



UNIVERSITY OF AGDER

**THE ROLE OF HUMAN
RESOURCE MANAGEMENT
PRACTICES IN THE MIGRATION
OF MEDICAL DOCTORS IN
DEVELOPING COUNTRIES:
THE CASE OF TANZANIA**

Ndikumana David Emmanuel

ERRATA

This doctoral Dissertation contains some errors in Table 3.1, Table 3.2 and Table 5.2. Readers should kindly note the following corrections.

Location (Page Number)	Error	Corrections
Page 60, Table 3.1, 2 nd Row, 2 nd and 3 rd Columns	Year of establishment of both Hospital A and Hospital B is 1953	Year of establishment of Hospital A is 1897 and Hospital B is 1955
Page 62, Table 3.2, 3 rd Row, 5 Column	The total number of Human Resource Directors is 2	Total number of Human Resource Directors is 1
Page 62, Table 3.2, 5 th Row, 5 th Column	The total number of doctors in Tanzania is 18	The total number of doctors in Tanzania is 19
Page 92, Table 5.1, 1 st Row, 2 nd Column	Year of establishment of Hospital A is 1920	Year of establishment of Hospital A is 1897

The Role of Human Resource Management Practices in
the Migration of Medical Doctors in Developing
Countries: The Case of Tanzania

Ndikumana David Emmanuel

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Practices in the Migration of Medical Doctors in
Developing Countries:
The Case of Tanzania

Doctoral Dissertation

University of Agder
School of Business and Law

2018

Doctoral Dissertation at the University of Agder 181

ISSN: 1504-9272

ISBN: 978- 82- 7117- 880-2

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Printed by the Wittusen & Jensen
Oslo

In memory of my late Parents.

Acknowledgement

On the outset, I wholeheartedly thank the Almighty God for giving me the vision, spirit and endurance to complete this study. To Him be all the glory forever!

This study is not solely the strength and wisdom of the researcher. Rather, there are a great many persons and institutions to be thanked for their contribution to this Dissertation. The list being so long, it would be unpractical to mention each and every one. There is however a few among them that I absolutely wish to cite.

I highly appreciate the scholarship award of the Norwegian Agency for International Cooperation (NORAD) in the first three years of the PhD study programme. I acknowledge with great thanks the role of the Mzumbe University Management for the financial support after the expiry of the NORAD Support to Mzumbe University and the study leave during the whole period of PhD training.

I owe a huge debt of gratitude to my Principle supervisor, Professor Emeritus Harald Knudsen for volunteering to continue supervising me after his retirement. He provided unlimited, invaluable, active guidance and encouragement throughout an array of meetings and communications that enhanced my research skills and competences. I am profoundly indebted to my Assistant Supervisor, A Assistant Professor Bjørn-Tore Flåten of the School of Business and Law of the University of Agder for being extremely supportive and in giving me valuable comments. The dual supervision from both supervisors and their joint wrap up of considered comments on my drafts were very useful guides in the entire period of the study.

I am profoundly honoured to express my appreciation to the management of the two hospitals involved in my study. Their warm welcome and considered introduction to all responsible staff paved way for smooth conversations with participants. By extension, I highly appreciate the commitment and cooperation the interviewees accorded to me despite their busy work schedules atypical of hospital settings. For ethical reasons, their identities remain anonymous.

I express my heartfelt thanks to the Programme Directors of the PhD in International management > These include Professor Trond Randoy, Professor Andreas Wyller Falkenberg and Professor Roy Mersland for their immense encouragement, inspiration and support during the period of the study.

I am very grateful to the administrative staff at the then Faculty of Economics and Social Sciences and later the School of Business and Law. These include Inger-Lise (Senior Administrative Officer, Uia), Målfrid Tangedal, Elise Frølich Furrebøe (Counselor adviser, School of Business at Uia) and Anna Færavaag (Senior Adviser, HR) for their kind support, care cooperation and guidance on logistical requirements in the PhD programme implementation.. As an international student, you made me feel at home.

I register high appreciation to University Library and IT staff for rendering high class services that created a cordial learning environment.

I am very grateful to the first PhD cohort at the “Little House on the Prairies” Mursali A. Milanzi, Bjørn-Tore Flåten, Rotem Shneor and Jens, Ø. Hansen, for the numerous discussions and reflections which enhanced knowledge and experience sharing.

I owe my gratitude to my fellow colleagues at Mzumbe University. In particular, I am grateful to Dr. Daudi Pascal Ndaki, Dr. Mursali, A.Milanzi for numerous consultations on how best I could improve my Dissertation.

I thank all SOPAM colleagues for their encouragement in the course of this learning journey. In particular, I am very thankful to Dr. Orest Masue; Dr. Denis Kamugisha, and Messers Peter Andrea and Anosisye Kesale for shouldering my teaching work load in the wrap up stages of the study.

Last but not least, my heartfelt gratitude goes to my family. The pursuit of a doctoral study requires a tremendous sacrifice – not only on the part of the student, but in many cases, of the family as well. I thank my family for letting me use their valuable time to

work on this project. My deepest thanks go to my entire family, particularly my lovely spouse, Christina and our lovely children- Christian, Davis, Derick and Diana for their inspiration, amazing patience, encouragement and loving support throughout this study. Furthermore, I express my sincere appreciation and thanks to my young brothers and sisters for the all sorts of encouragement.

Abstract

This study is part of a Doctoral research within the International Management PhD Programme offered at the University of Agder, Norway. Data were collected in two hospitals in Tanzania (a small hospital in a distant rural area and a bigger hospital in a city setting.) between July 2008 and August 2009 following a one-year course work.

The study sought to explain the factors that influence the decision and choices of medical doctors to stay in Tanzania hospitals or leave to work outside the country. An underlying issue is to explain the role of HRM policies and practices in employee retention.

Exploring a little known phenomenon like the dynamics of migration decisions to stay or leave in a developing country context like Tanzania merit adoption of an inductive approach to unearth lived experiences of the participants.

Cognisant of the multi dimensional nature of the mobility of talent across countries, this study attempts to distil tenets from HRM, human capital, social capital, social exchange and organizational support theories through the the Psychological contract, Dual factor theory and meaning seeking lenses to identify and explain the factors that are potential levers for improving our understanding of the migration decision making process in a less developed country context.

It transpires from the study that leadership style, duties to family and society, trusting relationships and opportunities for building professional competence overshadowed factors such as income. The insights indicate that a person's work values increases job satisfaction irrespective of displeasure experiences in the work environment.

While past studies attributed migration to be largely driven by economic rewards, this study revealed that the tendency to migrate is modified by doctors having a strong sense of duty and it may be reversed with good leadership practices such as employee recognition even in the wake of limited wages and scarce resources. Collegial recognition, supportive team work and respect and fulfillment of career expectations, cultural values in

terms of duty to extended family and nuclear family appear to have considerable influence on employee retention.

It emerges that there is synergy between the literatures of IHRM and careers in less developed countries with limited technological capabilities required to enhance professional skills atypical of health specialties. These insights underpin the ethos of global management literature.

The findings illustrate the extent to medical doctors' resort to dual practice, the motives for doing so, and the outcome of this engagement which had hitherto been under studied in Tanzania.

This study integrates spirituality and retention literature and vindicates their relationship with employee motivation and commitment to stay in an organization. It brings to the fore the role of spiritual/religious values in enhancing employee motivation and commitment. It underscores the fact that spirituality in the work place may enhance employee loyalty and commitment to provide physical and spiritual services to the patients. The role of spirituality and religion in the work place and in the management literature is a relatively new area of inquiry with regard to developing countries. In spite of the fact that religious diversity has been accommodated in work places through fair recruitment policies in the public sector, the influence of moral satisfaction in employee retention noted in hospital B has been largely under theorized in western HRM literature.

Loss of human capital through migration of highly skilled professionals like medical doctors and associated loss of investment in health and education in a resource limited developing country like Tanzania is a significant obstacle to improving the health system in the wake of development challenges such as high population growth and increased burden of diseases. This make Tanzania to be a good research setting to unravel the root causes of the mobility of talent outside the country. This knowledge can facilitate design of appropriate strategies to attract and retain skilled human resources.

There are potential areas which merit inquiry. Much as the findings reflected many areas which deserve further studies, greater priority could be directed to enlarge sample size of Tanzanian Diaspora, the potential conflict of interest arising from engagement of doctors in dual private practice in medicine and the need for a conceptual and empirical development of the role of spirituality and religion in the retention literature.

The findings of this study can be tested in environments with similar contexts using other theoretical and methodological approaches for the development of more insights into the factors that may enhance understanding of organization and country strategies to retain talent.

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CHAPTER ONE: INTRODUCTION

1.1 Background

International migration of human resources is a large scale and long standing phenomenon with policy implications owing to its significant economic, political and cultural influences in both developed and developing countries. Although the migration of highly skilled persons is not a new phenomenon in the global economy, there is an ongoing increase in global migration (Castles, De Haas, & Miller, 2013). The past few decades have witnessed a growing trend of international migrations characterized by a more integrated global economy and free movement of capital in a permeable geographic, institutional and cultural boundaries (Agarwal, 2017; Kamoche, 2011; Pries, 2013). Skilled International migrants are now considered to constitute an important part of the global talent pool driving innovation and competitive business environment (Al Ariss & Sidani, 2016; Howe-Walsh & Schyns, 2010). Nevertheless, the loss of human capital to international migration retards development programmes like health and education in developing countries like Tanzania. The retention of skilled human resources in developing countries is not only necessary but also urgent in order to ensure adequate provision of health care services to the populace.

