Psycho-Social, Financial and Health Predictors of a Quality Retirement Life: A Kenyan Case

By

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Abstract
Research has established a positive correlation between pre-retirement life and quality of life (QoL) in retirement. Yet, many retirees in Kenya continue to experience endless challenges and a low QoL. Hence, this study was conducted to assess the pre-retirement predictors of retirement satisfaction with a view to making appropriate recommendations. A multi-dimensional approach was utilized to assess retirement preparation in the psychosocial, financial and health domains and its influence on the overall QoL of retirees. Ten percent of the target population was randomly sampled, giving 447 respondents. Quantitative data was collected using interview schedules and analyzed using SPSS. QoL was found to be positively related to retirement preparation in the psychosocial, financial and health domains. Most respondents were found to be inadequately prepared for retirement and consequently experienced a low quality retirement life. The study recommends a multi-faceted retirement preparation framework that is more responsive to QoL needs.
Key words: Retirement preparation, predictors, quality life, retirees, Kenya

1.1 Introduction

Quality of life (QoL) is multi-dimensional and refers to an individual's overall life satisfaction and total well-being (Prinsloo, 2009; Thuku, 2016). It encompasses how an individual perceives the 'goodness' of the multiple aspects of his/her life and may be assessed in terms of psychological well-being, physical health, economic prosperity, and social connectedness (Wong & Earl, 2009; Bowling, 2014). Generally, it is a function of the degree to which each identified human need is met in relation to its relative contribution to one's subjective wellbeing (Maina & Mugenda, 2013). Due to the phenomenon of longevity, demographers project that for the first time in history, there will be more people aged 60 years and above than children under 15 by the year 2050 (UNFPA & HAI, 2012). As longevity is celebrated globally, the World Health Organization (WHO) recommends adding quality to longevity for older people (WHO, 2012).

An ageing population is both a blessing and a challenge. It can be an impending economic burden of concern for most governments as it implies a need for additional resources to support increasing populations of senior citizens for more years (Browning et al, 2012). Specifically, expenditure on retirement pensions has been on the increase and is set to rapidly increase as larger populations of employees attain the mandatory retirement age, and live longer than previously anticipated (Barasa, 2009; Browning et al, 2012). However, this can be converted into opportunities if appropriate interventions are put in place to increase their independence.

Research confirms that the transition from a role of employee to that of retiree is fundamental and can affect an individual's QoL (Wong & Earl, 2009; Chung, 2017). When an individual retires, he/she parts from a significant activity that affects many life domains. The transition requires personal adjustment to changes in income, free time, social network and occupational identity (Lubega, 2012). As explained by Atchley (2000), a quality retirement life requires that retirees be financially independent, physically able-bodied, socially connected and mentally able to structure their own lives. However, scholars disagree about the effects of retirement on the quality of life of retired persons (Calvo & Sarkisian, 2011). While some scholars emphasize the positive outcomes of retirement (Mein et al, 2003; Mojon-Azzi et al, 2007; Westerlund et al, 2009), others view retirement as full of challenges (Alavinia & Burdorf, 2008; Almeida & Wong, 2009; Kithinji, 2012). However, other researchers have argued that retirement does not significantly affect the quality of life of individuals but rather, what matters are the preparation activities they undertook prior to retirement (Butterworth et al. 2006; Coe & Lindeboom 2008; Neuman 2008; Chung, 2017). Despite the lack of consensus on the predictors of QoL among retirees, many scholars around the world have found a significant positive relationship between retirement preparation and subsequent QoL (Muratore & Earl, 2010; Wang & Hesketh, 2012, Thuku et al, 2016). In Australia, Wang and Hesketh (2012) found that retirees who had prepared extensively for retirement were more likely to enjoy a higher quality of life. In Brazil, Alvarenga et al (2009) reported a positive relationship between retirement preparation and retirement satisfaction. In South Africa, Prinsloo (2009) observed that although retirement preparation was the best predictor of retirement adjustment, only 45 percent of the respondents had adequately prepared prior to retirement. A study conducted in Uganda found that most employees were not sure of their individual roles in achieving quality retirement (Lubega, 2012). In Kenya, there is need for more research as very few studies on QoL have been conducted (Ondigi & Mugenda, 2011; Maina and Mugenda, 2013).

Although the area of retirement has been extensively researched, majority of studies focus on preparation mainly in the financial domain, contrary to recommendations that affirm the need to prepare for retirement in all areas of QoL (Muratore & Earl, 2010; Lubega, 2012; Osborne 2012; Muthondeki et al, 2014; Chung, 2017). Osborne (2012) observed that many employees were reasonably aware of the need for financial preparation but overlooked the critical contribution of psychosocial preparation. In addition to financial and psychosocial preparation, healthcare is an important aspect of retirement preparation. This is because; pre-retirement health status has been found to be a strong predictor of post-retirement health condition and the subsequent QoL (Albert, 2006; Wang and Hesketh, 2012). A study by Kenyatta University (KU, 2014) reported that retirees who were unable to meet their health needs did not age gracefully and encountered an early death. An observation by Osborne (2012) revealed that a reduction in economic wellbeing that usually accompanies retirement does not necessarily lead to a decrease in overall QoL. In view of the complexity of pre-retirement factors that influence QoL, a multi-dimensional approach to retirement preparation is critical. This study therefore assessed the QoL of retirees in Kenya and analysed their retirement preparation using a multi-faceted approach, with a view to establishing the existence of significant relationships. The findings informed the formulation of a retirement preparation framework that may be more responsive in meeting the QoL needs of retirees.

