensioners. The researchers reached out to retired pensioners who met the study criteria and invited them to participate in the study.

3.7.4. Methods of Data Collection Tools

To gather all data pertinent to the research questions for the present study, the researcher used both in-depth interviews and Focus Group Discussions (FGDs).

(a) In-depth interviews

According to Myers and Newman (2007), qualitative interviews are one of the most crucial and powerful data-gathering methods in qualitative research. Moreover, to gain an in-depth understanding of the meanings attributed to particular psychological phenomena, researchers often use interviews to elicit verbal data. In this study, in-depth interviews were employed to explore the subjective meanings participants attach to their well-being and living conditions.

The interviews were conducted with 13 purposively selected retired pensioners from six woredas across three sub-cities in Addis Ababa. The researcher developed an interview guide aligned with the objectives of the study. This guide was informed by a review of prior research and by translating the study objectives into research questions. Initially, 20 items were developed; including six main open-ended questions (see Appendix A), using the general interview guide approach described by Patton (2002). The guide was a rigid script but a flexible list of key topics and questions. In line Lincoln and Guba (1985) recommendation, the guide began with "throw-away" questions to build rapport and gather demographic information.

Throughout the interviews, the researcher used essential questions focused on the conceptualization of subjective well-being (SWB) and participants' living conditions, along with probing questions to elicit rich, detailed responses. Non-leading probes were used to encourage participants to share their perspectives openly. The data collected is understood as a reflection of the participants' subjective meanings and lived experiences.

(b) Focus Group Discussions (FGDs)

FGDs were selected as an additional data collection method due to their effectiveness in encouraging participants to express their spontaneous feelings and experiences, particularly regarding the conceptualization of SWB and their living situations. The group setting helped foster open and relaxed discussions.

The researcher developed a flexiable FGDs guide based on the study objectives (see Appendix B), allowing for participant input and adaptability (Cresswell & Poth, 2007). Concept checking was performed by summarizing key points during and after the discussions for participant confirmation. Three FGDs were conducted with 18 participants who were not involved in the in-depth interviews. The groups were organized for participants' convenience. FGD participants ranged in age from 60 to 85 years (mean=69.8 years, SD= 6.90).

3.7.5. Procedures of Data Collection

All research materials are submitted for review and approval to the Institutional Review Committee of the College of Education and Behavioral Studies (CEBS-IRC) of Addis Ababa University, before the start of the study, including the proposal, the in-depth interviews, and FGDs guides. After obtaining ethical approval from the Institutional Review Committee of

CEBS with Reference No. CEBS_IRC/003/2022; then concerned officials in the EEPNA was communicated through formal letters sent from the School of Psychology, Addis Ababa University. The researcher arranged a meeting with the EEPNA coordinators and explains the details of the study. The recruitment of potential participants involves holding discussions with EEPNA authorities to identify participants who fit the above inclusion criteria. Then, the participants of the study were tracked and contacted for recruitment before the in-depth interviews and FGDs. The participants are recruited based on the inclusion criteria mentioned earlier and then the researcher makes contact with the respective participants from six woredas in three sub-cities in Addis Ababa.

Before starting the data collections, oral informed consent was obtained from all participants of the study. Participants in both groups were also reminded that they are free to withdraw from participating in the study if they want to do so at any point in time during the interviews or the FGDs. Finally, all participants who agreed to participate in the study for both interviews and focus groups contacted by the researcher and then an appointment was made for an in-depth interview and FGDs. The interview and FGD guides were piloted with 11 (4 women and 7 men) purposively selected retired older adults from Yeka sub-city, to check the clarity and understandability of the questions. Then minor modifications and edits were made on the wording of some items.

The interview was conducted among 13 participants in the EEPNA woredas office or in participants' homes. The interview was carried out in Amharic language, the official language of the country, and also a language convenient for the participants of the study. The interviewer used a mobile phone and audio-recorder to record the entire interview and noted some key

phrases and participants' facial expressions. Both the audio records and written notes were informed to the participants before the interview. The duration of the interviews ranges from 35 minutes to 90 minutes. At the end of each interview session, the researcher transcribed the recorded interviews to avoid any missing important statements. In all, the interviews generated 200 pages of transcribed text with a spacing of one and a half lines. Essential notes were also used in tandem with the audio recordings to reduce the fear that mechanical failure might happen unexpectedly, and to facilitate the interview and analysis process of the inquiry (Patton, 2002).

For the FGDs the researcher used the EEPNA woreda office; it is a small and quiet room that is free from visual and outside distractions, with participants seated circularly behind tables. Before the discussion, the participants in each focus group were welcomed, and an explanation of the focus group's purpose was described. FGDs were audio recorded using a digital recorder and contemporaneous notes were taken. It is carried out in the Amharic language, a language convenient for the participants of the FGDs. Tapes were immediately transcribed into the Amharic language and translated into the English language. The FGDs sessions lasted from 60 minutes to 120 minutes. Finally, the researcher generated 100 pages of transcribed text from the FGDs.

3.7.6. Strategies to Ensure Research Quality

The current study has drawn upon the notion of trustworthiness proposed by Guba and Lincoln (1994) as cited by Enworo (2023) it involves a thorough conceptualization of the concepts of qualitative 'validity' and 'reliability'. The principles of credibility, transferability, dependability, and confirmability were considered in the present study to ensure the quality of the study.

According to Guba and Lincoln (1994), credibility is concerned with the compatibility of the meanings interpreted by the researcher and the actual meanings of participants. Credibility can be attained through member validation (checks) and peer evaluation; prolonged engagement with participants to the point of data saturation. In this study, duration of a maximum of two hour used allocated for each interview to allow participants to communicate a great deal of information to the point of saturation. Participants were also invited to contact the researcher if they desire to share further to allow for data saturation to be achieved. Member validation (checks) involves presenting themes to the individual participants in a follow-up interview. The aim is to allow the participants the opportunity to assess themes that emerged from the analyzed data and comment on the congruence of their feelings and the results of the study. Thus, follow-up interviews and feedback discussions were employed in this study to ensure the quality of the current study.

The second principle of Guba and Lincoln's 'trustworthiness' is transferability, which refers to "the extent to which the findings can be applied in other contexts or with other respondents". Transferability is attained by providing a comprehensive description of all aspects of the research study, including the participants and the research context. To this end, the participants and research contexts were described as extensively as possible in this study. Ensuring that participants meet the inclusion criteria for the research also contributes to the transferability of this research.

Dependability describes the extent to which the data reflects findings that are congruent with the research findings (Van der Riet & Durrheim, 2006). For this study, dependability was achieved by providing rich and thorough accounts of the development of events and situations

during the research process. To enhance the dependability of the data analysis, the technique of reading the transcripts repeatedly and rechecking the themes can be applied in this study. To ensure the dependability of this study, the researcher employed the following strategies: conceptualizing the topic clearly, ensuring participants understand the research problem, and being consistent with the data collection process.

The other principle of 'trustworthiness' is conformability, this refers to the degree to which the findings from the research process reflect the focus of the research process and are not the product of the researcher's biases (Babbie & Mouton, 2001). Qualitative research in general acknowledges the researchers' ongoing role in the research process (Chih-Pei & Chang, 2017). To ensure confirmability in the current study, the researcher was engaged in continuous supervision with a dissertation supervisor during the entire research process. The researcher also continuously reflects on his contribution to the research. Personal biases are also reflected upon and made explicit within this study.

3.7.7. Data Storage and Retrieval of the Study

Concerning data storage in this study, following the permission of the participants of the study, the interviews of each participant and FGD was audio recorded as a primary data storage method. To this end, the researcher was used a digital audio recorder. Regarding field notes, scholars assert that field notes are a secondary data storage method in qualitative studies. Patton (2002), however, argues, "The use of a tape recorder does not eliminate the need for taking notes, but does allow you to concentrate on taking strategic and focused notes, rather than attempting verbatim notes" (p. 383). Despite serving as a backup in case the audio recorder fails, taking field notes facilitates both the interview and FGDs process itself and the data transcription

process after the interview (Patton, 2002). Thus, field notes were used as a data storage method in this particular study. Thus, in this study, the researcher used both audio recording and field notes as primary data storage methods.

Concerning data retrieval of the study, the researcher use reiterative reading, listening, and meticulous transcription. Specifically, the researcher were reiteratively listen to the recorded audio and read the field notes to get familiarity with the data, thereby engaging in transcription. Data collection, retrieval, and analysis are not separate tasks but rather interrelated and cyclical (Chih-Pei & Chang, 2017).

3.7.8. Methods of Data Analysis

A thematic data analysis which is proposed by Braun and Clarke (2006) was employed to analyze the data of the study. It proceeded in an iterative fashion that moved backward and forwards from one level of analysis to another. Two researchers, who had an experience in qualitative research and learned about a thematic data analysis, participated in the data analysis. From this process, a set of themes was derived that characterized the perceptions of participants about SWB and their current living situations. In the current study, after collecting of qualitative data, the researcher listened to the audio record and transcribed them into written transcripts within 12 hours. Then 2 researchers checked their transcripts, and if any discrepancies were found, they would listen to the audio record again until they reached a consensus. Then the collected data was translated into English language by the researcher of the study. All transcripts were imported to Nvivo 10, a software used to analyze qualitative data. Data collection and analysis informed each other throughout the progress of the study.

This thematic data analysis approach has the following phases:

Phase 1: Familiarization with data

The researcher must immerse himself/herself in the data to the extent that the researcher is familiar with the depth and breadth of the content (Braun & Clarke, 2006). Thus, the researcher actively listened to the audio-recorded data several times to get familiarity with the data and after the transcription of verbal data, the researcher involves 'repeated reading' of the transcribed data, and reading the data in an active way of searching for meanings, patterns and so on. Repeated reading contributed to getting a better understanding and enhanced researchers' familiarity with the data. Moreover, the researcher spends more time familiarizing himself with the data, and also checked the transcripts back against the original audio recordings for 'accuracy'.

Phase 2: Generating initial codes

Following the initial phase, the researcher begins by active read and familiarizing himself with the data and have generated an initial list of ideas about what is in the data and what is interesting about them. Generating initial codes (coding) from the data set that had a reoccurring pattern was performed in the second phase. Coding was carried out through a systematic way of organizing and gaining meaningful characteristics of data related to the research question. The researcher began the process of initial coding; all transcriptions were coded one by one.

Codes identify a feature of the data (semantic content or latent) that appears interesting to the analyst, and refer to 'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon'. Finally, all data have been

initially coded and collated, and the researcher has a long list of the different codes that identified across the data set. The software NVivo 10 was used as a helpful tool for analysis.

Phase 3: Searching for themes

This phase, which re-focuses the analysis on the broader level of themes, rather than codes, involves sorting the different codes into potential themes and collating all the relevant coded data extracts within the identified themes (Braun & Clarke, 2006). Thus, the researcher is starting to analyze identified codes and consider how different codes may combine to form an overarching theme then the researcher uses visual representations like a thematic map to sort the different codes into themes. To visualize and explore trends and relationships in the source data, codes, and themes, tree mapping was formulated using NVivo wizards. In this phase, the researcher started to think about the relationship between codes, between themes, and between different levels of themes (e.g, main overarching themes and sub-themes within them).

Phase 4: Reviewing themes

According to Braun and Clarke (2006), recommendation phase four begins when you have devised a set of candidate themes, and it involves the refinement of those themes. Patton's (2002) dual criteria judging categories /internal homogeneity and external heterogeneity/ are worth considering here in this phase. Derived themes were reviewed in phase four of the analysis, through a cyclical process that involves back-and-forth movements between phases of data analysis until consensus was reached on the final themes. Data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes. Thus, the researcher, in this phase reviews and refines identified themes to check if the thematic

map does fit the data set or not. Finally, after further reviewing and refining of data set the researcher has devised a satisfactory thematic map of the research data. Moreover, the researcher has a fairly good idea of what different themes are, how they fit together, and the overall story they tell about the data.

Phase 5: Defining and naming themes

In phase five, researchers then define and further refine the themes that will be present for the analysis, and analyze the data within them (Braun & Clarke, 2006). Thus, in this phase, the researcher has identified the 'essence' of what each theme is about (as well as the themes overall) and determined what aspect of the data each theme captures through refining existing themes and subthemes that will be presented in the final analysis. Moreover, the researcher has clearly defined what themes are and what they are not by describing the scope and content of each theme in a couple of sentences.

Phase 6: Producing the report

According to Braun and Clarke (2006), this phase involves the final analysis and write-up of the report. The analysis (the write-up of it, including data extracts) must provide a concise, coherent, logical, non-repetitive, and interesting account of the story the data tells / within and across themes. Finally, depending on fully worked-out themes, the researcher is involved in the final analysis and write-up of the report. Here the researcher is provided sufficient evidence of the themes within the data through vivid examples and perspectives.

3.8. Phase 2: Study Three

- *Development and validation of instrument for measuring retired older adults subjective well-being in the context of Ethiopia*

The purpose of this phase of study was to develop and validate a locally relevant instrument for measuring retired older adults SWB. In order to achieve this objective, a five-phase model was proposed: The first phase of the study was designed to specify and conceptualize SWB, generate items, and determine scaling format; phase two was to assess the content validity of the instrument; phase three was to purify the scale; phase four was to assess the validity of the scale, and phase five was to develop the norm of the scale.

The development of this new SWB scale was guided by finding from a qualitative study (study two). In general, the first phases were explored qualitatively while the remaining four phases were examined quantitatively.

3.8.1. Sample and Sampling Techniques

A multistage random sampling method was employed in this study. According to Sedgwick (2015) multistage sampling involves two or more stages of random sampling depending on the hierarchical structure of natural clusters (for example, sub-cities and woredas) within the population. Addis Ababa was predetermined from the very beginning. In the first stage, four sub-cities were selected (Kolfe Keranio, Kirkos, Addis Ketema, & Yeka) randomly using a lottery method among the 11 sub-cities of Addis Ababa City Administration. The sub cities were selected based on their geographical location (West, Central, & East) to ensure wider coverage and fair representations of Addis Ababa. The procedure allowed the research to have wider coverage and

fair representation of older adults in Addis Ababa. According to EEPNA office (2022), with an estimated 110,000 retired older adults, were live in the selected four sub-cities. In the second stage, three woredas from each of the four sub-cities were selected purposively (with better documentation). A total of twelve woredas were selected to determine the sampling frame and select sample for the study. Once the wordas and number of retired older adults are identified the next step was to carry out preliminary assessment for each woredas to determine the samples eligible for the present study. Finally it was decided to randomly select participants from each woredas those who are eligible older adults as a sample. The final sample size was determined based on the factorial analysis.

3.8.2. Sample Size

Regarding instrument validation (EFA & CFA), sample size determination was based on the assumptions of factor analysis. Sample size determination was based on participant to item ratio for the first phase, and participant to parameter ratio for the second phase. As recommended by many researchers (e.g. Hair et al., 2010), a minimum participant to item ratio of at least 5:1 is required for EFA. In this phase, therefore, 276 samples were used for 46 potential items (i.e., 6:1 ratio), which were identified based on content validity analysis. Considering the non response rate, 10% of the sample was added. Hence, the total sample size was 304. Similarly, various researchers (e.g. Bentler, 1990) recommended that at least a 5:1 ratio of participants to number of parameters is required for CFA. Therefore, on the second phase, 320 samples were used for 64 parameters (i.e., number of items in the model = 27, number of errors in the model = 27, and number of correlations between factors in the model = 10), which were identified based on EFA. Considering the non response rate, 10 % of the sample was added. Hence, the total sample size

was 352. Based on this suggestion, independent samples were drawn from each woredas proportionally in two phases.

In the first phase for the EFA, a total of 304 participants aged between 60 and 74 years, were randomly selected from the twelve woredas. However, the final data analysis was made only for 272 (men=176; women=96) accounting for about 89.5 percent of the participants who appropriately and correctly responded to all items. The mean age of the study participants was 65.176 with a standard deviation of 3.767.

Secondly, to examine the a priori factor structure of the instrument, a CFA was performed. For this purpose, a second sample consisting of 352 participants were randomly selected for CFA, convergent and discriminant validity analysis. The final data analysis was made only for 259 participants (men=168; women=91) aged from 60 to 74 years old (M=65.15; SD=3.75), whereas 93 (26.4%) participants did not respond to all items. The latter were excluded from the study.

3.8.3. Method of Data Collection

In this study, both qualitative and quantitative data were gathered. In the present study first a qualitative data were collected to assess the content validity of the scale and a new scale subjected to expert judges to obtain data for assessing content validity. Based on the data obtained from the expert judges, appropriate items were selected. The selected items were then, administered to the study samples to get data for preliminary analysis such as EFA, and reliability analysis. The researcher and three experienced data collectors conducted both the qualitative and quanitiative data of the study. Socio-demographic characteristics were measured

using a structured questionnaire to collect data on gender, age, education, marital status, living arrangement, and number of children. Following this, the refined items were face to face questionnaire administered to the study samples to obtain data for EFA, CFA, convergent and discriminant validity analysis.

3.8.4. Procedure of Data Collection

Initially, permission for data collection was obtained from EEPNA office. Approval was sought from each woredas prior to data collection. The purpose of the study was explained to the participants, and informed verbal consent to participate in the study was obtained from all the participants who involved in each data collection phase. Participation was entirely voluntary, and participants' responses were kept confidential.

To achieve the purpose of the present study phase, a preliminary study was carried out by making all older adults in the selected twelve woredas fill out the assessment form. The form that inquires basic information about older adults (e.g. age, gender, retired, registered pensioners, resided in the community, aged 60 or older etc) was distributed and the required information was gathered. Based on the preliminary data findings, older adults who fulfilled the inclusion criteria were identified and 656 registered pensioners older adults were selected from the sampling frame determined for the study. Only volunteer older adults that fulfill the inclusion criteria were included in the study sample.

First qualitative data were collected using focus group discussions to generate items of SWB. Second, the generated items of the construct were subjected to expert judges to obtain data for assessing content validity. Based on the data obtained from the expert judges, appropriate

items were selected. The selected items were then, administered to the study samples to get data for preliminary analysis such as EFA, and reliability analysis. Following this, the refined items were also administered to the study samples to obtain data for CFA, convergent and discriminant validity analysis.

This study employed a systematic process to develop instrument based on established scale development and validation models such as Churchill (1979), DeVellis (2003), Hinkin (1998), and Slavec and Drnovsek (2012). In the present study, the researcher tried to adapt and integrate these models for scale development and validation in five phases.

Phase 1: Specifying the construct, generating items, and determining the scaling format

The scale development in the present study was based on the assumption of inductive approach, this approach also known as grouping or classification from below (qualitative study). In order to explore conceptualization and identify the dimensions of SWB among retired older adults in Addis Ababa, qualitative data were gathered using in-depth interviews and Focus Group Discussions (FGDs) with 31 participants in the second study of the present research and six major SWB dimensions (physical and mental health, family and social interactions, financial stability and security, optimism and autonomy, religious faith and practices, and opportunity to work and contribute to the community) were identified (Kondale Gurara et al., 2025). Then, participnats were also requested to define each of the emerged dimensions of older adults SWB.

After defining each dimensions of SWB, participants were asked to list as many indicators as possible to represent each of the identified dimensions of older adults SWB. A pile sorting exercise was used to categorize items based on their dimensions. After this process one

FGD were conducted with 10 purposively selected older adults (6 men & 4 women), therefore, all the generated items were presented to the participants one at a time and the discussion was made based on the definitions given. In line with this, if an item was misunderstood, the researcher asked them how the item could be improved.

Once the drafted items were generated, they were converted into self-descriptive statements with a five-point Likert type scale ranging from 5 (Strongly Agree) to 1 (Strongly Disagree), together with clear instruction and resulting in a 60-item first draft SWB scale (see Appendix C).

Phase 2: Content Validity

Following item generation and determining its format, the resulting lists of items were given to expert judges for assessing content validity. Following Lawshe's (1975) guidelines, ten experts were selected purposively (two each from developmental psychology, social psychology, measurement and evaluation, social work, and languages) to quantify the content validity of the instrument. This sampling method was preferred in order to get the appropriate panel experts with good knowledge, specific training and professional experience on the area of the construct.

The experts were presented with the draft of a new constructed instrument together with cover letter explaining the purpose of the study, the need for content validation of the research instrument, and the detail description of how to evaluate the items, and were requested to independently express their viewpoints regarding the contents of the draft instrument of SWB in terms of its' relevance, clarity, simplicity, and comprehensiveness (Devon et al., 2007) and then the expert panel requested to give their professional subjective judgment on the items of each

dimension of the construct. Independent of the other panelists, each panelist was asked to respond to each item. How essential is the item to measure the construct? For each item, experts assessed the relevance of each item in a three-point scale: 1= the item is essential; 2=the item is useful, but not essential; 3= the item is non-essential. According to Lawshe (1975), 0.62 minimum CVR values required for 10 numbers of experts.

They also asked to make their observations regarding grammatical errors, punctuations, the used of wordings in constructing the statements, correct order of arrangement, and scoring formats for the items. They are encouraged to provide any kinds of professional remarks that can further improve the validity of the items in the instrument. The researcher had multiple face-to-face meetings with experts to discuss the rating and wording of statements for finalizing the draft instrument. They were given seven days, after which the researcher went round and collated their inputs.

Phase 3: Scale Purification

On the scale purification phase, data were collected twice, one for assessing both EFA and reliability analysis, and the other for examining CFA, convergent and discriminant validity analysis.

After assuring the content validity of the generated items, those items were subjected to further analysis to determine the underlying factors and to meet the standards of reliability. For this purpose, items retained on the content validity phase were administered to 304 participants. Based on the participants' response, data entry was performed using IBM SPSS version 23.0 software. The data set was then checked for data entry accuracy using (a) the minimum and

maximum scores of each item to detect responses outside of the acceptable ranges, and (b) frequency distribution to detect missing data.

Following data cleaning, EFA was computed using the Principal Component Analysis extraction method varimax with Kaiser Normalization was used to determine the number of factors extracted and to select items that best represent each factor. Prior to conducting EFA, the underlying assumptions like random sampling, interval or ratio-scaled data, linearity, and normality were checked. Moreover, the two indicators (i.e., Kaiser-Meyer-Olkin measure of sampling adequacy index & Bartlett's test of sphericity) were examined to check whether the sample and the correlation matrix appropriate for EFA.

To determine the number of factors, three general rules of thumb (i.e., factors with eigenvalues greater than one (Kaiser Criterion as cited by Braeken & Van Assen, 2017); factors above the elbow line in the scree plot; & cumulative percent of variance extracted) were considered. The following specific criteria were used to retain the items that clearly load on a single factor, items loading of greater than .30 used in judging factor loadings, and item loading greater than .30 used for communality (Ford et al., 1986). This led to the final version of the scale of SWB. Following EFA, the internal consistency reliability of each factor was examined using Cronbach Alpha.

Once the number of factors and their indicators were identified with EFA, the next step was investigating whether or not the established SWB measurement model fitted the new data observed. For this purpose, CFA was employed. To do this, items refined with EFA were administered to 352 participants. After data entry, with the same procedure like EFA, error data in the database and the underlying assumptions of CFA were checked before running the

analysis. The analysis was performed using IBM SPSS with AMOS 23.0 software. The fit between the model and the data was assessed using:(1) the chi-square test; (2) alternative fit indices, such as GFI, AGFI, NFI, NNFI, RMSEA, and the chi-square/df ratio, and (3) significance tests for factor loadings.

Phase 4: Reliability and Validity Analysis

Reliability is necessary but not sufficient to establish validity (Kim, 2009). With this intent, both convergent and discriminant validity of SWB scale were evaluated. In this study, convergent validity was examined by comparing the values of CR with the values of AVE. Moreover, convergent validity was assessed using the Bentler-Bonett coefficients (NFI & NNFI), and t -values. On the other hand, discriminant validity was checked using the values of AVE compared with the values of MSV and ASSV. In addition to this, it was also assessed by comparing the square root of the average variance extracted of each factor with its correlation coefficients of other factors.

Phase 5: Developing Norms

The final phase in the scale development process was to develop norms to aid in the interpretation of scores on the scale. Therefore, the means and standard deviations of SWB sub scales were presented. Furthermore, the scoring criteria and their interpretation were addressed.

3.8.5. Methods of Data Analysis

Before data analysis, evaluation of data accuracy was done via randomly selected input of 20% of the questionnaires and all were judged as good. First, to identify the underlying factors

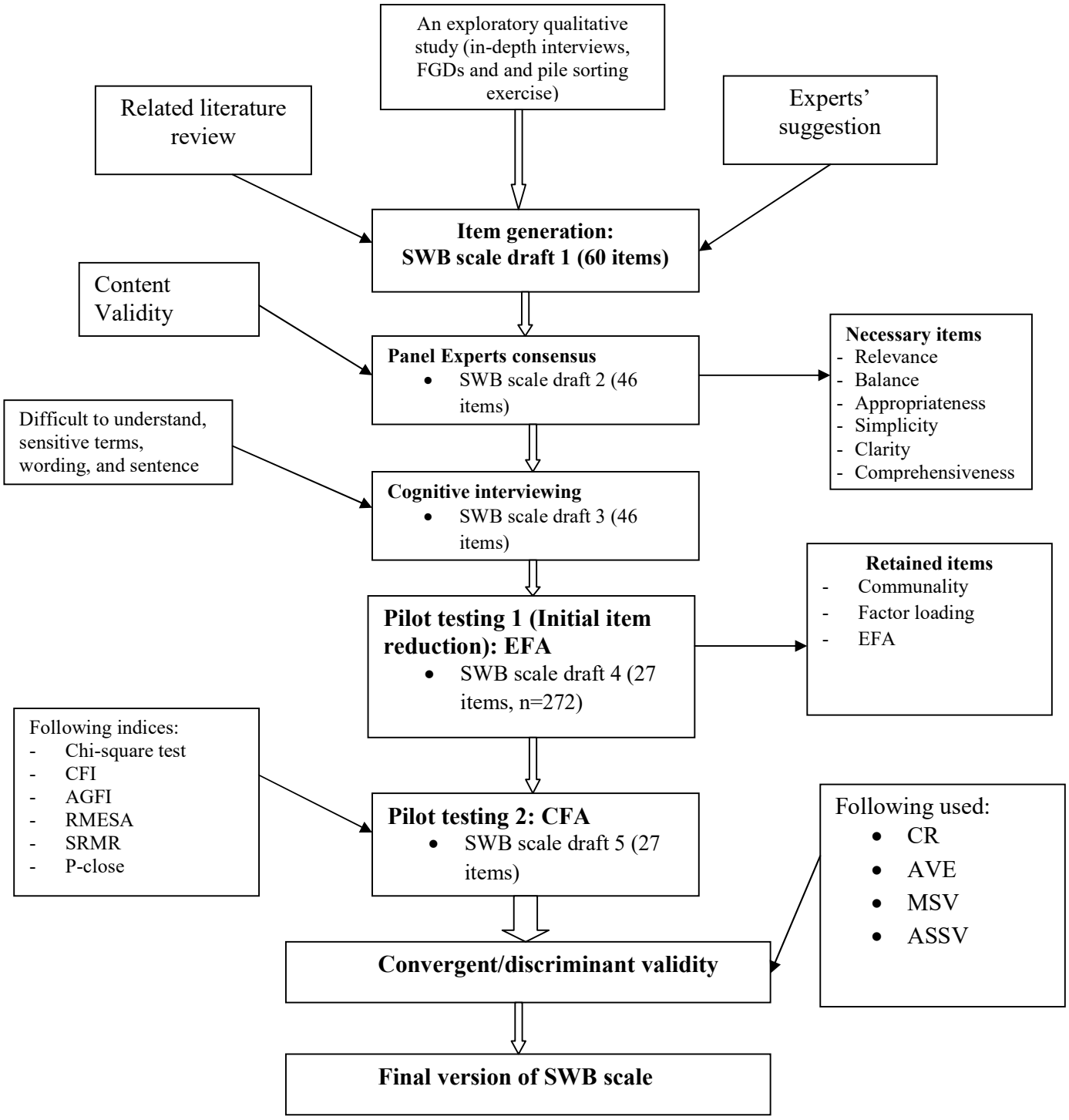
and nature of the relationship between factors of the scale an EFA was computed. Before running EFA, its assumption was checked and values of KMO (>0.60), Bartlett's test of sphericity ($P<$ 0.05), factor loading (>0.30), factor correlation matrix (>0.30), etc., were satisfied. As a result, the rotated factors were assumed to be correlated; varimax with Kaiser Normalization was used. In retaining the factor structure of the scale eigenvalues of >1, actual eigenvalues > criteria values from Monte Carlo principal components analysis for Parallel analysis, removal of items with loading values of <0.30 and exclusion of cross-loading items >0.35 in at least two factors were used as criteria and that there should be a minimum of three items on each factor (Güvendir & Özkan, 2022).

In order to examine the fitness of the model obtained via EFA, CFA was done using the maximum likelihood (ML) method. Absolute and incremental fit indices were used to estimate the sufficiency of the overall fit of the measurement models: Satorra-Bentler χ^2/df ratio (Bentler, 1990), NNFI (Bentler & Banett, 1980), CFI (Hu & Bentler, 1999), SRMR (Güvendir & Özkan, 2022; Hu & Bentler, 1999), and RMSEA (Hu & Bentler, 1999). The NNFI and CFI indices range from 0 to 1, with values above 0.900 representing an acceptable fit of the model (Bentler, 1990; Hu & Bentler, 1999). According to Güvendir and Özkan (2022), values of SRMR and RMSEA close to or lower than 0.05 demonstrate an acceptable fit. The cut-off criterion for SRMR is close to 0.080 and for RMSEA is close to 0.060 (Hu & Bentler, 1999). According to Bentler and Banett (1980), if at least 3–4 of the goodness of fit indices fall within the specified threshold, the overall model fitness is regarded as acceptable. To test the internal consistency, Güvendir and Özkan (2022) suggested that Cronbach's α coefficient should exceed 0.70 for an acceptable internal consistency.

Convergent validity of a scale can be confirmed in two ways, the first one is by examining the AVE which should be more than 0.50 and the second one is by analyzing standardized loading or composite reliability of each dimension, which needs to be greater than 0.70 (Hair et al., 2010). Discriminant validity is used to measure the extent to which the construct of each dimension differs from other dimensions. Discriminant validity of the scale can be confirmed by two methods: first one is that the ASVE of dimensions needs to be higher than the correlation square between dimensions (r^2) as suggested by Hair et al. (2010) and the second one is that all MSV and ASV values must be less than AVE.

Figure 2

Flow diagram for the procedures followed to develop and validate the SWB scale



Chapter 4: Results

In this section, detailed presentations of the study results are presented. It is organized into two phases; the first phase presents the results of study one and two, the second phase is about study three. The detailed data presentation was presented as follows.

4.1. Socio-Demographic Characteristics of the Participants in Study One and Two

The interview included 13 participants: nine men (69.2%) and four women (30.8%). The mean age of participants was 68.76 years (SD=7.27), and the majority (77%) lived with their families. Two-thirds of the participants (69.2%) were in a marital union, and only 15.4% of participants had tertiary-level education. All participants were pensioners. Regarding their religious affiliation, the majority were Christian (76.9%), with Orthodox Christians being the largest subgroup; only 23.1% were Muslim.

FGDs were conducted with 18 participants, seven women (38.9%) and eleven men (61.1%), ranging in age from 60 to 85 years (mean= 69.77 years, SD=6.90). Eight of the men were married, one was divorced, and two were widowers, while three of the women were married and four of the women were widows. Twelve participants lived with families, while six lived alone. The average household size for the twelve participants who lived with families was five persons. Four of the 18 elders were not able to read and write. In total, 14 study participants were followers of Christianity and four were Muslim. For a better understanding of their background profiles, the socio-demographic characteristics of retired pensioners' who participated in the interviews and FGDs are depicted in Table 4 and 5. Participant names were pseudonymized to protect their privacy and preserve their anonymity.

Table 4

Interview participant characteristics

Pseudonym	Sex	Age	Marital status	Educational status	Religion	No of children	Living arrangement
Ayele	M	64	Married	8th	Orthodox	4	With family
Bikila	M	63	Widowed	11th	Muslim	3	Alone
Mekuriya	M	74	Married	7th	Protestant	2	With family
Worke	F	60	Married	Not literate	Orthodox	3	With family
Etitu	F	72	Married	2nd	Orthodox	2	With family
Fole	M	65	Widowed	Not literate	Muslim	4	With family
Ketsela	M	67	Married	8th	Orthodox	3	With family
Hagos	M	80	Married	12th	Orthodox	5	With family
Etenesh	F	63	Married	6th	Protestant	2	With family
Getu	M	66	Widowed	4th	Orthodox	3	Alone
Gebiru	M	85	Married	6th	Orthodox	4	With family
Abebech	F	65	Married	Not literate	Orthodox	3	With family
Mohammed	M	70	Widowed	6th	Muslim	4	Alone

Note: Field interviews (February, 2022)

Table 5

FGD participant characteristics

Pseudonym	Sex	Age	Marital status	Educational status	Religion	No. of children	Living arrangement
Kedir	M	66	Married	6th	Muslim	7	With family
Tesema	M	71	Widowed	Not literate	Orthodox	4	Alone
Jemal	M	65	Married	3rd	Muslim	1	With family
Eshete	F	66	Widowed	Not literate	Orthodox	6	Alone
Birbo	M	64	Married	8th	Protestant	3	With family
Gelete	F	67	Married	12th	Orthodox	7	With family
Kebede	M	74	Divorced	7th	Orthodox	7	Alone
Gebiru	M	85	Married	6th	Orthodox	7	With family
Beriha	F	80	Married	12th	Muslim	5	With family
Worke	M	68	Widowers	8th	Orthodox	3	Alone
Alula	M	67	Married	3th	Orthodox	7	With family
Yohannies	M	66	Married	6th	Orthodox	7	With family
Ayelu	F	73	Widowed	3rd	Orthodox	4	Alone
Tessema	M	66	Married	4th	Orthodox	7	With family
Fikrete	F	84	Married	4th	Muslim	4	With family
Getahun	M	67	Married	12th	Orthodox	5	With family
Gete	F	67	Widowed	Not literate	Orthodox	7	Alone
Sara	F	60	Widowed	Not literate	Orthodox	4	With family

Note: Field interviews (February, 2022)

4.2. Phase 1: Study One

Title: *Explore the current challenges of retired pensioners in Addis Ababa: Experience due to their meager income benefits and pensions.*

4.2.1. The Living Situation of Retired Pensioners

The study examined the living situation of retired older adults to understand their perspectives on the challenges they face due to their meager income benefits and pensions. The concise and refined themes gained after a laborious and reiterative reduction, naming and connecting the themes attained from the raw data collected from three FGDs (18 participants) and 13 interview participants are presented in detail below.