Research on health workers in low and middle income countries is indeed spurred by concerns that emigration of health workers is exacerbating the scarcity of health workers. Globalization forces and interdependency among countries are posing major challenges is the attraction and retention of skilled professionals in developing countries like Tanzania. As the world increasingly become a global village, competitive pressures on talent is increasing. Organizations are thus required to constantly revisit their human resource policies to keep pace with the tide of change.

The early literature in IHRM was focused on the challenges of international staffing within the MNC context (McPhail, Fisher, Harvey, & Moeller, 2012). Global staffing is being increasingly seen as a primary human resource practice used by MNCs to control and coordinate their spatially dispersed global operations (Reiche, Mendenhall, & Stahl, 2016). The importance of global staffing hinges on the recognition that the success of

international business depends, increasingly, on hiring top quality senior executives to address complex HRM challenges in different contexts in the wake of internationalization of SMEs. Within the global staffing theme, there is use of short term rotational assignments to respond to the high costs and risks of failure involved in expatriation (Cooke, Veen, & Wood, 2017).

Recent HR research within a trans national dimension has expanded to encompass a more comparative dimension that draws parallels between international and domestic HRM practices. It underscores the importance of culture to international management, diffusion and convergences of HRM policies in a globalized world (Iles & Zhang, 2013). The bulk of work in the comparative HRM field has concentrated on the nature and impact of institutional differences between countries, the consideration of which HRM practices are more or less culturally sensitive, and an empirical examination of patterns of convergence or divergence of management practices across different cultures and nations (Brewster, Houldsworth, Sparrow, & Vernon, 2016; Lucio, 2013).

Despite the importance of international migrants to the host countries and organizations, human resource management of this group of individuals remains under-researched (Haslberger, Brewster, & Hippler, 2013). Understanding the drivers of migration decision choices is crucial to developing relevant human resource programs and practices that can facilitate retention of skilled professionals. In this regard, the role of migration dynamics in location preferences represents a new and emerging area of research in international business with strong policy implications. Drawing on the multi-dimensional nature of migration, this study attempts to integrate theories from diverse research strands to explain migration decision dynamics in a less developed context.

1.2 Personal motives for the research study

The motivation to undertake this study arose during my undergraduate training at the then Institute of Development Management (IDM), Mzumbe, located in Morogoro Region, in Tanzania. The institute, whose history dates back to 1953 when it was established as a Local Government Training Centre was elevated as one of the institutions of higher

learning in the country to train middle and high level government employees in 1972 and was later transformed into Mzumbe University in 2001.

One of the core subjects in the three-year programme were Human Resource Management and Human Resource Planning. I found these subjects to be very relevant to the scenario of the employment scene in Tanzania. Historical accounts of acute skill gaps in the post independence period and brain drain of skilled professionals from the public to the private sector and outside the country in the post Arusha Declaration period through the economic crisis of the 1980s increasingly attracted my attention. This was largely due to the fact that the quest for self sufficiency in qualified human resources in the public sector was being compromised. The public sector was the main actor in training the required human resources for the country's development. This was in part attributed to the government's priority setting and cost implications which could not be incurred by a hitherto underdeveloped private sector in the then socialist policy environment in Tanzania. The expanded public sector increasingly required corresponding increase in student enrolment in different training programmes in order to meet increased number of public institutions.

Drawing on an array of HRM topics which we covered, reward issues came to the fore as factors determining placement preferences of graduates. Differentiated reward systems triggered internal migration of graduates from the central government to public enterprises (semi autonomous institutions) entrusted to spearhead economic development in the post Arusha Declaration of 1967. This was a policy which promulgated Socialism as the roadmap of Tanzania's development. It adopted the nationalization policy through which all commanding heights of the economy were put under state control. This paved way for the establishment of many public enterprises (semi autonomous bodies) introduced as engines of economic growth. The parastatal enterprises had better conditions of service and reward system compared to the civil service. These differences increasingly attracted internal migration of skilled employees.

International migration of skilled professionals retarded government concerted efforts of investment in training and development of human resource. This interest grew over time in the course of my teaching career at Mzumbe University. Owing to increased concerns

that migration of health professionals from developing to developed countries aggravated the weakening delivery of health services, I narrowed my foci on medical doctors. This is indeed a challenge which is raging on to date.

1.3 Problem Statement

The role of hospitals in the provision of quality healthcare required for the socio-economic and technological advancement of any nation or organization cannot be over-emphasized (Fritzen, 2007; Guest, 2011). This is well documented in the HRM literature (Dessler & AlAriss, 2012; Truss, Shantz, Soane, Alfes, & Delbridge, 2013). The potential of human resources stems from their human and social capital (Boxall & Purcell, 2011; Gross, Pfeiffer, & Obrist, 2012; Manzi et al., 2012). Human resources have been described as the backbone of an organization in any country (Ozden & Parsons, 2016; WHO, 2010).

Like in any other organization, the efficiency and effectiveness of healthcare systems hinges to a large extent availability of requisite human resources in terms of quantity, quality and commitment (Dieleman, Toonen, Touré, & Martineau, 2006; Mathauer & Imhoff, 2006). Health professionals are key drivers of effective health systems. This perception is premised on the wide recognition that skilled human resources are the most valuable assets in an organization (Armstrong & Taylor, 2014). Hospitals are expected to be repository of the most specialized and skilled health staff. A health care system has three major inputs namely human resources, physical capital and consumables (Lehmann, 2008).

The health workforce is heterogeneous. It is composed of an array of different clinical and non-clinical professionals including doctors, nurses, pharmacists, allied professionals and administrators. Each of these professional domains is further sub-divided into diverse specialties. Loss of generally any of these cadres or a combination of the cadres invariably plunges a health facility into dies-equilibrium. Taking into account that human resources are active agents of health changes (Omaswa, 2014; Zulu, Kinsman, Michelo, & Hurtig, 2014), the policies and practices used to manage the human resource can facilitate or hinder health service delivery and indeed quality. In order to properly manage and lead

health workers towards realization of health vision, mission, goals and objectives within a human resource strategy, hospitals have to formulate and most importantly implement policies and practices that ensure attraction, utilization, development and retention of health staff.

The capacity to perform a set of anticipated functions is a core challenge faced by any organization generally and a health facility in particular. Like in any other organization, the efficiency and effectiveness of healthcare systems hinges to a large extent availability of requisite human resources in terms of quantity, quality and commitment ((Dieleman et al., 2006; Mathauer & Imhoff, 2006).

The crucial role of human resources is vivid when an organization has critical shortages. This is particularly so in a labour intensive sector like health in developing countries with high population growth. In order to attain this equilibrium, human resources have to be supported by appropriate systems, policies and practices for good health outcomes (Armstrong & Taylor, 2014; Pfeffer, 1998). Hospitals have to formulate and most importantly implement policies which ensure attraction, utilization, development and retention of health staff. Although human resources are often considered as just another type of input, like financial or physical resources (WHO, 2010), this might arguably be a narrow a view of human resources since health workers are not mere instruments for delivering necessary health care but rather strategic actors who can act individually or collectively to modify the quality of health care (Anand & Bärnighausen, 2012; Sikika, 2013; Tankwanchi, Özden, & Vermund, 2013).

One of the challenges of human resource practitioners is matching the ever changing organization and employee needs. This is particularly so in the highly dynamic environment with fast changes in technology, economic conditions political forces and social cultural values (Kiggundu, 2002). However, one of the major challenges to the Tanzania health systems is lack of human resources generally and doctors in particular (Clemens & Pettersson Gelerder, 2006a; Sikika, 2010; Tibaijuka, 1998a). One of the key contributors to the crisis of staff shortages is migration of doctors which manifests in two

patterns namely international and external migration (Hagopian et al., 2005; Leshabari, Muhondwa, Mwangu, & Mbembati, 2008).

In spite of concerted efforts to attain self sufficiency in qualified human resources in all sectors of the economy, attempts to retain them have not always been successful. The health sector is beset with serious shortages of health staff generally and medical doctors in particular. It has been established that out migration of medical doctors is raging on in Tanzania and other Sub Saharan African countries (Anand & Bärnighausen, 2012; Blacklock, Ward, Heneghan, & Thompson, 2014). This study responds to call for an inquiry of the key reasons for international migration of skilled professionals in developing countries (Poppe et al., 2014; Sirili et al., 2014). The study is based on the belief that intervention to attract and retain medical doctors should be preceded by a better understanding of factors that determine their mobility across countries. The central research question in this study therefore is “What is the role of HRM practices in the migration of doctors in Tanzania? An underlying issue is to identify and explain the factors that influence migration decision choices.

1.4 Significance of the Study

The study expands knowledge in different theoretical strands. It contributes to the field of International Business and particularly to the sub-field of International Human Resource Management in the stream of research on health worker migration. This sub-field has traditionally focused on expatriates (Cerdin & Selmer, 2014). The foci has specifically examined the way in which multinational corporations (MNCs) manage their human resources across different national contexts in order to understand HRM functions that had to change when firms went international. Since finding and nurturing the people able to implement international strategy was seen as critical for such firms, considerable attention was given to the management of expatriates. Concerns have been linked to how expatriates could best adapt and adjust to their local environments to overcome their liability of foreignness (Brewster & Mayrhofer, 2012; Pudelko, Reiche, & Carr, 2015). In this regard, the role of migration dynamics in location preferences in developing countries

represents a new and emerging area of research in international business with strong policy implications.

While cross cultural management literature have invariably reported expatriate failure in foreign markets, this study shows expatriate success stories through collaborations involving capacity building in the form of professional mentoring. This increases our understanding of the role of mentoring in employee retention and expands the literature on knowledge transfer and knowledge exchange in the context of a less developed country.