1.2 Statement of the Problem

The long term goal of every society is to enhance the QoL of its members (Thuku et al, 2016). Kenya's development strategy outlined in 'Vision 2030' aims at improving the quality of life of all citizens. In this regard, the Retirement Benefits Authority (RBA), the National Social Security Fund

(NSSF), the media and other relevant bodies have intensified retirement preparation campaigns with a view to improving the retirement preparation behaviour of prospective retirees and the subsequent QoL (Kwena, 2009). Hence, with relevant institutional and policy frameworks in place, a high quality retirement for Kenyans would be expected. Yet, studies continue to report on numerous challenges faced by retirees in the country (Kamau, 2012; Kithinji, 2012; KU, 2014; Muthondeki et al, 2014; Thuku, 2016). This may be an indicator that retirement preparation has been ineffective in achieving a high QoL for retirees, hence the need for more research.

This study was conducted to assess the retirement preparation of retirees from a multi-dimensional approach and its influence on the overall QoL. The study aimed at identifying the psycho-social, financial and health factors in retirement preparation that significantly predicted a high quality retirement life, with a view to recommending an effective retirement preparation framework.

1.3 Objectives of the Study

The general objective of this study was to assess the psychosocial, financial and health predictors of a quality retirement life in Kenya. The study was guided by three specific objectives. To;

1. Assess the retirement preparation in the psychosocial, financial and health domains.
2. Analyse the QoL of retirees from a multi-dimensional perspective.
3. Examine the factors in retirement preparation (psychosocial, financial and health) that significantly influenced the QoL of retirees.

1.4 Research Hypotheses

To achieve the objectives, the study tested the following research hypotheses;

i. Quality of life in retirement is significantly related to psychosocial preparation.
ii. Quality of life in retirement is positively related to financial preparation.
iii. Quality of life is positively related to retirement preparation in the health domain.

2.0 Research Methodology

The study utilized a mixed method design to ensure that any biases inherent in any single approach were neutralized. Quantitative data was collected using structured interview schedules through face to face interviews with respondents. The Statistical Package for Social Sciences (SPSS Version 20) was used to analyze the data.

2.1 Site Selection, Sampling Design, Sample Size and Data Collection Instruments

The study was conducted in Nyeri County, Kenya. The County was purposively selected mainly because it is among the counties with the highest percentage of people aged 65 years and above, has the highest literacy level (86.5 percent), and is among the counties with the highest life expectancy at birth. Purposive, cluster, simple and proportionate stratified random sampling techniques were utilized in selecting the final sample.

The County is sub-divided into eight Sub-Counties. Based on the existing sub-counties, the county was divided into 8 clusters and 4 sub-counties were then randomly selected for the study. The sampling frame was composed of registered members of Kenya Association of Retired Officers (KARO). Out of the 4,469 retirees from the formal sector who were residing in the county at the time of the study, 10 percent were sampled giving 447 respondents. Structured interview schedules were used to collect data from the respondents. Both the dependent and independent variables were operationalized to make them measurable.

2.2 Data Analysis and Presentation:

Quantitative data was cleaned, coded and keyed into a computer using the Statistical Package for Social Sciences (SPSS, Version 20). Frequencies and percentages were run to show the general characteristics of the respondents and cross-tabulation was done to reveal any associations between variables of interest. In order to enable quantitative analysis and thus test for the significance of relationships between the dependent and independent variables, the respondents' qualitative responses were quantified by awarding scores using the Likert Scale. In hypotheses testing, Chi-square tests were conducted to examine whether any significant relationships existed between the dependent variable (QoL) and each of the independent variables. The null hypothesis was rejected and the relationship between QoL (dependent variable) and the independent variables considered significant if $p \leq 0.05$. The Spearman correlation coefficient was used to explain the strength and direction of the relationships. A logistic regression analysis was conducted to delineate the significant predictors of the dependent variable. In order to identify the variables for use in regression analysis, the reliability of the scale was tested using Cronbach's Alpha which was calculated for related items measured on Likert Scale.

3.0 RESULTS AND DISCUSSION

The data was collected from 400 respondents out of the sampled 447, indicating a response rate of 89.5 percent. The sample was composed of respondents of different ages, gender, marital status, education levels and income hence representative of the general population

3.1 Retirement Preparation of Respondents

Retirement preparation is a necessary activity for achieving retirement satisfaction (Prinsloo, 2009; Chung, 2017). This study assessed the extent of retirement preparation done in each of the three domains of study namely; psychosocial, financial and health.

3.1.1 Retirement Preparation in the Psychosocial Domain

Psychosocial domain involves aspects of both social and psychological behavior (Ondigi & Mugenda, 2011). In line with this definition, this study assessed retirement preparation by analysing the respondents' engagement with various psycho-social variables of interest. They were expected to respond whether their level of engagement was; very high, high, low, very low or not at all, as shown in Table 3.1.