Based on the responses gathered from the interview and FGD participants, the qualitative analysis generated five overarching themes: unattended health issues and unaffordable health care*;* absence of recreational places; lack of respect and feeling disengaged; vulnerable livelihoods and precarious lives; and the overlooked value and contributions of retired older adults. Key block quotes representing participant narratives under the identified themes are presented, along with the pseudonym.

Theme 1: Unattended health issues and unaffordable health care

"I am going through a lot of hardships"

The participants described their health conditions as challenges related to aging; they had been subjected to different health-related problems. These descriptions expressed the general conditions of older adults in the study area related to their health. The recurring sicknesses of the participants have also drained on their happiness with their situation in old age. They have

experienced synchronic sicknesses in old age like never before. The conditions have been obstacles to their active engagement in different social activities.

According to the study participants, many older adults cannot move and are confined at home or bedridden. The most commonly mentioned health problems that are widespread among older adults are visual; loss of memory; dental problems; physical disability (mobility); cardiovascular disease; diabetes mellitus; stress; and hypertension. Ketsela (Men, age 67), shared his experience of physical disability and how it affects their lives as follows:

> *There is one sister of mine; her legs are paralyzed. She cannot walk now. She had been trading since a young age to feed her family. She is a member of the elders' association. She had two sons, but we do not know where they are. Only one daughter of hers is there to support her. She used to live by selling firewood, charcoal, and animal dung at home with her granddaughter.*

Etitu (Women, age 72) described her suffering as follows:

> *As an older woman, I thought it is better to die than to continue living as I was. As I grow older, my eyesight fades, experience dental problems, physical limitations, diabetes mellitus, and hypertension. Old age has several hardships and health problems. I'm going through a lot of hardship in various ways.*

Most of them also believed that since they are old, they can easily be exposed to such health problems, and these health problems worsened the lives of older adults and increased their vulnerability to several hardships. As was indicated in the group discussions, most of them mentioned that their living conditions can expose them to different health-related problems.

Mohammed (Men, age 70) described the health status of older adults in the community as follows:

> *I have experienced synchronic sicknesses in old age like never before. We do not know whether we will die tomorrow or the day after because we have several health problems.*

Regarding health insurance services, most of the respondents stated that they have health insurance services. Since the pension is determined through direct support, older adult have been included in health insurance by default as the government organizes the healthcare services. It is being provided free of charge, and members of their families also get the service. However, some older adult still have been rejected from getting health insurance coverage because they cannot pay for it.

They also described that to get free healthcare services; they have to pay for health insurance for themselves and their families. Previously, it was declared that elderly and destitute people would get healthcare services free of charge. However, currently, they have to pay for their health insurance, and they will get the medical service. One of the main challenges they stated related to health insurance services was the amount of money they requested to get the services. Hagos (Men, age 80), shared her experience:

> *About a year before, we were paying one hundred fifty Birrs. However, now, we are asked to pay five hundred something birrs. It is only for us. If we add our family members, the payment is going to increase.*

Mekuriya (Men, age 74), shared his experience as follows:

> *Whenever a patient meets a doctor, some percent of his/her illness will be cured. For instance, if I meet a sick older man and take him to the hospital, who will accept me? They are not registered on the cards.*

Some participants stated that when the cases are severe, they are expected to pay or go to private healthcare centers. Kebede (Men, age 74), described it as follows:

> *Nevertheless, there are problems where they used to say we have to buy drugs outside at our own expense. It is a big challenge now. Especially since there is no healthcare service offered explicitly for older adults. There is not. I have never seen any healthcare service specifically being offered for older adults.*

Participants also mentioned that many older adults are still denied health insurance coverage because they cannot pay for it. In the group discussions, Ayelu (Women, age 73) shared her experience related to health insurance services and the associated challenges:

> *There are still several older adults who cannot afford such a payment because they do not have a salary or adequate pension. The pensioners themselves are even forbidden to be involved in it. They are prohibited from getting involved in the health insurance policy by covering the payment. As they do not have a pension, it will be a must that they pay for it to get the service.*

In a group discussion, most of the participants described that; even after paying for their health insurance, there are many problems the elderly face in healthcare centers. They will go

there when they are sick and get prescribed different drugs after they get diagnosed. However, they may only get one type of drug that has been prescribed. So, they will be required to buy the drugs outside. Tessema (Men, age 66), shared his experience:

> *If we cannot afford to buy from the private pharmacies, they will give us a support letter to buy from Kenema Public Pharmacies. When we go there, they usually say such a drug is not available for free; hence, we have to pay for that. Nothing we have benefited from except they are wasting the government's expenses. They used to say, 'there is no drug produced in the country; there is only a drug imported abroad, so you have to pay for that.' You will just leave at that time. There are such problems.*

Besides physical health challenges, participants reported that they have issues related to their mental health. Depression, anxiety, acute stress and other mental health disorders are becoming more common among older adults. However, older adults believe that their mental health issues are despite the high prevalence of depression, anxiety, and other mental health conditions in this population, they often go unrecognized and untreated.

In the group discussion participants expressed that their life style exposes them to a variety of mental health issues. Fole (Men, age 65), expressed his mental health problems in this way:

> *Nowadays, I feel like a constant battle between my mind and my heart. My mind tells me I'm worthless, while my heart yearns for a glimmer of hope. I am feeling trapped, and hopeless, and it's hard to see a way out from my problems.*

Participants also mentioned older adults challenges related to memory problems. Most of participants in the group discussion expressed those older adults who face memory problems, specifically in relation to depression. They are started to develop frustration and confusion associated with forgetting important details, such as the location of items, names of peoples or intended destinations. This difficulty can be distressing and impact daily functioning. Gelete (Women, age 67) expressed the issues as follows:

> *The biggest problem I am having right now, in my opinion, is losing things or forgetting where I placed them.*

Participants are at risk of a range of health problems, including chronic diseases, physical disabilities, and depression. Furthermore, the health insurance system in Ethiopia seems to be inadequate to address the health needs of older adults, especially those who are financially disadvantaged. Many older adults cannot afford the cost of health insurance, and even those who have health insurance may still face challenges in accessing healthcare services. The challenges faced by older adults in urban Ethiopia with regard to their health status have significant implications for their quality of life and well-being.

Theme 2: Absence of recreational places

"Older adults' leisure needs are not given enough attention"

According to participants of the study, one of the main challenges that older adults face nowadays is a lack of a place to spend their leisure time. Most of the participants described that the occasions and the people when older adults spent their time with them were very limited.

The majority stated that they had become estranged from one another due to a lack of a specifically organized place to spend their leisure time. Bikila (Men, age 63) described the situation concerning the lack of a specific recreation place for older adults, as follows:

> *Being an old man myself, I have observed a severe lack of leisure activities that are suited to our needs and interests. While there are many facilities and activities accessible for younger generations, it appears that elderly people's leisure needs are not given enough attention.*

Abebech (Women, age 65), also emphasized a lack of consideration for the leisure requirements of older adults, as follows:

> *The current lack of a specific recreation place for older adults leaves us feeling excluded and overlooked. It's disheartening to see the focus primarily on younger demographics while neglecting the needs of an aging population. We deserve a place where we can thrive, stay active, and continue to enjoy life to the fullest.*

Concerning to a place where older adults can spend their times, most of the participants mentioned a place such as attending religious services or local community centers. Gebiru (Men, age 85), described where older adults were spending their time, as follows:

> *Older adults who are somewhat stronger can go to church with the help of others. They can spend their time there. Where else can they go, then? Alternatively, they can expose themselves to the sunlight in their backyard. That is it. They cannot go anywhere else.*

Getu (Men, age 66), described his case as follows:

> *I spend most of my time in the church. In addition, I also have vegetables in my backyard. So, I used to take care of my garden. I used to seed -- I do not have time off.*

The other thing the participants mentioned is a lack of a permanent job. That means most of them do not even have a job and they spend their time at home. Getahun (Men, age 67), shared:

> *Well, I wander here and there. I used to take rest at home in the afternoon. I have nothing except that. The reason is I do not have any work to do. There is nowhere I go to work. I do not have my own private business to manage.*

They also described how they previously had a place to spend their time together. However, now, they have prohibited older adults from going anywhere. They do not have one specific place to spend their time; thus, they usually spend most of their time at home. Sara (Women, age 60) spoke about this situation as follows:

> *Spending time at home is a common occurrence for older adults lack of suitable recreational places. Therefore, older adults have become estranged from one another due to a lack of a specifically organized place to spend their leisure time.*

Some participants also said they might spend time with their neighbors by sharing coffee. They also described how older adults who can come away from home and have better mobility might spend their time in the Kebele retreat lounges. Concerning the Kebele retreat lounge, Ayele (Men, age 64), described the situation as follows:

> *We can go there, sit for a while, and return home because our living conditions do not allow us to spend money there. Most of the time, older people are there. Different people may spend their time there. However, elders mostly use those places in the daytime than the night. They often stay there for a short while.*

In the group discussion, some participants also stated that they would engage in intellectual activities at home (for example, reading newspapers and watching television) since they do not have places to spend their time outside the home.

The participants also mentioned the negative impact of the lack of a suitable recreational place on their well-being. In the group discussion, participants shared their view that physical activity is important for maintaining physical health and mobility in older ages, and without access to recreational places, older adults may struggle to engage in physical activity. Kedir (Men, age 66) described the negative effect of the lack of a designated place for older adults as follows:

> *Older adults who are without access to a social space or recreational place, they may struggle to maintain social connections and a sense of community. This can lead to feelings of depression, anxiety, and isolation.*

Hence, the lack of recreational places for older adults can limit their opportunities for physical activity, socialization, and engagement. Further, it has a negative effect on their mental and emotional well-being. Therefore, there is no specifically arranged place where older adults in Ethiopia can enjoy their leisure time. There is nothing at all. There is no chance, for that matter. This is the actual situation for the elderly.

Theme 3: Lack of respect and feeling disengaged

"They don't consider older adults as human beings"

The participants described their social participation as contexts for the adverse events they had been subjected to, and these descriptions expressed a general pattern of vulnerability to stigma and discrimination. Most believe that older adults are segregated from society's activities and are not receiving the required respect and attention from their communities and the government. Consequently, their engagement in social and community activities is becoming very low. Abebech (Women, age 65) mentioned her experience relating to the lack of respect for older adults in the community, as follows:

> *We had a tradition where older adult were respected among all the people in previous times. For example, if I have an older brother, I have to respect him because he is older than me. However, now, such a tradition is being forgotten. It is not there. In the places where we go, there are no people who may invite us to take their chairs by getting up themselves. It is difficult to say there is such respect.*

Participants reported feeling more isolated from their community and confined to their homes. In the group discussions, participants noted the changing relationships within families and communities, in particular, the lack of respect younger people showed toward older generations. Many participants felt no sense of belonging and found it difficult to receive support from neighbors. Etitu (Women, age 72) mentioned her experience as follows:

If you take the case with transportation, it is all the same. The respect is not there. The situations where older people are being respected are very limited. It is just dropping from time to time. The situation looks like this.

Most said that they think older adult in their community have not received the care they deserve. Even people in their surroundings do not visit older adult and cannot even collaborate to help them. Majority of the participants expressed feelings of social isolation, loneliness, and depression. These feelings were associated with their confinement to their homes and lack of interaction with family and friends. Ayelu (Women, age 73) described her experience as follows:

I am alone, no one cares about me, no one protects me, no one asks me about my living situation, and nobody even comes to my house; it is horrible.

All participants in the group discussion shared stories about respect for older adults and described younger people's disrespectful behaviors toward older people. Most of them believe that this generation is very difficult for older adults, stating that they just scorn at their parents rather than look after them. Participants also stated that older adults are not being treated well; they are discriminated against and not taken care of well, even by their children. Whenever people are aging, they might be isolated from many things. They may even be stigmatized and influenced by their children. Fole (Men, age 65) shared his experience as follows:

There is a situation where rich people send their parents to old age homes. Their parents gave birth to them, reared them, educated them, and helped them until they became independent. However, such people try to pay for their parents to be cared

> *for by others because they don't want to see them suffer. They try to hand them over to the institutions. There are such people, which is something despicable.*

Most of them also mentioned that older adults could not enjoy their prestigious social position as before because of a lack of love and respect from society. Ketsela (Men, age 65) described it as follows:

> *At this time, this situation has deteriorated. It has weakened. People who used to ask me have decreased. We are losing the most important thing in the old days. They don't consider older people as human beings.*

Kedir (Men, age 66) shared as follows:

> *Starting from the pejorative naming given against older adults from the outset….nowadays, even the generation. Let me tell you one thing; God has given me time to look after my mother and father. I feel sad when I see them.*

Further, their health status or lack of good health may result in older adults' isolation from social bonds. Most participants mentioned that older adults could play a significant role in social and community activities. Mohammed (Men, age 70) shared his view about the value of older adults as follows:

> *If there are people who have quarreled, if there are problems, people request me to mediate the issue. Most people also agree with that. If some people have been ostracized, we take them back home and support them.*

In the group discussion, participants with strong social support networks explained that their relationships and interactions brought them happiness and comfort and expressed gratitude for those who cared for them. Yohannies (Men, age 66) positively mentioned the community's perception of older adults, as follows:

> *The other thing is that they are not as stereotyped or stigmatized by the community because people are improving in awareness and education since older adults are provided with free healthcare services to treat their illnesses. Yet, they may not have someone to take them to healthcare institutions.*

Getu (Men, age 66) shared his view concerning the value of caring for older people as follows:

> *I am sure that the blessings of my parents have kept me alive. If I can hide their flaws, I will just harvest what I sowed tomorrow. Therefore, whenever I take care of my parents, my children will -- When I would get annoyed by my mother and express this, my children used to stand against me. All my daughters and sons used to take care of her. When they did so, I used to thank them and say "The care you are giving her today will bring you benefits from God tomorrow."*

The lack of respect and attention toward older adults in Ethiopia can have a significant impact on their social participation and sense of belonging in their communities. Social isolation and loneliness are common problems among older adults, and the lack of social support and interaction can lead to feelings of depression and anxiety. In general, there is inadequate or no formal care and support for older adults, and those provided by family members are dwindling due to several factors.

Theme 4: Vulnerable livelihood and precarious life

"The government does not care about us"

Most said that some older adults benefit from the pension payment, while others get direct support from the government and others are not benefited. Most of the participants stated that they do not have any additional sources of income than their pension. As stated by most participants, children are also the other source of livelihood. Etenesh (Women, age 63) described this issue as follows:

> *My children mainly provide for me. The government does not care about us. Even though what my children give me is insufficient, I still manage. Old age is like a curse because you do not have what you need. It is suffering. It is only when my children visit me that I am sure of even feeding well.*

Fikrete (Women, age 84), shared her experience as follows:

> *Although my children provide for me because I do not have any other means, their support is inadequate because they do not have good jobs. They are the only ones that are taking care of me.*

Bikila (Men, age 63) shared as follows:

> *My life is good; thanks to God. My children are already there. I have my own house. At about the end of my life, I bought a small piece of land and built a house. That strength came in because of my children. And my life is well; thanks to God.*

In relation to the pension payment system, most said that they were facing several difficulties. This money was paid via a bank. It can't be deposited in the bank book and to collect the money, their physical presence is required. If three months pass without collecting the money, they will be canceled from the benefits package. In this regard, most said that older adults face a number of problems with the bank. Getu (Men, age 66) described his experience as follows:

> *She is mentally ill. They have to ask for her presence even if she is mentally sick. As a result, I have taken the case to court, and it has been decided with the help of witnesses. She is now bedridden. She is being taken care of on her bed.*

Bikila (Men, age 63) described the situation as follows:

> *They even came in and warned us. If we do not take the money for three consecutive months, we will be considered as if we have a comfortable life. It was just after that time that I decided to take the money once in two months.*

Ayele (Men, age 64) were described as follows:

> *I am very sick but no one wants to accept my condition. So, I am forced to take my 'dead body' to the bank to collect my three hundred birrs.*

In the case of transportation, most said that they usually take the money once every two months to minimize the cost of a taxi. This is very difficult for most of them. Gebiru (Men, age 85) shared:

We have to pay one to two hundred Birr for a taxi to bring three hundred Birr from the Bank. Sometimes, we use to take a payment for two months at a time But, if three months have passed away, they will terminate the payment, assuming that someone does not need the money.

All of the participants stated that the cost of living is becoming very difficult. Hagos (Men, age 80) described the situation as follows:

We can't buy Teff or something else with the pension. Things are expensive at this time. Can I manage it to buy Teff with one thousand or something Birrs at this time? On top of that, I have been given with wheat flour last time. I use to bake small bread with it and eat with my children; be it with cabbage or 'Shiro'. But, the Teff is verily expensive. The situation is horrible. The situation is too much horrible.

There is also an inadequate provision of funding for nursing homes and community care services for the elderly in Ethiopia. The very few institutional homes for the aged are not funded adequately. Pension, the only formal social security in place, is not received on time or at all; it also has inadequate coverage. In traditional societies to have as many children as possible is common because children were sources of wealth, old age security and social and political prestige. Therefore, the elderly viewed children as a source of care and support and had as many as possible in their old age.

In addition, the rising cost of living has now become unpredictable and turbulent. Etenesh (Women, age 63) described this situation as follows:

My living standard is just very low. I mean ... when I say it is very low, the increasing cost of living seriously affects our lives, especially for elders. The income we get right now is very low. Because of this ... the government is the one who made it low. Since we were working with a low salary before retirement, our pension is also low. It has even been one thousand five hundred Birrs very recently because the government increased the scale some time ago. Immediately before I retired, my salary was three hundred five Birrs. Therefore, the economic burden has started since I retired.

Bikila (Men, age 63) shared his situations as follows:

I don't have any work. My living condition is this one you are seeing. I don't have a pension. I do not have any work to do. I am simply sitting idle at this time. I rent one small room for one thousand two hundred Birr. We make a living with that money. Government is under the curse of God for abandoning us and not making plans for us."

Most said that some older adults take care of their grandchildren even if they live in tough conditions. They stressed that it is possible to imagine how life could be difficult for them. Fole (Men, age 65) shared his experience as follows:

I am raring my orphaned grandchildren as their mother, my daughter, has passed away. I have four children as well. So, I am much troubled because of them.

Participants also mentioned that even older adults in their community who were considered better off economically were living at a subsistence level because of the high cost of living and inflation. Sara (Women, age 60) shared her experience as follows:

Forget my living condition; people with a high economic class, high salary, and those engaged in good businesses are facing challenges nowadays. The issue of the increasing cost of living is even worse among older people, affecting their income and living conditions.

Most of the participants in the group discussions described the living standards of the elderly, especially non-pensioners, as being at their worst and not difficult to witness. The situation is a good witness, even if we don't speak it. Birbo (Men, age 64) shared this life as follows:

I have retired while my salary was two hundred seventy Birr. I have entered into one thousand Birrs in recent times. What can be bought with one thousand Birrs nowadays? Forget the other things; it can't even buy a cabbage. The living situation is very difficult. However, I thank God, for He has given me a better health. . I just thanks to God for I am being healthy. Forget my living condition; people with a high economic class, high salary, and those engaged in good businesses are being challenged nowadays. The challenge of the increasing cost of living is even worst among elderly people; in relation to their income and living conditions.

Beriha (Women, age 80) described the living standards of the elderly as follows:

Concerning the living standard…. It is difficult to say we are living. There is nothing we predict how we live to say like this or like that. The reason is that the cost of living is increasing alarmingly. We are getting up to one thousand five hundred Ethiopian Birrs per month! But, how much is the dollar transacted? It is being transacted up to

fifty something Birrs. We are not just living. But, God…. I am telling you frankly; as God told us in his words like '"yeteekefte guroro sayizega ayadirm" (translated God feeds everyone), we do not stay a day without having something to eat. We used to eat whatever we got, whether roasted cereals or 'Injera.' Thanks to God. However, if we take this as life, it is difficult to say we are living.

Based on their story, the challenges that elderly people face nowadays with aging are more painful and agonizing. Most said that they were living a lower standard of life. Most of them don't have any source of permanent income. When they described their living standard, the situation was worsening from time to time. In addition, the increasing cost of living has a serious effect on people's lives, especially the elderly. The income they get right now is very low. Since they were working with a low salary before retirement, their pension was also low. Most participants believed that the economic burden starts at their retirement time. Even if they decide to work, no one wants to create opportunities for them. Most of them say they are in the worst situation.

Theme 5: The overlooked value and contribution of older adults

"If we provide the opportunity for older adults, they can be involved"

Despite the physical, mental, social, and financial hardships described by participants, several expressed their belief that older adults could play a significant role in social and community activities. Regarding their economic contribution, participants in the FGDs argue that rather than being a drain on resources, older adults are a foundation to provide positive economic contributions and social glue to the community. Kedir (Men, age 66) described the economic contribution of older adults:

> *I know older farmers who are actively involved in the farm workforce and plant different vegetables and crops. If we provide the opportunity for older adults, they can be involved in the labour market, for example, men in construction and trading, and older women as housemaids, traders, domestic support workers, and craft makers.*

Some participants shared that older adults are the mainstay of many families and households by providing financial assistance, care, and support to their families. Hagos (Men, age 80) described the contribution of older adults:

> *These days, we regularly support and care for our family members, providing financial support to them. I mean, we are sharing our pension benefits with our family members.*

In addition to financial contributions, most participants mentioned that older adults could play a significant role in social and community activities. Mohammed (Men, age 70) shared his view about the value of older adults as follows:

> *If there are people who are in conflict, people request me to mediate. Our engagement fosters a sense of purpose, promotes social connections, and contributes to the overall well-being of individuals and communities.*

Regarding the welfare of the community, participants believed that older adults have a wealth of knowledge and lived experience and continue to contribute to the welfare of their community. Getu (Men, age 66) described the contribution of older adults as follows:

In times of crisis or war, older adults will play a role in resolving conflict between parties. Even if we provide opportunities, they will play an important part in the reconstruction efforts and mentoring younger people.

Participants also reflected on the contribution of older adults as primary caregivers for children. Sara (Women, age 60) shared her experience as follows:

Far from being a burden on the local community, older adults in our community are providing care and struggling to provide the necessary food, shelter, and emotional support for younger generations and their extended families. They can sacrifice their own needs just for the sake of their grandchildren following the deaths of their children.

In the group discussion, most believe that elderly people do have great potential. Older adults with exceptional quality, knowledge, and potential are being wasted by sitting idle, as there is no opportunity to work and apply their potential. Most said that if they are given a chance to be involved in development activities like farming or animal breeding, they have the potential to handle it successfully. Alula (Men, age 67) described the capability of older adults as follows:

Even older adults can move a rock with two men, while ten young men cannot do it. I am telling the truth; there are many knowledgeable people here. But where can they move? Their limbs are already tied up. They are choked. Where can they go? What can they do? Except for such constraints, there are many older adults with amazing potential and skills. So, the situation looks like this.

4.3. Phase 1: Study Two

Title*: Understand the Conceptualization of Subjective Well-Being among Retired Older Adults in Addis Ababa, Ethiopia.*

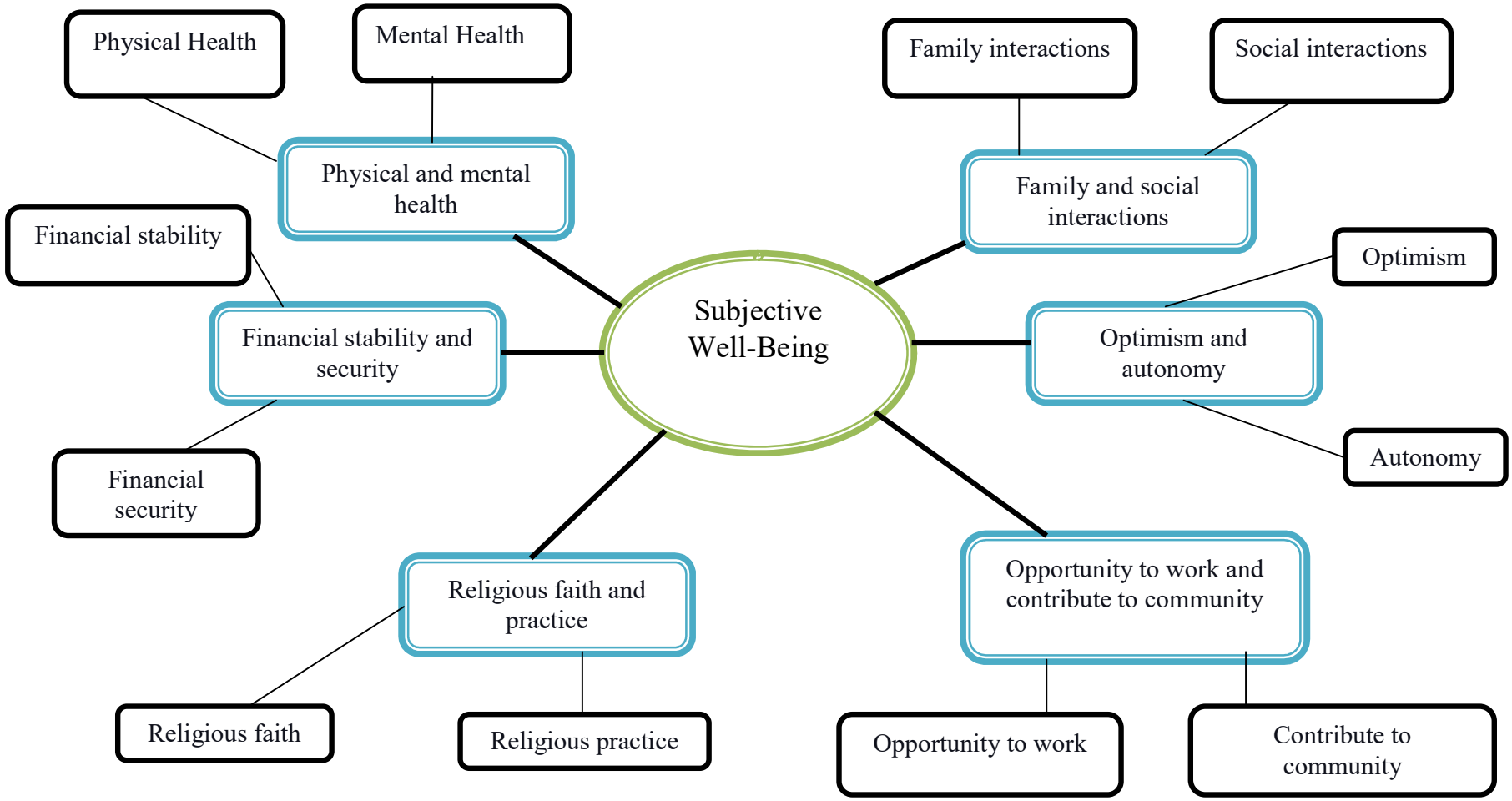
4.3.1. Conceptualization of Subjective Well-Being

The study aimed to explore the conceptualization of SWB from the perspective of retired older adults in Ethiopia. In the beginning, the researcher identified several themes, and the researcher tried to connect common themes across individual themes that emerged from the individual narrations of the participants in an effort to form superordinate themes. Then, the researcher named the themes based on their essential essence (Braun & Clarke, 2006).

Six major themes were generated, giving insight into the participants' perspectives about their own well-being. The six themes identified were *physical and mental well-being, family and social interactions, financial stability and security, optimism and autonomy, religious faith and practices, and opportunity to work and contribute to the community*. Key quotes representing participants' perspectives are presented to substantiate each theme. Older adults' conceptualization of SWB is based on a combination of social, psychological, physical, financial, environmental, and spiritual aspects.

Figure 3

The SWB conceptual framework emerged from qualitative phase



Theme 1: Physical and mental health

"A good life meant a person is physically and mentally healthy."

The first theme revolved around physical and mental well-being, highlighting the participants' perspectives on maintaining good physical and mental health. Most of them stated that maintenance of physical and mental health is the most stated health-related dimension among the participants concerning their well-being. Being an older adult was not a problem by itself, the ambiguity was that older adults might be healthy, skillful, and knowledgeable, and they can no longer take it for granted. These experiences are linked to two indicators, including physical well-being and mental well-being. Etitu (Women, age 72) shared her view about the link between physical and mental well-being as follows:

> *Staying active and taking care of my body allows me to enjoy life and maintain a positive mindset.*

They use the following phrases related to physical well-being: having good physical appearances, self-care, eating and sleeping, sufficient bodily resources, mobility, and engaging in healthy behaviors (e.g., free from substance abuse, doing physical exercise activity) were viewed as important indicators in older adults' SWB. Getu (Men, age 66) described his view as follows:

> *A good life or well-being meant a person is physically healthy; if he/she is in good physical condition, he/she can be engaged in physical labor and lead their life. If he/she is sick and substance abuse, however, he/she cannot be in a good well-being.*

Kedir (Men, age 66) shared his experience about the effect of substance abuse on well-being as follows:

> *Substance abuse can impact aging well; it includes alcohol, cigarettes, and other people indulging in different things. I do not think such people can live well. Whenever those obstacles thwart the health of older adults, it will also affect their family members. This, in turn, affects their well-being.*

Bikila (Men, age 63) shared his view on the value of basic needs on well-being as follows:

> *Someone with well-being is capable of eating and drinking good things; someone capable of taking showers, washing one's clothes, and getting dressed well. This will make the person happy.*

The participants in the interviews and group discussions frequently talked about staying active in terms of physical functioning, which was viewed as a useful tool for aging well. Staying active was also connected to good physical functioning, helping older adults to maintain good physical functioning and keep good health. Moreover, being active was also connected with continuing to work. Work is frequently mentioned by participants as a positive indicator of subjective well-being. Active involvement in work was also considered an important attribute for good physical health and aging well throughout the interview and group discussion participants.

The participants expressed the importance of doing some work to stay active and energetic. Frequently, most of the participants said that aging well can be achieved with one job activity. Satisfaction is up to the standard of work of the individual; be it healthy or ill. Satisfaction is

going to be judged based on the work effort we make. Birbo (Men, age 64) described this issue as follows:

> *If someone is physically disabled, they cannot lead their lives according to their potentiality for work and effort to sustain them. This will be difficult if the working potential and the support they receive are limited. If they get the support, however, it will be easy.*

Etenesh (Women, age 63) shared older adults' challenges related to work as follows:

> *It is possible to work. For example, if capable older adults are interested in working, they will have economic restrictions. I mean, finance. Secondly, they may not have the chance to access land even if they have health and strength. If they even get the money to start a business on a loan, they may face problems with scarcity of land. Therefore, older adults have financial constraints. Given such chances, the older adults capable of working are interested in being engaged at work.*

For the interview participants, aging well meant when an older adult was physically healthy, able to accomplish his/her daily routine, and free from different diseases. Etenesh (Women, age 63) shared her perspective about healthy aging:

> *What I call healthy aging does not involve diabetes, high blood pressure, kidney, and other diseases. If an older person does not have these [diseases], you may call that healthy aging. I was sick and diagnosed with Bone TB. I had anemia. You call a person healthy when she/he eats and drinks what she/he wants. I, for*

example, no longer drink liquor. I will get sick. We consider a person old when she/he gets physically weak, stays home, becomes inactive, etc.

Maintaining good mental health is also mentioned as an important dimension of subjective well-being among retired older adults. They use the following phrases related to good mental health: being mentally alert, having a good memory, being free from stress and depression, having a positive attitude, hope, and being optimistic. In a group discussion, participants described ways to maintain good mental health, including mental exercise, reading, playing games, learning new things, challenging themselves, and engaging in hobbies and creative activities, which were significant for their well-being. Mekuriya (Men, age 74) shared his view as follows:

It goes beyond eating and drinking something. The main satisfaction and well-being are that if someone has no psychological problems and no substance addiction if he's healthy or can take his time with friends, it is a great well-being.

Moreover, participants of the study indicated the value of reading newspapers and books, watching TV, playing mental games, and listening to the radio to be important to keep their mental health and to age well. Mohammed (Men, age 70) shared his experiences:

If, for example, people are stressed, annoyed, or saddened, will this, in turn, affect their well-being so that they have to actively engage in a mental activity like reading newspapers and watching TV every day.

Ketsela (Men, age 67) shared:

> *People with some mental and physical illnesses cannot be the same as other people. It has its influence. Like me, someone who is mentally healthy can perform anything confidently.*

The general mental health status of older adults has implications not only for their well-being but also for society's well-being in general. Birbo (Men, age 64) described this issue as follows:

> *Older adults contribute to society in many ways–whether within their family, local community, or society more broadly. However, the extent of these resources and the opportunities available as we age will heavily depend on one key characteristic: our mental health.… If declines in physical and mental capacities dominate these added years, the implications for older adult and society may be much more damaging.*

As the participants realized, the aging body would make their body and mind vulnerable and may cause physical or mental discomfort. The participants disclosed problems in sleeping, reading, hearing, and moving. Sometimes, the participants admitted they perceived themselves that they were more able than they were in reality. Healthy aging was considered a blessing. For the participants, healthy aging meant when a person was healthy and could work, accomplish his/her daily routine without a problem, and have a good appetite for food.