The HRM literature often seems to take American or European main cultural patterns more or less for granted. However, this study underscores the need to incorporate the cultural factor when studying HRM phenomena in non-western societies.

Past studies on medical migration predominantly focused on reasons for leaving. Little is known on the reasons that make some professionals stay irrespective of the driving forces which could potentially make them leave. This is an area hitherto under studied in developing countries like Tanzania.

Dual practice seems to influence employee retention. This is particularly so in the public health sector. The findings illustrate the extent to medical doctors' resort to dual practice, the motives for doing so, and the outcome of this engagement which had hitherto been under studied in the Tanzania.

The role of spirituality and religion in the work place and in the management literature is a relatively new area of inquiry with regard to developing countries. This study integrates spirituality and retention literature and vindicates their relationship with employee motivation and commitment to stay in an organization. A strong organizational culture reinforced by religious orientation appears to be an asset in employee retention as it created moral satisfaction. In spite of the fact that religious diversity has been accommodated in work places through fair recruitment policies in the public sector, the

influence of moral satisfaction in employee retention noted in hospital B has been largely under theorized in western HRM literature.

The findings underpin the fact that spirituality in work place promotes vocation and spearhead greater work commitment .Religion seem to influence doctors to stay in hospital B even in the wake of problems besetting their work setting. This extends knowledge on the role of religiosity in work behavior in developing countries. Retention interventions increasingly call for provision of a work culture and environment that give room for religious accommodation.

The findings depicts theoretical linkages of the Psychological Contract, Herzberg's Two Factor theory and the meaning seeking lenses that influence employee decisions to stay or leave. Employing these lenses, this study demonstrates that a person's work values increases job satisfaction irrespective of displeasure experiences in the work environment. Cognizance of the fact that quantitative methods have dominated in migration research studies; there is need for more contextual qualitative research. This elicits rich insights that unveil contextual factors embedded in the study settings. The use of a qualitative method in this study allows for a better understanding of individuals' experiences and perceptions of work location choices which can enhance employee retention rates. In this vein, this study contributes to context bound knowledge on the dynamics of migration decision making in developing countries.

Tanzania is a low income country which inherited an underdeveloped health care system at independence in 1961. In spite of concerted efforts to invest in education and health sectors in terms of human resource capacity and infrastructure, .these initiatives have been reversed by among other things, migration of professionals including medical doctors. This ushers a host of development challenges such as loss of investment on human resource capacity, lack of leadership capacity in the public sector and lack of requisite health infrastructure in the wake of changing extended family culture towards nuclear family These dynamics have made the health sector to be unresponsive to health targets such as increased burden of diseases and difficulty to attain the Millennium Development Goals. In this vein, Tanzania is a good case which merits a context specific study on the

dynamics of reasons which make doctors leave or stay. This focus has not been adequately addressed in the international HRM literature. The contextual knowledge gained can help policy makers to develop appropriate interventions that can foster attraction, and retention of doctors in hospitals operating in similar contexts.

1.5 Organization of the Dissertation

This dissertation is composed of nine chapters. The introductory chapter presents theoretical and personal motivation for the research study. It describes the research problem by positioning the role of human resources in the wake of the crisis in human resource for health in many developing countries generally and Tanzania in particular. It indicates the significance of the study and presents the overall structure of the dissertation.

The second chapter provides an overview of the literature relating to factors that attract and retain skilled human resources in organizations. It defines and describes the key terms namely HRM and International migration. It makes a theoretical review of determinants of migration decisions through the prism of HRM main functions and practices. It describes theoretical underpinnings in an array of theories considered to have potential relevance to the study. The chapter further makes a review of empirical studies done in Tanzania and other developing countries. It describes knowledge gaps and concludes with a summary.

The third chapter describes the methodology employed in this study. It presents the philosophical stance of the study, the research perspectives and the research paradigm through ontological and epistemological perspectives. It elaborates on the research strategy, presents the research design and justifies the choice of the methodological approach. It draws on established criteria to assess the quality of the research.

The fourth chapter describes the research setting. It elaborates the contextual background of the study in geographical, political and socio-economic contexts. It presents the evolution and growth of the health sector in terms of staffing and training levels, highlights trends of doctor migration and concludes with a summary.

The fifth chapter describes the organization profile, mission, structure, and governance context in hospital A. It presents and discusses the findings by focusing on the key issues discerned. The chapter is concluded by a summary.

The sixth chapter describes the organization profile, mission, structure, and governance context in hospital B. It presents and discusses the findings and concludes with a summary.

The seventh chapter identifies convergences and divergences between the main findings in the two hospitals, factor by factor. The issues discerned are then interpreted along literature review in chapter 2. The chapter is concluded by a summary.

The eighth chapter draws on findings from hospital A (chapter 5), hospital B (chapter 6) and cross case comparison (chapter 7) along with the review of literature in chapter 2 to identify the main themes that seem to explain migration dynamics in decisions to stay or leave the hospital contexts. It presents and describes the conceptual framework that emerged from this study. The results are interpreted through the psychological contract, the Hertzberg's dual factor and meaning-seeking lenses. The chapter concludes with a summary.

The ninth and final chapter presents a resume of the findings, identifies methodological limitations of the study, presents theoretical contributions and highlights managerial and future research implications in HRM and related fields. Finally is a conclusion which wraps up the findings and major recommendations.

CHAPTER.TWO: REVIEW OF THE LITERATURE

2.1 Introduction

This chapter identifies and presents theories considered relevant in explaining migration dynamics of skilled professionals. It adopts a multi theoretical approach which is premised on the idea that a single theory cannot explain the multifaceted nature of migration decision making. This is consistent with the notion that “*research projects should neither be under theorized nor carry theory beyond its proper limits*” (Silverman, 2006, pp. 6 - 7). It was thus considered necessary to adopt a variety of theoretical perspectives from different theoretical lenses which can pave way for better understanding of why medical doctors leave their work places to seek employment elsewhere while others prefer to stay and render health services in their work settings. This chapter is a platform to facilitate theoretical sensitivity. The theories reviewed enhanced data collection and interpretation in the conduct of the study. The chapter begins with definition of key terms. It presents theoretical and empirical reviews on factors that influence migration decisions in work settings. Before we delve into the review, it is worth delineating the operational definitions adopted in this study.

2.2.1 HRM defined

HRM has been defined as “*all those activities associated with the management of work and people in organizations*” (Boxall & Purcell, 2011, p. 1). From this definition, we learn that human resources are composed of talents and energies which enhance creation and realization of the organization’s mission, vision, strategy and goals. HRM employs policies and practices to organize work in key organization activities such as recruitment, selection , training and reward management at firm level and embedded in the wider social context (Granovetter, 1985).

2.2.2 International migration of skilled human resources

International migration of highly skilled human resources is known by several nomenclatures. These include brain drain (with a negative connotation) and brain circulation or exchange - referring to knowledge exchange (Kanchanachitra et al., 2011). The term brain drain is rooted in the post-World War II period in which there was migration of the large numbers of scientists from the UK to the US.

An international migrant is defined as:

“an individual who moves from one geographical location to another, crossing national borders and changing the dominant place of residence (Andresen, Bergdolt, Margenfeld, & Dickmann, 2014).

External migration refers to crossing international boundaries. These may include categories of migrants' namely legal, illegal or refugees. In our study we are referring to both legal and illegal skilled labour who emigrates to other countries. The pattern of out-migration manifest in different directions. These ranges from developed to developed country (e.g. Britain to the United States), and developing country to developing country (e.g. Tanzania to Botswana or South Africa) (Ishengoma, 2016).

2.3 Theoretical review of determinants of migration decisions

The mobility of skilled professionals like medical doctors is rooted in a multiplicity of factors which transcends HRM functions and practices anchored in an array of theories. This underscores the need to use the prism of various theoretical lenses. Drawing on the inspirations from previous studies (Blaauw et al., 2013; Boxall & Purcell, 2011; Lee, 1966) and theoretical seminal works, the Push -Pull model, Career anchor and the Psychological contract were assumed would be the most salient in understanding the factors that drive skilled professionals to stay in a country or leave to work abroad. Based on the insights from the findings, I later had to also include the Human capital theory, The Social Capital theory, Social exchange theory, Transformational and Transactional leadership styles, Organizational Support theory and Herzberg's Two Factor theory.

2.3.1 An Overview of Human Resource Management functions

The HRM literature (Armstrong & Taylor, 2014; Boxall & Purcell, 2011) identifies a number of HRM functions. These include Recruitment and Selection, Training and Development, Performance Management, and Reward Management These functions are presented below.

a) Recruitment and Selection

Recruitment refers to staffing activities and initiatives related to identification of suitable candidates to fill organizational roles which are specified by long term objectives and goals (Armstrong & Taylor, 2014; Guest, 2011). It is a continuous process which is aligned to organizational growth and needs. The overall aim of recruitment and selection process is to obtain at minimum cost the quantity and quality of employees required to meet human resource needs of the organization.(Chan & Kuok, 2011; Truss et al., 2013).

There is consensus that a rigorous recruitment and selection system provides selected employees a sense of being valued by the organization which arouses high expectation of high performance (Torrington & Hall, 2010). Competitive pressures in the labour market which value employee skill and competences have elevated recruitment and selection processes as major levers to support business strategies (Meister, Willyerd, & Foss, 2010). Much as employee recruitment is a positive organization initiative, the adoption of a range of sophisticated human resource management infrastructures is more likely to ensure sustainability of committed employees (Chew & Chan, 2008; Guest, 2011).