Table 3.1 Respondents' Extent of Psychosocial Preparation for Retirement

Psychosocial Preparation for Retirement	Not at all	Very low extent	Low extent	High extent	Very high extent	Total
	%	%	%	%	%	%
Discussing retirement with spouse	20.25	19.75	36.25	23.75	0.00	100.00
Discussing retirement with other family members	5.00	29.75	60.25	5.00	0.00	100.00
Discussing retirement with friends	5.00	10.00	75.25	9.75	0.00	100.00
Reading literature on retirement	50.00	44.75	5.25	0.00	0.00	100.00
Listening to retirement programs	25.00	59.75	15.25	0.00	0.00	100.00
Attending retirement workshops	89.50	10.50	0.00	0.00	0.00	100.00

Spending free time with colleagues	0.00	35.00	40.50	24.50	0.00	100.00
Spending free time with family	0.00	0.50	17.75	81.75	0.00	100.00
Spending free time with friends	0.00	0.00	51.50	48.50	0.00	100.00
Spending time with religious associates	0.00	54.00	21.50	15.50	9.00	100.00
Spending free time on official work	19.50	20.25	40.50	19.75	0.00	100.00
Spending free time on leisure	0.00	45.00	36.00	14.00	5.00	100.00
Spending free time on family activities	0.00	0.00	20.50	70.25	9.25	100.00
Spending free time generating extra income	0.00	10.00	25.50	54.50	10.00	100.00
Spending free time on religious activities	0.00	54.25	20.75	25.00	0.00	100.00

As shown in Table 3.1, none of the respondents discussed retirement to a very high extent. To allow for a quantitative analysis of psychosocial preparation for retirement, scores were awarded to the respondents' qualitative responses. The following Likert Scale was used to award the scores; 'very high extent' (score=4), 'high extent' (score=3), 'low extent' (score=2), 'very low extent' (score=1) and 'not at all' (score=0). Since there were 15 questions, each with a maximum score of 4 and a minimum of 0, the maximum expected score was 60 (15*4) and the minimum was 0. For anybody to be regarded as adequately prepared for retirement, he/she needed to have scored at least 3 (high extent) in each of the 15 questions. However, out of the expected maximum score of 60, the highest score obtained by respondents was 36 while the lowest was 18. Since none of the respondents scored 45 and above, no-one was regarded as adequately prepared for retirement in the psychosocial domain.

3.2.2 Retirement Preparation in the Financial Domain

Financial preparation for retirement focuses on guiding an individual to save, invest and raise money to meet financial needs during retirement (Lubega, 2012). This study assessed the financial preparation of respondents by analyzing the extent to which they had made financial savings, asset investment, insurance and expected retirement estimates prior to retirement. A 5-point Likert scale ws used to examine whether retirement preparation had been carried out to; 'a very high extent', 'high extent', 'low extent', 'very low extent' or 'not at all' as shown in Table 3.2.

Table 3.2 Respondents' extent of Retirement Preparation in the Financial Domain

Variable Indicator	Not at all	Very low extent	Low extent	High extent	Very high extent	Total
	%	%	%	%	%	%
Made general financial savings	0.00	35.25	64.75	0.00	0.00	100.00
Savings made specifically for retirement use	30.25	69.75	0.00	0.00	0.00	100.00
Made long-term financial investments	4.75	42.75	34.50	18.00	0.00	100.00
Ownership of retirement residence	9.75	0.25	11.25	78.75	0.00	100.00
Life insurance coverage	54.75	15.75	29.50	0.00	0.00	100.00
Medical insurance coverage	54.25	31.50	14.25	0.00	0.00	100.00
Estimated financial retirement needs	99.25	0.75	0.00	0.00	0.00	100.00
Estimated expected retirement income	98.75	1.25	0.00	0.00	0.00	100.00
Engaged in extra income-generation	20.00	35.25	36.00	8.75	0.00	100.00
Saved for future emergencies	20.25	75.25	4.50	0.00	0.00	100.00

Saved for leisure expenses	90.25	9.75	0.00	0.00	0.00	100.00
Saved through pension schemes	84.50	10.75	4.75	0.00	0.00	100.00
Saved through SACCOs	4.50	31.25	55.25	9.00	0.00	100.00
Made asset investments	40.25	21.25	38.5	0.00	0.00	100.00
Planned how to spend lump-sum pension	14.75	11.50	63.75	10.00	0.00	100.00

Table 3.2 shows that all respondents made financial savings to some extent although none of them saved to a high extent. To allow for a quantitative analysis, scores were awarded to the respondents' responses using the following Likert Scale; 'very high extent' (score=4), 'high extent' (score=3), 'low extent' (score=2), 'very low extent' (score=1) and 'not at all' (score=0).

Since there were 15 questions, each with a maximum score of 4 and a minimum of 0, the maximum expected score was 60 (15*4) and the minimum was 0. When the frequencies were run, out of the maximum expected score of 60, the maximum score obtained by respondents was 27 and the minimum was 3. Considering that the highest score obtained (27) was less than half of the expected score, the findings imply that financial preparation for retirement was inadequately done by all the respondents. This corresponds with prior studies that identified inadequate financial preparation as one of the major causes of retirement challenges (Kwena, 2009; Muthondeki et al, 2014).

3.2.3 Retirement Preparation in the Health Domain

Pre-retirement health status has been found to be a strong predictor of the post retirement one (Albert, 2006; Browning et al., 2012; Ondigi & Mugenda, 2011; Wang and Hesketh, 2012). To assess the retirement preparation of respondents in the health domain, the study analyzed whether their engagement in the activities of interest was to 'a very high extent', 'high extent', 'low extent', 'very low extent' or 'not at all'. The responses are shown in Table 3.3.