Theme 2: Family and social interactions

"I feel a deep sense of contentment…when I am engaged in meaningful social interactions."

The second theme identified was family and social interactions, encompassing the participants' perceptions of their family and community relationships, social engagement, and

social support. Family and community relationships have been repeatedly reflected as an indicator of social well-being. Participants highlighted the need to have good relationships and engagement with spouses, family, friends, and children to age well. Most of the participants also described how important it was for them to be accepted, recognized, and involved in family and community life. As one participant, Abebech (Women, age 65) eloquently, expressed:

> *I am very close to my family, so that definitely, keeps me alive and well. If I didn't have them, I don't know what the hell I would do. I feel a deep sense of contentment and happiness when I am surrounded by my loved ones and engaged in meaningful social interactions.*

Etenesh (Women, age 63) shared her experience:

> *Living peacefully in a family or one's surroundings is a good indication of our well-being. This is an important point, not only for me but also for other older adults to think about.*

Participants also described the importance of relating with others to age well. Older adults described the importance of maintaining close relationships with others and socializing with friends. Most said that it is possible to attain healthy aging through bonding with other people. Mekuriya (Men, age 74) shared his view as follows:

> *If someone has no interaction with people and cannot exchange ideas, nothing will be acquired and will affect our well-being. Yes, it is hard to live alone, but I go out and share on different occasions; social contact is a good motivator for us as we grow old to be well.*

Living with children can be considered as important to their well-being. Gebiru (Men, age 85) described his view about the value of living with children in old age as follows:

> *I am living with my children. My children are always around me whenever I need them, which helps a lot; they do not let me alone at all, which is why I am living well now.*

Concerning social engagement, most of them point out that an activity in the community provides life satisfaction, an opportunity to gain respect, happiness, social inclusion, and a good aging. The participants indicated that activities including communication with others, participation in the community (volunteering, cultural activities), religious activities (church attendance, praying, listening to spiritual songs), and leisure activities (physical exercise) are essential for their subjective well-being. Therefore, remaining active in activities that older adults like and community involvement can indicate their social well-being. Etitu (Women, age 72) shared as follows:

> *Our engagement with different social activities is an important indicator of our well-being, which includes continuing to be productive and contribute to society, being out and about, staying active and involved, and engagement in activities that provide pleasure or benefit and goods for us.*

In FGDs, participation in neighbourhood events, religious activity, and community events (e.g., community voluntary work, conflict resolution) was described by participants as a helpful tool for older adults to stay socially active. The participants reflected on how voluntary work or

being involved in charitable work may enhance their well-being. Worke (Men, age 60) described as follows:

> *Social and community involvement, strength in one's path of faith, and health are good means to achieve subjective well-being.*

Participants in the study also mentioned the importance of receiving social support from children, families, and significant others to age well. Most stated that their support from family, friends, community, and government (environmental and social policies) can significantly contribute to their well-being. Moreover, they described having access to social support as providing social support to family, friends, and neighbors, which helped to ward off boredom and loneliness and was a source of encouragement or motivation in staying healthy. Mohammed (Men, age 70) stated as follows:

> *If we get that social support from different institutions like religious centers, the weaker people will be strong.*

Kebede (Men, age 74) shared his experience as follows:

> *I am now walking because of the support that I received from my children's and others' good deeds. Older adult like to be fed like young children. They need to be fed now and then.*

The social network was also frequently mentioned among the study participants concerning their subjective well-being. The social networks that older adults have in their lives could be essential to accessing different support. Most participants mentioned that being isolated

and lonely might seriously hinder their well-being. In the group discussion, Getahun (Men, age 67) mentioned the value of social networks as follows:

> *I believe that our active relationship with others can mitigate the negative effects of loneliness and alleviate feelings of alienation and isolation that can be detrimental to well-being.*

The participants thought they still had the courage and strength of a younger person. The participants believed that work was important, and they perceived themselves as less happy when they could not work. They enjoyed working, and they preferred independence instead of living on support from others. Ketsela (Men, age 67) mentioned his views as follows:

> *Never… I don't feel old. I can do whatever any healthy young person can do. There is nothing that worries me. I still have the courage and strength. When I see people doing something, I get motivated to participate. I do not choose between jobs. I do anything. I am still strong and very healthy. I feel bad about living on support from others. You should rely on yourself. You might someday get in a conflict with the people who support you and something bad might happen. Thus, it is good to depend only on oneself.*

Most of the participants believed that modernization and urbanization have severely eroded their social well-being, and this has exposed them to vulnerability and social neglect.

Theme 3: Financial stability and security

"This sense of financial security empowers me…."

Most of the participants described the role of financial stability and security as being integral to their subjective well-being. Throughout the interview and group discussion, older adults viewed feeling financially secure and being satisfied with financial status as the most important determinants of their subjective well-being. Mohammed (Men, age 70) shared his view as follows:

> *So, good life is meant wealth. If someone has sufficient money, he will be happy and will not worry about anything. He will have a happy life. Life is all about money. If someone doesn't have enough money, he is going to be worried about what to eat and what to dress. Someone who don't have adequate money will have a lot of worries. He will just lead a stress-driven life; they can't live happily.*

Abebech (Women, age 65) emphasized the value of financial well-being for older adults to age well, as follows:

> *Having enough financial resources to meet basic needs gives me peace and security.*

Etenesh (Women, age 63) expressed the issues as follows:

> *If someone does not have enough money, he/she will be worried about what to eat and dress. Someone who does not have adequate money will have a lot of worries and life stress. They will just lead a stress-driven life; they can't live happily.*

Furthermore, Fikrete (Women, age 84) shared her valuable insights on this matter, as follows:

> *By attaining financial well-being, I am not only able to meet my immediate obligations but also to plan for the future. This sense of financial security empowers me to make choices that align with my values and aspirations, contributing significantly to my overall well-being.*

Throughout the interview and group discussion, older adults viewed they are not feeling financially secure and being satisfied with their financial status as the most important determinants of their well-being. Ketsela (Men, age 67), also shared his perspective on financial well-being as follows:

> *Financial stability allows older adults to lead lives without constant worry and uncertainty. It grants older adults the freedom to pursue their aspirations, invest in their future, and create a sense of abundance for themselves and their loved ones.*

According to the participants of the study, financial security and satisfaction was particularly important in terms of having enough money through paid employment or retirement/pension to support oneself in meeting basic needs, to manage life pressures, meeting living expenses, accessing and maintaining health insurance, and maintaining a sense of independence. Worke (Men, age 60) described his view as follows:

> *Next to health is work. If someone has a job, it will contribute for having a good health. The other thing is money. If someone has money and has the strength to work, he can work. These are the important things.*

Most participants in the present study stated that financial wealth is more important for increasing older adults' subjective well-being. Insecurity in financial status constrains older adults' opportunities for stable relationships, personal expressiveness, and their productivity. Thus, it can not only interfere with satisfaction of physical needs, such as food and shelter, but it can also block access to exercising competencies, pursuing interests, and maintaining relationships, which would provide psychological needs satisfaction. Thus, among older adults in Ethiopia, the value of money for satisfying needs may be more critical than having access to some basic resources for pursuing their goals.

Theme 4: Optimism and autonomy

"I am blessed. There are a lot of things that are not so good in my life, but I try and think positively—we have to."

Other attributes that were mentioned by participants in relation to their SWB are optimism and autonomy. Throughout the interview and group discussion, older adults were described as being able to do things that one likes to do without help; living independently; taking care of oneself without depending on others; maintaining good mobility; and well-functioning motor skills are viewed as the indicators of SWB. Frequently, the participants of the study use the following phrases to describe the role of personal characteristics in their well-being including: adapting to the aging body, accepting the aging process, use coping techniques, maturation, and living to an advanced age. One participant, Getu (Men, age 66), eloquently expressed as follows:

> *Being true to myself, embracing my strengths, and dedicating myself to constant learning and personal growth contribute significantly to my overall well-being.*

Yohannies (Men, age 66) shared his experience as follows:

> *I think older adults need to adapt to the normal physical changes of the body, such as graying hair, changes to eyes and hearing, mobility, and chronic diseases without much complaint, and being able to take one day at a time and accept the new role of old age with dignity by having realistic expectations.*

Most participants frequently mentioned not being or becoming a burden to others. During the interactive discussions, the participants reflected on the necessity of staying independent in performing their daily life activities, including personal and instrumental ones. Etenesh (Women, age 63) shared her experience:

> *I am taking care of myself, my health is good, I need to stay healthy and mentally oriented, so I won't seek anybody help. This helped me to be well.*

So, apart from the participants' living status (alone or with family), the importance of being independent was connected with the autonomous status of the older adults. From the accounts of the participants, it appeared that they were concerned about their future lives. Simply put, they would not have dependable caregivers if they became completely reliant on them for their care. Thus, they wish they would die before they become dependent on others for their care. Fole (Men, age 65) shared:

> *I live alone, I have a big house. I do everything by myself; nobody brings me even a glass of water.*

Participants in the group discussion frequently stated the importance of positive thinking about their well-being. Most said that older adults must maintain a positive attitude and mental outlook, celebrate and accept old age, be happy and satisfied with life, choose gratitude instead of worries, have peace of mind, maintain emotional well-being, engage in positive thinking, and being optimistic, have self-acceptance and self-contentment, focus on the present, acknowledge accomplishments, invest in oneself, and engage in humor and happiness. The older adults described the need to maintain a positive attitude despite changes due to aging, such as not being able to perform the same activities that one could when younger. Gebiru (Men, age 85) shared his views as follows:

> *These older adults are people. We, all human beings, are not the same. Our thinking is different. If all the people can protect their dignity, everything is wide open. Dignity or respect is essential, whether with a family, strangers, or people away from home or neighbors. We just need to keep our dignity. If we can keep our dignity, we will face nothing.*

Optimism is strongly linked to indicators of older adults' well-being. Most participants stated that optimism is a powerful personal resource at all stages of life. It helps the capacity to hope, visualize desirable events in the future, and anticipate with confidence that these will occur. Older adults in the study describe the greater value of being optimistic in old age when there is illness and disability. Abebech (Women, age 65) shared as follows:

> *I am blessed. There are a lot of things that are not so good in my life, but I try and think positively – we have to.*

Another participant, Ketsela (Men, age 67), shared his thoughts on the theme, stating,

> *Embracing my individuality and celebrating my authentic self has been an empowering experience. It allows me to cultivate a sense of self-worth, confidence, and inner harmony, contributing profoundly to my well-being.*

Moreover, Bikila (Men, age 63) offered valuable insights, saying,

> *Recognizing and honoring my values, passions, and aspirations has been transformative. It enables me to align my actions with my true self, fostering a sense of fulfillment and a deep connection to my innermost desires.*

These narratives exemplify the significance of personality in shaping older adult well-being. By embracing authenticity, personal strengths, and a commitment to continuous growth, individuals can cultivate a sense of self-empowerment, inner harmony, and alignment with their core values and aspirations.

Theme 5: Religious faith and practices

"Throughout my life, my religious faith has been my guiding light, and it remains an essential source of my well-being and happiness."

In the interviews and group discussions, religious faith and practice are frequently mentioned by the study participants as contributing factors to their SWB. Participants also described religion as a source of hope, happiness, and peace in their later lives. Some older adults expressed that getting old was a gift from heaven and being involved in church, religion, and spirituality was important, gave meaning or a sense of purpose in life, and helped in preparing for the end of life. Gebiru (Men, age 85) described the issues as follows,

> *A strong faith in God provides invaluable guidance, comfort, solace, and a profound sense of purpose. Even it allows me to age with a sense of fulfillment and contentment.*

Participants also described religion as a source of hope, happiness, and peace in their later lives. Some older adults expressed that getting old was a gift from heaven and being involved in religious practice such as attending church and spirituality was important, gave meaning or a sense of purpose in life, and helped prepare for the end of life. Mohammed (Men, age 70) shared as follows:

> *Allah has never troubled me in my entire life. I have never been troubled. I am living with great happiness. I have already let my children get married. I am happy, except I feel sick right now. I was so happy. I can't do anything.*

Bikila (63 year old man) shared his perspective of how religious faith contributes to his well-being:

> *Throughout my life, my religious faith has been my guiding light, and it remains an essential source of my well-being and happiness, I can find relief and a deep sense of internal peace that helps me in facing the challenges of older adult in Ethiopia through my prayer and religious activities.*

Kedir (Men, age 66) shared:

> *Do you know what a good life is? Only Allah can bestow a good life on you. Allah will give people with an ample amount of wealth. My faith in Allah reminds me that I am never alone and that there is always a reason to keep moving forward.*

Concerning religious engagement, Gebiru (Men, age 85) shared:

> *I think someone who is engaged in one's religion will get a great benefit. No one should negotiate about their religion. People have to excel in their religion more than anything. Everything will appear as they are whenever I am strong enough in faith. If we cannot do it that way, it will negatively affect our well-being.*

Fikrete (Women, age 84) shared her view about the value of religious engagement in her well-being:

> *Being a part of religious activities such as rituals, prayers, and spiritual teachings has helped to promote my overall well-being as I grow older. The fellowship, support, and shared values within my religious group provide a sense of belonging and social connection that enriches my life and helps me face the challenges of aging with resilience.*

Another participant, Fole (Men, age 65), eloquently described the transformative power of spirituality,

> *Through my spiritual practices and devotion, I find inner peace and a deep sense of harmony with the universe. It is within this sacred space that I discover strength, resilience, and a renewed sense of hope.*

Furthermore, Etenesh (Women, age 63) conveyed the impact of faith on her well-being:

> *My unwavering faith in God sustains me through life's trials and tribulations. It instills in me a sense of optimism, grounding, and a belief in something greater than myself.*

Most of the participants described that religious faith and practices encompasses a sense of purpose, meaning, and connection to something greater than oneself. It involves exploring and nurturing one's beliefs, values, and personal identity, as well as engaging in practices that promote a sense of inner peace and fulfillment. Therefore, it plays a vital role in the lives of many Ethiopian older adults, providing a framework for understanding the meaning of life, coping with challenges, and finding solace in times of adversity.

Theme 6: Opportunity to work and contribute to the community

"Age should never be a barrier to pursuing our passions."

Opportunity to work and to contribute meaningfully in one's community was reviled as key dimensions of subjective well-being for Ethiopian older adults. These emerged as significant factors influencing the quality of life and sense of fulfillment among the elderly population in Ethiopia.

Opportunities to work

Participants frequently associated well-being with the ability to continue working. Having opportunities to work was frequently mentioned by participants as a positive indicator of subjective well-being. The participants expressed the importance of doing some work to stay active and energetic. Most participants believe aging well can be achieved through job activity.

Work satisfaction is judged based on individual effort and standard of work. Opportunity to work emerged as a positive indicator of subjective well-being among Ethiopian older adults. Birbo (Men, age 64) emphasized the value of older adults' knowledge and expertise:

> *I believe that we have a wealth of knowledge and expertise that can contribute significantly to the workforce. While age may bring certain physical limitations, it does not diminish our ability to work effectively and make meaningful contributions. With the right support and accommodations, we can continue to excel and thrive in our chosen careers.*

Etenesh (Women, age 63) highlighted the importance of inclusive work environments:

> *As older adults, we have a lifetime of skills, knowledge, and work experience that can benefit organizations. It's crucial for society to acknowledge and tap into the potential of older adults, creating inclusive work environments that value and utilize the talents of individuals across all age groups.*

Participants' believe that it is important to provide opportunity for older adults to continue working. It keeps them engaged, mentally stimulated, and connected to the broader community. Kedir (Men, age 66) stated that:

> *I believe that as long as we are willing and able, age should never be a barrier to pursuing our passions and contributing to society through meaningful work. I am confident in my ability to continue making valuable contributions in the workforce.*

Etenesh (Women, age 63) also pointed out some challenges older adults face:

> *It is possible to work. For example, if capable older adults are interested in working, they will have economic restrictions. I mean, finance. Secondly, they may not have the chance to access land even if they have health and strength. If they even get the money to start a business on a loan, they may face problems with scarcity of land. Therefore, older adults have financial constraints. Given such chances, the older adults capable of working are interested in being engaged at work.*

Most respondents stated that older adults still can work, including in cloth making, cotton spinning, tailoring, baking Injera, teaching and guiding the next generation, and other work where they can be successful. Therefore, if older adults are gathered, organized, and given a place to work, they can still contribute to their well-being and the welfare of society. Some other respondents said that older adults can still teach and guide the next generation through their knowledge and experience. Abebech (Women, age 65) shared as follows:

> *If they come across the opportunities, however, they can work. There are also other sectors where elders can be engaged by organizing themselves. For example, they can be engaged in baking 'Injera' through associations. Elders can manage such things on their own. They do have the potential. Differently, with their ages, they have the same abilities. Some younger people lack the abilities. This might be caused by diseases or poor health. Yet, there are a lot of older people capable of working.*

The ability to work seems like it is very important to the participants in relation to maintain their well-being. Ability to work is one of the dimensions of SWB that are important to Ethiopian elders for their well-being. Many participants prefer to continue working as long as they are physically and mentally capable, as it provides a sense of well-being and fulfillment in life.

Contributing to the community

Participants strongly associated aging well with making contributions to their communities. This emerged as another crucial dimension of Ethiopian older adults' well-being. Most of them stated that older adults contribute to society in many ways–whether within their family, local community, or society more broadly if they get the opportunity. Nearly all participants believed that older adults can contribute to the community's well-being. Community contribution is seen as vital for well-being. Ayele (Men, age 64) emphasized the importance of community problem-solving:

> *Since we are leading our own respective homes, one way or another, we share the same neighbourhood. Whenever problems arise, there are ways they could be settled through traditional mechanisms. So, we have to consolidate on such means. However, for someone who deviates from that, we can do nothing except distance ourselves from them; this can affect our well-being.*

Another participant, Fole (Men, age 65), described older adults' active community engagement:

> *We actively seek opportunities to contribute our knowledge, skills, and experiences for the betterment of society. Older adults take pride in sharing their*

> *wisdom, mentoring younger generations, helping to resolve conflicts in our neighborhoods, and actively participating in community development projects; this can contribute for our well-being.*

Participants believed that older adults possess a deep understanding of our cultural heritage and traditional practices. And they can play a vital role in preserving and passing on this knowledge to younger generations, ensuring the continuity of our rich cultural identity. Gebiru (Men, age 85) highlighted the role of older adults in preserving cultural heritage:

> *I think older adults are the custodians of our oral traditions, storytelling, and cultural practices. We actively engage in passing down these traditions to preserve our heritage and reinforce a sense of identity and pride within our communities.*

The opportunity to work and contribute to the community emerged as crucial dimensions of subjective well-being for Ethiopian older adults. These factors provide a sense of purpose, engagement, and fulfillment in later life.

4.4. Phase 2: Study Three

Title: *Development and validation of an instrument to assess retired older adults' subjective well-being.*

This section presented the results of the study three in accordance with the proposed model for development and validation of older adult SWB scale.

4.4.1. Specifying the Construct (Older Adults' SWB)

The first phase of the proposed scale development and validation process of this study was specifying the construct. In study two, 31 retired older adults in in-depth interview and FGD were identified six major themes of SWB. These six themes were the following: *(1) physical and mental well-being, (2) family and social interactions, (3) financial stability and security, (4) optimism and autonomy, (5) religious faith and practice, and (6) opportunity to work and contribute to the community*. Once the dimensions of SWB were identified, the next task was defining each SWB dimensions. Then, participants in the FGD 1 (4 men and 3 women) were asked to define the six dimensions of retired older adults SWB they listed. Therefore, they defined these dimensions of SWB as illustrated in Table 6.

Table 6

Dimensions of SWB and their definition

Dimensions of SWB	Definition
Physical and mental well-being	*This dimension refers to maintaining good physical and mental health. It includes aspects such as physical appearances, self-care, proper nutrition and sleep, sufficient bodily strength and mobility, and engaging in healthy behaviors (e.g., free from substance abuse, regular physical activity). It also encompasses mental alertness, good memory, a positive attitude, hope, and optimism.*
Family and social interactions	*This dimension refers to having satisfying family and community relationships. It involves feeling accepted, recognized, and actively involved in family and community life. It also emphasizes the importance of maintaining strong, meaningful connections and engagement with spouses, family, friends, and children.*
Financial stability and security	*This dimension refers feeling financially secure and being satisfied with one's financial situation. It inloves having enough money, paid employment or retirement/pension, having sufficient financial resources to meet basic needs, adequate pensions and benefits, managing life pressures, and preserving independence and freedom to plan for the future and pursue aspirations.*
Optimism and autonomy	*This dimension refers to the ability to engage in activities one enjoys independently, without relying on others. It includes living independently; practicing self-care, maintaining good mobility, and adapting to the physical changes associated with aging. It also involves accepting the aging process, using effective coping techniques, demonstrating personal growth and maturity, and well-functioning motor skills.*
Religious faith and practice	*This dimension refers to having faith in God and being engaged in religious activities, church involvement, and personal and spirituality.*
Opportunity to work and contribute to the community	*This dimension refers to the ability to continue working, having opportunities for employment or meaningful tasks, staying active and energetic through work, and making valuable contributions to the communities.*

After dimensions of SWB have been defined, the process of item generation followed. Therefore, participants in the FGD 1 were asked to list as many indicators as possible to represent each of the six identified dimensions of SWB. As a result, 11 items for physical and mental well-being, 10 items for family and social interactions, 9 items for financial stability and

security, 9 items for optimism and autonomy, 14 items for religious faith and practice, and 7 items for opportunity to work and contribute to the community were generated. Totally, 60 items of SWB scale were generated (see Appendix C).

4.4.2. Content Validity Assessment

On this phase, the generated 60 draft items with the definitions of the six dimensions of SWB were subjected to 10 expert judges to rate each item as *(3) Not necessary; (2) Useful but not essential; (1) Essential.* As a result content validity assessment, 46 items had Content Validity Ratio (CVR) score over the acceptable threshold (>0.62), whereas 14 items had a CVR less than the ideal value (<0.62) (Lawshe, 1975). Then, cognitive debriefing was done with 5 older adults (3 men; 2 women) on the 46 items. Additionally, a panel of five experts from the EEPNA evaluated item clarity and assessed reliability. The experts' meticulous examination revealed no issues regarding clarity, indicating a high level of understanding and reliability in the evaluated items.

A face to face questionnaire was developed in which the first part contains items about socio-demographic characteristics of the participants (age, gender, education, marriage status, religious, and living arrangement) and the second part constitutes the 46 SWB items rated on a 5-point Likert scale (1= strongly disagree to 5= strongly agree) (see Appendix D). After securing the necessary approvals and participant informed verbal consent, the scale was administered to 656 retired older adults for further analysis, in two phases.

4.4.3. Scale Purification

Exploratory Factor Analysis

Participants' Characteristics

Of the total 272 participants who completed the questionnaire, 176 (64.70%) were men and 96 (35.3%) were women. The age range of participants was 60 to 74 years old (mean = 65.17, SD = 3.76). Regarding marital status, 117 (43.0%) were married, 51 (18.8%) were separated, 78 (28.7%) were widowed, and 26 (9.6%) were divorced. As for the level of education, 33 (12.1%) could not read and write, 184 (67.7%) had primary school completed, 33 (12.1%) could not read and write, 184 (67.7%) completed primary school, 33 (12.1%) completed secondary school, and 22 (8.1%) completed college. The religious composition was 140 (51.5%) orthodox, 95 (34.9%) muslim, 28 (10.3%) protestant, and 9 (3.3%) other religious groups. Living arrangements showed 164 (60.3%) living with family and 108 (39.7%) living alone.

Table 7

Socio-demographic characteristics of participants (n= 272)

Characteristics	Participants	
	Frequency	**%**
Gender		
Women	96	35.3
Men	176	64.7
Age (in years)		
Range (Minimum-Maximum)	60-74	
Mean (SD)	65.17 (3.76)	
Marital Status		
Married	117	43.0
Separated	51	18.8
Widowers	78	28.7
Divorced	26	9.6
Education		
Cannot read and write	33	12.1
Primary school	184	67.7
Secondary school	33	12.1
College	22	8.1
Religion		
Orthodox	140	51.5
Muslim	95	34.9
Protestant	28	10.3
Others	9	3.3
Living arrangement		
With family	164	60.3
Alone	108	39.7

Before running the EFA, an item analysis procedure was conducted on the 46 items of SWB scale. The result of the initial factor extraction on the 46-item draft SWB scale indicated that 19 items were removed because the initial communalities were lower than 0.30 and did not significantly load (loadings < 0.30) onto any factors. This resulted in a 27-item scale. The Bartlett's test of sphericity was statistically significant (χ = 5085.859, df = 351, P < .001), and the Kaiser–Meyer–Olkin statistic (KMO = 0.810 (>0.60)) was greater than its threshold value of .60, and the participant-item ratio of 10:1 (i.e., 272/27) was met. Data from this study

demonstrated a normal distribution with no univariate or multivariate outliers or curvilinear relations among items; therefore, the data were deemed suitable for EFA.

The remaining 27 items were subjected to principal component analysis with varimax rotation. The rotated factor loading matrix was evaluated and analyzed thoroughly. In the rotated factor pattern, items having a factor loading equal to or greater than 0.30 are generally considered as a part of the proposed dimension. The principal component analysis of older adult SWB items was produced for the five factors with an eigenvalue of more than one (as shown in Figure 3). Table 8 shows the descriptive statistics and reliability among the proposed instruments of older adult SWB scale.

Table 8

Descriptive statistics and reliability of variables (n= 272)

Dimensions of older adult SWB	No. of Items	Mean	SD	Cronbach's *a*	Skewness		Kurtosis	
					Statistic	Std. Error	Statistic	Std. Error
PMH	6	14.51	5.84	.846	.425	.148	-.644	.294
OA	5	13.51	4.92	.894	.127	.148	-1.241	.294
FSI	5	14.08	4.86	.854	-.063	.148	-.786	.294
RFP	7	21.94	7.57	.938	-.291	.148	-.870	.294
FSS	4	8.10	2.80	.875	.541	.148	.407	.294

Source: The author.

Notes*: PMH (Physical & Mental Health); OA (Optimism & Autonomy); SW (Family & Social interactions); RFP (Religious Faith & Practices); FSS (Financial Stability & Security).*

Considering the internal consistencies of the dimensions of the new instrument, the "religious faith and practices" was seen as the most reliable factor with a high Cronbach reliability value of 0.938, which was followed by "optimism and autonomy" (0.894), "financial

stability and security" (0.875), "family and social interactions" (0.854), and "physical and mental health" (0.846), being the lowest. Each of these dimensions had more than three item indicators. Furthermore, the reliability results through Cronbach's alpha were found to be acceptable for each dimension from 0.846 to 0.938. The reliability of the draft SWB instrument (27 items) was better and acceptable (Cronbach's alpha = 0.759). Table 9 presented the distribution of the instrument with 27 retained items after deletion. Overall, the results of this study indicated that the NEWLY DEVELOPED SCALE is a reliable measure of SWB.

Table 9

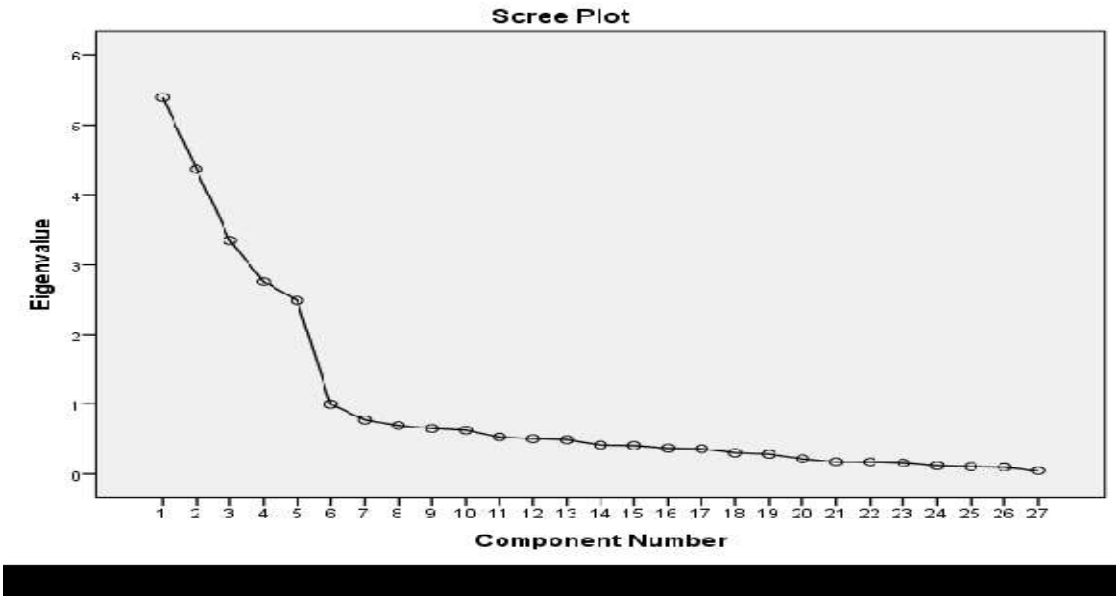
The distribution of the SWB scale data used for EFA (n= 272)

Scale	No. of items	M	SD	Median	Mode	Skew	Kurt	Min.	Max.
SWB	27	72.15	11.95	73.00	78.00	-.179	-.275	40.00	105.00

Source: The author.

Figure 4

Scree plot of items and their eigenvalue



Source: The author

Moreover, inspection from the scree plot was done, and the turning point was observed at factor five with transition points between factors with high and low eigenvalues. Finally, Monte Carlo PCA for Parallel which could compare the actual eigenvalues with its corresponding criterion values was inspected and verified that the five-factor solution was supported. These evidenced that a five-factor solution derived from the total variance explained is the best principal component solution for the scale.

Table 10

The eigenvalues, total percentage of variance, and the cumulative percentage of variance accounted for by the five factors

	Total	**Initial Eigenvalues % of Variance**	**Cumulative %**
1 RFP	5.393	19.972	19.972
2 OA	4.370	16.184	36.156
3 PMH	3.353	12.417	48.573
4 FSI	2.759	10.219	58.792
5 FSS	2.497	9.247	**68.038**

Source: The author.
***Notes**: PMH (Physical and Mental Health); OA (Optimism and Autonomy); FSI (Family and Social Interactions); RFP (Religious Faith and Practices); FSS (Financial Stability and Security).*

In this regard, Varimax Rotation with Kaiser Normalization and an absolute value of the standardized factor loading of >0.3 were set to run the analysis. The computed PCA suggested a five-factorial solution with eigenvalues >1, explaining a total of 68.038% of the variance.

Factor 1 is religious faith and practices. Religious faith and practices relate to all aspects of religious life, including relationship with God, prayer and religious activities, viewing aging as a gift from heaven, optimism and a sense of purpose and meaning in life, a sense of belonging, and preparing for the end of life and so on. This factor consists of seven items—for example, 'I

view aging as a gift from heaven'. The variance explained by this dimension is 19.97 percent with an eigenvalue of 5.39.

Factor 2 is optimism and autonomy. It consists of items related to adapting to the aging body, having a positive outlook on life, being independent in daily activities, accepting the aging process, coping, living in a new reality, making valuable contributions in the workforce, maturation, and living to an advanced age. This factor consists of 5 items—for example, 'I am confident in my ability to make valuable contributions in the workforce despite my age'. The variance explained by this dimension is 16.18 percent with an eigenvalue of 4.37.

Factor 3 is physical and mental health which involves performing basic self-care tasks independently (e.g., eating, bathing, dressing), accomplishing daily routine without difficulty, engaging in work and self-care activities, being mentally alert, having a good memory, staying optimistic, and so on. This factor consists of six items—for example, 'I can perform basic self-care tasks independently (e.g., eating, bathing, dressing)'. The variance explained by this dimension is 12.41 percent with an eigenvalue of 3.35.

Factor 4 is family and social interactions. It includes engaging in meaningful social interactions, feeling accepted and recognized, involving in family and community life, living peacefully with family and surroundings, having a positive connection with children, receiving support, contributing to the community, and ability to work. This factor consists of 5 items for example, 'I have a positive connection with my children'. The variance explained by this dimension is 10.21 percent with an eigenvalue of 2.75.

Factor 5 is financial stability and security which involves having enough money, paid employment or retirement/pension, having sufficient financial resources to meet basic needs, adequate pensions and benefits, managing life pressures, and preserving independence and freedom to plan for the future and pursue aspirations. This factor consists of four items—for example, 'I have sufficient financial resources to meet my basic needs'. The variance explained by this dimension is 9.24 percent with an eigenvalue of 2.49.

The total variance explained by all items of the older adult SWB scale is 68.038%. The findings of EFA representing the respective factor loadings of 27 items along with their respective dimensions are provided in Table 11. The magnitude of factor loadings ranged from .699 to .938.