Selection refers to the process by which an organization attempts to identify human resources from potential sources of labour supply (Scott-Ladd, Travaglione, Perryer, & Pick, 2010). Prospective employees are selected on the basis of predetermined attributes and skills which evolve from job analysis. This is regarded as a critical stage in the recruitment and selection process which entails getting detailed information about a job (Iles, Preece, & Chuai, 2010).

The aim of job analysis is to generate a job description and a person specification. While a job description delineates a job context, its associated tasks, duties and responsibilities, a person specification identify the requisite knowledge, skills, competences, experiences and attributes deemed necessary to the job (Armstrong & Taylor, 2014). The fate of an organization depends on its ability to recruit and retain skilled employees. Failure to retain medical doctors disrupts the quality of service rendered and increases the costs incurred in their human resource development plans.

b) Training and Development

Human resource development and utilization refers to the practices used for enhancing employee skills through training and other forms of knowledge and skill enhancement (Fallon & Rice, 2015; Manzi et al., 2012). Training entails imparting employees with the requisite skills required to efficiently and effectively perform their duties and responsibilities. Pursuit of this function is a clear indicator of the employer's commitment to their workforce (Chan & Kuok, 2011; Meister et al., 2010). This view is premised on the idea that training and developing employees is one of the organizational strategies to add value of the human capital (Becker & Gerhart, 1996).

Training is an important component which influences higher levels of organizational commitment. The importance of training employees can well be mirrored from the following Chinese saying:

“If you to plan for a year, sow seeds, if you wish to plan for ten years plant trees, if you wish to plan for a life time develop men” cited from (Bhatia, 2007, p. 3).

Human resource development and utilization improve the human capital that people bring with them in the organization. Human capital is commonly taken to include people's knowledge and skills that has been acquired through education, training and development (Bernsen, Segers, & Tillema, 2009). Trained employees have economic value to the organization. Human capital theories posit that some labour is more productive than other labour because more resources have been invested into the training of that labour, in the

same manner that a machine that has had more resources invested into it is apt to be more productive (Pajo, Coetzer, & Guenole, 2010).

In today's stiff competitive environment characterized by the knowledge economy certain employee attributes and competences are increasingly becoming important to ensure efficient delivery of services in an organization (Chen, 2014). While a number of different dimensions influence how a country's human resource for health are planned and managed, perhaps the most critical are how they are trained and deployed (Zurn et al., 2011). Underlying these trends is the idea that organizations that invest heavily on the training of their employees will develop greater capacity which will enable them to respond to new challenges. Theorists maintain that successful business strategies are developed around the core competences or the skill of the organization rather than relying solely on the assessment of the market opportunities (Mullan et al., 2011).

Training is one of the major means of coping with the fast increasing changes in technology. It has been underscored that training is only meaningful if it is based on needs analysis (Blacklock et al., 2014). The rationale for training will therefore depend on whether poor performance is due to lack of requisite knowledge, skills, attitudes and competencies. Although it is not a panacea to all organization problems; proper training is generally viewed to be beneficial for the achievement of both individual and organizational objectives (Armstrong & Taylor, 2014). Human capital theory posits that a person will make a decision to leave a job or career based on how much investment has been made in it (Cohen, 2011).

It has been argued that for an organization to compete successfully in a competitive environment, it is important to recruit sufficiently educated and skilled employees and provide them with lifelong learning. The value of employees stems from among other things, their accumulated experience (Pfeffer, 2000). However, taking into account that organizations operate in rapidly changing technology and uncertain competitive environments in which employees depreciation over time, periodic training and development is crucial to endure that they keep pace with the tide of change in both the internal and the external environment. Organizations have to adopt new ways of doing

things to ensure that their staffs keep pace with such tide of changes by supporting employees to continuously advance their knowledge and skills through opportunities for personal growth and development in their respective specialties.

Most training literatures have emphasized the benefits organizational gained from adopting a systematic approach to human resource learning and development. Research has demonstrated that provision of regular training and development opportunities are more likely to remain in the organization (Bernsen et al., 2009). Studies across an array of industries and sectors have all found that while training inculcates requisite employee knowledge, skills and competences, it is also signals employer's commitment to their workforce (Newman, Thanacoody, & Hui, 2011). The high labour mobility is viewed as a major disincentive to the broad provision of training (Buchan, Fronteira, & Dussault, 2011) and indeed a barrier to employees' career development. Studies have confirmed that training and developing employees enables them to maintain their capabilities and that this can foster their retention. This view hinges on the idea that once employees feel that they are not growing; they begin to look externally for new job opportunities (Rodriguez, 2008, p. 53).

c) Performance Management

Performance management is geared towards assessing individual performance in organizations. It has become increasingly applied in many public and private sector organizations in the developed world (Cole & Kelly, 2011) and developing countries (Bussin, 2012). The meaning of the concept remains elusive. This is in part attributed to the tendency of scholars to use it interchangeably with performance measurement; performance evaluation and performance monitoring make (McAdam, 2005). It has been underscored that performance management goes beyond the concepts of performance appraisal or performance related pay which only address how a person should be rewarded after working for a specific period (De Waal, 2007).

Performance management is commonly used to describe a range of activities designed to monitor, measure and adjust aspects of individual and organizational performance (Brown, Lauder, & Ashton, 2010). It is meant to ensure that the organization focusing on

future performance planning and improvement rather than on retrospective performance appraisal (Armstrong & Taylor, 2014). The process has been described as a system through which organizations 'set work goals, determine performance standards, assign and evaluate work, provide performance feedback, determine training and development needs, and distribute rewards (Briscoe & Claus, 2008, p. 15). The process ensures that employee's activities and outcomes are congruent with organizational goals through provision of constructive feedback to enhance subsequent performance.

According to Carroll and Dewar (2002, p. 413), four main elements make up a performance management system. These include: (a) deciding the desired level of performance; (b) measuring performance; (c) reporting or communicating performance information; and (d) using performance information to compare actual performance to the agreed performance level. In the light of the preceding literature, performance management seems to be a potential way of helping managers to focus on goals of the organization.

It has been posited that the key driver of performance management is retention of skilled and competent staff (Fryer, Antony, & Ogden, 2009). The process is thus essentially about measuring, monitoring and enhancing the performance of staff with a view to contributing to the overall organizational performance (Frenk et al., 2010). Many scholars have located the emergence of performance management in public sector organizations to the new public management philosophy (Larbi, 2006, pp. 37 - 38) is of the view that performance management is a core theme of the New Public Management, and is underpinned by the Principal-Agent theory.

This theory is suspicious of managers and organizations freely making changes to improved performance in the interest of the public and policy makers unless there are incentives or sanctions for them to do so. The basic tenet of relieving managers from organizational entropy, has however been seen as providing the theoretical acumen for developing and implementing performance management system.

Performance management in the public sector has drawn the attention of organization scholars. It has been argued that performance management leads to managerial freedom from unnecessary bureaucratic controls and gives greater autonomy for enhanced performance (Cole & Kelly, 2011). Managerial freedom denotes operational autonomy as distinct from strategic autonomy which is the freedom to choose one's own agenda. For scholars who believe in managerial freedom, the traditional bureaucratic organization encapsulates public managers, creating a 'bureaucratic web' that leads them to be less innovative and accountable. Such managers follow rules that hinder the effective and efficient use of resources and the service delivery (Brown et al., 2010).

All organizations exist for a purpose. In order to achieve the purpose, goals and objectives have to be set. Management by objectives (MBO) or Management by results was conceptualized by Drucker (1954) and later developed by Odiorne (1978) and McGregor, Bennis, and Schein (1966). MBO is described as a process whereby the superior and the subordinate jointly identify a common goal, defines each individuals major areas of responsibility in terms of the results expected of him, and use these measures as guides for operating the unit and assessing the contribution of each of its members (Odiorne, 1965). The essence of MBO is participative goal setting. The thrust of this definition is the major role played by subordinates in setting their objectives rather than merely receiving them from the top. The MBO theory is spanning over five decades and it has been extensively applied in many domains including the health sector (Kyriakopoulos, 2012).

d) Reward Management

The term "reward" is described as something that the organization gives to the employees in response to their contribution and performance. Pay is perceived as an important feature of HRM strategy. Scholars acknowledge that a good compensation system can be a potential source of competitive advantage (Armstrong & Taylor, 2014; Perkins, White, & Jones, 2016). Increasingly, viewing a person as an economic being motivated by material rewards (Taylor, 1911) is being questioned and employers are required to have a human face as long advocated by Herzberg (1968). Underlying this line of thinking is the idea that job dissatisfaction invariably has dire consequences on employee behaviour

(Guest, 1998). Employee involvement and participation are one of the central tenets of HRM. practices. This is implemented through empowerment; team works and autonomy.

According to Kohli and Deb (2008), rewards can be categorized into three broad components. namely direct financial rewards, indirect financial rewards and non financial rewards. Direct financial rewards are direct monetary rewards involving the payment of cash to employees for the work accomplished. Examples include salary, wage, incentives, and commissions. Indirect financial rewards are indirect monetary rewards. They include those items of financial value provided by the organization to employees that do not result directly in employee's receiving spendable cash. Examples include medical insurance, life insurance, and various benefits such as company car etc (Chappell & Glennie, 2010). Non financial rewards consist of the satisfaction that a person receives from the job itself or from the psychological and/or physical environment in which the person works (Adzei & Atinga, 2012). Examples of this form of reward include opportunities to perform meaningful work, social interactions with others in the workplace, job training, career advancement opportunities, recognition..