Table 3.3 Respondents' extent of Retirement Preparation in the Health Domain

Variable Indicator	Not at all	Very low extent	Low extent	High extent	Very high extent	Total
	%	%	%	%	%	%
Engaged in physical exercises	0.25	84.25	10.75	4.75	0.00	100.00
Engaged regularly in physical/manual work	0.00	19.50	40.50	40.00	0.00	100.00
Observed a balanced diet	5.75	60.25	34.00	0.00	0.00	100.00
Avoided excessive alcohol intake	9.50	15.75	30.00	15.75	29.00	100.00
Avoided cigarette smoking	5.00	10.00	20.50	35.25	29.25	100.00
Had planned for medical care in retirement	74.25	11.00	14.75	0.00	0.00	100.00
Undertook regular medical check-ups	10.00	54.00	31.00	5.00	0.00	100.00
Sought specialized treatment if necessary	0.00	0.00	1.00	99.00	0.00	100.00
Followed doctors' prescriptions	0.00	0.00	0.50	94.25	5.25	100.00
Sought health-promoting information	0.00	5.25	60.00	29.75	5.00	100.00

As shown in Table 3.3, about 4.75 percent of the respondents had engaged in physical exercises to a high extent and 40 percent of them engaged in physical work to a high extent. This observation was a positive indicator of pre-retirement physical activity by many of respondents. However, none of

them had adequately planned how their medical needs would be catered for in retirement, an indication that they had not paid much attention to their future medical needs.

In order to allow for more comprehensive analysis, responses were quantified by using the following Likert Scale; 'a very high extent' (score=4), 'high extent' (score=3), 'low extent' (score=2), 'very low extent' (score=1) and 'not at all' (score=0). There were 10 questions, each with a maximum score of 4 and a minimum of 0, hence the maximum score expected was 40 (10*4) and the minimum was 0. A minimum score of 30 (3*10) was required for any respondent to be regarded as adequately prepared for retirement in the health domain. See Appendix 1 for the distribution of respondents based on their extent of preparation in the health domain.

As Appendix 1 shows, out of the expected maximum score of 40, the highest score obtained by respondents was 27 and the lowest was 15. None of the respondents scored 30 and above, implying that no one had prepared adequately for retirement in the health domain. However, more than half of them (59.5 percent) scored above half of the expected score, indicating that many respondents had engaged in health promoting activities and were fairly prepared in the domain.

3.3 Establishing Quality of Life of Retirees

QoL is a function of the degree to which each identified human need is met in relation to its relative contribution to one's subjective wellbeing (Maina & Mugenda, 2013). According to Browning et al (2012), it is important to use domains of QoL that are meaningful to the people themselves, and to recognize that these domains may vary according to the person's life circumstances, culture and social characteristics. This study therefore measured QoL by analyzing the respondents' extent of satisfaction with selected variables that were considered important for a quality retirement. In tandem with retirement preparation, QoL was assessed as a multidimensional construct encompassing psychosocial well-being, financial security and good health. In total, 17 indicators were utilized to measure the QoL.

This study assessed QoL by asking each respondent to indicate whether his/her experience with the particular measures of QoL was 'very satisfactory', 'satisfactory', 'unsatisfactory', 'very unsatisfactory' or 'not applicable'. Table 3.4 presents the responses of respondents based on their perceived QoL in the psychosocial, financial and health domains.

Table 3.4 Respondents' Responses based on their QoL in Various Domains

Variable Indicators	**Not Applicable**	**Very Unsatisfactory**	**Unsatisfactory**	**Satisfactory**	**Very Satisfactory**	**Total**
	%	**%**	**%**	**%**	**%**	**%**
Quality of support from spouse	20.00	3.00	15.25	53.25	8.50	100.00
Quality of support from children	0.00	3.00	21.00	48.25	27.75	100.00
Quality of support from siblings	0.00	1.25	7.00	67.00	24.75	100.00
Extent of inclusion in family matters	0.00	4.5	0.00	95.25	0.25	100.00
Support from neighbours	0.00	0.00	4.50	95.50	0.00	100.00

Support from religious associates	0.00	0.00	3.25	77.75	19.00	100.00
Reliability of friends	0.00	0.00	0.25	99.50	0.25	100.00
Security in the neighbourhood	0.00	0.00	5.20	94.80	0.00	100.00
Satisfaction with retirement life	0.00	4.80	20.20	74.80	0.20	100.00
Satisfaction with social inclusion	0.00	0.00	25.0	75.00	0.00	100.00
Ability to meet basic needs	0.00	5.00	35.25	59.75	0.00	100.00
Ability to finance emergencies	0.00	10.00	56.75	33.25	0.00	100.00
Ability to finance leisure	0.00	54.75	40.00	5.25	0.00	100.00
Perceived financial security	0.00	10.50	76.25	13.25	0.00	100.00
Access to medical care	0.00	4.50	50.50	45.00	0.00	100.00
Quality of medical care received	0.00	0.00	75.25	24.75	0.00	100.00
Satisfaction with one's health status	0.00	0.00	15.25	84.75	0.00	100.00

As shown in Table 3.4, the overall QoL was measured using indicators from the psychosocial, financial and health domains. To show a clearer analysis of the respondents who were satisfied and/or dissatisfied with their QoL, their responses were summarized. This was done by combining 'very unsatisfactory & unsatisfactory' responses to form 'unsatisfactory' and 'satisfactory & very satisfactory' to form 'satisfactory' QoL. Although the 'Not applicable' responses imply neither satisfaction nor dissatisfaction, they were added to the 'unsatisfactory' category because the respondents concerned were regarded as not having experienced any satisfaction in the aspect of interest. The summary is presented in Table 3.5.