Table 11

Rotated component matrix of older adult SWB (n=272)

Rotated Component Matrix[a]					
	Component				
	1	2	3	4	5
Religious faith and practices					
1. My religious faith serves as an essential source of happiness in my life.	.895				
2. I find a deep sense of internal peace through religious activities.	.863				
3. I view aging as a gift from heaven.	.848				
4. My faith reminds me that I am never alone.	.794				
5. My religious belief gives me a sense of purpose.	.854				
6. My religious group provides a sense of belonging that helps me face aging challenges with resilience.	.856				
7. My faith in God sustains me through life's challenges.	.857				
Optimism and autonomy					
1. Despite life's challenges, I maintain a positive outlook on my circumstances.		.836			
2. I adapt well to the changes in my body as I age.		.857			
3. I maintain independence in my daily activities		.861			
4. I believe that age should not prevent me from pursuing my passions.		.834			
5. I am confident in my ability to make valuable contributions in the workforce despite my age.		.775			
Physical and mental health					
1. I am in a good physical health to lead my future life well.			.852		
2. I can perform basic self-care tasks independently.			.717		
3. I accomplish my daily routine without difficulty.			.706		
4. In this day, I felt downhearted and depressed.			.717		
5. Engaging in work keeps me mentally stimulated.			.791		
6. I maintain good mental health.			.699		
Family and social interactions					
1. I experience a deep sense of contentment when engaged in meaningful social interactions.				.831	
2. I feel accepted in family life.				.775	
3. I live peacefully with peoples in my surroundings.				.768	
4. I have a positive connection with my children.				.813	
5. I am not isolated or lonely				.732	
Financial stability and security					
1. I have a sense of financial security that empowers me to make choices aligned with my values and aspirations.					.725
2. I have sufficient financial resources to meet my basic needs.					.938
3. My current income adequately meets my financial needs.					.899
4. My financial situation allows me to cope with life pressures.					.834

Source: The author.

Notes*:*

- *Loadings >.3 are in boldface. F1: RFP, F2: OA, F3: PMH, F4: FSI & F5: FSS*

- *Extraction Method: Principal Component Analysis.*
- *Rotation Method: Varimax with Kaiser Normalization.*
- *Rotation converged in five iterations.*

The above table summarizes the item loadings for each factor. Findings from this study showed that the 27 items in the newly developed measure of older adults' SWB tapped physical and mental health, financial stability and security, family and social interactions, optimism and autonomy, and religious faith and practices. Each of these factors had more than three item indicators. On the basis of exploratory analysis, the researcher confirmed that the older adult well-being scale comprised five dimensions with their corresponding 27 items: religious faith and practices (7 items), physical and mental health (6), family and social interactions (5 items), optimism and autonomy (5 items), and financial stability and security (4 items). Overall, the results of this study indicated that the SWBS is a reliable measure of retired older adults' well-being. Therefore, a total of 27 items of the scale with 5-factor structures were retained for CFA (see Appendix E).

Reliability Analysis

The most common method of assessing internal consistency reliability estimates is through the use of coefficient alpha. Therefore, the reliability estimate for internal consistency was computed based on Cronbach's Alpha for each of the five SWB subscales (see Table 12). The reliability estimates for physical and mental health, family and social interactions, optimism and autonomy, financial stability and security, and religious faith and practices SWB subscales were .848, .854, .894, .875, and .938 respectively.

Table 12

Items and reliability coefficients of the five SWB subscales (n = 272)

Subscale	Items	No of items	Reliability coefficient
Religious faith and practices	1,2,3,4,5,6,7	7	.938
Optimism and autonomy	8,9,10,11,12	5	.894
Physical and mental health	13,14,15,16,17,18	6	.848
Family and social interactions	19,20,21,22,23	5	.854
Financial stability and security	24,25,26,27	4	.875

Confirmatory Factor Analysis

Participants' Characteristics

Following EFA and reliability analysis, the final 27 items were administered to 352 participants to carry out CFA. Of the total 259 participants who completed the questionnaire, 168 (64.9%) were men and 91 (35.1%) were women. The age range of participants was 60 to 74 years old (mean = 65.15, SD = 3.75). Regarding marital status, 113 (43.6%) were married, 49 (18.9%) were separated, 73 (28.2%) were widowers, and 24 (9.3%) were divorced. As for the level of education, 31 (12.0%) could not read and write, 184 (67.7%) had primary school completed, 33 (12.1%) could not read and write, 176 (67.9%) completed primary school, 31 (12.0%) completed secondary school, and 21 (8.1%) completed college. The religious composition was 134 (51.7%) orthodox, 89 (34.4%) muslim, 27 (10.4%) protestant, and 9 (3.3%) other religious groups. Living arrangements showed 156 (60.2%) living with family and 103 (39.8%) living alone.

Table 13

Socio-demographic characteristics of participants (n= 259)

Characteristics	Participants	
	Frequency	**%**
Gender		
Women	91	35.1
Men	168	64.9
Age (in years)		
Range (Minimum-Maximum)	60-74	
Mean (SD)	65.15 (3.75)	
Marital Status		
Married	113	43.6
Separated	49	18.9
Widowers	73	28.2
Divorced	24	9.3
Education		
Cannot read and write	31	12.0
Primary school	176	67.9
Secondary school	31	12.0
College	21	8.1
Religion		
Orthodox	134	51.7
Muslim	89	34.4
Protestant	27	10.4
Others	9	3.3
Living arrangement		
With family	156	60.2
Alone	103	39.8

To confirm the measurement model of the SWBS and formally assess its construct validity, a CFA was performed with Sample 2 (n=259). The hypothesized model was assessed through AMOS version 23 maximum likelihood factor analyses. Furthermore, the basic assumptions of CFA were checked for each scale and were found to be tenable.

Table 14

The distribution of the SWB data used for CFA (n= 259)

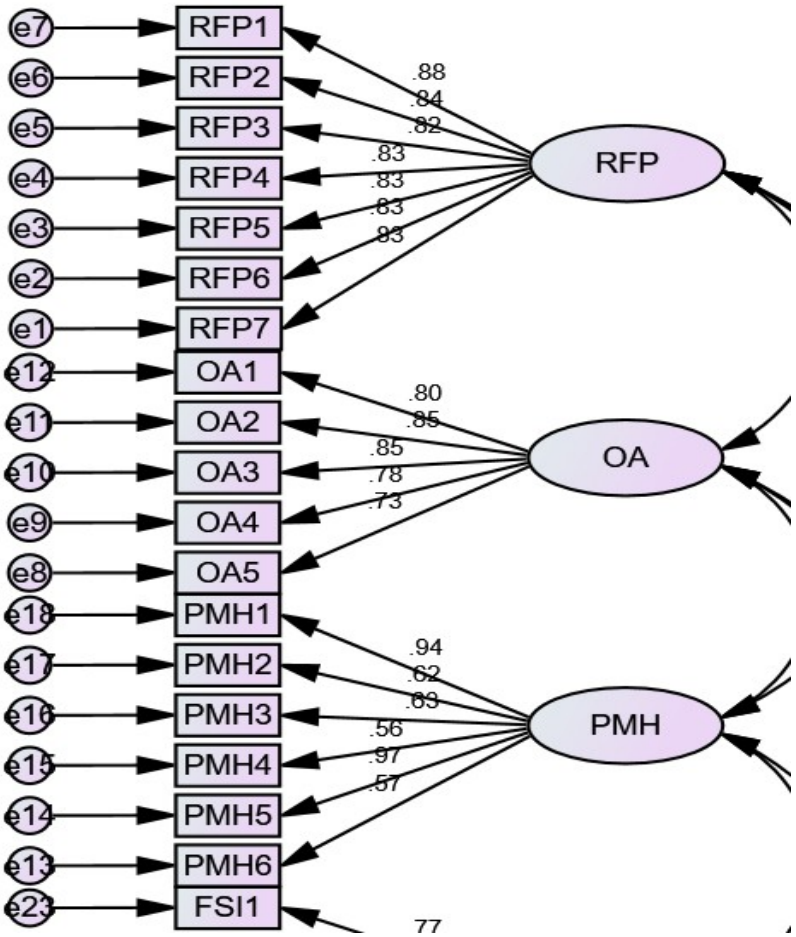
Scale	No. of items	M	SD	Median	Mode	Skew	Kurt	Min.	Max.
SWBS	27	72.32	12.05	73.00	**78.00**	-.213	-.264	40.00	105.00

Source: The author.

The initial standardized CFA for the five-factor SWB model with 27 items is shown in Figure 4. The initial measurement of the model's values ($\chi 2 = 1037.109$, df = 314, $\chi 2/df = 3.303$, GFI = 0.756, AGFI = 0.706, NFI = 0.807, CFI = 0.856, TLI = 0.839, and RMSEA = 0.094) did not offer acceptable results for a well-fitting model. Therefore, the researcher created a covariance of error terms based on modification indices (MI > 30). After modification, the fit indices of the final CFA model (Figure 5) have improved ($\chi 2 = 563.490$, df = 305, $\chi 2/df = 1.848$, GFI = 0.865, AGFI = 0.833, NFI = 0.895, CFI = 0.948, TLI = 0.941, and RMSEA = 0.057) and meet the values of requisite fit indices. The CFA thus confirms that the older adult SWB scale has 27 items with 5 dimensions.

Figure 5

Initial standardized CFA of the SWB scale with 27 Items

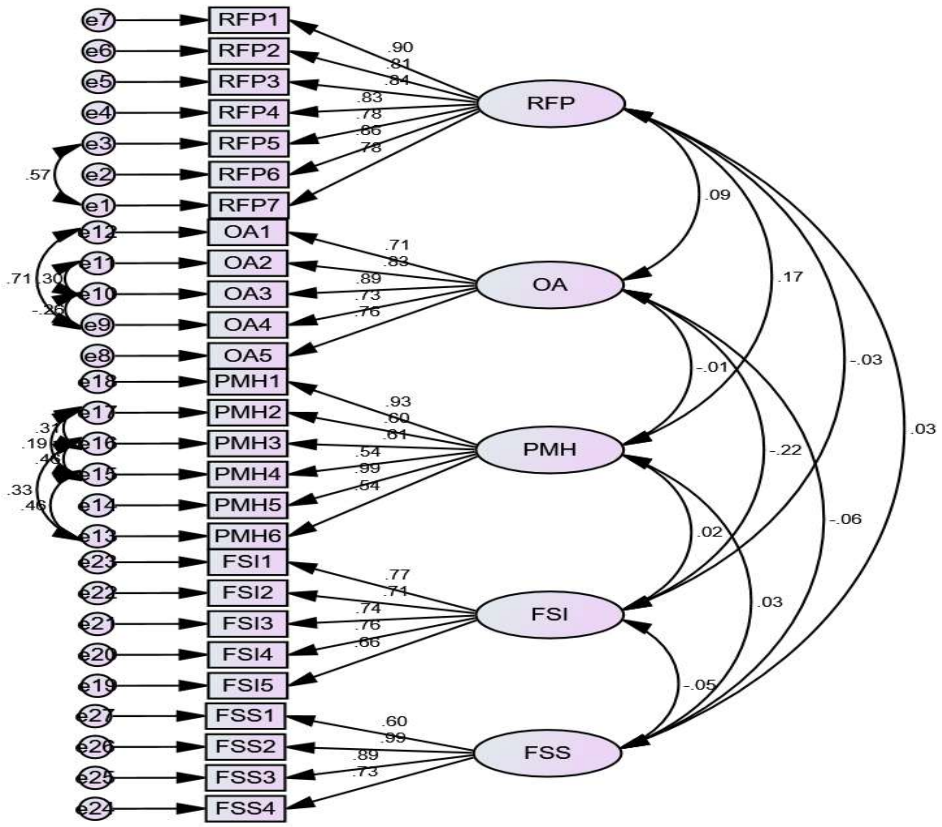


Source: The author.

Notes: PMH (Physical and Mental Health); OA (Optimism and Autonomy); FSI (Family and Social Interactions); RFP (Religious Faith and Practices); FSS (Financial Stability and Security).

Figure 6

Final standardized CFA of the SWB scale with 27 Items



Source: The author.

Notes: PMH (Physical and Mental Health); OA (Optimism and Autonomy); FSI (Family and Social Interactions); RFP (Religious Faith and Practices); FSS (Financial Stability and Security).

4.4.4. Validity Analysis

In the present study, construct validity of the newly developed SWB scale was examined by assessing convergent and discriminant validity. Findings of the present study in Table 15 mention that Average Variance Extracted (AVE) for each dimension is higher than 0.50

(religious faith and practices = 0.689, physical and mental health = 0.529, optimism and autonomy = 0.616, family and social interactions = 0.534, and financial stability and security = 0.667), and composite reliability for each dimension is higher than 0.70 (physical and mental health = 0.863, family and social interactions = 0.851, optimism and autonomy = 0.888, financial stability and security = 0.885, and religious faith and practice = 0.939). Therefore, it can now be stated that the older adults SWB scale with 5 dimensions and 27 items possessed convergent validity. Discriminant validity of the scale was confirmed by the square root of AVE being more than the latent variables correlation. Table 15 clearly shows that both the convergent and discriminant validity conditions have been established.

Table 15

Convergent and discriminate validity analysis

No.	Latent variables	Sum of the squared Standardized loadings	No. of indicators	AVE	CR	Square root of AVE
1	PMH	3.176	6	0.529	0.863	0.727
2	FSS	2.668	4	0.667	0.885	0.816
3	FSI	2.674	5	0.534	0.851	0.731
4	OA	3.080	5	0.616	0.888	0.784
5	RFP	4.827	7	0.689	0.939	0.830

Source: The author.

Note: Average Variance Extracted (AVE); Composite Reliability (CR); PMH (Physical and Mental Health); OA (Optimism and Autonomy); FSI (Family and Social Interactions); RFP (Religious Faith and Practices); FSS (Financial Stability and Security).

4.4.5. Norms of the Scale

In order to show the norms of the scale, the mean and standard deviation of the five subjective well-being subscales were computed.

Table 16

Items, mean, standard deviation, minimum score, and maximum score of the five SWB subscales (n =259)

Subscales	Items	Mean	SD	Minim.	Maxim.
Physical and Mental Health	13,14,15,16,17,18	14.51	5.75	6.00	30.00
Optimism and Autonomy	8,9,10,11,12	13.26	4.89	5.00	24.00
Family and Social Interactions	19,20,21,22,23	14.20	4.89	5.00	25.00
Financial Stability and Security	24,25,26,27	8.14	2.83	4.00	16.00
Religious Faith and Practices	1,2,3,4,5,6,7	22.19	7.62	7.00	35.00

As shown in Table 16, the mean and standard deviation values of physical and mental health, optimism and autonomy, family and social interactions, financial stability and security, and religious faith and practices SWB subscales were 14.51 (5.75), 13.26 (4.89), 14.20 (4.89), 8.14 (2.83) and 22.19 (7.62) respectively. Moreover, in order to determine which individual scores signify, the percentile rankings of physical and mental health, optimism and autonomy, family and social interactions, financial stability and security, and religious faith and practices SWB subscales were presented in Table 17.

Table 17

The norms of SWB subscales in terms of percentile rank (n =259)

Physical and mental health		Optimism and autonomy		Family and social interactions		Financial stability and security		Religious faith and practices	
Score	**Percentile**	**Score**	**Percentile**	**Score**	**Percentile**	**Score**	**Percentile**	**Score**	**Percentile**
6.00	7.7	5.00	3.5	5.00	6.2	4.00	17.4	7.00	6.2
7.00	10.8	6.00	6.6	6.00	7.3	5.00	20.8	10.00	10.8
8.00	15.4	7.00	10.0	7.00	9.7	6.00	21.6	11.00	11.2
9.00	23.6	8.00	18.9	8.00	12.7	7.00	27.8	13.00	12.4
10.00	31.3	9.00	23.6	9.00	15.1	8.00	71.8	14.00	20.5
11.00	34.7	10.00	42.5	10.00	31.3	9.00	77.2	15.00	21.2
12.00	46.3	11.00	47.1	11.00	34.4	10.00	79.9	16.00	26.6
13.00	48.3	12.00	49.8	12.00	37.8	11.00	84.6	17.00	29.7
14.00	52.5	13.00	53.7	13.00	42.1	12.00	93.8	18.00	37.8
15.00	57.5	14.00	59.1	14.00	49.0	13.00	96.1	20.00	38.2
16.00	62.9	15.00	63.3	15.00	56.4	14.00	96.9	21.00	44.8
17.00	66.4	16.00	69.5	16.00	62.9	15.00	97.3	22.00	47.1
18.00	72.6	17.00	71.8	17.00	68.7	16.00	100.0	23.00	50.2
19.00	76.8	18.00	81.1	18.00	79.9			24.00	50.6
20.00	81.9	19.00	84.9	19.00	85.7			25.00	52.5
21.00	88.0	20.00	92.7	20.00	91.5			26.00	53.7
22.00	91.1	21.00	96.5	21.00	95.4			27.00	56.4
23.00	93.4	22.00	99.6	22.00	97.3			28.00	91.5
24.00	96.1	24.00	100.0	23.00	97.7			29.00	92.3
25.00	97.3			24.00	98.5			30.00	93.1
26.00	97.7			25.00	100.0			35.00	100.0
27.00	98.1								
28.00	98.8								
30.00	100.0								

Chapter 5: Discussion

The purpose of the research is three fold: (1) to explore the current situations of retired pensioners, (2) to understand how retired older adults in Ethiopia conceptualize SWB, and (3) to develop and validate an instrument to measure the SWB.

5.1. The Living Situation of Retired Pensioners

This exploratory descriptive study aimed to gain an in-depth understanding of retired pensioners in Addis Ababa regarding the precarious lives they face due to the interplay of meager income benefits and pensions with various individual and policy-related factors. The analysis yielded five themes leading to precarious life in old age: *unattended health issues and unaffordable health care, an absence of recreational places for older adults, lack of respect and feeling disengaged, vulnerable livelihoods leading to precarious life, and the overlooked value and contributions of older adults*. These five themes are not independent of one another, but they intersect and shape the lives of older adults in tandem. Older adults who participated in this study faced several life challenges pertaining to their physical, emotional, social, financial, and mental well-being. These challenges restrict their ability to participate in activities of daily living, recreational activities, and social interactions. The majority of study participants expressed significant inadequacies in meeting even their basic needs. Likewise, Abate et al. (2020) reported a distressing statistic that 26.6% of individuals aged 65 years and older in Ethiopia suffer from malnutrition.

Participants described their unattended health issues and unaffordable health care as primary challenges related to their daily living. This finding was consistent with studies

conducted by Abud et al. (2022) and Toye et al. (2021), indicating that older adults experience a heavy burden of health issues without adequate social security systems or well-functioning health care systems. A study conducted by WHO (2018) likewise showed that chronic diseases and disabilities are becoming a health challenge among older adults in resource-poor environments. Indeed, the challenges faced by older adults in terms of their health and access to healthcare services are complex and multifaceted (Abud et al., 2022). Similarly, a study on older adults' health status in Kenya indicated that poor income was one of the major factors that significantly affected older adults' health status (Waweru et al., 2003). Older adults in Ethiopia are struggling with deteriorating health challenges that oblige them to rely on family care and traditional remedies (Abate et al., 2020). Most participants in this study indicated that the financial challenges and unaffordable health insurance further intersects with their existing health challenges and worsens their lives and increased their precarity to other hardships.

Previous studies also indicate that financial hardship experienced by older adults makes it difficult for them to access the healthcare services they need, which can exacerbate their health problems (Lloyd-Sherlock, 2000; Worku, 2017). Additionally, the deterioration of health that many older adults experience can limit their ability to maintain their independence and personal agency, negatively impacting their overall quality of life (Toye et al., 2021; Zelalem & Gebremariam, 2020).

The present study also revealed the absence of recreational places for retired older adults to spend their free time outside of their homes. Studies in other nations have brought to light a correlation between active engagement in leisure activities and the attainment of dignity including enhanced physical and psychological well-being (Zhao et al., 2023) as well as an

improved quality of life (Lord et al., 2011). They also identifed sociopsychological factors that are important to ageing well, including access to social and recreation opportunities, and access to community-based services and support (Macaluso & Free, 2023). Regrettably, the current investigation highlights a concerning issue: the lack of recreational places designated for older adults. This dearth poses a significant obstacle, impeding their ability to partake in physical activities, cultivate social connections, and foster meaningful engagement.

Lack of respect and feeling disengaged is viewed as one of the critical factors influencing retired older adults' welfare and health, as well as an important issue in older adult's rights (Moradi et al., 2013). Several studies indicate that diseases, quality of life, and even the mortality of older adults are related to their social participation (Levasseur et al., 2010). Thus, paying attention to older adults' opportunities for social participation is of particular importance (Bukov et al., 2002), and its promotion is one of the key recommendations of the World Health Organization (He et al., 2017). Despite the value of social participation for older adults' well-being, in the present study, older adults described their social participation as a context for the adverse events including a general pattern of vulnerability to stigma and discrimination. As a result of a lack of respect and attention, older adults' engagement in social and community activities is diminishing over time with older adults experiencing increased stigma and negative attitudes by younger people, even family members.

Studies have confirmed the effects of decreased social participation on social isolation and loneliness in old age (Fakoya et al., 2020; Shankar et al., 2013). Likewise, the present study indicates that study participants faced barriers to social participation due to stigma, discrimination, and a lack of respect and attention. These factors can lead to decreased

engagement in social and community activities, which can trigger social isolation and loneliness among older adults. Furthermore, as reported by study participants their health and economic problems may also lead to decreased social participation among older adults. Having limited financial resources makes it difficult for older adults to participate in recreation or engage in social activities, ultimately resulting in disengagement. The traditional African belief that extended families and communities will care for older adults is being challenged by urbanization, modernization, and the effects of HIV/AIDS (Mberu et al., 2017). The precarity model developed by Grenier et al. (2017) emphasizes financial risks and vulnerabilities in old age while underscoring the impact of globalization and neo-liberalization on care systems for older adults. These changes are altering family structures and the social fabric, leading to an erosion of the family support system. Consequently, there is an increase in the number of older adults struggling to earn a living with many lacking sufficient income to support themselves (Zamuee, 2022).

The present study shows that the lack of formal pensions and other social welfare schemes is a significant challenge facing older adults in Ethiopia and it leads to vulnerable livelihood and precarious life. Formal pensions tend to pay minimal benefits and cover only a small fraction of the older adult population. Even those who have access to retirement pensions indicated that the amount they receive is meager and cannot cover their basic needs. This is consistent with the findings of studies by HelpAge International (HAI, 2018) and MoWSA (2016) which indicate that few older adults in Ethiopia have access to old age pensions or other forms of secure income. The challenges that older people face with aging, such as lack of financial and material resources and the high cost of living and inflation, severely impacts their standard of living and thus their quality of life (Chawla et al., 2007; HAI, 2018). Study

participants in Ethiopia struggle to meet their basic needs due to a lack of resources, significantly impacting their health and well-being. Older adults whose basic needs go unmet can experience negative health outcomes. For example, they may have difficulty accessing healthcare services, adequate nutrition, and safe housing, leading to a decline in their physical and mental health, as well as a reduced quality of life (Waweru et al., 2003).

Finally, despite the physical, mental, social, and financial hardships, older adults expressed their belief that they could play a significant role in social and community activities. Regarding their economic contribution, older adults are a foundation to provide positive economic contributions and social glue to the community. Older adults have a wealth of knowledge and lived experience and continue to contribute to the welfare of their community.

The challenges faced by retired older adult in Ethiopia regarding their living standards are significant and need to be addressed urgently. The high cost of living, inflation, and the lack of permanent income severely affects their lives. Even those who are considered better off economically are struggling to maintain a decent level of subsistence. The lack of financial and material resources makes it difficult for older people to meet their basic needs. Thus, they must rely on their children and grandchildren for support. The low pension payments and the challenges associated with accessing their pensions make the situation worse. Although all the participants of this study have meager pensions in the context of unprecedented cost of living and inflation, their late-life precarity significantly intersects with their various characteristics such as gender, health condition, marital status, living arrangement, and the level of social and economic support from their children.

The economic burden starts at retirement, and even if older adults desire to work, opportunities to do so are severely limited. No one is creating opportunities for them. The increasing cost of living impacts their lives unpredictably, and the situation is worsening over time. Most participants believe that the living standards of older adults are at their lowest in their lifetime. Despite major challenges, study participants assert that older adults have great potential, knowledge, and skills. These assets are unfortunately being wasted due to a lack of opportunities. Study participants affirm that older adults have the potential to engage in a variety of development activities if given a chance.

To address retired older adults' challenges in Ethiopia, it is imperative for the Ethiopian government to establish welfare schemes, including long-term national policies that provide a basic income to uphold the inherent dignity of older citizens. Community centers are needed to address the psychosocial and informational needs of older adults in Ethiopia. Such centers would serve as vital hubs for fostering an environment of active aging, providing spaces for recreational activities, socialization, and engagement. Diverse income-generating mechanisms are also needed to empower older adults to maintain self-sufficiency and lead independent lives. By providing basic income support to older adults, prioritizing the creation of community-based centers, developing geriatric health centers, and implementing sustainable income-generating initiatives, Ethiopia can ensure that older adults receive the necessary support to thrive and enjoy a fulfilling life. A national social protection policy should encompass providing a baseline pension for all older adults, irrespective of their working salary. Additionally, ensuring comprehensive coverage for medical care, medications, transportation, and offering stipends for grandparents who serve as caregivers are essential components. Furthermore, developing age-friendly policies within the community, such as establishing senior centers, recreation facilities, and other resources tailored to the needs of older adults, plays a crucial role in enhancing their quality of life. Without such large-scale changes

coming from the national government, the aging population in Ethiopia will experience an elongation of hardship and suffering, rather than the enrichment of lifelong opportunities.

5.2. Conceptualization of Subjective Well-Being

The second purpose of this study was to understand how retired older adults conceptualize their well-being. Concerning participants' perspectives on their well-being, the six themes identified were physical and mental health, family and social interactions, financial stability and security, optimism and autonomy, religious faith and practice, and opportunity to work and to contribute meaningfully to one's community. The present study findings provide a holistic view that encompasses multiple dimensions that determine an older adult's individual experience of SWB. These dimensions and their meanings are broadly inconsistent with previous studies of SWB (e.g., Diener et al., 2009; Keith et al., 1994; Rowe & Kahn, 1997; Ryan & Deci, 2001, 2017; Ryff, 1989). The findings of the present study contradict with a study by Etxeberria et al. (2019) that results indicated that SWB among older adults was mainly predicted by personality traits. Functional capacity, physical health, cognition and social support were not found to be influential factors of SWB (Etxeberria et al., 2019). Meanings linked to good SWB in late life are derived from older adults' cultural and normative expectations that have not yet been considered in the scholarly literature.

One of the significant findings of this study was that SWB involves the maintenance of physical and mental health. The study revealed that having good physical and mental health included a positive mindset; sufficient bodily resources; mobility, having a good memory; being free from stress and depression; being optimistic; and engaging in healthy behaviors were viewed as important indicators in older adults' physical and mental well-being. Empirical results

have supported these speculations. Studies (Bag et al., 2014; Hassan et al., 2018) showed that people who report high SWB also report better health and fewer unpleasant physical symptoms and functional limitations. In this study also older adults reported that maintaining physical and mental health required them to engage in certain activities, such as mental exercise, reading, playing games, learning new things, challenging oneself, and engaging in hobbies and creative activities (Rozanova et al., 2015; Tate et al., 2003). This finding was consistent with Rowe and Kahn (1997) that the presence of a low probability of disease and disability, maintenance of high physical and cognitive functioning, and continued engagement in social and productive activities are considered indicators of older adults' SWB.

The second significant finding of this study was that the SWB of retired older adults involves family and social interactions. Family and social interaction was the most frequently noted theme, predominantly with friends and family. There has been increasing appreciation in applied development psychology science for the fundamental importance of warm, trusting, and supportive interpersonal relationships for SWB. This finding is supported by the activity theory that good SWB results from older adults staying active, particularly regarding social interactions and engaging with others (Havighurst, 1963). Previous research shows positive relationships between participation in various activities and quality of life among older adults (Menec, 2003). These activities include talking with friends and family, participation in community and religious activities, and leisure activities. As active engagement in various life domains helps older adults realize active aging and quality of life (Adamek et al., 2024), opening up leadership positions at different levels to older adults would contribute to the positive reframing of aging.

The present study findings are consistent with the propositions of activity theory rather than disengagement theory. In this study older adults perceived that social engagement through

volunteering, providing help to others, working, and being a member of social clubs were indicators of good subjective well-being. Being engaged in life was related to feeling valuable, and being able to contribute gave a sense of satisfaction and a purpose in life (Hörder et al., 2013; Nimrod & Ben-Shem, 2015). Our findings support this point, suggesting that older adults should be encouraged to develop new interests and social activities to find satisfaction and well-being in their lives. Furthermore, active engagement will help older adults stave off isolation and loneliness two common social ills among the older population (Walsh et al., 2020).

The present study also showed that financial stability and security was one of the major dimensions of Ethiopian retired older adults' SWB. Feeling financially secure contributed to self-contentment and was described as a way to manage life pressures. The study participants stated that avoiding poverty; having no financial worry; financial resources and well-being; living in good living conditions, and having a good financial status are associated with attaining good SWB. Financial security was particularly important in terms of having enough money through paid employment or retirement/pension, to support oneself in meeting basic needs, meet living expenses, access and maintain health insurance, and maintain a sense of independence. The findings of this study conform to the findings reported in previous studies (Chen, 2015; Nimrod & Ben-Shem, 2015), they in their study found financial status was more correlated with life satisfaction in poorer nations than in wealthier nations. Thus, among older adults in Ethiopia, the value of money for satisfying needs may be more critical than having access to some basic resources for pursuing their goals. Furthermore, studies (Barrett & Kecmanovic, 2013; Diener et al., 2009; Netemeyer et al., 2018) showed that financial status significantly affects the well-being of those living at the poverty level or in underdeveloped nations, the strength of the link between wealth and life satisfaction decreases at higher levels of income.

In the present study, optimism and autonomy was mentioned as one of the important dimensions of retired older adults' SWB. Adapting to the aging body, accepting the aging process, coping, living in a new reality, maturation, and living to an advanced age were frequently mentioned in the SWB of older adults. SWB is, after all, subjective, so one would expect it to be affected by personality and interpretive and reporting styles. Previous studies also indicated that older adults' autonomy and independence, including personal dignity and authenticity, as important elements of successful aging. Autonomy and independence were described as being able to do things that one likes to do without help, living independently, taking care of oneself without depending on others, maintaining good mobility and well-functioning motor skills, or if needing assistance with mobility, not being bedbound (Hilton et al., 2012; Jopp et al., 2015; Nimrod & Ben-Shem, 2015). Autonomy and independence were equated with having a sense of freedom, enabled older adults to maintain personal dignity, and contributed to the retention of the authentic self (Hörder et al., 2013; McCann et al., 2008). Therefore, helping older adults' to be optimistic and autonomous were important for their SWB and determines their perception of aging well.

Religious faith and practice was also one of the major dimensions of retired older adults' conceptualization of SWB. The importance of religious faith and practice of older adults significantly molds older adults' SWB in Ethiopia. Older adults who are engaged in religious activity tend to experience higher well-being, and more specifically, participation in religious services, strength of religious affiliation, relationship with God, and prayer have all been associated with the SWB of older adults. Empirical results have supported these speculations. Previous studies indicate higher levels of religiosity have been linked to higher life satisfaction and lower suicide rates (e.g., Aglozo et al., 2021; Lawler-Row & Elliott, 2009; Soósová et al.,

2021; Velasco-Gonzalez & Rioux, 2014). Religiosity plays a salient role in the lives of older adults as it acts as a protective shield against the trajectories of ill-being (Hamid et al., 2012). The positive link between high well-being and religiosity is thought to originate from a sense of meaning and purpose and the social networks and support systems created by churches and other institutions of organized religion.

Finally, participants of this study further indicated that opportunity to work and contribute to the community as important dimensions of SWB. Participants emphasized the importance of continuous engagement in old age as a critical indicator of SWB in late life. Despite being in a very difficult life situation, characterized by inflation and a growing cost of living, displacement, relocation and resettlement, and lack of peace and stability in the country, study participants indicated that contribution and generativity to the community are nevertheless key dimensions of well-being in late life. These emerged as significant factors influencing the quality of life and sense of fulfillment among the elderly population in Ethiopia.

5.3. Development and Validation of an Instrument to Measure Subjective Well-Being among Retired Older Adults

Through a rigorous exploratory sequential mixed-method research design, the present study have conceptualized, developed, and validated a scale for measuring retired older adults SWB. Given the rigorous testing, the final 27-item scale for SWB is established as a reliable and valid tool for measurement. The scale pivots around five crucial dimensions, offering a holistic perspective on SWB. Based on their defining characteristics, these emergent factors have been christened as: physical and mental health, financial stability and security, family and social interactions, autonomy and optimism, and religious faith and practices.

To begin, religious faith and practices were one of the major dimensions of retired older adults' well-being. Relationship with God, prayer and religious activities, viewing aging as a gift from heaven, optimism and a sense of purpose and meaning in life, a sense of belonging, and preparing for the end of life were indicators of retired older adults' SWB. The variance explained by this dimension is 19.97 percent with an eigenvalue of 5.39. A study conducted by Sadler and Biggs (2006) indicated that religious well-being in later life has been mostly ignored as a source of successful aging. Their findings illustrate the importance of spirituality in understanding and fostering successful aging. Moreover, Cowlishaw et al. (2013) showed that religious practices influenced longitudinally successful aging. The present study confirms that religious faith and practices can be considered as one dimension of SWB.

Next, optimism and autonomy were identified as important dimensions of retired older adults' well-being. Adapting to the aging body, having a positive outlook about life, being independent in daily activities, accepting the aging process, coping, living in a new reality, making valuable contributions in the workforce, maturation, and living to an advanced age were indicators of older adults' SWB. The variance explained by this dimension is 16.18 percent with an eigenvalue of 4.37. Autonomy and independence were described as being able to do things that one likes to do without help, living independently, taking care of oneself without depending on others, maintaining good mobility and well-functioning motor skills, or, if needing assistance with mobility, not being bedbound (e.g., Hilton et al., 2012; Jopp et al., 2015). Autonomy and independence were equated with having a sense of freedom, enabled older adults to maintain personal dignity, and contributed to the retention of the authentic self (Hörder et al., 2013). Thus, helping older adults to remain optimistic and autonomous was integral to their perception of aging well. A good life is not just about pleasure and happiness but involves developing oneself

and realizing one's potential (Ryff & Keyes, 1995). Similarly, positive functioning can be seen from the perspective of developmental psychology, as personality changes articulate well-being as trajectories of continued growth across the life cycle (Erikson, 1959). A study by Bialowolski et al. (2022) reported that living an autonomous life, with the ability to carry out their basic tasks of daily life, is a key aspect for maintaining quality of life for the elderly persons.