The compensation system enables an organization to attract more and better candidates and to retain essential employees for longer periods of time. Important employment benefits include items such as retirement, health insurance, life insurance, paid leave, paid holidays, and flexible work schedules to name a few. It has been noted that a compensation system based on excellent performance results in increased employee performance in the same way that a profit sharing system increases productivity and contributes to employee performance by, among other things, decreasing turnover (Brewster & Mayrhofer, 2012).

While findings from several studies underline pay as one of the most important factors influencing one's level of job satisfaction (Carr et al., 2011; Chandler, Chonya, Mtei, Reyburn, & Whitty, 2009; de Waal, 2012), evidence from other researches has shown that individuals who earn more are not necessarily more satisfied in their jobs (Herzberg, Mausner, & Snyderman, 1959). It has been established that employees tend to remain with the organization when they feel their capabilities, efforts and performance

contributions are recognized and appreciated. When employers express respect to their employees and acknowledge their achievements and contributions to the organization's success, it builds employee loyalty (Fu & Cheng, 2014).

The preceding theoretical review of HRM functions cement the fact that the functions are inextricably linked. There has to be a clear link and fit between a human resource plan and the business plan. The HRM functions have to support the business strategy.

HRM employs policies and practices to organize work in key organization activities such as recruitment, selection, training and reward management at firm level and embedded in the wider social context. The functions are means to an end rather than being ends in themselves. The implementation of one function paves way for the other. The functions should be viewed in a holistic manner of a human resource management system. Following human resource gaps, an organization has to attract potential candidates with requisite qualifications as specified in the job description and job specification. After employees are recruited in the organization, they have to be given some orientation of their respective roles, duties and responsibilities. In order to arouse employee commitment, they have to be involved in planning their business strategies as per set priorities.

In the course of performing their roles, employees have to be evaluated over time in order to determine employee strengths and weaknesses in terms of knowledge and skills. Like other organization resources, employees depreciate (lose value) due to skill obsolescence triggered by among other things, technological changes. This calls for training and development interventions to enhance their knowledge, skills and competences to enhance performance.

In the context of the psychological contract, there is mutuality between the organization and the employees. Organizations run the risk of losing skilled and experienced employees if they fail to enforce agreed obligations between the two parties. Reward management therefore facilitates employee retention. Following the review of HRM functions, it transpires that the functions are integrated and skewed towards the organization strategy.

2.3.2 Retention: HRM outcome

While some writers include retention among HRM functions (Iles, Chuai, & Preece, 2010; Parry & Tyson, 2011), this study consider it as the outcome of good HRM practices. This line of reasoning stems from the idea that the bottom line of implementing HRM functions is to ensure that an organization is well placed to attract, develop and most importantly retain her human resources. Cognizant of the fact that human beings cannot be totally owned by an organization, the decision to stay is invariably an individual decision, retention is a hoped for outcome which can be influenced by good HRM practices rather than execution of HRM functions. In recalling the nexus of this study, an attempt is made to explore the role of HRM practices in the migration of medical doctors in Tanzania.

In the wake of increased globalization forces and accelerating rate of technological advancement, the retention of valuable employees is becoming an extremely important strategy for human resource managers (Boselie, Dietz, & Boon, 2005). This is premised on the fact that the organization can maintain a pool of knowledgeable and skilled employees who can spearhead the organization mission. Retention of skilled employees greatly requires good human resource management practices (Spero, McQuide, & Matte, 2011).

Effective HRM practices have been deemed by many researchers to be of utmost importance in providing firms with competitive advantages and the ability to operate effectively within a competitive landscape (Khan, 2010). Previous research has identified several factors that have an influence on employee retention. One of the factors is employees' organizational commitment (Buchan, 2010). Employees with a high organizational commitment are those who have a strong identification with the organization, value the sense of membership with it, agree with its objectives and value systems, are likely to remain in it and, finally, are prepared to work hard on its behalf (Bärnighausen & Bloom, 2009).

The success of retention practices hinges on the alignment of employees' values. Scholars emphasize that retention entails thorough examination of the reasons why employees join an organization (Snow et al., 2011). It is documented that employee turnover stems from different factors including the internal structure of the organization, recruitment policies and strategies, career progression opportunities, rewards and benefits, and training and development (Guest, 2011).

Conversely, it has been acknowledged that good HRM practices have the potential of reducing employee turnover, and improving commitment levels (Dieleman, Shaw, & Zwanikken, 2011). Using different terms, researchers have posited the importance of effective HRM practices on employee attraction and retention. These include "best practices" (Pfeffer, 1998), and "high commitment practices" (Armstrong & Taylor, 2014). Previous research suggests that greater use of high commitment HR practices is likely to enhance employee retention (Landy & Conte, 2016).

According to Pepe (2010), retention management of employees is influenced by several key factors, which should be managed congruently: organizational culture which instil team work, recruitment strategy, pay and benefits philosophy, employee support programs, and a training and career development system. Consequently, organizations utilize a wide range of these HRM factors driving retention and commitment (Zurn et al., 2011).

The quest to attract and retain competent workforce poses formidable challenges to many organizations (Leon & Kolstad, 2010) as they fears rise with regard to the implications of high staff turnover compared to high investment in recruitment and training employees who will not have big value in furtherance of the organization mission. Although employee retention has emerged as a focal point in talent management, it has been noted that only a few studies have examined the concept (Dolea, Stormont, & Braichet, 2010). This is particularly an urgent scholarly inquiry in developing countries which lose their skilled professionals through migration.

2.3.3 Human Resource Management practices

In line with the foci of the study, it is crucial that a review of literature is made with regard to HRM practices. HRM practices create a platform on which employee trust can evolve. However, good the theories may be promulgated in the organization vision and mission; they are useless unless they are translated into practice. In what follows, an attempt is made to unearth what good practices entail.

A recurring theme in a wide range of HRM literature is indeed the view that people are the most valuable asset in organizations (Armstrong & Taylor, 2014). HRM practices are viewed as the backbone of an organization (Guest, 1997; Pfeffer, 2000). Underlying this view is the idea that HRM practices function as a mediator between HRM strategies and HRM outcomes. Organizations formulate human resource policies stemming from their core beliefs and principles regarding the relationship between management and employees. In order to retain skilled professionals, good HRM practices are crucial since they are perceived by employees as employers' commitment to them (Patterson et al., 2010).

HRM practices involve managing a pool of organizational activities and directing them towards the fulfilment of organizational goals and objectives (Dessler & AlAriss, 2012). Policies and practices for dealing with human resource aspects of management include recruitment and selection, training and development, performance management, and reward systems (Mullan et al., 2011). Scholars have underscored the need for organizations to develop human resource policies and strategies that reflect their beliefs and principles as well as maintaining acceptable relationships between management and employees (Fajana, Owoyemi, Elegbede, & Gbajumo-Sheriff, 2011).

Over the years, many researchers have attempted to link HRM practices to the various aspects of organization functions. Few scholars (Brewster & Mayrhofer, 2012; Teclemichael Tessema & Soeters, 2006) have identified HRM as a source of competitive advantage of an organization and that effective performance of an organization hinges on application of a set of effective HRM practices.

This seem to be the reason that most strategic HRM researchers have tended to take a holistic view of employment and human capital, focusing on the extent to which a set of practices is used across all employees of a firm as well as the consistency of these practices across all employees (Pfeffer, 2000). They suggest that there is an identifiable set of best practices for managing employees that has universal, additive, positive effects on organizational performance (universalistic approach). Whilst it has been argued that just as there may be no universally best set of HR practices for every firm, there may actually be no one best set of practices for every employee within a firm (Jackson, Schuler, & Werner, 2011).

The integration of recruitment, training, performance and reward management functions have been acknowledged to be potential functions that are likely to yield better outcomes if they are means to an end rather than being ends in themselves (Martineau, 1998). There is wider perception that they may be more effective in the attraction, utilization, development, motivation and indeed retention strategies if they are applied as a bundle rather than in isolation (Tichy, Fombrun, & Devanna, 1984).

Studies on HRM performance link have demonstrated that HRM practices have significant impact on employee turnover and operational performance (e.g. (Pfeffer, 1998) in the US, and (Bosilie et al., 2005) in the UK. HRM studies related to the health sector in Sub Saharan Africa (Awases, Gbary, Nyoni, & Chatora, 2004; JLI, 2004) have underscored greater impetus to human resource issues.

There is wider perception that HRM practices are positively related with the organization commitment (Dessler & AlAriss, 2012; Gerhart, 2007). It is argued that, “Having good HRM is likely to generate much loyalty, commitment, or willingness to expend extra effort in furtherance of organization’s objectives “ (Pfeffer, 2000). In a similar vein, it is remarked that, “HRM is either part of the problem or part of the solution in gaining the productive contribution of people” (Boxall & Purcell, 2011). There has been increasing interest among HRM scholars and practitioners in the degree to which employees are satisfied with their jobs It has been reported that implementation of HRM bundles as a

high involvement approach to management can be associated with higher levels of job satisfaction (Boselie et al., 2005).

It transpires from the above literature that despite structural and vision differences among organizations their achievement of objectives hinges on the calibre of human resource in terms of knowledge, skills, competences and experiences accumulated over time. However, health systems in some developing countries pay lip service to the importance of human resources (Dessler & AlAriss, 2012).

HRM functions and the attendant practices in recruitment and selection, training and development, reward management and retention are key levers through which employment relationship can flourish (Kew & Stredwick, 2016). Given the pivotal role of employees in the achievement of organization vision, mission and hence objectives, it is strongly advised that organizations should institute policies and implement practices that enhance cordial relations between the major parties in the employment scene (Guest, 2011; Pfeffer, 2000).