Table 3.5 Summary of the Respondents' Satisfaction/Dissatisfaction with QoL

Variable Indicators	**Unsatisfactory**	**Satisfactory**	**Total**
	%	**%**	**%**
Quality of support from spouse	38.25	61.75	100.00
Quality of support from children	24.00	76.00	100.00
Quality of support from siblings	8.25	91.75	100.00
Extent of inclusion in family matters	4.50	95.50	100.00
Support from neighbours	4.50	95.50	100.00
Support from religious associates	3.25	96.75	100.00
Reliability of friends	0.25	99.75	100.00
Security in the neighbourhood	5.20	94.80	100.00
Satisfaction with retirement life	25.00	75.00	100.00
Satisfaction with social inclusion	25.0	75.00	100.00
Ability to meet basic needs	40.25	59.75	100.00
Ability to finance emergencies	66.75	33.25	100.00
Ability to finance leisure	94.75	5.25	100.00
Perceived financial security	86.75	13.25	100.00
Access to medical care	55.00	45.00	100.00
Quality of medical care received	75.25	24.75	100.00
Satisfaction with one's health status	15.25	84.75	100.00

As shown in Table 3.5, more than half of the respondents indicated satisfaction in most variables. However, high levels of dissatisfaction are notable in some indicators, for example, where 86.75

percent feel financially insecure and 66.75 percent have inadequate finances to handle emergency situations. Apparently, lthough only 45 percent of respondents indicated satisfaction with their access to medical care, more than three-quarters were satisfied with their health status. The dissatisfaction with accessibility to quality medical attention could be attributed to congestion in public hospitals that make it challenging for older retirees to queue for treatment.

The qualitative responses in Table 3.5 were then quantified by awarding scores using the Likert Scale; satisfactory (score=1), unsatisfactory (score=0). Using this Scale, frequencies were run to show the distribution of respondents based on their QoL. Since there were a total of 17 indicators, each with a maximum score of '1' and a minimum of '0', the maximum expected score was 17.

For purposes of interpretation, a score of less than half (8.5) of the maximum points implied that the respondent was dissatisfied in more than half of the measures of QoL and was therefore regarded as having a low QoL. Those who scored between 8.5 (half of the maximum score) and 12 (three-quarters of the maximum score) were considered to be fairly satisfied, while those who scored above 12 were regarded as experiencing a high QoL as presented in Table 3.6.

Table 3.6 Respondents' Extent of Satisfaction with Overall QoL

Satisfaction with QoL	Scores on overall QoL	Frequency	Percent	Cumulative Percent
Low QoL	4	18	4.50	4.50
	5	2	0.50	5.00
	8	40	10.00	15.00
Fairly Satisfactory QoL	10	41	10.25	25.25
	11	61	15.25	40.50
	12	72	18.00	58.50
Satisfactory QoL (High QoL)	13	71	17.75	76.25
	14	60	15.00	91.25
	15	24	6.00	97.25
	16	11	2.75	100.00
Total		400	100.00	

Table 3.6 shows that the minimum score obtained by respondents was 4 and the maximum was 16. Only 15 percent of the respondents scored below half of the maximum expected score (17/2=8.5), and were regarded as having a low QoL. Out of the remaining respondents, 43.5 percent scored between 10 and 12 and were considered to be fairly satisfied with their QoL while 41.5 percent had above 12 points and were regarded as experiencing a high QoL. The findings imply that although many respondents experienced a low QoL in several measures of wellbeing, satisfaction in others counteracted the adverse effects thus enhancing their overall QoL. The findings correspond to an observation by Osborne (2012) where a reduction in economic wellbeing that usually accompanies retirement does not necessarily lead to a decrease in overall QoL. Considering that retirement preparation has been strongly correlated with QoL, the study analyzed the influence of retirement preparation on QoL by testing the three research hypotheses.

3.4 Hypotheses Testing and Delineating Significant Predictors of QoL

The three research hypotheses were tested using the chi-square test. The null hypotheses; $H_0$1, $H_0$2 & $H_0$3 (Table 3.7) were tested by conducting a chi-square test between QoL and psychosocial preparation, financial preparation and preparation in the health domain respectively.

In order to meet the chi-square requirement, the 5-point Likert Scale on retirement preparation was collapsed into three categories in order to ensure that none of the expected cell frequencies were less than one and at least 80 percent were more than five (Eliott & Woodward, 2007). The recoding was done as follows; the responses 'not at all' and 'very low extent' were combined and transformed into the variable 'unprepared', 'low extent' was re-coded to 'slightly prepared' and 'high extent' plus 'very high extent' were re-coded to 'adequately prepared'. The new Likert Scale formed was awarded scores as follows; 'unprepared' (score=0), 'slightly prepared' (score=1) and 'adequately prepared' (score=2).

Frequencies based on the latter categories were run to analyse extent of retirement preparation in psychosocial, financial and health domain respectively. The results are presented in Table 3.7.