Following that, physical and mental health emerged as a core dimension of retired older adults' well-being in this study. Having good physical and mental health, including good physical health, performing basic self-care tasks independently (e.g., eating, bathing, dressing), accomplishing daily routines without difficulty, engaging in work and self-care activities, being mentally alert, having a good memory, and staying optimistic are the indicators of physical and mental health dimensions of older adults well-being. These elements of physical and mental health collectively determine the well-being older adults. The variance explained by this dimension is 12.41 percent with an eigenvalue of 3.35. Previous studies (e.g., Bag et al., 2014; Fatima et al., 2019; Zanjari et al., 2016) also showed that older adults who report high well-being also report better health and fewer unpleasant physical symptoms and functional limitations.

Family and social interactions are the other major dimension for retired older adults' well-being in low-income countries, such as Ethiopia. Indicators include engaging in meaningful social interactions, feeling accepted and recognized, being involved in family and community life, living peacefully with family and surroundings, having a positive connection with children, receiving support, contributing to the community, and having the ability to work. The variance explained by this dimension is 10.21 percent with an eigenvalue of 2.75. Studies (e.g., Tiwery et al., 2023; Gallardo-Peralta et al., 2020) consistently show a favorable relationship between social

dimensions and older adults' well-being. This aligns with activity theory, suggesting that good SWB results from older adults staying active, particularly in social interactions (Havighurst, 1963). Despite other research documenting the critical value of interpersonal relationships in the knowledge base of SWB (e.g., Cooke et al., 2016), this study is one of the few empirical studies that incorporate family and social interactions in a multidimensional assessment of this construct. Although family and social interaction, and financial stability and security are a more fundamental part of life and meaningful to people from more collectivistic cultures than individualistic cultures.

Finally, financial stability and security dives into having enough money, paid employment or retirement/pension, having sufficient financial resources to meet basic needs, adequately pensions and benefits, managing life pressures, and preserving independence and freedom to plan for the future and pursue aspirations are the indicators of this dimension of older adults' well-being. The variance explained by this dimension is 9.24 percent with an eigenvalue of 2.49. Financial stability and security have been shown to play a protective role in the general well-being of older adults (Bialowolski et al., 2024); little is known about it as a dimension of older adults well-being. Regarding its role in older adults well-being, high incomes have been shown to improve evaluations of life and lower the risk of depression and other mental disorders (e.g., Kahneman & Deaton, 2010; Kourouklis et al., 2020), and savings have been indicated to positively contribute to emotional well-being (Białowolski et al., 2022). The nexus between financial stability and well-being in resource-poor countries cannot be understated, financial concerns having the potential to significantly dent the overall well-being of older adults (e.g., Antwi et al., 2024; Braun Santos et al., 2016; Utkarsh et al., 2020).

Several studies on subjective well-being can be found, but Diener et al. (2009) underline that these studies often measure a single dimension of well-being or ill-being. Diener et al. (1999) provided a way to assess subjective well-being through both cognitive and emotional dimensions. Other questionnaires assess life quality of satisfaction but are adapted to make comparisons with reference groups and do not reflect the specificity of older adults in a different context. Finally, there are several tools to assess life quality or subjective well-being, but they are validated with different target populations and objectives. The 5-factor structure of the SWBS allows retired older adults to report on five dimensions of well-being. The reseacher assumed that these five factors are determining dimensions in the assessment of retired older adults well-being. Overall, these studies add to a growing corpus of research emphasizing the different dimensions of well-being among older adults. Recognizing these five dimensions as a significant resource for older adults enables researchers and healthcare professionals to create interventions and support systems that address the needs of older adults, thereby improving their overall subjective well-being and quality of life. In summary, policymakers should consider the multidimensional and contextual nature of subjective well-being.

Chapter 6: Conclusion

6.1. Conclusion

The results of this study revealed five main themes related to the living conditions of retired older adults: unattended health issues and unaffordable health care; absence of recreational places; lack of respect and feeling disengaged; vulnerable livelihoods and precarious lives; and the overlooked value and contribution of older adults. It is disheartening to learn about the difficult living situations of these older adults, especially with the increasing cost of living and low income, particularly for retired older adults. The lack of opportunities for work and development activities for older adults further exacerbates the challenges they face. It is commendable that some older adults are taking care of their grandchildren, even though they themselves are living in tough conditions. Overall, the study highlights the challenges faced by retired older adults in Addis Ababa, Ethiopia.

In this study, retired older adults' conceptualization of SWB is a multidimensional construct composed of a variety of different externally and internally controlled components of well-being. That is, older adults relayed their experience of and perspective on the conceptualization of SWB as a combination of social, psychological, physical, financial, environmental, and spiritual aspects. While they included physical and mental health, family and social interactions, financial stability and security, optimism and autonomy, religious faith and practices, and opportunity to work and contribute to the community, are the main dimensions of retired older adults' SWB. These dimensions influence the extent to which one can achieve good SWB. The findings provide a holistic view of older adults that encompasses a large number of facets that may be influencing an older adult's individual experience of good SWB. As we have

seen with past theoretical models, reductionism does not facilitate understanding and can promote oppressive thinking. Moreover, utilization of these dimensions may support older adults to move forward and maintain a good SWB in their lives. Developing strategic psychosocial interventions and rehabilitative plans is needed to enhance retired older adults' well-being and promote their good SWB.

Based on the findings of study two, it can be concluded that the SWB scale is a reliable and valid tool for understanding the different dimensions of SWB among retired older adults. The preliminary findings suggest that the SWBS is a well-validated and reasonably comprehensive instrument to assess the determinants of SWB in retired older adults. The study highlights the importance of considering multiple dimensions of well-being when designing interventions for older adults. Rather than focusing solely on one aspect, such as physical health, it is crucial to address the five dimensions of well-being: health (both physical and mental), family and social interactions, religious faith and practices, financial stability and security, optimism and autonomy. This holistic approach can lead to more effective interventions that promote overall well-being among older adults. The findings also underscore the significance of assessing the impact of well-being in policy proposals. By considering the five dimensions of well-being, governments can develop policies that address the diverse needs of older adults and promote their overall well-being. This can include measures to improve access to healthcare, enhance social support networks, facilitate religious participation, and support financial planning for retirement. In conclusion, the SWBS instrument provides valuable insights into the well-being of older adults and emphasizes the importance of addressing multiple dimensions of well-being in interventions and policy proposals. Further research and development of the SWBS can

contribute to a better understanding of the determinants of SWB in older adults and inform targeted strategies to enhance their overall well-being.

6.2. Implication

On the basis of the results of the present study, the following implications are drawn in order to address the SWB of Ethiopian older adults.

Implication for practice

Recognizing the different dimensions of SWB of older adults means that interventions to support older adults' SWB must account for these dimensions. Healthcare providers, policymakers, and community organizations must collaborate to support older adults, who are valuable members of their families, communities, and society, in improving their well-being. By understanding and addressing the various challenges faced by this segment of the population, we can facilitate the creation of an empathetic environment in which the rights, autonomy, and feelings of older adults are highly respected. There is no other institution that can fully replace family in providing care for older adults in countries where the extended family system is widely exercised. Family takes responsibility for providing irreplaceable care for the overwhelming majority of older adults. Therefore, strengthening family care as the priority will have the significant advantage of providing older adults with the necessary care while they are in their home environment.

The second option will be to encourage community care. Moreover, consider the design of social and infrastructural services and facilities appropriate to the needs of older adults. While retirement benefits must be improved, efforts should be made to ensure the continued

participation of the elderly in productive work. In this context, cooperatives and production centers for handicrafts, managed by the elderly themselves, could be organized. Promotion of self-employment opportunities for the elderly would foster independence and self reliance as well as increasing the productive capacity of the economy in general.

Implications for policy

The findings of this study have important implications for government policy affecting the care and support of older adults. Institutional support from the government and agencies has a paramount effect on the well-being of older adults. Current policy focuses on vulnerability in relation to age alone, but these findings support calls for a broader policy framework that accounts for the diversity of circumstances among older adults.

- Undertake awareness-raising activities to change the attitude of the community and employers using different means to get rid of biases against the competence and productivity of older adults.
- Allow older adults to live independently; increase their employment opportunities by providing land, seeds, and farm implements; and assisting them in finding a market for their products or services.
- No doubt that the ideal would be the establishment of comprehensive social security schemes covering all the older adults
- In light of the financial implications of broad-scale income security programs and the decreasing ability of traditional social networks to continue to provide support, income security policies should focus on real income security, rather than simply monetary income security.

Implications for future research

Clearly, there is still significant research work to be done regarding the conceptualization and measurement of SWB among older adults. In fact, a substantial amount of research still needs to be conducted before greater consensus can be reached on how SWB can be conceptualized and measured in a valid manner. The literature reviewed does not suggest consensus regarding an exemplary conceptualization and instrument for measuring well-being. More research is needed to identify the important biopsychosocial components of SWB and whether there are aspects of health and SWB that can be reliably differentiated from constructs such as life satisfaction, happiness, quality of life, and wellness. Therefore, it was verified that more studies that relate to subjective well-being in relation to psychosocial variables in the elderly population are needed. Additionally, it also indicates the need for further research to examine the concurrent validity of the newly developed SWB scale and the validity of SWB scale in different settings (e.g., urban and rural). Further, data must be collected to evaluate the effectiveness of the implementation of social security systems, which could inform future improvements.

References

Abate, T., Mengistu, B., Atnafu, A., & Derso, T. (2020). Malnutrition and its determinants among older adults people in Addis Ababa, Ethiopia. *BMC Geriatrics, 20*, 1-9. doi:10.1186/s12877-020-01917-w

Abdullahi, A. M., Orji, R., Rabiu, A. M., & Kawu, A. A. (2020). Personality and subjective well-being: towards personalized persuasive interventions for health and well-being. *Online Journal of Public Health Informatics*, *12*(1), e1. doi: 10.5210/ojphi.v12i1.10335

Abebe, T. (2020). *The lived experience of institutional life for elderly people. The case of Kibre Aregawuyan Migbaresenay Dirijit in Addis Ababa.* St. Mary's University.

Abell, N., Springer, D. W., & Kamata, A. (2009). *Developing and validating rapid assessment instruments.* Published by Oxford University Press, Inc. 198 Madison Avenue, New York.

Abud, T., Kounidas, G., Martin, K. R., Werth, M., Cooper, K., & Myint, P. K. (2022). Determinants of healthy ageing: A systematic review of contemporary literature. *Aging Clinical and Experimental Research, 34*(6), 1215-1223.

Adamek, M. E., Kotecho, M. G., & Teshome, A. Z. (2024). Promoting the well-being of older people in Ethiopia: Lost opportunities due to the poverty of policy. *Innovation in Aging*, *8*(4), igad120.

Adams, D. L. (1969). Analysis of a Life Satisfaction Index. *Journal of Gerontology*, 24, 4, 470-4.

Aglozo, E. Y., Akotia, C. S., Osei-Tutu, A., & Annor, F. (2021). Spirituality and subjective well-being among Ghanaian older adults: optimism and meaning in life as mediators. *Journal of Aging & Mental Health, 25*(2), 306-315.

Alambo, F. I., & Yimam, H. A. (2019). Elderly care and social support systems among the Gedeo of Southern Ethiopia: Socio-cultural contexts, forms, dynamics and challenges. *Journal of African Studies Quarterly, 18*(3), 15-28.

Alex Linley, P., Joseph, S., Harrington, S., & Wood, A. M. (2006). Positive psychology: Past, present, and (possible) future. *The Journal of Positive Psychology*, *1*(1), 3-16.

Amalia, D. (2009). The importance of theory in gerontological social work. *Journal of Gerontological Social Work*, 2, 40-43.

Amalia, S. (2019). *Happiness in Elderly: Contribution of Health's Perception and Filial Piety.* Paper presented at the 4th ASEAN Conference on Psychology, Counselling, and Humanities (ACPCH 2018).

An, H. Y., Chen, W., Wang, C. W., Yang, H. F., Huang, W. T., & Fan, S. Y. (2020). The relationships between physical activity and life satisfaction and happiness among young, middle-aged, and older adults. *International Journal of Environmental Research and Public Health*, *17*(13), 4817. doi: 10.3390/ijerph17134817

Anastas, J. W. (2004). Quality in qualitative evaluation: Issues and possible answers. *Research on Social Work Practice, 14*(1), 57-65.

Angelini, L., El Kamali, M., Mugellini, E., Abou Khaled, O., Röcke, C., Porcelli, S., ... & Andreoni, G. (2022). The NESTORE e-coach: designing a multi-domain pathway to well-being in older age. *Journal of Technologies*, *10*(2), 50.

Angner, E. (2012). Subjective well-being: When, and why, it matters. *Available at SSRN 2157140*.

Antwi, P. K. A., Addai, B., Duah, E., & Kubi, M. T. (2024). The impact of financial literacy on financial well-being: *A Systematic Literature Review*. Available

online: https://www.researchsquare.com/article/rs-5187088/v2: DOI:10.21203/rs.3.rs-5187088/v2

Arifin, S. R. M. (2018). Ethical considerations in qualitative study. *International Journal of Care Scholars*, *1*(2), 30-33.

Assefa, B. (2010). Profile of older persons in Ethiopia, in Inter-generational challenges in Ethiopia: Understanding family, children and the elderly; . *Proceedings of the sixth annual conference of the Ethiopian Society of Sociologists, Social Workers and Anthropologists 14 and 15 December 2007, pp.41-52,Addis Ababa, Ethiopia.*

Atchley, R. C. (1989). A continuity theory of normal aging. *The gerontologist, 29*(2), 183-190.

Ayana, A. (2012). *Who takes care of the elderly in Ethiopia when reciprocal relationships breakdown?* [Unpublished Master's Thesis]. Lund University.

Babbie, E. and Mouton, J. (2001). *The practice of social research*. Cape Town: Oxford University Press.

Bag, J., Chakrabarti, A., Daniel, L., & Sanyal, D. (2014). Assessment of subjective well-being status of elderly people in old age homes in Kolkata in relation to their perceived physical health and cognitive functioning. *Journal of Mental Health and Human Behaviour*, *19*(1), 32. https://doi.org/10.4103/0971-8990.143888

Bagozzi, R. P., Yi, Y., & Phillips, L. W. (1991). Assessing construct validity in organizational research. *Administrative Science Quarterly*, *36*, 421-458.

Baltes, M., & Lang, R. (1997). Everyday functioning and successful aging: the impact of resources. *Journal of Psychology and Aging, 12*(3), 433.

Baltes, P. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. *Journal of Developmental Psychology, 23*(5),611.

Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. *Successful aging: Perspectives from the behavioral sciences*, *1*(1), 1-34.

Barrett, G. F., & Kecmanovic, M. (2013). Changes in subjective well-being with retirement: assessing savings adequacy. *Journal of Applied Economics, 45*(35), 4883-4893.

Baru, A., Wonde, D., & Jibat, N. (2018). Socio-economic Situation of the Elderly in Jimma Zone, Oromia/Ethiopia. *The Ethiopian Journal of Social Sciences and Language Studies (EJSSLS), 5*(2), 3-22.

Becker, C., Kirchmaier, I., & Trautmann, S. T. (2019). Marriage, parenthood and social network: Subjective well-being and mental health in old age. *PloS one*, *14*(7), e0218704. doi: 10.1371/journal.pone.0218704

Belay, G. (2010). *Self-esteem and perceived adequacy of social support among older persons in DebreMarkosTown*. Unpublished MA Thesis: Institute of Psychology: AAU.

Belay, T., & Teshome, K. (2014). Subjective Quality of Life and Perceived Adequacy of Social Support among the Elderly in Arbaminch Town. *Ethiopian Journal of the Social Sciences and Humanities, 10*(1), 1-26.

Belaynesh, S. (2007). *The self-esteem of elderly engaged in different roles and activities:the case of residents of Yeka and Addis Ketema sub cities in Addis Ababa*, Unpublished MA Thesis, AAU.

Bengtson, V. L., Gans, D., Putney, N. M., & Silverstein, M. (2009). Theories about age and aging. *Handbook of Theories of Aging, 2*, 3-23.

Benin Holland, M., Stock, W. A., & Okun, M. A. (1988). Positive and negative affect: a maximum-likelihood approach. *Journal of Social Indicators Research*, 20, 2, 165-75.

Bentler, P. M. (1990). Comparative fit indexes in structural models. *Psychological bulletin*, *107* (2), 238.

Bentler, P. M., & Banett, D. G. (1980). Significance tests and goodness of fit in the analysis of covariance structures. *Psychological bulletin*, *88*(3), 588.

Berry, J. W. (1989). Imposed etics—emics—derived etics: The operationalization of a compelling idea. *International Journal of Psychology, 24*(6), 721-735.

Bialowolski, P., Cwynar, A., & Weziak-Bialowolska, D. (2022). The role of financial literacy for financial resilience in middle-age and older adulthood. *International Journal of Bank Marketing*. https://doi.org/10.1108/IJBM-10-2021-0453

Bialowolski, P., Xiao, J.J. & Weziak-Bialowolska, D. (2024). Do All Savings Matter Equally? Saving Types and Emotional Well-Being Among Older Adults: Evidence from Panel Data. *Journal of Family and Economic Issues* 45, 88–105 (2024). https://doi.org/10.1007/s10834-023-09891-2

Bianchi, M. S., Hotz, V. J., McGarry, K., & Seltzer, J. A. (2007). Intergenerational ties: Alternative theories, empirical findings and trends, and remaining challenges (a paper prepared for the 2006 Penn State Symposium on family issues, *"Caring and Exchange within and across Generations"* October 4 & 5th): State College

Bigot, A. (1974). The relevance of American Life Satisfaction Indices for research on British subjects before and after retirement. *Journal of Age and Ageing*, 3, 113-21.

Binstock, R. H., George, L. K., Cutler, S. J., Hendricks, J., & Schulz, J. H. (2011). *Handbook of Aging and The Social Sciences*: Elsevier.

Birren, J. E., Schaie, K. W., Abeles, R. P., Gatz, M., & Salthouse, T. A. (2001). *Handbook of the Psychology of Aging* (Vol. 3): Gulf professional publishing.

Bollen, K.A.(1989). A new incremental fix index for general structural equation models. *Sociological Methods and Resaech, 17*, 303-316.

Borglin, G., Edberg, A.-K., & Hallberg, I. R. (2005). The experience of quality of life among older people. *Journal of Aging Studies, 19*(2), 201-220.

Bowling, A. (2007). Aspirations for older age in the 21st century: What is successful aging? *The International Journal of Aging and Human Development, 64*(3), 263-297.

Bowling, A., & Dieppe, P. (2005). What is successful aging and who should define it? *British Medical Journal*, 331, 1548-1551.

Bowling, A., & Gabriel, Z. (2007). Lay theories of quality of life in older age. *Ageing & Society, 27*(6), 827-848.

Bowling, A., Gabriel, Z., Dykes, J., Dowding, L. M., Evans, O., Fleissig, A., Sutton, S. (2003). Let's ask them: a national survey of definitions of quality of life and its enhancement among people aged 65 and over. *The International Journal of Aging and Human Development, 56*(4), 269-306.

Bradburn, N. M. (1969). *The Structure of Psychological Well-Being*. Chicago: Aldine.

Braeken, J., & Van Assen, M. A. (2017). An empirical Kaiser criterion. *Journal of Psychological Methods*, *22*(3), 450–466. doi:https://doi.org/10.1037/met0000074 (open in a new window).

Brandtstädter, J., & Renner, G. (1990). Tenacious goal pursuit and flexible goal adjustment: explication and age-related analysis of assimilative and accommodative strategies of coping. *Journal of Psychology and Aging, 5*(1), 58.

Braun Santos, D., Mendes-Da-Silva, W., Flores, E., & Norvilitis, J. M. (2016). Predictors of credit card use and perceived financial well-being in female college students: a B razil-U

nited S tates comparative study. *International Journal of Consumer Studies*, *40*(2), 133-142.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bruner, J. (1990). Culture and human development: A new look. *Human development, 33*(6), 344-355.

Bukov, A., Maas, I., & Lampert, T. (2002). Social participation in very old age: Cross-sectional and longitudinal findings from BASE. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 57*(6), P510-P517.

Butler, J., & Kern, M. L. (2016). The PERMA-Profiler: A brief multidimensional measure of flourishing. *International Journal of Wellbeing*, *6*(3).

Byrne, B. M. (2001). *Structural equation modeling with Amos: Basic concepts, applications, and programming.* Mahwah, N. J.: Lawrence Erlbaum Associates.

Carr, D. (2004). The desire to date and remarry among older widows and widowers. *Journal of Marriage and Family*, *66*(4), 1051-1068.

Carstensen, L. L. (2006). The influence of a sense of time on human development. *Journal of Science, 312*(5782), 1913-1915.

Carstensen, L. L., Isaacowitz, D. M., & Charles, S. T. (1999). Taking time seriously: a theory of socioemotional selectivity. *American psychologist, 54*(3), 165.

Cattell, R. B. (1966). The scree test for the number of factors. *Multivariate Behavioral Research*, *1,* 245-276.

Central Statistical Agency (CSA)[Ethiopia] and ICF. (2016). *Ethiopia demographic and health survey, Addis Ababa, Ethiopia and Calverton, Maryland, USA, 1*.

Chane, S., & Adamek, M. E. (2015). Factors contributing to elder abuse in Ethiopia. *Journal of Adult Protection, 17*(2), 99-110.

Charles, S. T. (2010). Strength and vulnerability integration: a model of emotional well-being across adulthood. *Psychological bulletin,* 136 (6), 1068.

Chatrungrueangchai, C. (2016). *Demographic and economic factors affecting adults' perceptions toward the elderly in Thailand (bachelor's thesis).* Chulalongkorn University, Thailand

Chawla, M., Betcherman, G., & Banerji, A. (2007). *From red to gray: The" third transition" of aging populations in Eastern Europe and the former Soviet Union*: World Bank.

Chen, K. L. (2015). Rethinking successful aging: Older female volunteers' perspectives in Taiwan. *Asian Journal of Women's Studies, 21*(3), 215-231.

Chen, Z., & Davey, G. (2009). Subjective quality of life in Zhuhai City, South China: A public survey using the International Wellbeing Index. *Social Indicators Research*, *91*, 243-258.

Chih-Pei, H. U., & Chang, Y. Y. (2017). John W. Creswell, research design: Qualitative, quantitative, and mixed methods approaches.

Cho, J., Martin, P., Poon, L. W., & Study, G. C. (2015). Successful aging and subjective well-being among oldest-old adults. *The Gerontologist, 55*(1), 132-143.

Christopher, J. C. (2018). Let it be: Mindfulness and releasement—Neglected dimensions of well-being. *Journal of Theoretical and Philosophical Psychology*, *38*(2), 61.

Churchill Jr, G. A. (1979). A paradigm for developing better measures of marketing constructs. *Journal of Marketing Research*, *16*(1), 64-73.

Clarke, P. J., Marshall, V. M., Ryff, C. D., Wheaton, B. (2001). Measuring psychological well-being in the Canadian study of health and aging. *International Psychogeriatrics*, 13, 1, 79-90.

Cohen, R. J., Swerdlik, M. E., & Phillips, S. M. (1996). *Psychological testing and assessment: An introduction to tests and measurement*. Mayfield Publishing Co.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 385-396.

Conceicao, P., & Bandura, R. (2012). Measuring subjective well being. *A summary review of the literature*.

Connidis, I. (1984). The construct validity of the Life Satisfaction Index A and Affect BalanceScales: a serendipitous analysis. *Social Indicators Research*, 15, 117-29.

Cooke, P. J., Melchert, T. P., & Connor, K. (2016). Measuring well-being: A review of instruments. *The Counseling Psychologist*, *44*(5), 730-757. doi: 10.1177/0011000016633507

Cosco, T. D., Prina, A. M., Perales, J., Stephan, B. C., & Brayne, C. (2013). Lay perspectives of successful ageing: a systematic review and meta-ethnography. *British Medical Journal open, 3*(6), e002710.

Cowlishaw, S., Niele, S., Teshuva, K., Browning, C., & Kendig, H. (2013). Older adults' spirituality and life satisfaction: alongitudinal test of social support and sense of coherence as mediating mechanisms. *Journal of Ageing & Society*, 33, 1243-1262. doi:10.1017/S0144686X12000633

Cresswell, J. W., & Poth, C. N. (2007). Five qualitative approaches to inquiry. *Qualitative inquiry and research design: Choosing among five approaches, 2*, 53-80.

Creswell, J. W., Hanson, W. E., Clark Plano, V. L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The counseling psychologist*, *35*(2), 236-264.

Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). Best practices for mixed methods research in the health sciences. *Bethesda (Maryland): National Institutes of Health, 2013*, 541-545.

Cumming, E., & Henry, W. E. (1961). *Growing old, the process of disengagement*: Basic books.

Cummins, R. A. (2010). Fluency disorders and life quality: Subjective wellbeing vs. health-related quality of life. *Journal of Fluency Disorders*, *35*(3), 161-172.

Cummins, R. A., Lau, A. L., & Stokes, M. (2004). HRQOL and subjective well-being: noncomplementary forms of outcome measurement. *Expert review of pharmacoeconomics & outcomes research*, *4*(4), 413-420. doi: 10.1586/14737167.4.4.413

Dawis, R.V. (1998). Scale construction. In A. E. Kazdin (Ed.), *Methodological issues and strategies in clinical research* (pp. 193-213). Washington, DC: American Psychological Association.

Dawson, C. (2019). *Introduction to Research Methods 5th Edition: A Practical Guide for Anyone Undertaking a Research Project*: Robinson.

De Vellis, R. F. (*2003*). *Scale Development Theory and Applications* (2nd ed., Vol. 26). Thousand Oaks, CA Sage Publications.

De Vos, A. S., Strydom, H., Fouche, C. B., & Delport, C. S. L. (2002). *Research at grass roots or the social sciences and human service professions* (2nd Ed.). Pretoria: Van Schaik Publishers.

Deci, E. L., & Ryan, R. M. (2008a). "Facilitating optimal motivation and psychological wellbeing across life's domains".

Deci, E. L., & Ryan, R. M. (2008b). Hedonia, eudaimonia, and well-being: An introduction. *Journal of Happiness Studies, 9*(1), 1-11.

DeVellis, R. F. (2003). *Scale development: Theory and applications*. Newbury Park, CA: Sage.

Devins, G. M., Beiser, M., Dion, R., Pelletier, L. G., & Edwards, G. (1997). Cross-cultural measurements of psychological well-being: the psychometric equivalence of Cantonese, Vietnamese, and Laotian translations of the Affect Balance Scale. *American Journal of Public Health*, 87, 794-9.

DeVon, H. A., Block, M. E., Moyle-Wright, P., Ernst, D. M., Hayden, S. J., Lazzara, D. J., & Kostas-Polston, E. (2007). A psychometric toolbox for testing validity and reliability. *Journal of Nursing Scholarship*, *39*(2), 155-164.

Diener E., Emmons, R.A, Larsen, RJ, & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, *8*(45), 1–2. https://doi.org/10.1207/s15327752jpa4901

Diener, E. & Emmons, R. A. (1985). The independence of positive and negative affect. *Journal of Personality and Social Psychology*, 47, 5, 1105-17.

Diener, E. (1984). Subjective well-being. *Psychological Bulletin*, 95, 3, 542-72.

Diener, E. (2013). The remarkable changes in the science of subjective well-being. *Perspectives on Psychological Science*, *8*(6), 663-666.

Diener, E., & Chan, M. Y. (2011). Happy people live longer: Subjective well-being contributes to health and longevity. *Applied Psychology: Health and Well-Being*, *3*(1), 1-43. doi: 10.1111/j.1758-0854.2010.01045.x

Diener, E., & Emmons, R. A. (1984). The independence of positive and negative affect. *Journal of Personality and Social Psychology, 47*(5), 1105.

Diener, E., & Suh, E. M. (2000). Measuring subjective well-being to compare the quality of life of cultures. *Journal of Culture and subjective well-being*, 3-12.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, 49, 1, 71-5.

Diener, E., Pressman, S. D., Hunter, J., & Delgadillo-Chase, D. (2017). If, why, and when subjective well-being influences health, and future needed research. *Applied Psychology: Health and Well-Being*, *9*(2), 133-167.

Diener, E., Scollon, C. N., & Lucas, R. E. (2009). The evolving concept of subjective well-being: the multifaceted nature of happiness.

Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, 125(2), 276–302. https:// doi. org/ 10. 1037/ 0033- 2909. 125.2. 276

Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D. W., Oishi, S., & Biswas-Diener, R. (2010). New well-being measures: Short scales to assess flourishing and positive and negative feelings. *Journal of Social Indicators Research*, *97*, 143-156.

Diener, Napa Scollon, C., & Lucas, R. E. (2009). The evolving concept of subjective well-being: The multifaceted nature of happiness. *Assessing well-being: The collected works of Ed Diener*, 67-100.

Dodge, R., Daly, A. P., Huyton, J., & Sanders, L. D. (2012). The challenge of defining wellbeing. *International Journal of Wellbeing, 2*(3).

Dolan, P., Peasgood, T., & White, M. (2008). Do we really know what makes us happy? A review of the economic literature on the factors associated with subjective well-being. *Journal of Economic Psychology*, *29*(1), 94-122.

Douma, L., Steverink, N., Hutter, I., & Meijering, L. (2017). Exploring subjective well- being in older age by using participant-generated word clouds. *The Gerontologist, 57*(2), 229-239.

Ebner, N. C., Freund, A. M., & Baltes, P. B. (2006). Developmental changes in personal goal orientation from young to late adulthood: from striving for gains to maintenance and prevention of losses. *Journal of Psychology and Aging, 21*(4), 664.

Enworo, O. C. (2023). Application of Guba and Lincoln's parallel criteria to assess trustworthiness of qualitative research on indigenous social protection systems. *Qualitative Research Journal*, *23*(4), 372-384.

Erikson, E. H. (1959). Identity and the life cycle: Selected papers. *Psychological Issues, 1*, 1–171. https://doi.org/10.1080/21674086.1960.11926165

Etxeberria, I., Etxebarria, I., & Urdaneta, E. (2019). Subjective well-being among the oldest old: The role of personality traits. *Journal of Personality and Individual Differences, 146*, 209-216.

Fabrigar, L. R., Wegener, D. T., MacCallum, R. C., & Strahan, E. J. (1999). Evaluating the use of exploratory factor analysis in psychological research. *Psychological Methods, 4*, 272-299.

Fakoya, O. A., McCorry, N. K. & Donnelly, M. (2020). Loneliness and social isolation interventions for older adults: A scoping review of reviews. *BMC Public Health 20,* 129. https://doi.org/10.1186/s12889-020-8251-6

Fasil, N. (2010). *Exploring the effects of institutional care on the life of older persons: A case study on Kaliti Institutional Care Centre for the Elderly*. Unpublished M.A. thesis. Addis Ababa University: Addis Ababa.

Fatima, J., Sharma, V., & Sarkar, S. (2019). Subjective well-being, perceived physical and mental health status of elderly: A comparative study in urban and rural India. *Journal of Psychiatric Nursing*, (April). https://doi.org/10.21088/jpn.2277.9035.7318.4

Fischer, J., & Corcoran, K. (1994). *Measures for clinical practice*: A sourcebook: Couples, families and children (2nd ed.). New York City, NY: The Free Press.

Flammer, A. (1995). Developmental analysis of control beliefs. *Self-efficacy in changing societies*, 69-113.

Ford, J. K., MacCallum, R. C., & Tait, M. (1986). The application of exploratory factor analysis in applied psychology: A critical review and analysis. *Journal of Personnel Psychology*, *39*(2), 291-314.

Forgeard, M. J., Jayawickreme, E., Kern, M. L., & Seligman, M. E. (2011). Doing the right thing: Measuring wellbeing for public policy. *International Journal of Wellbeing, 1*(1).

Freund, A. M., & Baltes, P. B. (2002). Life-management strategies of selection, optimization and compensation: Measurement by self-report and construct validity. *Journal of Personality and Social Psychology, 82*(4), 642.

Freund, A. M., & Ebner, N. C. (2005). The aging self: Shifting from promoting gains to balancing losses. *The adaptive self: Personal continuity and intentional self-development*, 185-202.

Fry, C., Ikels, C., Poon, L., & Cohen-Mansfield, J. (2011). Culture and meaning: Strategies for understanding the well-being of the oldest old. *Understanding well-being in the oldest old*, 261-280.

Gabriel, Z., & Bowling, A. N. N. (2004). Quality of life from the perspectives of older people. *Journal of Ageing & Society*, *24*(5), 675-691.

Gallardo-Peralta, L. P., Mayorga Muñoz, C., & Soto Higuera, A. (2020). Health, social support, resilience and successful ageing among older Chilean adults. *Journal of International Social Work*, 65(2), 283-299. doi:10.1177/0020872819901147

Garson, G. (2007). *Testing of assumptions*. Retrieved in June 21, 2013 from http://faculty.chass.ncsu.edu/garson/PA765/assumpt.htm.

Garver, M. S., & Mentzer, J. T. (1999). Logistics research methods: Employing structural equation modeling to test for construct validity. *Journal of Business Logistics*, *20*, 1, 33-57.