This line of thinking is equally shared by Torrington and Hall (2010) who posit that human resources practices affect organizational outcomes by shaping employee behaviours and attitudes. This is particularly so taking into account that employee's perception of HRM practices greatly influences their commitment level and indeed their retention in an organization (Stredwick, 2013).

Research has focused on the ways in which HRM policies can encourage employees to become aligned with organizations' objectives. It has been argued that one of the most successful methods of encouraging full employee commitment is through the use of profit sharing and stock ownership, schemes that naturally develop improved levels of participation and communication between employees and management within a firm (Ashmore & Gilson, 2015). The key message is the notion that the pendulum of the employment scene is determined by the modus operandi of enforcing HRM policies to win the hearts of skilled professionals like medical doctors.

2.3.4 The Push Pull Model

The push –pull theory refers to the influences felt by professionals within a source country that creates an impetus to seek employment elsewhere within or outside their country. This seminal work on the Laws of migration in the late 19th Century provided the first systematic principles that explained the dynamics of migration. He was one of the earliest migration theorists whose work led to the development of classic push-pull (Microeconomic Equilibrium Theory). His work was based on five general propositions. First, is the existing relationship between migration and distance. He distinguishes between short and long term migrants, with male predominance in long distance migration and female predominance in short distance movements. Second, Ravenstein identified a process of stage migration: migrants will come first from nearby villages towards the centre of attraction or urban areas.

However, he notes that as industry and commerce continue to grow, migrants will be attracted from very distant villages as well. Third, he notes that rural-urban differences in the propensity to migrate, whereby the urban population displays a lesser propensity to migrate than the rural population. Fourth, he argues that developments in technology and modes of transportation, lead to an increase in migration. Five, he claims that the migration process is an individual rational decision. These viewpoints were later enhanced by (Lee, 1966) model that explains migration as the result of an imbalance between negative and positive issues in the sending and receiving countries. The factors were classified into two major factors namely push and pull factors.

Push factors are those factors that occur within the country of origin, motivating professionals to leave. Push factors stem from among others, poor human resource management practices. These include, among others, low salary levels, poor working conditions, low job satisfaction, poor research facilities, lack of further training and clear career advancement, unemployment, under employment, security issues, underdeveloped education system, non competitive employment, ineffective management of resources, and low salary levels (Blacklock et al., 2014; Kirby & Siplon, 2012).

Kiggundu (1989, p. 172) identifies the following as some of the reasons for the brain drain from developing to industrialized countries: (1) salary and benefits differentials; (2) inadequate professional and career opportunities; (3) large technological gaps and inadequate or weak local technological capacity; (4) lack of willingness to change by the home country; (5) the relevance or applicability of foreign education, training, and attitudes; (6) discrimination; (7) political balkanization or instability; and (8) lack of realistic and accurate human resources policies and plans.

Pull factors results from influences arising from recipient countries. These include among others, availability of information on employment opportunities and educational advancement, better remuneration and opportunities for intellectual growth, better learning opportunities, access to high quality scientific infrastructure and technology improved or better standard of living, health and productive working environment, better research facilities and opportunity for professional growth and development (Anand & Bärnighausen, 2012; Poppe et al., 2014).

Much as the pull push model has gained currency over time, we take cognizance of the limitations of the pull push model which mirror mechanistic outlook in the way individuals are painted as being driven by these forces beyond their inherent decision making arena. This justifies the need to explore other theories which can shed more light on the prism of migration of professionals. Indeed, it can easily be seen that many of these are outside the control of individual managers and institutions. Clearly, national poverty levels and lack of national infrastructure is beyond managerial control in the organization. However, human resource practices related to working conditions, mission and strategies, remuneration, promotion, governance, opportunities for learning and specialization, and other factors related to job satisfaction are at least to some extent the responsibility of general management and human resource management at organizational level.

2.3.5 Career Anchor Theory

Research into careers has spanned many decades (Coetzee & Schreuder, 2014) and has garnered increased attention (Savickas, 2011). The literature on the concept has been described as ‘multidisciplinary, multi level and difficult to distil’ (Wils, Wils, & Tremblay, 2010). Orthodox career theory relates to the “organizational careers” followed by employees in a single employment setting as they move vertically up the organization hierarchy (Schreuder & Coetzee, 2011). The concept of career anchor refers to a pattern of self perceived talents and abilities, basic values, and the evolved sense of motives and needs (as they pertain to the career) that influences a person’s career related decisions (Coetzee & Bergh, 2009; Rodriguez, 2008; Schein, 1996).

Career anchors are stable career identities, which determine priorities and define how people see themselves and their work (Feldman & Bolino, 1996; Rodriguez, Johnstone, & Procter, 2015; Schein, 1978). The career anchor is seen as an internal resource that functions as a set of driving and constraining forces on individuals ‘career decisions and choices (Coetzee & Schreuder, 2014). It has been noted that individuals will either be attracted to, or pulled back into, environments more congruent with the stable self concept or career identity represented by the career anchor (Chang, Jiang, Klein, & Chen, 2012). A common thread in these definitions is the continuous nature of career changes in the employment scene as personal choices and preferences are redefined over time.

The career as field of study dates back to the Chicago School of Sociology in the 1920s and 1930s. The field has attracted the attention of scholars and practitioners from a range of disciplines: Sociology, Psychology, Economics and Political Science. The career anchor model was developed by Schein (1978) when he coined the term career anchor to describe a constellation of self-perceived attitudes, values, needs and talents that develops over time, and which when developed, shapes and guides career choices and direction. Drawing on his ten years of study at the Massachusetts Institute of Technology in the 1960s, Schein (1996) developed five career anchors namely Technical/functional competence; Managerial competence; Security and stability; Autonomy and independence; and Entrepreneurial creativity. These anchors were to be used in to identify

and predict individual behaviour within organizations. Subsequent studies on career anchors (DeLong, 1982, 1984) identify three additional career anchors: (i.e. service and dedication to a cause, identity, and, variety. These anchors are described below. Table 2.1 presents a brief description of each of the career anchors.

Table 2.1: Description of Schein's (1985) Career Anchors

Career Anchor	What you would never give up
Technical-Functional expertise	The ability to apply and continually develop your skill in that particular discipline
General Management competence	The opportunity to manage the contribution of others from across an organization to achieve results.
Autonomy/Independence	The enduring freedom to control your own activities
Security/Stability	The opportunity for financial or job security
Entrepreneurial creativity	The challenge to create an enterprise of your own, built on personal endeavours
Service/dedication to a cause	The ability to achieve something of benefit or value to others.
Pure challenge	The opportunity to achieve the almost impossible
Life style integration	The harmonious balance of personal, family, and work positions.

Source: Schein (1985, p. 124).

The identified career anchors were clustered into three groups namely need based, value based and talent based (Feldman & Bolino, 1996). The talent-based anchors consist of managerial competence (willingness to solve complex, whole of-organization problems and undertake subsequent decision making, technical and functional competence (the achievement of expert status among peers) and entrepreneurial creativity (opportunity for creativity and identification of new businesses, products or services).

The needs-based anchors consist of security and stability (long-term employment for health benefits and retirement options), autonomy and independence (personal freedom in job content and settings) and lifestyle motivations (balancing one's personal and family welfare with work commitments).

The value-based anchors consist of pure challenge (testing personal endurance through risky projects or physically challenging work) and service or dedication to a cause

(working for the greater good of organizations or communities). Table 2.2 gives an overview of each cluster.

Table 2.2: Major clusters of Career Anchors

Need-Based Career Anchor	Values-Based Anchor	Talents-based Career Anchors
<i>Autonomy/Independence</i> Personal freedom in job content and settings	<i>Service/Dedication to a cause</i> Working for the greater organizations or communities	<i>Technical/Functional Competence</i> Achievement of expert status among peers
<i>Security and Stability</i> Long-term employment for health benefits and retirement options	<i>Pure Challenge</i> Testing personal endurance through risky projects or physically challenging work	<i>Managerial Competence</i> Willingness to solve complex, whole-of-organization problems and undertake subsequent decision making
<i>Lifestyle</i> Obtaining balance between personal and the family's welfare with work commitments		<i>Entrepreneurial Creativity</i> Opportunity for creativity and identification of new businesses, products or services

Source: Extracted from Feldman and Bolino (2000); Baruch (2004); Coetzee and Schreuder (2008)

Schein and Mueller (1992) did subsequent career history interviews of several hundred people in various career stages found that the identity anchor can be viewed as an extension of the security/stability anchor. Other studies (Ituma & Simpson, 2009) however, have identified a type of career anchor defined by the belief that it should somehow be possible to integrate work, family, and self-concerns into a coherent lifestyle the Lifestyle integration anchor. Similarly, it has been reported that the Variety anchor is favoured by individuals who defined all work situations as self-tests that are won or lost against either an absolute standard or an actual competitor. Thus the label pure challenge was adopted as the essence of the variety anchor (Schein, 1996; Willis-Shattuck et al., 2008).

The lifestyle integration anchor supports the recent trend in human resource management that recognizes the way people value the importance of balancing work and family responsibilities (Oosthuizen, Coetzee, & Mntonintshi, 2014). The pure challenge anchor, on the other hand, illustrates the general contention about the ‘winning’ attitude of executives; that is, they value competition and challenge as essential ingredients of success (Tams & Arthur, 2010). These characteristics are especially true among

executives whose career success orientations are getting ahead, getting free, and getting high (Creager, 2011).