Table 3.7 Extent of Preparation for Retirement in Various Domains

	Extent of Retirement Preparation	Frequency	Percent	Cumulative Percent
Psychosocial Domain	Unprepared	19	4.75	4.75
	Slightly Prepared	304	76.00	80.75
	Adequately Prepared	77	19.25	100.00
	Total	400	100.00	
Financial Domain	Unprepared	299	74.8	74.8
	Slightly Prepared	101	25.2	100.0
	Adequately Prepared	0	0.0	100.0
	Total	400	100.00	
Health Domain	Unprepared	162	40.5	40.5
	Slightly Prepared	238	59.5	100.0
	Adequately Prepared	0	0.0	100.0
	Total	400	100.00	

As shown in Table 3.7, 4.75 percent of the respondents were categorized as unprepared, 76 percent as slightly prepared and 19.25 percent as adequately prepared for retirement in the psychosocial domain. In the financial domain, none of the respondents had made adequate financial preparation for retirement. About three-quarters (74.8 percent) fell into the 'unprepared' group in the while 25.2 percent were slightly prepared. The health domain was not much better with none of the respondents being adequately prepared and 40.5 percent being unprepared. However, 59.5 percent were slightly prepared, showing a general inadequacy of retirement preparation in both financial and health domains.

To assess the influence of retirement preparation on QoL, the extent of preparation in each of the domains (Table 3.7) was cross-tabulated against the extent of satisfaction with QoL (Table 3.6). Chi-square tests (at the 95 percent confidence level) were conducted to establish whether any relationships existed between the variables of interest and whether the relationships were significant, as presented in Table 3.8.

Table 3.8: Chi-square Tests on Influence of Retirement Preparation QoL in Retirement

Null Hypothesis	**Test**	**Value**	**p (at 0.05 sig. level)**
$H_0$1: *There is no relationship between Quality of life in retirement and psychosocial preparation.*	Pearson Chi-Square	12.28	0.000
	Somers'd	0.21	0.000
	Gamma	0.43	0.000
	Spearman Correlation	0.23	0.000
$H_0$2: *There is no relationship between quality of life in retirement and financial preparation.*	Pearson Chi-Square	55.95	0.000
	Somers'd	0.35	0.000
	Gamma	0.72	0.000
	Spearman Correlation	0.37	0.000
$H_0$3: *There is no relationship between Quality of life and retirement preparation in the health domain.*	Pearson Chi-Square	14.15	0.000
	Somers'd	0.54	0.000
	Gamma	0.85	0.000
	Spearman Correlation	0.59	0.000
	N of Valid Cases	400	

According to Table 3.8, results for the first hypothesis ($H_0$1) show that Pearson chi-square was significant ($p<0.001$) implying a significant relationship between Psychosocial preparation for retirement and QoL. In addition, the directional and symmetric measures, Somers'd and Gamma coefficients were significant with values of 0.21 and 0.43 respectively. Furthermore, the Spearman correlation coefficient had a value of 0.23 implying a fairly weak but positive relationship between psychosocial preparation and QoL. Hence, $H_0$1 was rejected and the alternative hypothesis was accepted leading to the conclusion that 'quality of life in retirement is significantly related to psychosocial preparation'.

Results on the second hypothesis ($H_0$2) also reveal a positive relationship. Pearson chi-square was significant ($p<0.001$) implying a significant relationship between financial preparation for retirement and QoL. In addition, the directional and symmetric coefficients Somers'd and Gamma were also significant with values of 0.35 and 0.72 respectively. The Spearman correlation coefficient had a value of 0.37 implying a positive relationship between financial retirement preparation and QoL. Hence, $H_0$2 was rejected and the alternative hypothesis accepted.

On the third hypothesis ($H_0$3), The Pearson chi-square statistic was significant ($p<0.001$) implying a significant relationship between retirement preparation in the health domain and QoL of respondents. In addition, the directional and symmetric coefficients Somers'd and Gamma were significant with strong values of 0.54 and 0.85 respectively. The Spearman correlation coefficient

had a value of 0.59 indicating a strong positive relationship. In view of this, the null hypothesis ($H_0$3) was rejected and the alternative hypothesis adopted. Hence, QoL is positively related to retirement preparation in the health domain.

The study therefore went ahead to delineate the factors in each of the three domains (psychosocial, financial and health) that significantly predicted the QoL in retirement by conducting a binary logistic regression. A summary is presented in Table 3.9.

Table 3.9 Logistic Regression: Predictors of QoL in Retirement

	Predictor Variable Name	Parameter Estimates	Std. Error	Wald X^2	df	Sig. (p-value)	Exp(B) (Odds Ratio)
Psycho-social Domain	Spending free time with friends	2.435	0.377	41.730	1	0.000*	11.417
	Spending time on extra income-generating activities	3.187	0.501	40.401	1	0.000*	24.220
	Spending free time on family activities	3.265	0.586	31.011	1	0.000*	26.190
	Spending free time on leisure activities	-5.558	0.703	62.463	1	0.000*	0.004
	Spending free time on office (job) work	-2.666	0.600	19.728	1	0.000*	0.070
Financial Domain	Engaged in extra income generation	2.558	1.473	3.018	1	0.008*	12.914
	Had life insurance	-3.455	1.270	7.399	1	0.007*	0.032
	Saved money for future leisure activities	-2.013	0.583	11.905	1	0.001*	0.134
Health Domain	Had medical insurance	-3.487	1.776	3.857	1	0.050*	0.031
	Engaged in physical work	-4.089	0.416	96.784	1	0.000*	0.017
	Had a plan on retirement healthcare provision	-1.770	0.290	37.287	1	0.000*	0.170
	Sought health-promoting information	2.372	0.399	35.405	1	0.000*	10.722

As shown in Table 3.9, psychosocial variables that were significant predictors of overall QoL include; Spending free time with friends, on extra-income generating activities, family activities, office work and leisure activities prior to retirement. However, while spending free time with friends, on extra-income generating activities and family activities predicted a high QoL, too much free time spent on job activities or leisure had lower odds.