Gasper, D. (2007). Uncounted or illusory blessings? Competing responses to the Easterlin, Easterbrook and Schwartz paradoxes of well-being. *Journal of International Development: The Journal of the Development Studies Association*, *19*(4), 473-492.

Gebremichael, A. Z., Teshome, A. Z., Kotecho, M. G., & Adamek, M. E. (2024). Reframing the image of older adults and advocating for their rights: the role of the older people's association in Ethiopia. *Working with Older People*. https://doi.org/10.1108/WWOP-07-2024-0037

George, L. K. (1981). Subjective well-being: conceptual and methodological issues. *Annual Review of Gerontology and Geriatrics*, 2, 345-82.

George, L. K. (2010). Still happy after all these years: Research frontiers on subjective well-being in later life. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *65*(3), 331-339.

Getinet, A. (2015). *Aging and retirement among Ethiopian elderly: Adjustment, challenges and policy implications.* Addis Ababa University.

Girum, T. (2012). *Psychological wellbeing as a function of religious involvement, spirituality and personal meaning in life among community-residing elders in Dessie Town*. Unpublished MA Thesis: Institute of Psychology: AAU.

Goldstein, M.C., & Beall, C.M. (1981). *Modernization in the third and fourth world*: Views from the rural hinterland in Nepal. Human Organization, 40(1), 48-55.

Goodwill, H. A. (2009). *Subjective well-being in older adults*. (Unpublished Doctoral dissertation, University of Birmingham).

Gorsuch, R. L. (1990). Common factor analysis versus component analysis: Some well and little known facts. *Multivariate Behavioral Research*, *25,* 33-39.

Green, K. W., Wu, C., Whitten, D. & Medlin, B. (2006). The impact of strategic human resource management on firm performance and HR professionals' work attitude and work performance. *International Journal of Human Resource Management*, *17*, 4, 559-579.

Gregory, R. J. (1992) *Psychological testing*: History, principles and applications, Allyn and Bacon: Boston.

Grenier, A., Lloyd, L., & Phillipson, C. (2017). Precarity in late life: Rethinking dementia as a 'frailed' old age. In P. Higgs & C. Gilleard (Eds.). *Ageing, dementia and the social mind,* (pp. 142-154). https://doi.org/10.1002/9781119397984.ch11

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, *2*(163-194), 105.

Güvendir, M. A., & Özkan, Y. Ö. (2022). Item removal strategies conducted in exploratory factor analysis: A comparative study. *International Journal of Assessment Tools in Education*, *9*(1), 165-180.

Hackert, M. Q., Brouwer, W. B., Hoefman, R. J., & van Exel, J. (2019). Views of older people in the Netherlands on wellbeing: A Q-methodology study. *Journal of Social Science & Medicine, 240*, 112535.

Hailu, E. (2020). *Assessment of Factors Affecting Elderly Living Conditions In Woreda 8, Lideta Sub-City, ADDIS ABABA.* St. Mary's University.

Hair J.F., Black W.C., Babin B.J., Anderson R.E. (2010) *Multivariate Data Analysis: A Global Perspective*. 7th Edition, Pearson Education, Upper Saddle River.

Hair, J. F., Black, W. C., Babin, B. J., Anderson, R. E., & Tatham, R. L. (2006b). Structural Equation Modeling: Confirmatory Factor Analysis, *Multivariate Data Analysis*, (6th Ed.). Upper Saddle River: Pearson Prentice Hall.

Hair, J. F., Black, W. C., Babin, B. J., Anderson, R. E., & Tatham, R. L. (2006a). *Structural Equation Modeling:* An Introduction, Multivariate Data Analysis, 6th ed. Upper Saddle River: Pearson Prentice Hall.

Hamid, T. A., Momtaz, Y. A., & Ibrahim, R. (2012). Predictors and prevalence of successful aging among older Malaysians. *Journal of Gerontology, 58*(4), 366-370.

Hammond, R. J. (2010). *Introduction to sociology* (Smashwords edition): Hammond, R.J., & Cheney, P.

Hamren, K., Chungkham, H. S., & Hyde, M. (2015). Religion, spirituality, social support and quality of life: measurement and predictors CASP-12 (v2) amongst older Ethiopians living in Addis Ababa. *Journal of Aging & Mental Health, 19*(7), 610-621.

Harding, S. D. (1982). Psychological well-being in Great Britain: an evaluation of the Bradburn Affect Balance Scale. *Personality and Individual Differences*, 3, 167-75.

Harmell, A. L., Jeste, D., & Depp, C. (2014). Strategies for successful aging: a research update. *Current psychiatry reports, 16*(10), 476.

Harrington, D. (2009). *Confirmatory factor analysis*. Oxford: Oxford University Press.

Hassad, R. A. (2007). *Development and validation of a scale for measuring instructors' attitudes toward concept-based or reform-oriented teaching of introductory statistics in the health and Behavioral sciences*. Unpublished Doctorial Dissertation, Touro University International, College of Health Sciences, Cypress, California. Retrieved on March 12, 2013 from http://iase-web.org/documents/dissertations/07.Hassad.Dissertation.pdf.

Hassad, R. A. (2010). Development and validation of a teaching practice scale (TISS) for instructors of introductory statistics at the college level. *arXiv preprint arXiv:1007.3654*.

Hassan, S. M. U., Hamid, T. A., Haron, S. A., & Ibrahim, R. (2018). A systematic review on psychosocial determinants of elderly subjective wellbeing. *Mediterranean Journal of Social Sciences, 9*(6), 107-107.

Hatcher, L. (1994). *A step-by-step approach to using the SAS system for factor analysis and structural equation modeling*. Cary, NC: SAS Institute.

Havighurst, R. J. (1963). Successful aging. *Processes of aging: Social and psychological perspectives, 1*, 299-320.

Havighurst, R. J., Neugarten, B. L., & i Tobin, S. (1963). Disengagement, personality and life satisfaction in the later years. U: Hansen, PF (ur.). *Age with a future*, 419-425.

He, Q., Cui, Y., Liang, L., Zhong, Q., Li, J., Li, Y., Huang, F. (2017). Social participation, willingness and quality of life: a population-based study among older adults in rural areas of China. *Journal of Geriatrics & Gerontology International, 17*(10), 1593-1602. https://doi.org/10.1111/ggi.12939

Heckhausen, J., & Schulz, R. (1995). A life-span theory of control. *Psychological review, 102*(2), 284.

Heckhausen, J., Wrosch, C., & Schulz, R. (2010). A motivational theory of life-span development. *Psychological review, 117*(1), 32.

Helliwell, J. F., & Putnam, R. D. (2004). The social context of well–being. *Philosophical Transactions of the Royal Society of London. Series B: Biological Sciences*, *359*(1449), 1435-1446. doi: 10.1098/rstb.2004.1522

Helmes, E., Goffin, R. D., & Chrisjohn, R. D. (1998). Confirmatory factor analysis of the Life Satisfaction Index. *Social Indicators Research*, 45, 371-90.

HelpAge International (2023). Enhancing financial inclusion of older urban poor in Ethiopia. https://www.helpage.org/news/enhancing-financial-inclusion-of-older-urban-poor-in-ethiopia/

HelpAge International (2018). Voice and accountability in social protection: Lessons from social pensions in Africa. https://www. helpage.org/resource/voice-and-accountability-in-social-protection-lessons-from-social-pensions-in-africa

HelpAge International (2018). *Vulnerability of Older People in Ethiopia:* The case of Oromia, Amhara, and SNNP Regional State. Addis Ababa.

Henrich, J., Heine, S. J., & Norenzayan, A. (2010). Most people are not WEIRD. *Nature, 466* (7302), 29-29.

Henson, R. K., & Roberts, J. K. (2006). Use of exploratory factor analysis in published research: Common errors and some comment on improved practice. *Journal of Educational and Psychological Measurement. 66*, 3, 393-416.

Hilton, J. M., Gonzalez, C. A., Saleh, M., Maitoza, R., & Anngela-Cole, L. (2012). Perceptions of successful aging among older Latinos, in cross-cultural context. *Journal of Cross-Cultural Gerontology, 27*, 183-199.

Hinkin, T. R. (1998). A brief tutorial on the development of measures for use in survey questionnaires. *Organizational Research Methods*, *1*(1), 104-121.

Holmes, J. (2006).*Successful ageing*: A critical analysis (doctoral dissertation).Massey University, New Zealand

Hörder, H., Frändin, K., & Larsson, M. H. (2013). Self-respect through ability to keep fear of frailty at a distance: Successful ageing from the perspective of community-dwelling older people. *International Journal of Qualitative Studies on Health and Well-being, 8*(1), 20194.

Hoyt, D. & Creech, J. (1983). The Life Satisfaction Index: a methodological and theoretical critique. *Journal of Gerontology*, 38, 111-6.

Hu, L. T., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives. *Structural equation modeling: a multidisciplinary journal*, *6*(1), 1-55.

Hudson, W.W. (1994). *Developing short-form assessment scales*. Atlanta: Annual Program Meeting of the Council on Social Work Education.

Hurley, A. E., Scandura, T. A., Schriesheim, C. A., Brannick, M. T., Seers, A., & Vandenberg, R. J. (1997). Exploratory and confirmatory factor analysis: Guidelines, issues, and alternatives. *Journal of Organizational Behavior*, *18*, 667-683.

Jember, T. (2007). Maximum benefit to old people through community based integrated holistic approach, in "Cross-generational challenges: Children, the family, and the elderly"

(unpublished abstracts),The 6th Annual Conference of the Ethiopian Society of Sociologists, Social Workers, and Anthropologists (ESSSWA), 14 & 15 December 2007, p.8., Addis Ababa, Ethiopia. .

John, R. (1984). Prerequisites of an adequate theory of aging: A critique and reconceptualization. *Mid-American Review of Sociology*, IX (2), 79-108.

Jopp, D. S., Wozniak, D., Damarin, A. K., De Feo, M., Jung, S., & Jeswani, S. (2015). How could lay perspectives on successful aging complement scientific theory? Findings from a US and a German life-span sample. *The Gerontologist, 55*(1), 91-106.

Jopp, D., & Smith, J. (2006). Resources and life-management strategies as determinants of successful aging: On the protective effect of selection, optimization, and compensation. *Journal of Psychology and Aging, 21*(2), 253.

Kafka, G. J. & Kozma, A. (2002). The construct validity of Ryff's Scales of Psychological Well-Being (SPWB) and their relationship to measures of subjective well-being. *Social Indicators Research*, 57, 171-90.

Kahneman, D., & Deaton, A. (2010). High income improves evaluation of life but not emotional well-being. *Proceedings of the National Academy of Sciences of the United States of America, 107*(38), 16489–16493. https://doi.org/10.1073/pnas.1011492107

Kaiser, H. (1974). An index of factorial simplicity. *Psychometrika*, *39*, 1, 31-36.

Kammann, R., Farry, M., & Herbison, P. (1984). The analysis and measurement of happiness as a sense of well-being. *Social Indicators Research*, 15, 91-115.

Kassahun, H. (2007). *Relationship of elderly with their adult children and their effects on adjustment to aging*: The case of Desssie Town. Unpublished MA Thesis: Institute of Psychology: AAU.

Kassahun, T. (2015). *Psychological and subjective well being of ethiopian adults: correlates and socio cultural constructions.* Ph. D Dissertation. Addis Ababa University.

Keith, J., Fry, C. L., Glascock, A. P., Ikels, C., Dickerson-Putman, J., Harpending, H. C., & Draper, P. (1994). *The aging experience: Diversity and commonality across cultures*: Sage Publications.

Keyes, C. L. (2006). Subjective well-being in mental health and human development research worldwide: An introduction. *Social indicators research, 77*(1), 1-10.

Kifle, M. (2002). *Old age and social change: an anthropological study of the lives of the elderly among the Amhara of Ensaro.* Unpublished M.A. thesis, Addis Ababa University, Addis Ababa.

Kim, Y. M. (2009). Validation of psychometric research instruments: The case of information science. *Journal of the American Society for Information Science and Technology*, *60*(6), 1178-1191.

Klar, M., & Kasser, T. (2009). Some benefits of being an activist: Measuring activism and its role in psychological well-being. *Journal of Political Psychology, 30*(5), 755-777.

Kline, T. (2005). *Psychological testing: A practical approach to design and evaluation*. Sage: Thousand Oaks, CA.

Kondale Gurara, T., Desie, Y., & Adamek, M. E. (2025). 'Age should never be a barrier to pursuing our passions': older adults' conceptualization of subjective well-being in Ethiopia. *Journal of Aging & Mental Health*, 1-10. doi: 10.1080/13607863.2025.2464711

Kopperud, K., H. & Vittersø, J. (2008). Distinctions between hedonic and eudaimonic well-being: results from a day reconstruction study among Norwegian jobholders. *The Journal of Positive Psychology*, 3, 3, 174-81.

Kotecho, M. G., Chane, S., Gebeyaw, G., Zelalem, A., Dawud, M., & Adamek, M. E. (2021). Life is hard and getting harder: The experience of aging in Ethiopia. In *Aging Across Cultures* (pp. 45-65). Springer, Cham.

Kotecho, M., & Adamek, M. (2017). Gender differences in quality of life of urban elders in Ethiopia. *Journal of Innovation in Aging, 1*(Suppl 1), 879.

Kourouklis, D., Verropoulou, G., & Tsimbos, C. (2020). The impact of wealth and income on the depression of older adults across European welfare regimes. *Journal of Ageing and Society, 40*(11), 2448–2479. https://doi.org/10.1017/S0144686X19000679

Kozma, A. & Stones, M. J. (1980). The measurement of happiness: development of the Memorial University of Newfoundland Scale of Happiness (MUNSH). *Journal of Gerontology*, 35, 6, 906-12.

Kubzansky, L. D., Kim, E. S., Boehm, J. K., Davidson, R. J., Huffman, J. C., Loucks, E. B., ... & Moskowitz, J. T. (2023). Interventions to modify psychological well-being: Progress, promises, and an agenda for future research. *Affective Science*, *4*(1), 174-184.

Lampropoulou, A. (2018). Personality, school, and family: What is their role in adolescents' subjective well-being. *Journal of Adolescence*, *67*, 12-21. doi:10.1016/j.adolescence.2018.05.013

Lange, J. K. (2002, November). Richard A. Krueger & Mary Anne Casey (2000). Focus groups. A practical guide for applied research. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* (Vol. 3, No. 4).

Larson, R. (1978). Thirty years of research on the subjective well-being of older Americans. *Journal of Gerontology*, 33, 1, 109-25.

Lawler-Row, K. A., & Elliott, J. (2009). The role of religious activity and spirituality in the health and well-being of older adults. *Journal of Health Psychology, 14*(1), 43-52.

Lawshe, C. H. (1975). *A quantitative approach to content validity*. Personnel Psychology, 28(4), 563–575.

Layard, R. (2010). Measuring subjective well-being. *Science*, *327*(5965), 534-535.

Lee, D. M., Vanhoutte, B., Nazroo, J., & Pendleton, N. (2016). Sexual health and positive subjective well-being in partnered older men and women. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *71*(4), 698-710. doi: 10.1093/geronb/gbw018

Lemma, S. (2014). *Experiences and practices of old age home care and support to the elderly living in the institutions*: Assessment at three selected institutions in Addis Ababa Unpublished Master's Thesis. Addis Ababa University, Addis Ababa, Ethiopia.

Levasseur, M., Richard, L., Gauvin, L., & Raymond, É. (2010). Inventory and analysis of definitions of social participation found in the aging literature: Proposed taxonomy of social activities. *Social Science &Medicine, 71*(12), 2141-2149.

Liang, J., van Tran, T., & Markides, K. S. (1988). Differences in the structure of Life Satisfaction Index in three generations of Mexican Americans. *Journal of Gerontology: Social Sciences*, 43, 1, 1-8.

Liang, Y., Niu, X., & Lu, P. (2020). The aging population in China: Subjective well-being of empty nesters in rural eastern China. *Journal of Health Psychology*, *25*(3), 361-372. doi: 10.1177/1359105317717599

Lincoln, Y., & Guba, E. (1985). Establishing trustworthiness. *Naturalistic inquiry, 289*(331), 289-327.

Lindquist, J. D., Vida, I., Plank, R. E. & Fairhurst, A. (2001). The modified CETSCALE: Validity Tests in the Czech Republic, Hungary, and Poland. *International Business Review*, *10*, 505–516.

Litwin, H. & Shiovitz-Ezra, S. (2006). The association between activity and wellbeing in later life: what really matters? *Journal of Ageing and Society*, 26, 2, 225-42.

Liu, C., Luo, D., Zhou, Y., Zhang, G., Feng, X., Wang, Z., & Bi, Q. (2022). Optimism and subjective well-being in nursing home older adults: the mediating roles of gratitude and social support. *Journal of Geriatric Nursing*, *47*, 232-238. doi: 10.1016/j.gerinurse.2022.07.020

Liu, H., Gan, Q., Tan, J., Sun, X., Liu, Y., & Wan, C. (2023). The association between quality of life and subjective wellbeing among older adults based on canonical correlation analysis. *Frontiers in public health*, *11*, 1235276. doi: 10.3389/fpubh.2023.1235276

Lloyd-Sherlock, P. (2000). Old age and poverty in developing countries: New policy challenges. *World Development, 28*(12), 2157-2168.

Lord, S., Chastin, S. F. M., McInnes, L., Little, L., Briggs, P., & Rochester, L. (2011). Exploring patterns of daily physical and sedentary behaviour in community-dwelling older adults. *Journal of Age and Ageing, 40*(2), 205-210.

Lowenstein, A., Katz, R., Prilutzky, D., & Mehlhausen-Hassoen, D. (2001).The intergenerational solidarity paradigm. In S. O. Daatland, K. Herlofson (Eds.) *Ageing, intergenerational relations, care systems and quality of life* (p.11-30).Norway: NOVA

Lynn, M. R. (1986). Determination and quantification of content validity. *Nursing research*, *35*(6), 382-386.

Macaluso, S., & Free, J. (2023). Assessing the needs of older adults in rural west Texas. *Journal of Innovation in Aging*, *7*(Suppl 1), 889.

Maciá, M. M. (2016). Pinning Down Subjective Valuations: A Well-BeingAnalysis Approach to Eminent Domain. *The University of Chicago Law Review* 83 (2), 945–999.

MacIntosh, R. (1998). A confirmatory factor analysis of the Affect Balance Scale in 38 nations: a research note. *Social Psychology Quarterly*, 61, 83-91.

Maddox, G. L. & Douglass, E. B. (1973). Self-assessment of health: a longitudinal study of the elderly. *Journal of Health and Social Behaviour*, 14, 1, 87-93.

Magyar, J. L., & Keyes, C. L. M. (2019). Defining, measuring, and applying subjective well-being. In M. W. Gallagher & S. J. Lopez (Eds.), *Positive psychological assessment*: A handbook of models and measures (pp. 389–415). American Psychological Association.

Mahlet, S. (2007). *Attitude of the community as perceived by the elderly people and its implication for successful aging*. The case of Tehuledere and Dessie ZureaWoredas.Unpublished MA Thesis: Institute of Psychology: AAU.

Maitland, S. B., Dixon, R. A., Hultsch, D. F., & Hertzog, C. (2001). Well-being as a moving target: measurement equivalence of the Bradburn Affect Balance Scale. *Journal of Gerontology: Psychological Sciences*, 56B, 69-77.

Malhotra, N. K. (2005). *Marketing research*: An applied orientation. New Delhi: Pearson Education.

Márquez, M. G., & Delgado, A. R. (2017). An exploratory sequential design to validate measures of moral emotions. *Psicothema, 29*(2), 261-267.

Mberu, B., Béguy, D., & Ezeh, A. C. (2017). Internal migration, urbanization and slums in sub-Saharan Africa. In H. Groth & J.F. May (Eds.). *Africa's population: In search of a demographic dividend*(pp. 315-332). Springer.

McCann Mortimer, P., Ward, L., & Winefield, H. (2008). Successful ageing by whose definition? Views of older, spiritually affiliated women. *Australasian Journal on Ageing, 27*(4), 200-204.

McDonald, L. (2007). Abuse & neglect of elders. In J. E., Birren (Ed.). *Encyclopedia of gerontology* (2nd ed., p. 1-9).

McGillivray, M., & Clarke, M. (2006). *Understanding human well-being*: United Nations University Press.

Meister, A. (1991). Glutathione deficiency produced by inhibition of its synthesis, and its reversal; applications in research and therapy. *Pharmacology & therapeutics*, *51*(2), 155-194.

Menec, V. H. (2003). The relation between everyday activities and successful aging: A 6-year longitudinal study. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 58*(2), S74-S82.

Mentzer, J. T., Flint, D. J., & Kent, J. L. (1999). Developing a logistics service quality scale. *Journal of Business Logistics*, *20*, 1, 9–32.

Minhat, H., Rahmah, M., & Khadijah, S. (2013). Continuity theory of ageing and leisure participation among elderly attending selected health clinics in Selangor. *IIUM Medical Journal Malaysia, 12*(2).

MoWSA (2006). *Development Social Welfare Policy of the Federal Democratic Republic of Ethiopia*: Ministry of Labor and Social Affairs. Ethiopia: Addis Ababa.

Moradi, S., Fekrazad, H., Mousavi, M. T., & Arshi, M. (2013). The study of relationship between social participation and quality of life of old people who are members of senior association of Tehran City in 2011. *Iranian Journal of Ageing, 7*(4), 41-46.

MoWSA (2012). *Development Social Welfare Policy of the Federal Democratic Republic of Ethiopia*: Ministry of Labor and Social Affairs. Ethiopia: Addis Ababa.

Mussie, T. (2006). *Theconsequences of HIV/AIDS in the traditional support networks of the elderly in Arada Sub-City, Addis Ababa*. Unpublished M.A. thesis. Addis Ababa University: Addis Ababa.

Muzindutsi, P.-F., & Sekhu, T. J. (2014). Determinants of wellbeing in a South African Township. *International Journal of Social Sciences and Humanity Studies, 6*(1), 47-57.

Myers, D., & Diener, E. (1995). Who is happy? *Psychological science, 6*(1), 10-19.

Myers, M. D., & Newman, M. (2007). The qualitative interview in IS research: Examining the craft. *Information and organization*, *17*(1), 2-26.

Netemeyer, R. G., Bearden, W. O., & Sharma, S. (2003). *Scaling procedures: Issues and applications*. London: Sage.

Netemeyer, R. G., Warmath, D., Fernandes, D., & Lynch Jr, J. G. (2018). How am I doing? Perceived financial well-being, its potential antecedents, and its relation to overall well-being. *Journal of Consumer Research, 45*(1), 68-89.

Neugarten, B. (1972). Personality and the aging process. *Gerontologist*, 12, 9–15.

Neugarten, B. L., Havighurst, R. J., & Tobin, S. S. (1961). The measurement of life satisfaction. *Journal of Gerontology*, 16, 134-43.

Nguyen, N. D., & Lin, Z. (2025). Social Isolation and Subjective Well-Being Among Older Adults: A Longitudinal Examination by Race/Ethnicity and Gender. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, gbaf066.

Nikitin, J., & Freund, A. M. (2021). Does focusing on others enhance subjective well-being? The role of age, motivation, and relationship closeness. *Journal of Psychology and Aging*, *36*(1), 69. doi: 10.1037/pag0000489

Nimrod, G., & Ben-Shem, I. (2015). Successful aging as a lifelong process. *Journal of Educational Gerontology, 41*(11), 814-824.

Nunnally, J. C. (1978). An overview of psychological measurement. *Clinical diagnosis of mental disorders: A handbook*, 97-146.

Oishi, S., & Westgate, E. C. (2022). A psychologically rich life: Beyond happiness and meaning. *Psychological review*, *129*(4), 790.

Padilla-Díaz, M. (2015). Phenomenology in educational qualitative research: Philosophy as science or philosophical science. *International Journal of Educational Excellence, 1*(2), 101-110.

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative Social Work, 1*(3), 261-283.

Pavlova, M. K., & Silbereisen, R. K. (2012). Participation in voluntary organizations and volunteer work as a compensation for the absence of work or partnership? Evidence from two German samples of younger and older adults. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *67*(4), 514-524. doi: 10.1093/geronb/gbs051

Pavot, W. & Diener, E. (1993). Review of the Satisfaction with Life Scale. *Psychological Assessment*, 5, 2, 164-72.

Pavot, W., Diener, E., Colvin, C. R., & Sandvik, E. (1991). Further validation of the Satisfaction with Life Scale: evidence for the cross-method convergence of well-being measures. *Journal of Personality Assessment*, 57, 1, 149-61.

Pinquart, M., & Sörensen, S. (2000). Influences of socioeconomic status, social network, and competence on subjective well-being in later life: a meta-analysis. *Journal of Psychology and Aging*, *15*(2), 187. doi: 10.1037/0882-7974.15.2.187

Potočnik, K., & Sonnentag, S. (2013). A longitudinal study of well-being in older workers and retirees: The role of engaging in different types of activities. *Journal of Occupational and Organizational Psychology, 86*(4), 497-521.

Pruchno, R., Heid, A. R., & Genderson, M. W. (2015). Resilience and successful aging: Aligning complementary constructs using a life course approach. *Psychological Inquiry*, *26*(2), 200-207.

Ram, B., Limb, E. S., Shankar, A., Nightingale, C. M., Rudnicka, A. R., Cummins, S., & Owen, C. G. (2020). Evaluating the effect of change in the built environment on mental health and subjective well-being: a natural experiment. *Journal of Epidemiol Community Health*, *74*(8), 631-638. doi: 10.1136/jech-2019-213591

Rank, M. R., & LeCroy, C. W. (1983). Toward a multiple perspective in family theory and practice: The case of social exchange theory, symbolic interactionism, and conflict theory. *Family Relations*, 32(3), 441-448.

Reker, G. T. & Wong, P. T. P. (1984). Psychological and physical well-being in the elderly: The Perceived Well-Being Scale (PWB). *Canadian Journal on Aging*, **3**, 1, 23-32.

Rook, K. S. (2015). Social networks in later life: Weighing positive and negative effects on health and well-being. *Current directions in psychological science*, *24*(1), 45-51. doi: 10.1177/0963721414551364

Rowe, J. W., & Kahn, R. L. (1987). Human aging: usual and successful. *Science*, *237*(4811), 143-149.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, *37*(4), 433–440.. https://doi.org/10.1093/geront/37.4.433

Rozanova, J., Noulas, P., Southwick, S. M., & Pietrzak, R. H. (2015). Perceptions of determinants of successful aging among older US veterans: Results from the national health and resilience in veterans study. *The American Journal of Geriatric Psychiatry, 23*(7), 744-753.

Rubin, A., & Babbie, E. R. (2005). *Research Methods for Social Work* (5th Ed.). Belmont, CA: Brooks/Cole-Thompson Learning.

Rumsey, N., & Marks, D. F. (2004). Getting started: the practicalities of doing research. *Research Methods for Clinical and Health Psychology. London, Thousand Oaks, New Delhi: Sage Publications Limited*.

Russell, H., Watson, D., & McGinnity, F. (2013). Unemployment and subjective well-being. *Economic crisis, quality of work, and social integration*, 229-255.

Russell, J. A. & Carroll, J. M. (1999). On the bipolarity of positive and negative affect. *Psychological Bulletin*, 125, 1, 3-30.

Rust, N. C. (2014). 30 population-based representations. *The cognitive neurosciences*, 337.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual review of psychology, 52*(1), 141-166.

Ryan, R. M., & Deci, E. L. (2017). Self-determination theory. *Basic psychological needs in motivation, development, and wellness*.

Ryff, C. D. & Keyes, C. L. M. (1995). The structure of well-being revisited. *Journal of Personality and Social Psychology*, 69, 719-27.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, 57, 6, 1069-81.

Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*(4), 719.

Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological inquiry, 9*(1), 1-28.

Ryff, C. D., & Singer, B. H. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of Happiness Studies*, *9*, 13-39.

Ryff, C. D., Lee, Y. H., Essex, M. L., & Schmutte, P. S. (1994). My children and me: midlife evaluation of grown children and self. *Journal of Psychology and Aging*, 9, 195-205.

Ryff, C., & Keyes, C. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, 69, 719–727. doi:10.1037/0022-3514.69.4.719

Sadler, E., & Biggs, S. (2006). Exploring the Links between Spirituality and 'Successful Ageing'. *Journal of Social Work Practice*, 20(3), 267-280. doi:10.1080/02650530600931757

Samuel, D. (2005). *Abuse and neglect of the elderly in Addis Ababa*. Unpublished MA Thesis. Addis Ababa University.

Sastre, M. T. M. (1999). Lay conceptions of well-being and rules used in well-being judgments among young, middle-aged, and elderly adults. *Social Indicators Research, 47*(2), 203-231.

Schaie, K. W., & Willis, S. L. (2010). *Handbook of the psychology of aging*: Academic Press.

Schiaffino, K. M. (2002). Other measures of psychological well-being. *Arthritis & Rheumatism*, 49, 5, 165-74.

Schriesheim, C. A., Powers, K., J., Scandura, T. A., Gardiner, C. C., & Lankau, M., J. (1993). Improving construct measurement in management research: Comments and a quantitative approach for assessing the theoretical content adequacy of paper-and-pencil survey-type instruments. *Journal of Management*, *19*, 385-417.

Schulz, R., & Heckhausen, J. (1996). A life span model of successful aging. *American psychologist*, *51*(7), 702.

Schumacker, R. E. & Lomax, R. G. (1996). *A beginner's guide to structural equation modeling*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers.

Sedgwick, P. (2015). Multistage sampling. *British Medical Journal. 351*, 41-55. https://doi:10.1136/bmj.h4155

Seid, A. M., & Babbel, N. F. (2023). Ethiopian ageing policy: A review of existing frameworks in relation to the Madrid International Plan of Action on Aging. *Public Health in Practice*, *6,* https://doi.org/10.1016/j.puhip.2023.100432

Setegn, A. (2010). *Community based care systems of Awuramba towards older persons*. Unpublished M.A. thesis. Addis Ababa University: Addis Ababa. .

Shankar, A., Hamer, M., McMunn, A., & Steptoe, A. (2013). Social isolation and loneliness: Relationships with cognitive function during 4 years of follow-up in the English Longitudinal Study of Ageing. *Journal of Psychosomatic Medicine, 75*(2), 161-170.

Şimşek, Ö. F. (2011). An intentional model of emotional well-being: The development and initial validation of a measure of subjective well-being. *Journal of Happiness Studies*, *12*(3), 421-442.

Slavec, A., & Drnovšek, M. (2012). A perspective on scale development in entrepreneurship research. *Economic and business Review*, *14*(1), 3.

Smith-Merry, J. (2008). Improving mental health and wellbeing in Scotland: a model policy approach. *Australian e-Journal for the Advancement of Mental Health*, **7**, 3, http://www.auseinet.com/journal/vol7iss3/smith-merry.pdf

Solomon, T. (2012). *The lived experiences of the abused elderly people in Bishoftu Town*: *A Phenomenological Study*. Unpublished M.A. thesis. Addis Ababa University: Addis Ababa.

Soósová, M. S., Timková, V., Dimunová, L., & Mauer, B. (2021). Spirituality as a mediator between depressive symptoms and subjective well-being in older adults. *Journal of Clinical Nursing Research, 30*(5), 707-717.

Soukiazis, E., & Ramos, S. (2016). The structure of subjective well-being and its determinants: A micro-data study for Portugal. *Social Indicators Research, 126*(3), 1375-1399.

Spector, P. E. (1992). *Summated rating scale construction: An introduction*. Newbury Park, CA: Sage Publications.

Springer, K. W. & Hauser, R. M. (2006b). Bad news indeed for the Ryff's six-factor model of well-being. *Social Science Research*, 35, 1120-31.

Square, M. S. (2014). *Response from the Older People's*: Commissioner for Wales to the Mid-Wales Healthcare Study: National Assembly for Wales' Inquiry into Public Libraries in Wales

Steptoe, A., Deaton, A., & Stone, A. A. (2015). Subjective wellbeing, health, and ageing. *The lancet*, *385*(9968), 640-648. doi: 10.1016/S0140-6736(13)61489-0

Stevens, J. (1996). *Applied multivariate statistics for the social sciences* (3rd ed.). Mahwah, NJ: Lawrence Erlbaum Associates.

Stevens, J. P. (2002). *Applied multivariate statistics for the social sciences* (4th ed.). MahwahNJ: LEA.

Steverink, N. (2014). Successful Development. *The Oxford handbook of clinical geropsychology*, 84.

Stewart-Brown, S., Tennant, A., Tennant, R., Platt, S., Parkinson, J., & Weich, S. (2009). Internal construct validity of the Warwick-Edinburgh Mental Well-being Scale (WEMWBS): a Rash analysis using data from the Scottish Health Education Population Survey. *Journal of Health and Quality of Life Outcomes*, 7, 15, http://www.hqlo.com/content/7/1/15

Stones, M. J. & Kozma, A. (1985). Structural relationships among happiness scales: a second order factorial study. *Social Indicators Research*, 17, 1, 19-28.

Straub, D. W., Boudreau, M. C, & Gefen, D. (2004).Validation guidelines for is positivist research, *Communications of the AIS*, *13*, 380-427.

Strauss, A. & Corbin, J. (2014). *Basics of Qualitative Research Techniques*. New York: Sage Publications.

Strehler, B. L. (1962). Further studies on the thermally induced aging of Drosophila melanogaster. *Journal of Gerontology (US), 17*.

Sutipan, P., Intarakamhang, U., & Macaskill, A. (2017). The impact of positive psychological interventions on well-being in healthy elderly people. *Journal of Happiness Studies, 18*(1), 269-291.

Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics*. Boston: Pearson Education Inc.

Tadesse, A. (2015). *Parenting style in Amhara region: Development and validation of parenting style scale and investigation of adolescents' self-esteem, identity style and psychological wellbeing*. Unpublished dissertation, Addis Ababa University.

Tate, R. B., Lah, L., & Cuddy, T. E. (2003). Definition of successful aging by elderly Canadian males: The Manitoba follow-up study. *The Gerontologist, 43*(5), 735-744.

Teater, B., & Chonody, J. M. (2020). How do older adults define successful aging? A scoping review. *The International Journal of Aging and Human Development*, *91*(4), 599-625.

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*: Sage.

Teka, A., & Adamek, M. E. (2014). "We prefer greeting rather than eating:" Life in an elder care center in Ethiopia. *Journal of Cross-Cultural Gerontology, 29*, 389-404.

Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., & Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Journal of Health and Quality of Life Outcomes*, **5**, 63, http://www.hqlo.com/content/5/1/63

Teshale, S. M., & Lachman, M. E. (2016). Managing daily happiness: The relationship between selection, optimization, and compensation strategies and well-being in adulthood. *Journal of Psychology and Aging*, *31*(7), 687.

Teshome, A. (2013). Informal and formal social protection in Ethiopia. *Informal and formal social protection systems in Sub-Saharan Africa*, 95-120.

Thompson B, Daniel, L.G. (1996). Factor analytic evidence for the construct validity of scores: A historical overview and some guidelines. *Journal of Educational and Psychological Measurement, 56,* 2, 197-208.

Thompson, B. (2004). *Exploratory and confirmatory factor analysis: Understanding concepts and applications.* Washington, DC: American Psychological Association.

Tilahun, F. (2010). *Exploring the psychosocial experiences of older people in Dangil Town*. Unpublished MA Thesis.Addis Ababa University.

Tinsley, H. E. A., & Tinsley, D. J. (1987). Uses of factor analysis in counseling psychology research. *Journal of Counseling Psychology*, *34*, 414-424.

Tiwery, W. Y., Heriani, I., & Rusvitawati, D. (2023). Effects of Age, Sex, Personality Traits, and Social Support on Successful Aging: A Longitudinal Study of Older Adults in Sukabumi City. *West Science Interdisciplinary Studies*, 1(02), 31-40. doi:10.58812/wsis.v1i02.45

Tomas, T. (2007). *Psychosocial profile of the Elderly at kaliti for the Aged*. Unpublished MA Thesis. Addis Ababa University.

Toye, F., Jenkins, C., & Barker, K. (2021). Understanding the experience of living well, beyond the age of 85 years: A qualitative analysis using themes from a meta-ethnography. *Journal of Age and Ageing, 50*(6), 2238-2245. https://doi.org/10.1093/ageing/afab179

United Nations (2024). World Population Prospects. United Nation. 1–52 p.

United Nations, Department of Economic and Social Affairs (UN DESA) (2020)

United Nations, Department of Economic and Social Affairs, Population Division. (2019). *World Population Prospects 2019: Highlights* (ST/ESA/SER.A/423).

United Nations, Department of Economic and Social Affairs, Population Division (2022). *World Population Prospects 2022*: derived from male and female life expectancy

Unruh, J. D. (2005). Changing conflict resolution institutions in the Ethiopian pastoral commons: The role of armed confrontation in rule-making. *GeoJournal*, 64(3), 225–237. https://doi.org/10.1007/s10708-005-5650-2

Urbina, S. (2004). *Essentials of psychological testing*. Hoboken, NJ: John Wiley & Sons.

Utkarsh, Pandey, A., Ashta, A., Spiegelman, E., & Sutan, A. (2020). Catch them young: Impact of financial socialization, financial literacy and attitude towards money on financial well-being of young adults. *International Journal of Consumer Studies*, *44*(6), 531-541.

Van der Riet, M., & Durrheim, K. (2006). Putting design into practice: Writing and evaluating research proposals. *Research in practice: Applied methods for the social sciences*, *2*, 80-111.

Van Dierendonck, D. (2005). The construct validity of Ryff's Scales of Psychological Well-being and its extension with spiritual well-being. *Journal of Personality and Individual Differences*, 36, 629-43.

Van Hoorn, A. (2007). *A short introduction to subjective well-being: Its measurement, correlates and policy uses.* Paper presented at the Trabajo presentado en la International conference: Is happy measurable and what do those measures mean for policy.

Van Schuur, W. H. & Kruijtbosch, M. (1995). Measuring subjective well-being: unfolding the Bradburn Affect Balance Scale. *Journal of Social Indicators Research*, 36, 1, 49-74.

Vanhoutte, B. (2014). The multidimensional structure of subjective well-being in later life. *Journal of Population Ageing, 7*(1), 1-20.

Varshney, S. (2007). *Predictors of successful aging: Associations between social network patterns, life satisfaction, depression, subjective health, and leisure time activity for older adults in India (doctoral dissertation)*. Texas: University of North Texas

Veenhoven, R. (2009). Well-being in nations and well-being of nations: Is there a conflict between individual and society?. *Journal of Social Indicators Research*, *91*, 5-21.

Velasco-Gonzalez, L., & Rioux, L. (2014). The spiritual well-being of elderly people: A study of a French sample. *Journal of Religion and Health, 53*, 1123-1137.

Vleioras, G., & Bosma, H. A. (2005). Are identity styles important for psychological well-being?. *Journal of Adolescence*, *28*(3), 397-409.

Wallace, K. A., & Wheeler, A. J. (2002). Reliability generalization of the Life Satisfaction Index. *Journal of Educational and Psychological Measurement*, 62, 4, 674-84.

Walsh, K., O'Shea, E., & Scharf, T. (2020). Rural old-age social exclusion: A conceptual framework on mediators of exclusion across the life-course. *Journal of Aging & Society*, 40, 2311–2337. https://doi. org/10.1017/S0144686X19000606

Wang, S. Y., & Kim, G. (2020). The relationship between physical-mental comorbidity and subjective well-being among older adults. *Journal of Clinical Gerontologist*, *43*(4), 455-464. doi: 10.1080/07317115.2019.1580810

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS Scales. *Journal of Personality and Social Psychology*, 54, 6, 1063-70.

Waweru, L., Kabiru, E., Mbithi, J., & Some, E. (2003). Health status and health seeking behaviour of the elderly persons in Dagoretti division, Nairobi. *East African Medical Journal, 80*(2), 63-67.

Westerhof, G. J., Whitbourne, S. K., & Freeman, G. P. (2012). The aging self in a cultural context: The relation of conceptions of aging to identity processes and self-esteem in the United States and the Netherlands. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 67*(1), 52-60.

Whitley, E., Popham, F., & Benzeval, M. (2016). Comparison of the Rowe–Kahn model of successful aging with self-rated health and life satisfaction: the West of Scotland Twenty-07 Prospective Cohort Study. *The Gerontologist*, *56*(6), 1082-1092.

Wilhelmson, K., Andersson, C., Waern, M., & Allebeck, P. (2005). Elderly people's perspectives on quality of life. *Journal of Ageing and Society, 25*, 585.

Williams, B., Onsman, A., & Brown, T. (2010). Exploratory factor analysis: a five-step guide for novices. *The Journal of Emergency Primary Health Care, 8*, 3, 143-162.

Wilson, G. A., Elias, J. W., & Brownlee, L. J. (1985). Factor invariance and the Life Satisfaction Index. *Journal of Gerontology*, 40, 3, 344-6.

Wood, V., Wylie, M. L., & Sheafor, B. (1969). An analysis of a short self-report measure of life satisfaction: correlation with rater judgments. *Journal of Gerontology*, 24, 4, 465-9.

Wood, W., Rhodes, N., & Whelan, M. (1989). Sex differences in positive well-being: a consideration of emotional style and marital status. *Psychological Bulletin*, 106, 2, 249-64.

Worku, Y. (2017). *Socio-Economic Status Of Elderly People*: The Case Of Merti District, Eastern Arsi Zone, Oromia Regional State, Ethiopia.

World Health Organization (WHO) (2018). *Aging and health: Key facts.* Geneva: WHO. https://www.who.int/news-room/fact-sheets/detail/ageing-and-health.

Worthington, R. L., & Whittaker, T. A. (2006). Scale development research a content analysi and recommendations for best practices. *The Counseling Psychologist*, *34*, 6, 806-838.

Yamaguchi, A., & Kim, M. S. (2015). Effects of self-construal and its relationship with subjective well-being across cultures. *Journal of Health Psychology*, *20*(1), 13-26. doi: 10.1177/1359105313496448

Zamuee, C. (2022). *An exploration of the care needs of frail older persons in Namibia: Perspectives and experiences of formal and informal caregivers.* Doctoral thesis, University of Cape Town, http://hdl.handle.net/11427/36729

Zanjari, N., Sani, M. S., Chavoshi, M. H., Rafiey, H., & Shahboulaghi, F. M. (2016). Perceptions of successful ageing among Iranian elders: Insights from a qualitative study. *International Journal of Aging and Human Development*, *83*(4), 381–401. https://doi.org/10.1177/0091415016657559

Zautra, A. J., Guarnaccia, C. A., & Reich, J. W. (1988). Factor structure of mental health measures for older adults. *Journal of Consulting and Clinical Psychology*, 56, 514-9.

Zelalem, A., & Gebremariam, M. (2020). Challenges of aging in rural Ethiopia:“Old age is like the sunset: It brings disrespect and challenges." *Journal of Gerontological Social Work, 63*(8), 893-916. https://doi.org/10.1080/01634372.2020.1814475

Zelalem, A., Kotecho, M., & Adamek, M. E. (2021). “The Ugly Face of Old Age”: Elders’ Unmet Expectations for Care and Support in Rural Ethiopia. *The International Journal of Aging and Human Development, 92*(2), 215-239.

Zerihun, A., Teshome, A., Kotecho, M., & Adamek, M. (2024). Reframing the image of older adults and advocating for their rights: The role of the Older People's Association in Ethiopia. *Working with Older People.* https://doi.org/10.1108/WWOP-07-2024-0037

Zeru, M. (2009). *Self-esteem, depression, loneliness, and coping mechanisms among retirees*: the case of arada sub-city in Addis Ababa. Unpublished MA Thesis. Department of psychology. Addis Ababa University.

Zhang, W. (2022). Social capital, income and subjective well-being: evidence in rural China. *Journal of Heliyon*, *8*(1). 8:e8705. doi: 10.1016/j.heliyon.2021.e08705

Zhao, P., Zhao, Z., Liao, C., Fang, Y., & Liu, Y. (2023). Urban park accessibility and the mental health of older adults: A case study of Haidian District, Beijing. *Journal of Leisure Studies, 42*(2), 235-252. https://doi.org/10.1080/02614367.2022.2094994

Zhou, Y., Zhou, L., Fu, C., Wang, Y., Liu, Q., Wu, H., & Zheng, L. (2015). Socio-economic factors related with the subjective well-being of the rural elderly people living independently in China. *International Journal for Equity in Health*, *14*, 1-9. doi: 10.1186/s12939-015-0136-4

Zikarge, T. H. (2017). *Life after Life*: An Assessment of Elderly Institutional Care in Addis Ababa City (in Particular Reference to Mekedonia Home for the Elderly and Mentally Disabled).

Appendices

Appendix A: Interview Guide

The original English version

Addis Ababa University

College of Education and Language Studies

School of Psychology

Topic Guide for Interview with Older Adults

I would like to thank you in advance for being a volunteer to take part in the present study. My name is Teshome Kondale Gurara and I am currently studying for a PhD in Applied Developmental Psychology, School of Psychology at Addis Ababa University. I am conducting research entitled "*Subjective Well-Being of Older Adults in Addis Ababa: Conceptualization and Instrument Development".* The purpose of the present study is to collect data from retired older adults about their current living situations, and perspectives on how retired older adults view their well-being. The result of the study would be used to develop comprehensive and contextually-relevant psychosocial and economic interventions aimed at improving the well-being of older adults. The interviews guide consist 22 questions into 4 sections and will not take more than 90 minutes to respond. All the responses will be kept anonymous and the data will be kept confidential and would be used only for the present research purpose.

Your genuine response is required to successfully attain the intended purpose of the study.

Thank you for agreeing to participate in this study and I appreciate your willingness to do so.

Part I: Socio-demographic characteristics of the participants

No.	Items	Response
1	Age (in years)	_____
2	Gender	Men ○ Women ○
3	Religion	Orthodox ○ Muslim ○ Protestant ○
4	Educational level	Cannot read and write ○ Primary school ○ Secondary school ○ College ○
5	Marital status	Married ○ Widowed ○ Divorced ○ Widowers ○
6	Living arrangement	With family ○ Alone ○
7	Number of children (in number)	_____

Part II-General Questions

1. Please tell me a little bit about yourself. Who do you live with?

   Probes:

   - Family circumstances
   - Work experience
   - Civic and community engagement
   - Living situation
   - Intellectual engagement (reading newspapers and books, watching TV, and listening to the radio)

2. Who supports you in all aspects of your life (including people, organization, & agencies)? What services/support do these people/organizations offer you?

   Probes:

   - Financial support
   - Materials support
   - Psychological support
   - Health care services

3. Could you tell me what kinds of social activities you participate in? With whom do you spend your time?

   Probes:

   - Volunteer
   - Community activities (Ider, ekub, church)
   - Civic and community engagement
   - Religious involvement

4. Could you please describe the situation of retired older adult's lifestyles in this community?

   Probes:

   - Living situation/arrangement
   - Leisure time
   - Health condition
   - Community participation

- Health care system
- Intellectual engagement

5. Can you tell me about the challenges and opportunities of being retired older adult in our community?

   Probes:

   - Living situation
   - Social support,
   - Economic situation
   - Health condition
   - Stereotype and stigma

Part III-Sense of subjective well-being sub-theme

1. How do you describe aging well? How do you feel about your life as a whole?
2. How do you think aging well can be achieved? Meaning how aging well can be facilitated?
3. What obstacles stand in the way of aging well?
4. What does the quality of life/good life mean to you?
5. What does subjective well-being mean to an older person like you?

   Probes:

   - Happiness
   - Life satisfaction
   - Positive affect
   - Work
   - Relationship

6. Are you happy with your subjective well-being? How do you explain it in words? And what is the reason for this?

Part IV: Indicators/dimensions of subjective well-being/aging well sub-theme

1. Can you please describe the essential indicators to be subjectively well/subjective well-being? What things are necessary to be well subjectively?

   Probes:

   - Social support
   - Life satisfaction

- Positive affect
- Religious involvement
- Civic and community engagement
- Physical and mental health

2. Can you tell me which life circumstance contributes to the subjective well-being of retired older adults in our community?

   Probes:

   - Social support
   - Life satisfaction
   - Positive affect
   - Religious involvement
   - Physical and mental health

3. What measures does the government or your organization take to enhance your subjective well-being? If any, would you explain it, please?

   Probes:

   - Financial support
   - Material support
   - Social support
   - Employment opportunities

4. What do you think should be done to help retired older adults to be subjective well in our community? Who should do what?

   Probes

   - Psychological support
   - Social support
   - Health care services
   - Financial support
   - Material support
   - Physical and mental health

The Amharic Version Interview Guide

በአዲስ አበባ ዩኒቨርሲቲ

የትምህርትና ቋንቋ ጥናት ኮሌጅ

የሳይኮሎጂ ትምህርት ቤት

<u>ከአረጋውያን ጋር ለሚደረግ ቃለ-መጠይቅ የተዘጋጁ ጥያቄዎች</u>

በቅድሚያ በዚህ ጥናት ተሳታፊ ለመሆን ፈቃደኛ ስለሆኑ የከበረ ምስጋናዬን ለማቅረብ እወዳለሁ፡፡ ስሜ ተሾመ ቆንዳሌ ጉራራ ሲሆን በአሁኑ ወቅት በአዲስ አበባ ዩኒቨርሲቲ የሶስተኛ ዲግሪ ትምህርቴን በአፕላይድ ደቨሎፕመንታል ሳይኮሎጂ የትምህርት ዘርፍ በመከታተል ላይ ስሆን ለመመረቂያ ማሟያ የሚሆን *አረጋውያን አጠቃላይ የህይወት ደህንነት ጽንሰ ሀሳብ እንዴት እንደሚረዱት ለመፈተሽ እና አጠቃላይ የህይወት ደህንነትን ለመለካት የሚያስችል መለኪያ* ለማዘጋጀት ጥናት በመስራት ላይ እገኛለሁ፡፡

የዚህ ጥናት ዓላማ በጡረታ ላይ ያሉ አዛውንቶች አሁን ስላላቸው የኑሮ ሁኔታ መረጃዎችን መሰብሰብ እና በጡረታ ላይ ያሉ አዛውንቶች ደህንነታቸውን እንዴት እንደሚመለከቱ አመለካከቶችን መሰብሰብ ነው። የጥናቱ ውጤት የአረጋውያንን ደህንነት ለማሻሻል የታለሙ አጠቃላይ እና አግባብነት ያላቸውን የስነ-ልቦና እና ኢኮኖሚያዊ ድጋፎችን ለማዘጋጀት ጥቅም ላይ ይውላል። የቃለ መጠይቁ መመሪያ 22 ጥያቄዎችን በ4 ክፍሎች ያካተተ ሲሆን መልስ ለመስጠት ከ90 ደቂቃ በላይ አይወስድም። መረጃው ሚስጥራዊ ሆኖ ይቆያል እናም ለአሁኑ የምርምር ዓላማ ብቻ ጥቅም ላይ ይውላል። ስለሆነም እያንዳንዱን የቃለ-መጠይቅ ጥያቄ በዝርዝር ይመልሱልኝ ዘንድ በአክብሮት እጠይቃለሁ፡፡

በዚህ ጥናት ውስጥ ለመሳተፍ ስለተስማሙ አመሰግናለሁ እናም ይህንን ቃለ-መጠይቅ ለማድረግ ፈቃደኝነትዎን አደንቃለሁ።

ክፍል 1፡- የቃለ-መጠይቁ ተሳታፊ አረጋውያን አጠቃላይ መረጃ

ተ.ቁ	ጥያቄ	ምላሽ
1	ዕድሜ (በዓመት)	_____ ዓመት
2	ጾታ	○ ወንድ ሴት○
3	ሃይማኖት	ኦርቶድክስ ○ ፕሮቴስታንት○ እስሌምና○
4	የትምህርት ደረጃ	ማንበብና መጻፍ የማይችል/የማትችል ○ አንደኛ ደረጃ○ ሁለተኛ ደረጃ ○ ኮሌጅ ○
5	የጋብቻ ሁኔታ	ያገባ(ች)○ የተፈታ(ች) ○ የተለያየ(ች) ○ ሚስቱ የሞተችበት(ባሎ የሞተባት)○
6	የአኗኗር ሁኔታ	ከቤተሰብ ጋር ○ ለብቻ ○
7	የልጅ ብዛት (በቁጥር)	_____

ክፍል 2፡- አጠቃላይ ጥያቄዎች

1. እባክዎን ስለእራስዎ ትንሽ ይንገሩኝ።

   ከዚህ በታች በተዘረዘሩት ጉዳዮች ዙሪያ አስተያየቶ እንዲያተኩር እጠይቃለሁ፤

   - የቤተሰብ ሁኔታ (ከማን ጋር ነው የሚኖሩት)
   - የሥራ ሁኔታ
   - የአኗኗር ሁኔታ
   - ጊዜዎን እንዴትና ከማን ጋር ያሳልፋሉ
   - የአዕምሯዊ ተሳትፎ (ጋዜጣና መጽሐፍትን ማንበብ ፣ ቴሌቪዥን ማየት እና ሬዲዮ ማዳመጥ)

2. በዕለት ተዕለት ህይወትዎ የተለያዩ ድጋፎችን ያገኛሉ? አዎ፣ ከሆነ መልሶ የሚደግፍዎት እነማናቸው? (ለምሳሌ፣ቤተሰብ፣ ግለሰቦች፣ ድርጅት ወይንም ኤጀንሲዎች) ከእነዚህ ሰዎች/ድርጅቶች ምን አይነት አገልግሎት/ድጋፍ ያገኛሉ?

   ከዚህ በታች በተዘረዘሩት ጉዳዮች ዙሪያ አስተያየቶ እንዲያተኩር እጠይቃለሁ፤

   - የገንዘብ ድጋፍ
   - የቁሳቁስ ድጋፍ
   - የስነ-ልቦና ማህበራዊ ድጋፍ
   - የጤና እንክብካቤ አገልግሎቶች

3. እርስዎ ምን ዓይነት ማህበራዊ እንቅስቃሴዎች ላይ እንደሚሳተፉ ሊነግሩኝ ይችላሉ?

   ከዚህ በታች በተዘረዘሩት ጉዳዮች ዙሪያ አስተያየቶ እንዲያተኩር እጠይቃለሁ፤

   - በበጎ ፈቃደኛነት
   - ማህበራዊ እንቅስቃሴዎች (እድር፣ እቁብ፣ለቅሶ)
   - የሲቪክ እና የማህበረሰብ ተሳትፎ
   - ሃይማኖታዊ እንቅስቃሴዎች ላይ መሳተፍ

4. እባክዎን በእኛ ማህበረሰብ ውስጥ በዕድሜ የገፉ ሰዎች (በጡረታ የተገለሉ) የአኗኗር ዘይቤዎችን ሁኔታ ምን እንደሚመስል ሊገልፁልኝ ይችላሉ?

   ከዚህ በታች በተዘረዘሩት ጉዳዮች ዙሪያ አስተያየቶ እንዲያተኩር እጠይቃለሁ፤

   - የኑሮ ሁኔታ
   - ኢኮኖሚያዊ ሁኔታ
   - ጊዜ ማሳለፊያ ቦታዎች እና ጊዚአቸውን እንዴት ነው የሚያሳልፉት
   - የጤና ሁኔታ
   - የማህበረሰብ ተሳትፎ
   - የጤና እንክብካቤ ስርዓት

- የስነ-አዕምሮ ተሳትፎ

5. በማህበረሰባችን ውስጥ በእድሜ መግፋት (ጡረተኛ መሆን) ምክንያት ሊያጋጥሙ የሚችሉ ተግዳሮቶች እና እድሎችን ሊነግሩኝ ይችላሉ?
   ከዚህ በታች በተዘረዘሩት ጉዳዮች ዙሪያ አስተያየቶ እንዲያተኩር እጠይቃለሁ፤
   - ከኑሮ ሁኔታ
   - ከማህበራዊ ሁኔታ
   - ከኢኮኖሚያዊ ሁኔታ
   - ከጤና ሁኔታ
   - ከአመለካከት አንጻር፡- ስለአረጋውያን ያለው የተዛባ ምልከታ (ስቴሪዮታይፕ) እና መገለል

ክፍል 3፡- አጠቃላይ የህይወት ደህንነት (subjective well-being) ጽንሰ ሀሳብ ንዑስ-ጭብጥ

1. ጥሩ እርጅና ሲባል ምን ማለት ነው? በአጠቃላይ ስለ ሕይወትህ ምን ይሰማሃል?
2. ጤናማ የሆነ እርጅና ማግኘት የሚቻለው እንዴት ነው? ይህም ማለት እርጅናን እንዴት ማመቻቸት ይቻላል?
3. ሰዎች ጤናማ የሆነ አጠቃላይ የህይወት ደህንነት (subjective well-being) እንዳይኖራቸው ሊያደርጉ የሚችሉ ዋና ዋና እንቅፋቶችን ያስረዱኛል?
4. ጤናማ/ደህና የሆነ አጠቃላይ የህይወት ደህንነት (subjective well-being) ሲባል ለእርሶ ምንድን ነው ወይም ጥሩ ሕይወት ማለት ለእርሶ ምንድን ነው?
5. አጠቃላይ የህይወት ደህንነት (subjective well-being) ማለት በእድሜ ለገፉና እንደ እርሶ ላሉ ሰዎች ምን ማለት ነው? ወይም እንዴት ይረዱታል/ይገልጹታል?
   ከዚህ በታች በተዘረዘሩት ጉዳዮች ዙሪያ አስተያየቶ እንዲያተኩር እጠይቃለሁ፤
   - ደስታ
   - የህይወት እርካታ
   - አዎንታዊ ተጽዕኖ
   - ሥራ
   - ግንኙነት (የቤተሰብ/ማህበራዊ)
6. ደህና/ጤናማ የሆነ አጠቃላይ የህይወት ደህንነት (subjective well-being) እንዴት ሊገኝ ይችላል ብለው ያስባሉ? ደህና የሆነ ግላዊ ደህንነትን እንዴት ማመቻቸት ይቻላል?

ክፍል 4፡- አጠቃላይ የህይወት ደህንነት ጽንሰ ሀሳብን አመልካቾች/ጠቋሚዎች/ ንዑስ ጭብጥ

7. እባክዎ አጠቃላይ የህይወት ደህንነት (subjective well-being) አመልካቾችን/ጠቋሚዎችን/ ሊለዩልኝና ሊያብራሩልኝ ይችላሉ?
   ከዚህ በታች በተዘረዘሩት ጉዳዮች ዙሪያ አስተያየቶ እንዲያተኩር እጠይቃለሁ፤

- ማህበራዊ ድጋፍ
- የህይወት እርካታ
- አዎንታዊ ተጽዕኖ
- የህይማኖታዊ ስራዎች ተሳትፎ
- የሲቪክ እና የማህበረሰብ ተሳትፎ
- የአካል እና የአእምሮ ጤና

8. በእኛ ማህበረሰብ ውስጥ በአረጋዊያን አጠቃላይ የህይወት ደህንነት ላይ ከፍተኛ አስተዋጽኦ ሊያበረክቱ የሚችሉ ዋና ዋና ምክንያቶችን ሊነግሩኝ ይችላሉ?
   ከዚህ በታች በተዘረዘሩት ጉዳዮች ዙሪያ አስተያየቶ እንዲያተኩር እጠይቃለሁ፤
   - ማህበራዊ ድጋፍ
   - የህይወት እርካታ
   - አዎንታዊ ተጽዕኖ
   - የሃይማኖት ተሳትፎ
   - የአካል እና የአእምሮ ጤና
9. መንግሥት የአረጋዊያን አጠቃላይ የህይወት ደህንነት ለማሻሻል ምን እርምጃዎችን መውሰድ አለበት ብለው ያስባሉ?
10. በጥሩ አጠቃላይ የህይወት ደህንነት ላይ ለመገኘት ምን ምን ነገሮች ያስፈልጋሉ?

Appendix B: Focus Group Discussions Guide

The original English version

Addis Ababa University

College of Education and Language Studies

School of Psychology

Topic Guide for FGDs with Older Adults

Dear FGDs Participants,

First of all, I would like to thank you so much for your cooperation and willingness to participate in the present study. I would like to ask you some questions about the current living conditions of retired older adults and their views about well-being.

Part I: Socio-demographic characteristics of the participants

No.	Items	Response
1	Age (in years)	_____
2	Gender	Men ○ Women ○
3	Religion	Orthodox ○ Muslim ○ Protestant ○
4	Educational level	Cannot read and write ○ Primary school ○ Secondary school ○ College ○
5	Marital status	Married ○ Widowed ○ Divorced ○ Widowers ○
6	Living arrangement	With family ○ Alone ○
7	Number of children (in number)	_____

Part II: Topic Guide for FGDs

Perception of retired pensioners about their living conditions in late life

1. How would you describe the general living conditions of retired pensioners in Addis Ababa?
2. What are the main challenges faced by retired older adults due to their meager income benefits and pensions?

3. Can you explain the major factors contribute most to precarity in late life?

Conceptualization of Subjective Well-Being in Older Age

4. How do you conceptualize or understand well-being in old age?
5. What aspects of late life do you consider most important for the well-being of retired older adults?

Recommendations

6. What role should the government or non-governmental organizations plays in maximize the general life quality of the elderly?
7. What types of support or services do you think are most needed?
8. Are there any specific programs or changes you would like to see implemented to improve safety, dignity, and quality of life for the elderly?

The Amharic Version Focus Group Discussion Guide

በአዲስ አበባ ዩኒቨርሲቲ

የትምህርትና ቋንቋ ጥናት ኮሌጅ

የሳይኮሎጂ ትምህርት ቤት

<u>ከአረጋውያን ጋር ለሚደረገው የቡድን ውይይት የተዘጋጁ ጥያቄዎች</u>

ውድ ተሳታፊዎች በመጀመሪያ ደረጃ በዚህ ጥናት ላይ ለመሳተፍ ላሳዩት ፍላጎት በጣም አመሰግናለሁ። የአረጋውያንን የኑሮ ሁኔታና ስለ ደህንነት ያላቸውን አመለካከት በተመለከተ አንዳንድ ጥያቄዎችን ልጠይቅዎ እወዳለሁ።

ክፍል 1፡- የቡድን ውይይት ተሳታፊ አረጋውያን አጠቃላይ መረጃ

ተ.ቁ	ጥያቄ	ምላሽ
1	ዕድሜ (በዓመት)	_____ ዓመት
2	ጾታ	○ ወንድ ሴት○
3	ሃይማኖት	ኦርቶድክስ ○ ፕሮቴስታንት○ እስሌምና ○
4	የትምህርት ደረጃ	ማንበብና መጻፍ የማይችል/የማትችል ○ አንደኛ ደረጃ ○ ሁለተኛ ደረጃ ○ ኮሌጅ ○
5	የጋብቻ ሁኔታ	ያገባ(ች)○ የተፈታ(ች) ○ የተለያየ(ች) ○ ሚስቱ የሞተችበት(ባሌ የሞተባት)○
6	የአኗኗር ሁኔታ	ከቤተሰብ ጋር ○ ለብቻ ○
7	የልጅ ብዛት (በቁጥር)	_____

ክፍል 2፡- ለቡድን ውይይት የተዘጋጁ ጥያቄዎች

ጡረተኛ አረጋውያን በኋለኛው የሕይወት ዘመናቸው ስለ ኑሮ ሁኔታ ያላቸው ግንዛቤ

1. **በአዲስ አበባ የሚገኙ ጡረተኞች አረጋውያን አጠቃላይ የኑሮ ሁኔታችው ምን እንደሚመስል ይነግሩኛል?**
2. **ጡረተኞች አረጋውያን የሚያገኙት የጡረታ ገቢ ስንት ነው? በዚህ ምክንያት የሚያጋጥሟቸው ዋና ዋና ችግሮች ምንድን ናቸው?**
3. **በኋለኛው የሕይወት ዘመን ለጭንቀት ዋነኛ አስተዋጽኦ የሚያደርጉትን ዋና ዋና ምክንያቶች ላይ ማብራራያ ይሰጡኛል?**

የአረጋውያን አጠቃላይ የህይወት ደህንነት ጽንሰ ሀሳብ

4. አጠቃላይ የህይወት ደህንነት ማለት በእድሜ ለገፉና እንደ እርሶ ላሉ ሰዎች ምን ማለት ነው? ወይም እንዴት ይረዱታል/ይገልጹታል?
5. አረጋውያን አጠቃላይ የህይወት ደህንነት እንዲኖራቸው በጣም አስፈላጊ የሆኑት ነገሮች የትኞቹ ናቸው?
6. አጠቃላይ የህይወት ደህንነት እንዴት ሊገኝ ይችላል ብለው ያስባሉ? ደህና የሆነ ግላዊ ደህንነትን እንዴት ማመቻቸት ይቻላል?

ተግባራዊ መደረግ ያለባቸው ነገሮች

7. አረጋውያን አጠቃላይ የኑሮ ደረጃቸውን ከፍ ለማድረግ መንግስት ወይም መንግስታዊ ያልሆኑ ድርጅቶች ምን ሚና ሊጫወቱ ይገባል?
8. ምን ዓይነት ድጋፍ ወይም አገልግሎት በጣም ያስፈልጋል ብለው ያስባሉ?
9. ለአረጋውያን ደህንነት፣ ክብርና የኑሮ ጥራት መሻሻል እንዲኖር የሚረዱ የተወሰኑ ፕሮግራሞች ወይም ለውጦች ምንድናቸው ብለው ያስባሉ?

Appendix C: Initial Draft Items
The Original English Version

Rater Code_____

Addis Ababa University

College of Education and Language Studies

School of Psychology

Instrument Content Validation

Dear Rater,

The purpose of this study is to develop and validate a new instrument to measure the subjective well-being among retired older adults. The development of this instrument was informed by findings from a prior qualitative study and is specifically designed to reflect the local context and experiences of retired older adults. As a content expert, I kindly ask you to evaluate each item in the instrument based on how essential and useful you believe it is for measuring the SWB of retired older adults in the Ethiopian context. Additionally, you are also expected to provide possible item modifications, and suggest new item as a replacement for the items with appropriateness/relevance. And please provide any kinds of professional remarks that can further improve the validity of the items in the instrument.

Your expert judgment is critical to ensuring the content validity of this instrument.

Thank you for your valuable contribution to this research.

Part 1: Demographic Information of the Rater

1. Name: _____
2. Gender: _____
3. Education Level (Highest Degree Earned): _____
4. Name of your institution: _____
5. Specialization/field of study: _____
6. Academic rank: _____
7. Number of years in Discipline: _____
8. Research experience in terms of No. of articles published: _____
9. Content validation Experiences (No. of instruments you validate): _____
10. (Answer at End) how long did it take to complete this task? _____

Part 2: Content Validity

The items in the following table are supposed to measure retired pensioners' SWB in Addis Ababa. Retired pensioners' SWB is defined as retired older adults' subjective perceptions/views of their quality of life. Six major themes were generated, giving insight into the retired older adults' perspectives about their own well-being. The six themes identified were *physical and mental well-being, family and social interactions, financial stability and security, optimism and autonomy, religious faith and practice, and opportunities to work and contribute to the community.*

To indicate the degree of relevance of an item, write (3) if the item is essential, (2) if the item is useful but not essential and (1) if the item is non-essential in the first column. Please suggest a modified item or an additional item (for each item), if you think that the item is not essential to measure the supposed construct.