Schein's seminal work on career anchors suggests that individuals develop "careers within careers" after their true abilities, needs and values become crystallized through a variety of real-world experiences. Schein's model is rooted in the attainment of congruence between employees' career anchor and the work environment. He posits that there are three major career outcomes namely work effectiveness, specific job satisfaction (e.g., type of work, pay and benefits, promotion system and advancement opportunities), and job stability (Lorsch, 1987; Schein, 1996; Vries, Irlam, Couper, & Kornik, 2010). Moreover, Feldman and Bolino (1996, p. 94) extends career outcomes to include work role adjustment, outside role conflict and overall psychological well-being. In sum, career anchors represent enduring characteristics that may affect the way individuals respond to events and experiences at work. It was posited that most people within a few years of entering employment, soon establish a dominant career anchor which will play a significant part in future career choices and decisions (Inkson, Gunz, Ganesh, & Roper, 2012).

Schein (1996) pointed out that all people develop some kind of picture of their work life and their own role in it. These anchors not only influence career choices but also affect the decisions to move from one organization to another and they invariably influence future career goals and objectives. The knowledge of one's career anchor is very important because of its influence on career choices and its effect in shaping individual goals in life. He demonstrated additional evidence that the emergence of a career anchor may also influence work attitude. Employees invariably seek meaning in their work and advancement (Arthur, 2008; Hall, 2004).

Numerous researches have indicated that promotion provides opportunities for personal growth, more responsibilities and increased social status and that job satisfaction is likely to be experienced by individuals who perceive promotional opportunities to be fair (Savickas, 2011; Schein, 2010). However, Coetzee and Schreuder (2008) showed that combinations of anchors could be found in a person's profile. While it is recognized that

work experience in early years is particularly influential in forming individual career anchors (Schein, 1978), these dispositions also are applicable in later career stages and multiple anchors could be organized in a model, given that some anchors would be close to each other while others would be contradictory (Coetzee & Schreuder, 2010).

Globalization has facilitated increased employability of medical doctors worldwide. This trend threatens the viability of health care systems in developing countries. The career literature highlights one of the forces triggering migration decisions. Fears of professional isolation and career retardation have intensified the pace of migration. Competitive labour markets prompt skilled professionals like medical doctors to diversify their occupations in order to seize opportunities within their career choices.

The uncertainty and turbulent business environment has elevated employees' career anchors as useful tools in devising retention strategies which can arouse employee commitment to stay in an organization. In the wake of loss of medical doctors to out migration, understanding the respective career anchors doctors are skewed to can help HRM managers to design appropriate retention strategies.

While traditionally, career paths emphasized upward movement in an organization (Arthur, 2008; Rousseau, 2004), the current career literature has elevated a new career term namely the boundaryless (or nomadic) career. Careers are not stable entities. They are no longer defined within one company (Arthur, Khapova, & Wilderom, 2005; Baruch, 2004; Coetzee & Schreuder, 2014). Boundaryless career entails movement across separate employers, external validation of market worth from outside the present employers, connectedness to external networks or information, and non-hierarchical reporting relationships (Chang et al., 2012).

The notion of boundaryless career has gained currency in recent career discourse and has been increasingly used as an umbrella concept for 'new career'. Extant studies on the boundaryless career have posited the changing nature of careers (Gubler, Arnold, & Coombs, 2014). The career literature underscores the fact that globalization and ICT developments have joined forces to create an atmosphere in which industrial restructuring

and attendant downsizing have created career disequilibrium (Coetzee & Schreuder, 2008; Tams & Arthur, 2010). This is viewed as ‘a sequence of job opportunities that goes beyond the boundaries of single employment settings (Coetzee & Schreuder, 2008).

Career development implies two dimensions: continuous education and promotion. Quality continuous education is important for attaining individual and organizational performance objectives. This requires a systematic review of candidate’s pre-entry training needs and monitoring and evaluation system for training inputs, outputs and outcomes. The availability of career development opportunities within an organization tends to promote a higher degree of organizational commitment among employees (Guest, 1997; Wils et al., 2010).

Lack of opportunities for career advancement is one of the major factors driving migration of doctors generally and newly graduated doctors in particular in many developing countries (Burch et al., 2011). Several surveys of doctors living outside their countries of training confirm that postgraduate training is among the reason for emigration (Awases et al., 2004; Pang, Lansang, & Haines, 2002). This is further supported by Bonenberger, Aikins, Akweongo, and Wyss (2014) who attribute migration to factors such opportunities for intellectual growth, improved or better standard of living, health and productive working environment, improved or better research facilities and opportunity for professional growth and development. In a similar vein, Chandler et al. (2009) and Kolstad and Lindkvist (2013) found that offering continuing education, increased salaries and hardship allowances, provision of housing, good infrastructure and equipment are powerful recruitment strategies.

The new agenda for careers in the employment scene has received much attention in general management literature. Underlying this trend is an increased individual responsibility for career and professional development. As Hall (2004) notes, the person, and no longer the organization, is in charge of the career. Moreover, Coetzee and Bergh (2009) argue that thinking and practice in career management is moving away from a psychological contract based on a long term relationship to one which implies a series of mutually beneficial transactions dependent on both organizational and individual needs.

Although high levels of incentives are important in attracting and retaining high quality workforce, they have been viewed as not sufficient (Schein, 1996; Wils et al., 2010). Schein underscores the need for a better understanding of employees' career dynamics. Since the early 1970s when Schein developed the concept of career anchors, career anchors have gained currency as avenues for keeping people motivated and productive. Thus far, the main difference between the traditional career ladder and the boundary less career is that career anchors operate within intra-company career patterns, whereas boundary less careers are more inter-company/cross-company and inter country mobility.

The foregoing review on career anchors mirror a scenario in which medical doctors are likely to be motivated by intra- anchors or boundary less opportunities. It transpires from this review that careers are increasingly becoming horizontal and more lateral in nature. This is in part attributed to the feeling that the hitherto assumption for lifelong engagement with an organization is challenged by the notion of "no job for life particularly in the wake of violation of the psychological contract. Like other organizations, hospitals operate in a highly dynamic environment in which economic conditions, technology and socio cultural values are constantly changing in response to global challenges. As organizations strive to attract, motivate and retain skilled human resources, it is crucial that there is a better fit between employee career goals and organization mission.

2.3.6 The Psychological Contract Theory

The concept of the psychological contract was first used by Argyris (1960) and subsequently popularized by Levinson, Price, Munden, Mandl, and Solley (1962) and Schein (1978, 1985). The relationship between an employer and an employee is typically guided by formal agreements through union management contracts or the government legislation that sets the standards of fair and equitable work. However, there is another contract namely the psychological work contract which is unwritten. It has been defined as:

“Individual beliefs shaped by the organization regarding terms of an exchange agreement between individuals and the organization” Rousseau (1995, p. 10). *It is individual beliefs regarding reciprocal obligations* Freese and Schalk (1996, p. 501). *“The terms of social exchange relationship that exists between individuals and their organization* Turnley and Feldman (2000, p. 30).

The common underlying dimension of these definitions of the psychological contract is denoted by an employee’s expectations, beliefs, responsibilities and promises with regard to representing a fair exchange within the margins of the employment relationship. It is a contract that exists between the employer and the employees. It is characterized as a match between the expectations the organization has of its employees, the expectations the employer hold of their organization and what the organization is equipped to offer in return (Freese & Schalk, 2008). Most employees develop a positive and enduring psychological bond with their organization. This bond is premised on the expectations about what the organization should offer them (Rossouw, Van Vuuren, Ghani, & Adam, 2010).

Employee’s perception of their reciprocal obligations is invariably aroused upon employment contract. The obligations cover a range of issues including training and career development, promotional avenues and the level of decision-making responsibility that the employee will be given (Cassar & Briner, 2011).

The psychological contract is commonly used in tandem with phrases such as perceptions, expectations, beliefs, promises and obligations (Guest, 1998; Guest & Conway, 2002). It is rooted in models in social psychology such as Homans’ social exchange theory of elementary social forms which posit that individuals enter into relationship with others to maximize their benefits (Chaudhry, Wayne, & Schalk, 2009). The model focuses on the employer-employee relationship and refers to a set of unwritten agreements about what one party expects to give and receive from the other (Guest & Conway, 2004). The psychological contract is regarded as a mental model, or a schema, which people use to interpret their world and generate appropriate behaviours (Rousseau, 2001). The term is commonly used in tandem with phrases such as perceptions, expectations, beliefs, promises and obligations (Freese & Schalk, 2008).

a) Types of Psychological Contracts

The employment scene has two major types of psychological contracts namely Transactional and Relational contracts Transactional contracts entail terms of exchange with monetary value and are short term bound. As Rousseau (2004) puts it, it is an employment arrangement with a short term or limited duration, which is primarily focused upon economic exchanges, specific narrow duties and limited employee involvement in the organization. It is “*a fair day’s work for a fair days pay*”. Relational contracts by contrast, have terms that cannot easily be monetized. They refer to the relationship between the individual employee (e.g. loyalty, commitment or trust) and the employer (guaranteed job security and training). Whilst transaction contracts are associated with economic exchange, relational contracts are linked to social exchange (Cohen, 2011) Table 2.3 shows the distinction.

Table 2.3: Transactional Vs Relational Psychological Contract

Transactional contract	Relational contract
Little organizational loyalty	High Organizational loyalty
Employee develop marketable skills	Employee develop company specific skills
Unstable employment	Stable employment
Flexibility or easy exit	Willing to commit to one company
Less willing to take on additional responsibilities	High intention to stay within organization
Reward system focuses on short term	Members highly socialized

Source: Rousseau (1995, p. 12).

b) The changing terrain of the Psychological Contract

The concept of psychological contract has been used increasingly as an analytic construct that explains the response to and impact of rapid change in organizations (De Vos, De Stobbeleir, & Meganck, 2009). It is premised on the exchange between an individual and the organization or agents of the organization in the context of explicit promises and expectations. It has been changing. In response to changes in the world of work in the external environment (e.g., globalization forces and technological developments (Scheepers & Shuping, 2011).