In the financial domain, the indicators that had a significant influence on QoL include; engagement in extra income generating activities, having life insurance, saving for retirement leisure, and having medical insurance. The respondents who engaged in extra income generation when they were still in employment increased their odds of a quality retirement than those who did not. This

was probably because the extra income generated was invested and thus contributed to retirement income thus cushioning individuals against reduction in income that is associated with retirement.

The significant retirement preparation predictors of QoL in the health domain were; engagement in physical work, having a healthcare plan for retirement and seeking health promoting information. While engaging in physical work was found to be negatively related to QoL probably due to the physical strain involved, seeking health promoting information increased the chances of a quality retirement. This could be due to the power that knowledge gives thus enabling informed individuals to make the right decisions on healthy living. Health promoting information if well utilized would enhance the pre-retirement health status and the consequent post retirement one (Albert, 2006; Wang and Hesketh, 2012).

4. Conclusion and Recommendations

The study found that QoL in retirement is significantly influenced by retirement preparation in the psycho-social, financial and health domains. However, most prospective retirees were found to be inadequately prepared for retirement in all the domains of study although the financial domain was the most affected. However, despite the low QoL experienced by many retirees in the financial and health domains, majority of them were fairly satisfied with their overall QoL. This implies that despite constraints and challenges that may come with retirement and normal ageing, retirees who have adequate psychosocial support can still experience a quality life. This underscores the critical contribution of retirement preparation in all domains to the overall quality of life.

Contrary to the popular belief that financial security is the key influence on QoL, this study established that preparation in the health domain is more strongly correlated to QoL than preparation in other domains. This leads to the conclusion that while a lot of effort has been put to enhance retirement preparation, the focus may have neglected some of the important domains thus the ineffectiveness of the strategies.

Although most of the findings correspond with prior research, some observations were contrary, an indication that there may be some confounding factors that lead to differences in QoL among people in the same society. For example, this study found that 'saving money through pension scheme' has no significant influence on QoL. This is contrary to findings from other scholars which emphasize the positive contribution of pension savings to a quality life (Prinsloo, 2009; kwena, 2009; Kamau, 2012; kithinji, 2012). The contradiction is probably due to current delays in disbursement of pension funds or inflation that makes pension unreliable and inadequate.

Hence, to improve QoL of future retirees, retirement preparation should be perceived as the responsibility of everyone. Strategic measures should be taken by all stakeholders by focusing on the various domains of QoL. There is need to remodel the retirement preparation framework to make it more multi-faceted by including the health and psychosocial domains to the traditional financial domain. This will reduce instances of biased findings which do not reflect the real situation and may not lead to an enhanced QoL for retirees.

Wholistic retirement preparation should be a social responsibility and an investment that reduces the future socio-economic burden of doing the contrary. The findings imply that prospective retirees should be encouraged to develop a meaningful social and economic life outside their place of employment so that they can easily transit into retirement when the time comes. In addition to

effectively implementing their employment responsibilities, prospective retirees should spend more of their free time with friends, diversify their income generating activities, allocate more time to family activities and seek more health-promoting information. Spending time on activities with friends and family prior to retirement enhances continuity after retirement since friends, family and business acquaintances continue to offer social support despite termination of employment.
Since no single study can exhaustively cover all aspects of QoL, this study recommends more research in the area of QoL, including a longitudinal study to analyze the life-course factors and their influence on quality of retirement life.

References

Alavinia, Seyed M. and Alex Burdorf. 2008. Unemployment and Retirement and Ill-health: A Cross-sectional Analysis across European Countries. *International Archives of Occupational and Environmental Health, 82*(1), 39-45.

Albert, L. (2006). *A Three Part Study on the Relationship between Retirement Planning and Health*. University of South Florida: Graduate School Theses and Dissertations

Almeida, D. M. & Wong, J. D., (2009). Life Transitions and Daily Stress Process. In G. H. Elder and J. Z. Giele (eds), *The Craft of Life Course Research* (pp.141-62). New York, NY: Guilford.

Alvarenga L., Kiyan L., Bitencourt B. & Wanderley K. (2009). The Impact of Retirement on the Quality of Life of the Elderly. *Rev Esc Enferm USP, 43*(4), 794-800

Atchley, R.C. (2000). *Social Forces and Aging* (9th ed.). Belmont, CA: Wadsworth

Barasa, L. (2009, March 7). Big Boost for Civil Servants. *Saturday Nation*, pp.1-2

Bowling, A. (2014). Quality of Life: Measures and Meanings in Social Care Research. London: School for Social Care Research

Browning, C., Heine, C., & Thomas, S. (2012). *Promoting Ageing Well: Psychological Contributions*. In L. Ricciardelli & M. Caltabiano (Eds.), Applied Topics in Health Psychology *(*pp. 57-71). Wiley-Blackwell.