S.N	**Items**	Non-essential (1)	Useful but not essential (2)	Essential (3)
Physical and Mental Health: *This dimension refers to maintaining good physical and mental health. It includes aspects such as physical appearances, self-care, proper nutrition and sleep, sufficient bodily strength and mobility, and engaging in healthy behaviors (e.g., free from substance abuse, regular physical activity). It also encompasses mental alertness, good memory, a positive attitude, hope, and optimism.*				
1	I am in good physical health, which is essential for my well-being as I age.	**1**	**2**	**3**
2	I maintain a good physical appearance and engage in self-care activities that contribute to my quality of life.	**1**	**2**	**3**
3	I can perform basic self-care tasks independently (e.g., eating, bathing, dressing), which is crucial for my happiness.	**1**	**2**	**3**
4	I accomplish my daily routine without difficulty, which is an important aspect of aging well for me.	**1**	**2**	**3**
5	I maintain good mental health (e.g., being mentally alert, having a good memory, staying optimistic), which is vital for my well-being as I age.	**1**	**2**	**3**
6	I am physically and mentally strong enough to work and complete daily tasks, which is essential for my healthy aging.	**1**	**2**	**3**
7	In this day, I felt downhearted and depressed.	**1**	**2**	**3**
8	Engaging in work keeps me mentally stimulated and connected to my community.	**1**	**2**	**3**
9	I feel full of energy for everyday life activities.	**1**	**2**	**3**

10	I stay away from activities that make me to concentrate/ focus.	**1**	**2**	**3**
11	I am actively engaging in mental activity like reading newspaper and watching TV every day.	**1**	**2**	**3**
Family and Social Interactions: *This dimension refers to having satisfying family and community relationships. It involves feeling accepted, recognized, and actively involved in family and community life. It also emphasizes the importance of maintaining strong, meaningful connections and engagement with spouses, family, friends, and children.*				
1	I experience a deep sense of contentment when engaged in meaningful social interactions.	**1**	**2**	**3**
2	I have good relationships with my spouse, family, friends, and children, which is essential for my well-being as I age.	**1**	**2**	**3**
3	I feel accepted, recognized, and involved in family and community life.	**1**	**2**	**3**
4	I live peacefully with my family and in my surroundings, which contributes significantly to my well-being.	**1**	**2**	**3**
5	I have a positive connection with my children, which is crucial for my well-being as an older adult.	**1**	**2**	**3**
6	My social involvement, faith, and health are important means to achieve my well-being.	**1**	**2**	**3**
7	I receive support from my family, friends, community, and government, which significantly contributes to my well-being.	**1**	**2**	**3**
8	I am not isolated or lonely, which could seriously hinder my well-being if I were.	**1**	**2**	**3**
9	I am actively attending any public meeting in which there was discussion of local community affairs.	**1**	**2**	**3**
10	I am satisfied with my standard of living and the social status.	**1**	**2**	**3**
Financial Stability and Security: *This dimension refers feeling financially secure and being satisfied with one's financial situation.*				
1	I have a sense of financial security that empowers me to make choices aligned with my values and aspirations.	**1**	**2**	**3**
2	I have sufficient financial resources to meet my basic needs, which provides me with peace of mind.	**1**	**2**	**3**
3	My current income (including pensions and benefits) adequately meets my financial needs.	**1**	**2**	**3**
4	I have financial security, which significantly contributes to my overall well-being.	**1**	**2**	**3**
5	My financial situation allows me to maintain my health, manage life pressures, and preserve my independence.	**1**	**2**	**3**
6	I have the ability to work or access to adequate pension, which contributes positively to my health and well-being.	**1**	**2**	**3**
7	I have financial stability, which provides me with the freedom to plan for the future and pursue my aspirations.	**1**	**2**	**3**
8	If I need assistance with my financial matters, I have someone.	**1**	**2**	**3**

9	Shortage of money stops me from doing the things that I want to do	**1**	**2**	**3**
Optimism and Autonomy: *This dimension refers to the ability to engage in activities one enjoys independently, without relying on others. It includes living independently; practicing self-care, maintaining good mobility, and adapting to the physical changes associated with aging. It also involves accepting the aging process, using effective coping techniques, demonstrating personal growth and maturity, and well-functioning motor skills.*				
1	Despite life's challenges, I maintain a positive outlook on my circumstances.	**1**	**2**	**3**
2	I adapt well to the changes in my body as I age and accept the aging process positively.	**1**	**2**	**3**
3	I maintain independence in my daily activities, which is crucial for my well-being.	**1**	**2**	**3**
4	I take care of my physical and mental health, which helps me remain self-reliant.	**1**	**2**	**3**
5	I maintain a positive attitude and celebrate my age, which contributes to my satisfaction with life.	**1**	**2**	**3**
6	I have an optimistic outlook, which significantly contributes to my overall well-being as an older adult.	**1**	**2**	**3**
7	In these days, I am experiencing positive emotions such as joy, affection, or hope.	**1**	**2**	**3**
8	I see myself as a worthless individual.	**1**	**2**	**3**
9	I am confident in my ability to handle a life crisis.	**1**	**2**	**3**
Religious Faith and Practices*: This dimension refers to having faith in God and being engaged in religious activities, practices, and personal and spirituality.*				
1	My religious faith serves as a guiding light and essential source of happiness in my life.	**1**	**2**	**3**
2	My religious practices contribute to my sense of fulfilment and contentment as I age.	**1**	**2**	**3**
3	I find relief and a deep sense of internal peace through prayer and religious activities.	**1**	**2**	**3**
4	Religion is a source of hope, happiness, and peace in my later life.	**1**	**2**	**3**
5	I view aging as a gift from heaven and find meaning in religious practice and spirituality.	**1**	**2**	**3**
6	My religious beliefs give me a sense of purpose and help me prepare for the end of life.	**1**	**2**	**3**
7	My faith reminds me that I am never alone and gives me reason to persevere.	**1**	**2**	**3**
8	I believe that engaging in my religion provides great benefits.	**1**	**2**	**3**
9	Participating in religious activities (rituals, prayers, spiritual teachings) promotes my overall well-being as I age.	**1**	**2**	**3**
10	The fellowship and shared values within my religious group provide a sense of belonging that helps me face aging challenges with resilience.	**1**	**2**	**3**
11	My faith in God sustains me through life's challenges.	**1**	**2**	**3**

12	My religious beliefs provide me with optimism and a sense of purpose.	**1**	**2**	**3**
13	My religious group provides a sense of belonging that helps me face aging challenges with resilience.	**1**	**2**	**3**
14	I frequently feel private prayer is very important to close with God and at important moments in my daily life.	**1**	**2**	**3**
Opportunities to Work and Contribute to the Community*: This dimension refers to the ability to continue working, having opportunities for employment or meaningful tasks, staying active and energetic through work, and making valuable contributions to the communities.*				
1	I believe that age should not prevent me from pursuing my passions.	**1**	**2**	**3**
2	Having the opportunity to work contributes positively to my well-being as an older adult.	**1**	**2**	**3**
3	Engaging in work keeps me mentally stimulated and connected to my community.	**1**	**2**	**3**
4	I am confident in my ability to make valuable contributions in the workforce despite my age.	**1**	**2**	**3**
5	I believe that, given opportunities, older adults like myself can contribute significantly to personal well-being and societal welfare.	**1**	**2**	**3**
6	Making contributions to my community is an essential part of aging well for me.	**1**	**2**	**3**
7	As an older adult, I play a vital role in preserving and passing on cultural heritage and traditional practices to younger generations.	**1**	**2**	**3**

Additional comment:

_____

_____

_____

_____

_____

_____

Appendix D: The Selected 46 Items
The original English version

Respondent's Code_____

Addis Ababa University

College of Education and Language Studies

School of Psychology

Questionnaire for retired older adult

The purpose of this questionnaire is to assess the reliability and validity of the newly developed SWB instrument. This questionnaire has two parts: the first part has demographic questions about the respondents, and the second part has a scale of SWB. The information you provide has a very important input on the direction and completion of this study, so please try to be honest, and careful. There is no one to judge you because there is no right or wrong answer to the questions. The information will be kept confidential and only used for the purpose of study. Your forthright information helps to reach the goals of the study.

Thank you very much for your cooperation!

Part I: Background Information

Direction: Please listen each of the following questions carefully and answer all the questions.

No.	Items	Response
1	Age (in years)	_____
2	Gender	Men ○ Women ○
3	Religion	Orthodox ○ Muslim ○ Protestant ○
4	Educational level	Cannot read and write ○
		Primary school ○
		Secondary school ○
		College ○
5	Marital status	Married ○ Widowed ○ Divorced ○ Widowers ○
6	Living arrangement	With family ○ Alone ○
7	Number of children (in number)	_____

Part II: Subjective Well-Being Scale (SWBS)

Direction: The under listed statements are prepared to explore your perception how you feel about your well-being. Please listen each of the following statements carefully and answer all the questions. Please rate each of them from 1 (strongly disagree); 2 (disagree); 3 (Undecided); 4 (agree) and 5 (strongly agree) using the scale below.

S.N	Items	Agreement Levels				
		1	2	3	4	5
1.	I feel that my physical health is good.					
2.	I regularly engage in self-care activities to support my health.					
3.	I am able to perform basic self-care tasks independently.					
4.	I am able to carry out my daily routine without difficulty.					
5.	I feel that I maintain good mental health.					
6.	I feel mentally strong enough of manining my daily tasks.					
7.	In this day, I felt downhearted and depressed.					
8.	I feel more motivated and energized when I am engaged in work.					
9.	I feel a deep sense of contentment when I am engaged in meaningful social interactions.					
10.	I have good relationships with my family.					
11.	I feel valued by the people in my community.					
12.	I live peacefully with people in my surroundings					
13.	I have a positive connection with my children.					
14.	My social involvement are important means to achieve my well-being.					
15.	I receive support from significant others.					
16.	I am not isolated or lonely.					
17.	I feel financial security, which allows me to make life choices that reflect my personal values and goals.					
18.	I have sufficient financial resources to meet my basic needs.					
19.	My current income adequately meets my financial needs.					
20.	I have financial security.					
21.	I feel that my financial situation allows me to cope with life challenges.					
22.	I receive an adequate pension that supports my needs.					
23.	I feel financial stability, which gives me with the freedom to plan for the future.					
24.	Despite life's challenges, I maintain a positive outlook on my circumstances.					
25.	I adapt well to the changes in my body as I age.					
26.	I maintain independence in my daily activities.					
27.	I take care of my mental health.					
28.	I maintain a positive attitude and celebrate my age.					
29.	I have an optimistic outlook.					

30.	My religious faith serves as a guiding light and essential source of happiness in my life.					
31.	My religious practices contribute to my sense of fulfilment and contentment as I age.					
32.	I find relief and a deep sense of internal peace through prayer and religious activities.					
33.	Religion is a source of hope, happiness, and peace in my later life.					
34.	I view aging as a gift from heaven and find meaning in religious practice and spirituality.					
35.	My faith reminds me that I am never alone and gives me reason to persevere.					
36.	I believe that engaging in my religion provides great benefits.					
37.	The fellowship and shared values within my religious group provide a sense of belonging that helps me face aging challenges with resilience.					
38.	My faith in God sustains me through life's challenges.					
39.	My religious beliefs provide me with optimism and a sense of purpose.					
40.	My religious group provides a sense of belonging that helps me face aging challenges with resilience.					
41.	I believe that age should not prevent me from pursuing my passions.					
42.	Having the opportunity to work contributes positively to my well-being as an older adult.					
43.	Engaging in work connected me to my community.					
44.	I am confident in my ability to make valuable contributions in the workforce despite my age.					
45.	I believe that, given opportunities, older adults like myself can contribute significantly to personal well-being and societal welfare.					
46.	Making contributions to my community is an essential part of aging well for me.					

Appendix E: The Selected 46 Items
The Original Amharic Version

በአዲስ አበባ ዩኒቨርሲቲ

የትምህርትና ቋንቋ ጥናት ኮሌጅ

የሳይኮሎጂ ትምህርት ቤት

የተሳታፊ መለያ ቁጥር _____

<u>ለአረጋውያን የቀረበ የጽሑፍ መጠይቅ</u>

በቅድሚያ በዚህ ጥናት ተሳታፊ ለመሆን ፈቃደኛ ስለሆኑ የከበረ ምስጋናዬን ለማቅረብ እወዳለሁ፡፡ ስሜ ተሾመ ቆንዳሌ ጉራራ ሲሆን በአሁኑ ወቅት በአዲስ አበባ ዩኒቨርሲቲ የሶስተኛ ዲግሪ ትምህርቴን በአፕላይድ ደቨሎፕመንታል ሳይኮሎጂ የትምህርት ዘርፍ በመከታተል ላይ ስሆን *ለመመረቂያ ማሚያ የሚሆን የአረጋውያን አጠቃላይ የህይወት ደህንነት በእራሳቸው እይታ ምን እንደሚመስል ለመለካት የሚያስችል መለክያ ለማዘጋጀት ጥናት በመስራት ላይ እገኛለሁ፡፡ የጥናቱ ውጤት የአረጋውያንን ደህንነት ለማሻሻል* የታለሙ አጠቃላይ እና አግባብነት ያላቸውን የስነ-ልቦና እና ኢኮኖሚያዊ ተግባራትን ለማዘጋጀት ጥቅም ላይ ይውላል። የጽሑፍ መጠይቁ 53 ጥያቄዎችን በ2 ክፍሎች ያካተተ ሲሆን መልስ ለመስጠት ከ50 ደቂቃ በላይ አይወስድም። ሁሉም ምላሾች ስም-አልባ ሆነው ይቆያሉ እና መረጃው ሚስጥራዊ ሆኖ ይቆያል እናም ለአሁኑ የምርምር ዓላማ ብቻ ጥቅም ላይ ይውላል። ስለሆነም እያንዳንዱን የጽሑፍ ጥያቄ በዝርዝር ይመልሱልኝ ዘንድ በአክብሮት እጠይቃለሁ፡፡

በዚህ ጥናት ውስጥ ለመሳተፍ ስለተስማሙ አመሰግናለሁ እናም ይህንን የጽሑፍ ጥያቄ ለማድረግ ፈቃደኝነትዎን አደንቃለሁ።

ስለ ትብብርዎ በቅድሚያ በጣም አመሰግናለሁ፡፡

ክፍል 1፡- የተሳታፊ አረጋውያን አጠቃላይ መረጃ

ተ.ቁ	ጥያቄ	ምላሽ
1	ዕድሜ (በዓመት)	_____ ዓመት
2	ጾታ	○ ወንድ ሴት○
3	ሃይማኖት	ኦርቶድክስ ○
		ፕሮቴስታንት○
		እስሌምና ○
4	የትምህርት ደረጃ	ማንበብና መጻፍ የማይችል/የማትችል ○
		አንደኛ ደረጃ ○
		ሁለተኛ ደረጃ ○
		ኮሌጅ ○
5	የጋብቻ ሁኔታ	ያገባ(ች)○ የተፈታ(ች) ○
		የተለያየ(ች) ○ ሚስቱ የሞተችበት(ባሎ የሞተባት)○
6	የአኗኗር ሁኔታ	ከቤተሰብ ጋር ○ ለብቻ ○
7	የልጅ ብዛት (በቁጥር)	_____

ክፍል ሁለት:- የግለሰባዊ ደህንነት መለኪያ (SWBS)

መመርያ:- ከዚህ በታች የተዘረዘሩት ጥያቄዎች ስለ ራስዎ ደህንነት ምን እንደሚሰማዎት ለማወቅ የተዘጋጀ ነው። እባካችሁ የሚከተሉትን ጥያቄዎች በጥንቃቄ አዳምጡ፣ ከዚያም ለቀረቡት ጥያቄዎች መልስ ስጡ። ከዚህ በታች ባሉት የስምምነት ደረጃ:-

1. በጣም አልስማማም
2. አልስማማም
3. እርግጠኛ አይደለሁም
4. እስማማለሁ
5. በጣም እስማማለሁ

ቁጥር	ጥያቄዎች	የስምምነት ደረጃ				
		1	2	3	4	5
1.	እንደ እድሜዬ የሆነ ጤናማ አካል አለኝ።					
2.	ጥሩ የሆነ የአካል ጤንነት ላይ መሆኔና እራሴን መጠበቅ መቻሌ ጥራት ያለው ህይወት እንድኖር አድርጎኛል።					
3.	መሰረታዊ የሆነ የዕለት ተግባራትን (መብላት፣መታጠብና መልበስ) በራሴ ማድረግ እችላለሁ።					
4.	የእለት ተግባሬን በቀላሉ ሳደርግ ደህና እንደሆንኩ ይሰማኛል።					
5.	ንቁ መሆኔ፣ አለመርሳቴና ነገሮችን በአውንታዊ መንገድ መመልከት መቻሌ ጤናማ የሆነ የአይምሮ ጤንነት ደህንነት ላይ እንዳለሁ ያሳየኛል።					
6.	የእለት ተግባሬን ለመፈፀም አካላዊና አዕምሮዊ ጥንካሬ አስፈላጊ ነው ብዬ አምናለሁ።					
7.	አሁን ባለሁበት ጊዜ ጭንቀት ይሰማኛል።					
8.	በስራ ላይ መሆኔ ከማህበረሰቡ ጋር ግንኙነቴ እንዲዳብር አድርጎኛል።					
9.	ማህበረሰቡ ትርጉም በሚሰጥባቸው ነገሮች በመሳተፌ ደስተኛ እንድሆን አድርጎኛል።					
10.	ከቤተሰቤ ጋር ሆነ ከጓደኞቼ ጋር ጥሩ የተባለ ግንኙነት መኖሩ ለጤናዬ ጠቀሜታ አለሁ ብዬ አምናለሁ።					
11.	ከቤተሰቤም ሆነ ከማህበረሰቡ ተቀባይነት አለኝ።					
12.	ከሰዎች ጋር በሰለም መኖሬ ለጤናዬ አስተዋጽኦ አለሁ።					
13.	ከልጆቼ ጋር ጤናማ የሚባል ግንኙነት አለኝ።					
14.	እምነቴና ማህበራዊ ተሳትፎዬ ለጤናዬ አስፈላጊ ነው።					
15.	ለደህንነቴ ከቤተሰቤም ሆነ ከጓደኞቼ እናም ከመንግሥት እርዳታዎችን እቀበላለሁ።					
16.	የመገለልም ሆነ ብቻዬን የመሆን ስሜት አይሰማኝም።					
17.	ከምወስናቸው ውሳኔዎች ጋር የሚጣጣም በቂ የሆነ የግንዘብ አቅርቦት አለኝ።					
18.	መሰረታዊ ፍላጎቴን ለሟሟላት የሚሆን በቂ የሆነ የግንዘብ አቅርቦት ስላለኝ ሰላም ይሰማኛል።					
19.	አሁን ላይ ያለኝ ገቢ የግንዘብ ፍላጎቴን ያሟላ ነው።					
20.	የማገኘው የግንዘብ መጠን በህይወቴ ላይ አጠቃላይ አስተዋፆ አለው።					
21.	ያለኝ የግንዘብ ሁኔታ ጤናዬን እንድጠብቅ ሆነ,የህይወትን ጫናን አቅልሎልኝል።					
22.	ስራዬ በበቂ ሁኔታ መስራት እንደምችል አውቃለሁ።					
23.	ሃሳቤን ለማሳካት በቂ ገንዘብ አለኝ።					
24.	በፊተና ዉስጥ ባልፍም ስለህይወት አውንታዊ እይታ አለኝ።					
25.	ከእድሜ ጋር ተያይዞ የሚመጣንለውጥበመልካምእቀበላለሁ።					
26.	የእለት ተግባሬን ያለምንም እርዳታ እፈጽማለሁ።					
27.	አካላዊም ሆነ አዕምሮዊ ጤናዬን እጠብካለው።					
28.	ለእድሜዬ ጥሩ አመለካከት አለኝ።					

29.	ስለህይወት ባጠቃላይ አዉንታዊ እይታ አለኝ፡፡					
30.	ህይማኖቴ የደስታ ምንጭ ነው በዬ አምናለሁ፡፡					
31.	ህይማኖታዊ ልምምድ ማድረግ ውስጣዊ ሰላምን ይሰጠኛል፡፡					
32.	ፀሎትና ህይማኖታዊ ልምምድን ማድረጌ ደስታን ያስገኝልኛል፡፡					
33.	ህይማኖቴ ተስፋን፣ደስታንና ሰላምን የማገኝበት ነው፡፡					
34.	እድሜ ፀጋ መሆኑንና ትርጉም የሚገኘው በመንፈሳዊነት እንደሆነ አምናለሁ፡፡					
35.	እምነቴ የብቸኝነት ስሜት እንዳይሰማኝ ጠብቆኛል፡፡					
36.	በህይማኖት ወስጥ መሆኔ ጥቅም እንደሰጠኝ አምናለሁ፡፡					
37.	ህይማኖታዊ የሆነ ህብረት ሜድረጌ እድሜን ተከትሎ የሚመጡ ለውጦችን እንድጋፈጥ አግዞኛል፡፡					
38.	በእግዛብሄር ላይ ያለኝ እምነት በህይወት ፈተና ውስጥ እንድፀና አርጎኛል፡፡					
39.	ህይማኖቴ ስለህይወት አዉንታዊ አመለካከት እንዲኖረኝና አላማ እንዲኖረኝ አድርጎኛል፡፡					
40.	የህይማኖት ስብሰብ ውስጥ መሆኔ እድሜዬን ተከትሎ የሚመጡትን ላውጦች እንድ ቀበልና እንድቀበል ረድቶኛል፡፡					
41.	ህልሜን ለማሳካት እድሜዬ እንደማይገድበኝ አውቃለሁ፡፡					
42.	ትልቅ እንደ መሆኔ የስራ እድል ማግኜቴ ለጤናዬ ጥሩ ግብአት አለው፡፡					
43.	በስራ ላይ መቆየቴ እንድነቃቃና ከማህበረሰቡ ጋር በጥሩ ግንኙነት እንድቆይ አርጎኛል፡፡					
44.	በስራዬ ጥሩ አስተዋፆ ለማበርከት አቅም እንዳለኝ በራሴ እተማመናለሁ፡፡					
45.	እንደ እኔ ላሉ ትልቅ ለሚባሉ ሰዎች የስራ እድልን መፍጠር ለጤናቸው ጥሩ ነው፡፡					
46.	ከእድሜዬ አንፃር ለማህበረሰቡ የራሴን አስተዋፆ ማድረግ አስፈላጊ ነው ብዬ አምናለሁ፡፡					

Appendix F: The Final Version of Older Adults SWBS
The original English version

Respondent's Code_____

Addis Ababa University

College of Education and Language Studies

School of Psychology

Questionnaire for retired older adult

The purpose of this questionnaire is to assess the reliability and validity of the newly developed SWB instrument. This questionnaire has two parts: the first part has demographic questions about the respondents, and the second part has a scale of SWB. The information you provide has a very important input on the direction and completion of this study, so please try to be honest, and careful. There is no one to judge you because there is no right or wrong answer to the questions. The information will be kept confidential and only used for the purpose of study. Your forthright information helps to reach the goals of the study.

Thank you very much for your cooperation!

Part I: Background Information

Direction: Please listen each of the following questions carefully and answer all the questions.

No.	Items	Response
1	Age (in years)	_____
2	Gender	Men ○ Women ○
3	Religion	Orthodox ○ Muslim ○ Protestant ○
4	Educational level	Cannot read and write ○
		Primary school ○
		Secondary school ○
		College ○
5	Marital status	Married ○ Widowed ○ Divorced ○ Widowers ○
6	Living arrangement	With family ○ Alone ○
7	Number of children (in number)	_____

Part II: Subjective Well-Being Scale (SWBS)

Direction: The under listed statements are prepared to explore your perception how you feel about your well-being. Please listen each of the following statements carefully and answer all the questions. Please rate each of them from 1 (strongly disagree); 2 (disagree); 3 (Undecided); 4 (agree) and 5 (strongly agree).

No.	Items	Level of Agreement				
		1	2	3	4	5
1.	My religious faith serves as a source of happiness in my life.					
2.	I find a deep sense of internal peace through religious activities.					
3.	I view aging as a gift from heaven.					
4.	My faith reminds me that I am never alone.					
5.	My religious beliefs provide me a sense of purpose.					
6.	My religious group provides a sense of belonging that helps me face aging challenges with resilience.					
7.	My faith in God sustains me through life's challenges.					
8.	Despite life's challenges, I maintain a positive outlook on my circumstances.					
9.	I adapt well to the changes in my body as I age.					
10.	I maintain independence in my daily activities.					
11.	I believe that age should not prevent me from pursuing my passions.					
12.	I am confident in my ability to make valuable contributions in the workforce despite my age.					
13.	I am in a good physical health to lead my future life well					
14.	I can perform basic self-care tasks independently.					
15.	I accomplish my daily routine without difficulty					
16.	In this day, I felt downhearted and depressed.					
17.	Engaging in work keeps me mentally stimulated.					
18.	I maintain good mental health.					
19.	I experience a deep sense of contentment when engaged in meaningful social interactions.					
20.	I feel accepted in family life					
21.	I live peacefully with peoples in my surroundings.					
22.	I have a positive connection with my children.					
23.	I am not isolated or lonely.					
24.	I have a sense of financial security that empowers me to make choices aligned with my values and aspirations.					
25.	I have sufficient financial resources to meet my basic needs					
26.	My current income adequately meets my financial needs.					
27.	My financial situation allows me to maintain my health, manage life pressures, and preserve my independence.					

Appendix G: The Final Version of Older Adults SWBS
The original Amharic version

በአዲስ አበባ ዩኒቨርሲቲ

የትምህርትና ቋንቋ ጥናት ኮሌጅ

የሳይኮሎጂ ትምህርት ቤት

የተሳታፊ መለያ ቁጥር _____

<u>ለአረጋውያን የቀረበ የጽሑፍ መጠይቅ</u>

በቅድሚያ በዚህ ጥናት ተሳታፊ ለመሆን ፈቃደኛ ስለሆኑ የከበረ ምስጋናዬን ለማቅረብ እወዳለሁ፡፡ ስሜ ተሾመ ቆንዳሌ ጉራራ ሲሆን በአሁኑ ወቅት በአዲስ አበባ ዩኒቨርሲቲ የሶስተኛ ዲግሪ ትምህርቴን በአፕላይድ ደቨሎፕመንታል ሳይኮሎጂ የትምህርት ዘርፍ በመከታተል ላይ ስሆን ለመመረቂያ ማሚያ የሚሆን *የአረጋውያን አጠቃላይ የህይወት ደህንነት በእራሳቸው እይታ ምን እንደሚመስል ለመለካት የሚያስችል መለክያ ለማዘጋጀት* ጥናት በመስራት ላይ እገኛለሁ፡፡ የጥናቱ ውጤት የአረጋውያንን ደህንነት ለማሻሻል የታለሙ አጠቃላይ እና አግባብነት ያላቸውን የስነ-ልቦና እና ኢኮኖሚያዊ ተግባራትን ለማዘጋጀት ጥቅም ላይ ይውላል። የጽሑፍ መጠይቁ 34 ጥያቄዎችን በ2 ክፍሎች ያካተተ ሲሆን መልስ ለመስጠት ከ30 ደቂቃ በላይ አይወስድም። ሁሉም ምላሾች ስም-አልባ ሆነው ይቆያሉ እና መረጃው ሚስጥራዊ ሆኖ ይቆያል እናም ለአሁኑ የምርምር ዓላማ ብቻ ጥቅም ላይ ይውላል። ስለሆነም እያንዳንዱን የጽሑፍ ጥያቄ በዝርዝር ይመልሱልኝ ዘንድ በአክብሮት እጠይቃለሁ፡፡

በዚህ ጥናት ውስጥ ለመሳተፍ ስለተስማሙ አመሰግናለሁ እናም ይህንን የጽሑፍ ጥያቄ ለማድረግ ፈቃደኝነትዎን አደንቃለሁ።

ስለ ትብብርዎ በቅድሚያ በጣም አመሰግናለሁ፡፡

ክፍል 1፡- የተሳታፊ አረጋውያን አጠቃላይ መረጃ

ተ.ቁ	ጥያቄ	ምላሽ
1	ዕድሜ (በዓመት)	_____ ዓመት
2	ጾታ	○ ወንድ ሴት○
3	ሃይማኖት	ኦርቶድክስ ○
		ፕሮቴስታንት○
		እስሌምና ○
4	የትምህርት ደረጃ	ማንበብና መጻፍ የማይችል/የማትችል ○
		አንደኛ ደረጃ ○
		ሁለተኛ ደረጃ ○
		ኮሌጅ ○
5	የጋብቻ ሁኔታ	ያገባ(ች)○ የተፈታ(ች) ○
		የተለያየ(ች) ○ ሚስቱ የሞተችበት(ባሎ የሞተባት)○
6	የአኗኗር ሁኔታ	ከቤተሰብ ጋር ○ ለብቻ ○
7	የልጅ ብዛት (በቁጥር)	_____

ክፍል ሁለት:- የግለሰባዊ ደህንነት መለኪያ (SWBS)

መመርያ:- ከዚህ በታች የተዘረዘሩት ጥያቄዎች ስለ ራስዎ ደህንነት ምን እንደሚሰማዎት ለማወቅ የተዘጋጀ ነው። እባካችሁ የሚከተሉትን ጥያቄዎች በጥንቃቄ አዳምጡ፣ ከዚያም ለቀረቡት ጥያቄዎች መልስ ስጡ። ከዚህ በታች ባሉት የስምምነት ደረጃ፡-

1. በጣም አልስማማም
2. አልስማማም
3. እርግጠኛ አይደለሁም
4. እስማማለሁ
5. በጣም እስማማለሁ

ቁጥር	ጥያቄዎች	የስምምነት ደረጃ				
		1	2	3	4	5
1.	ሃይማኖቴ የሕይወቴ የደስታ ምንጭ ነው።					
2.	በጸሎትና በሃይማኖታዊ ተግባራት የውስጥ እረፍትና ሰላም ይሰማኛል።					
3.	ሽምግልና ከእግዚአብሔር የተሰጠ ስጦታ እንደሆነ አምናለው።					
4.	እምነቴ ብቸኛነት እንዳይሰማኛና በህይወት ለመኖሪ ምክንያት ነው፡፡					
5.	ሃይማኖታዊ እምነት በህይወቴ ተስፋና ዓላማ እንዲኖረኛ አድርጎኛል፡፡።					
6.	በሃይማኖት ዙርያ ያሉ ሰዎች ከእድሜ ጋር የሚመጡ ፈተናዎችን እንድቋቋም እገዛ ያደርጉልኛል።					
7.	በእግዚአብሔር ላይ ያለኝ እምነት በህይወት ፈተናዎች እንድጸና አድርጎኛል፡፡					
8.	ምንም ህይወት አስቸጋሪ ቢሆንም አዎንታዊ አመለካከት አለኝ።					
9.	ከዕድሜ ጋር የሚመጡ አካላዊ ለውጦችን በጸጋ እቀበላለው፡፡					
10.	በዕለታዊ ተግባራቶችን በነፃነት አከናውናለው።					
11.	አሁንም ዕድሜ ሳይገድበኝ ህልሜን ማሳካት እችላለው፡፡					
12.	ዕድሜ ሳይገድበኝ አሁንም ዋጋ ያላቸውን አስተዋጽኦዎች ማድረግ እችላለሁ፡፡					
13.	የወደፊት ሕይወቴን ደህና ለማድረግ አሁን ላይ በጥሩ አካላዊ ጤና ላይ እገኛለው፡፡					
14.	መብላት፣ መታጠብ፣ መልበስ ያሉ መሰረታዊ የእራስን እንክብካቤ ተግባራት በራሴ መፈጸም እችላለሁ።					
15.	ዕለታዊ እንቅስቃሴዎቼን ያለምንም ችግር እፈጽማለው፡፡					
16.	አሁን ላይ የድባቴና ተስፋ የመቁረጥ ስሜት ይሰማኛል፡፡					
17.	በተለያዩ ሥራዎች ላይ መሳተፋ አእምሮዬን ለማነቃቃት ጠቅሟኛል፡፡					
18.	በተለያዩ ሥራዎች ላይ በንቃት መሳተፍ አእምሮዬን ጤና እንድጠብቅ አድርጎናል፡፡					
19.	ትርጉም ባለው ማህበራዊ ተግባራት ላይ በንቃት ስሳተፍ ክፍተኛ የሆነ የውስጥ ተስፋ ይሰማኛል።					
20.	በቤተሰብ ዘንድ ተቀባይነት አለኝ፡፡					
21.	በአከባቢዬ ካሉ ጋር በሰላም እየኖርኩ ነው።					
22.	ከልጆቼ ጋር አዎንታዊ ግንኙነት አለኝ።					
23.	እኔ የብቸኝነት ወይም የመገለል ስሜት አይሰማኝም።					
24.	ከእራሴ ፍላጎቶች ጋር የሚጣጣሙ ውሳኔዎችን ለመወሰን የሚያስችለኝ የፋይናንስ ደህንነት አለኝ።					
25.	መሰረታዊ ፍላጎቶቼን ለማሟላት በቂ የፋይናንስ ሀብት አለኝ።					
26.	አሁን ያለኝ ገቢ (ጡረታ) የፋይናንስ ፍላጎቶቼን በበቂ ሁኔታ እንዳሟላ አድርጎኛል።					
27.	አሁን ላይ ያለኝ የገቢ መጠን የጤናዬን ሁኔታ እንድቁጣጠር አስችሎኛል።					