Butterworth, P., Sarah G., Bryan R., Kaarin A., Elena V., & David M. (2006). Retirement and Mental Health: Analysis of the Australian National Survey of Mental Health and Well-being. *Social Science and Medicine, 62*(5), 1179-1191.

Calvo, E. & Sarkisian, N. (2011). *Retirement and Well-being: Examining the Characteristics of Life Course Transitions*. University of San Diego: Institute of Public Policy and Economics

Chung, S. (2017). Retirement Planning and Quality of Life in Retirement: Factors affecting the Korean American Elders' Retirement Satisfaction. *Journal of Sociology and Social Work*. *5*(1), 85-98.

Coe, N. & Lindeboom, M. (2008). *Does Retirement Kill You? Evidence from Early Retirement Windows.* Discussion Paper No. 3817, IZA, Bonn, Germany.

Eliott, A. C., & Woodward, W. A. (2007). *Analysis of Categorical Data*. In A. C. Elliott & W. A. Woodward (Eds.), Statistical Analysis Quick Reference Guidebook: With SPSS Examples (pp. 113-149). Thousand Oaks, CA: Sage.

Kamau, D. (2012). *Survey to Investigate the Experience of Retirees in Kenya.* Retirement Benefits Authority. www.rba.co.ke

Kenyatta University. (2014). *Risks and Opportunities Associated With Paying Lumpsum Benefits to Retirees in Kenya: Implications For Income Security*. Nairobi: Kenyatta University

Kithinji, C. (2012). *Aging and Retirement in Kenya; Focus on Aging and Retired Teachers under the Teachers Service Commission (TSC)*. Unpublished PhD Thesis: Kenyatta University

Kwena, R. (2009). *Enhancing Pension Awareness and Education in Kenya.* Retirement Benefits Authority. www.rba.co.ke

Lubega S. (2012). *Psychological Preparation For Retirement, Perceived Organisational Support, Financial Preparation for Retirement, Employee Engagement and Organisational Citizenship Behaviour in Uganda Revenue Authority*. Unpublished MBA Thesis: Makerere University

Maina, L. & Mugenda, O. (2013). Family-Related Factors Correlating with Quality of Life in Kenya. *Prime Journal of Social Science Vol. 2*(10), 474-481

Mein, G., Martikainen, P., Hemingway, H., Stansfeld, S & Marmot, M. (2003). Is Retirement Good or Bad for Mental and Physical Health Functioning? Whitehall II Longitudinal Study of Civil Servants. *Journal of Epidemiology and Community Health* 57(1), 46-49.

Mojon-Azzi, S., Alfonso S., & Rolf, W. (2007). The Effect of Retirement on Health: A Panel Analysis Using Data from the Swiss Household Panel. *Swiss Medical Journal, 137,* 41-52.

Muratore, A. M. & Earl, J. K. (2010). Predicting Retirement Preparation through the Design of a New Measure. *Australian Psychologist, 45*(2), 98-111.

Thuku, P. (2016). Influence of Socio-demographic Factors on Quality of Life of Retirees in Kenya *Imperial Journal of Interdisciplinary Research 2*(2), 90-100.

Thuku, P., Maina, L. & Gecaga, M. (2016). The Relationship between Psychosocial Preparation for Retirement and Quality of Life of Retirees in Kenya. *International Journal of Social Science and Humanities Research*, *4*(3), 251-260

Muthondeki, D., Sirera , M. & Mwenje, M. (2014). Psychosocial Challenges Faced by Retired Police Officers: A Case of Retired Administration Police Officers in Kenya. *Journal of Humanities and Social Science (IOSR-JHSS) 19* (8), 55-63

Neuman, K. (2008). Quit Your Job and Get Healthier? The Effect of Retirement on Health. *Journal of Labor Research, 29*(2):117-201.

Ondigi A. & Mugenda O. (2011). Psychosocial Determinants of Quality of Life among Kenyan Families. *International Journal of Humanities and Social Science, 1* (7), 125-136

Osborne, J. (2012). Psychological Effects of the Transition to Retirement. *Canadian Journal of Counselling and Psychotherapy, 46* (1), 45–58.

Prinsloo, H. (2009). *The Impact of Retirement Planning and Education on Retiree's Life Satisfaction.* Unpublished MBA Thesis: Nelson Mandela Metropolitan University

United Nations Population Fund (UNFPA) & HelpAge International (HAI). 2012. *Ageing in the Twenty-First Century: A Celebration and a Challenge.* New York: UNFPA

Wang, M. & Hesketh, B. (2012). *Achieving Well-being in Retirement: Recommendations from 20 Years' Research.* Society for Industrial and Organizational Psychology, Inc: SIOP White Paper Series

Westerlund, H., Mika K., Archana S., Maria M., Ferrie, J., Jaana P.….& Jussi V. (2009). Self-rated Health Before and After Retirement in France (GAZEL): A Cohort Study. *Lancet, 374* (9705), 1889-1896.

Wong, J. & Earl, J. (2009). Towards an Integrated Model on Individual, Psychosocial and Organizational Predictors of Retirement Adjustment. *Journal of Vocational Behaviour, 75*, 1–13

World Health Organization. (2012). *Good health adds life to years: Global brief for World Health Day 2012.* http://whqlibdoc.who.int/hq/2012/WHO_DCO_WHD_2012.2_eng.pdf