Whereas the old psychological contract was characterized by stability, predictability, security, recent years have witnessed changes in the relationship between employers and employees (Zhang, 2014). Nowadays employers emphasize “employability” rather than long-term loyalty in a specific job (Conway & Briner, 2005; Tornow, 2013). This new form of psychological contract is more evident because businesses are increasingly using non-core and part-time workers to gain flexibility at lower cost. The distinction between the old and the new psychological contract dimensions is delineated in Table 2.4 below.

Table 2.4: Old Vs. The New Psychological contract

Old Psychological Contract	New Psychological Contract
Stability, predictability	Change, uncertainty
Permanence	Temporariness
Paternalism	Self-reliance
Standard work patterns	Flexible work patterns
Job Security	Employment security
Commitment to company	Commitment to self
Linear career growth	Multiple career growth
One time learning	Lifelong learning

Source: Adopted from De Meuse and Tornow (1990).

c) Psychological contract fulfillment and breach

Researches on psychological contract have closely examined the frequency and impact of situations when organizations fail to adhere to the obligations to employees (Zhang, 2014). Invariably, non-compliance with the expected obligations triggers strong emotional reactions (Freese & Schalk, 2008). Indeed as Anderson and Schalk (1998) note, expectations of different levels (i.e., individual and organization) poses challenges on the consensus of parties. Breaches of the psychological contract occur when an employee perceives that the organization has failed to fulfil one or more of its obligations Perceived contract breach is thus associated with reduced effective commitment and loyalty (Cohen, 2012), lower trust (Coyle-Shapiro & Shore, 2007), greater willingness to leave the organization and increased cynicism (Zulu et al., 2014).

Guest (1998) posit that the strength of the psychological contract is dependent on how fair the individual believes the organization is in fulfilling its perceived obligations above and

beyond the formal written employment contract. This in turn determines commitment to the organization, motivation, job satisfaction and job security (Guest & Conway, 2004). Most employees develop a positive and enduring psychological bond with their organization. This bond is premised on the expectations about what the organization should offer them (Cohen, 2011). Employee's perception of their reciprocal obligations is invariably aroused upon employment contract. The obligations cover a range of issues including training and career development, promotional avenues and the level of decision-making responsibility that the employee will be given (Scheepers & Shuping, 2011).

In this vein, understanding the consequences of the breach or violation is very important. This view is premised on the following grounds. Firstly, organizations are better positioned to manage the expectations employees have and secondly, organizations can implement management practices that will minimize the effect on the organization of breach or violation of psychological contract.

Empirical studies show that organizational breach of psychological contract is associated with reduction in job satisfaction (Bal, Jansen, Van Der Velde, de Lange, & Rousseau, 2010; Conway, Guest, & Trenberth, 2011). When organization breaks their obligation of psychological contract trust is affected negatively (Lapointe, Vandenberghe, & Boudrias, 2013; Walker, DeWitt, Pallant, & Cunningham, 2012). Failure to deliver obligations result to decrease of organizational commitment (Cassar & Briner, 2011). Breach of psychological contract by organization lowers employees' organizational citizenship behavior (Lub, Blomme, & Matthijs Bal, 2011).

A framework for understanding situational constraints on employees' response to breaches of psychological contracts is provided by the exit, voice, loyalty, and neglect (EVLN) typology (Hirschman, 1970) that was later developed by other researchers (e.g. Schein (1990). The framework suggests that employees will respond to breaches of psychological contract with increased exit (leaving the organization), increased voice (taking initiative with superiors to improve conditions), decreased loyalty (decreased organizational citizenship behaviour), and increased neglect (putting in half-hearted effort, more absenteeism and lateness). In support of this, it has been posited that support

this by suggesting that: ‘An employee weighs his or her obligations towards the organization against the obligations of the organization towards them as they adjust behaviours on the basis of critical outcomes (Anderson & Schalk, 1998, p. 640).

According to the social exchange theory (Blau, 1964), parties to the employment relationship strives to attain reciprocity (i.e., the balance between their inputs and the rewards they receive). This review maps the relationship between the psychological contract and retention of employees. Skilled professionals like medical doctors tend to behave differently depending on the context in which they work. There are variations on the extent to which health facilities fail or succeed to attract and retain talent. The psychological contract seems to provide rich explanations on the dynamics in which migration decisions are made.

2.3.7 Human Capital Theory

Human capital has been conceptualized as a unit level resource that is founded on the interdependencies of individual knowledge, skills, and abilities (Becker, 1975; Schultz, 1961). The human capital theory states that employee development is vital in maintaining and developing the capabilities of individual employees, the organization and the nation at large. It suggests that human resources (employees and managers) are valuable and unique resources in which organizations must invest.

Human capital is the stock of skills that employees possess. The human capital of an organization constitutes the knowledge, skills and abilities utilized by individuals. The value of human capital is thus derived from its potential to enhance the efficiency and effectiveness of the organization. The theory posits that organizations invest in employees and make human capital through HRM practices, such as training and career development which pave way for knowledge sharing when professionals work in specialty teams (Conway et al., 2011). Organizations that are able to identify and employ individuals with higher abilities and skills are more likely to experience positive firm level outcomes, such as increased productivity and efficiency (Unger, Rauch, Frese, & Rosenbusch, 2011).

A central premise in perceived investment in employee development is that it creates conditions where employees appreciate their value, hence facilitating employee obligation towards the organization (Budhwar & Debrah, 2013). The theory stresses that continuous professional development is integral in increasing professional workers' production capacity. There is a need for large investments in human capital development, whereby the education that workers receive would increase their productivity and efficiency, and at the same time increase their motivation to perform – and in this case, their motivation to stay. Thus, investments in human capital may provide for a win-win situation. From the perspective of human capital management, people are considered as intangible assets (human capital) whose future value can be enhanced through investment (Shaw, Park, & Kim, 2013) and Knowledge sharing (Ployhart, Nyberg, Reilly, & Maltarich, 2014).

2.3.8 Social Capital Theory

Social capital is a broad term which includes social relationships, networks, and values that facilitate collective action for mutual benefit (Meijer & Syssner, 2017; Story, 2013). Social capital theory posits that social resources (i.e., social capital) in the work environment enable employees (to leverage existing resources) to be effective at work (Nahapiet & Ghoshal, 1998). The trustworthiness of the social environment manifest in three mechanisms through which social capital is generated: reciprocity exchanges, privileged access to information, and group enforcement of norms (Coleman, 1988).

Social capital takes the form of structures, institutions, networks and relationships which enable individuals to maintain and develop their human capital in partnership with others, and to be more productive when working together than in isolation (Coleman, 1990, p. 302). It includes families, communities, educational and health bodies.

Social capital is a valuable resource to an organization (Baraldi, Gressetvold, & Harrison, 2012). It plays a central role in improving employee knowledge, skills and attitude. While HRM practices are one of the determinants of human capital, social relations enhance social capital (Kwon & Adler, 2014). HRM practices may aid in fostering social capital between employees by developing their abilities, opportunities and motivation to access

other knowledge. HRM practices can also be a catalyst for building and developing social capital through design of work processes that promote team work. Human and social capital requires constant investment in specific HRM practices. HRM practices should provide employees with the opportunity to interact with other individuals for building interpersonal relationships. Organizational social capital is built through selection of employees with both technical and interpersonal skills.

Ogden, Morrison, and Hardee (2014) suggest various forms social capital – bonding, bridging and linking which are critical to strengthening social systems. Bonding social capital refers to the strengthening of heterogeneous ties with like minded people within a community (Ree, 2014). Bridging capital relates to inclusive solidarity between people from various backgrounds (Agger & Jensen, 2015). Linking social capital is the extent to which individuals build relationships with institutions or individuals who have relative power over them (Lancee, 2010).

2.3.9 Social Exchange Theory

Social exchange theory (Blau, 1964; Wikhamn & Hall, 2012) suggests that social behavior is the result of an exchange process. It focuses on the reciprocal relationships, interactions, and mutual ‘felt obligations’ between employees and their employers (Festing & Schäfer, 2014). The theory explains why a higher quality leader member exchange relationship is linked to more favorable outcomes for members. It contends that when the leader offers the valued resources to the member (e.g., sharing information and providing socio-emotional support), the member, in turn, may reciprocate by putting forth greater effort and initiative on tasks and by showing greater levels of satisfaction and commitment (Choi & La, 2013).

The theory is based on a central premise: that the exchange of social and material resources is a fundamental form of human interaction. It is a theoretical explanation for organizational citizenship behavior. The exchange is viewed as a social behavior that may result in both economic and social outcomes (Blau, 1964). The underlying norm in social exchange theory is reciprocity, individuals’ obligation to respond positively to favorable

treatment received by others (Pierro, Raven, Amato, & Bélanger, 2013). When employees' perceives that an employer adopts HRM practices which focus on their well-being, they will reciprocate by engaging themselves in extra role behavior such as social citizenship behavior and affective organization commitment. This is viewed as the strongest form of organizational commitment as it symbolizes the 'want to remain', compared to continuance commitment ('need to remain') and normative commitment ('ought to remain') (Mayer, Davis, & Schoorman, 1995; Morrow, 2011).

Conversely, when employees perceive that there is less organizational support exhibited by the failure of the employer to fulfill expectations of psychological contract, they reciprocate by withholding their involvement in extra role activities, which, in turn reduces job satisfaction, organization citizenship behavior and organizational commitment (Cook, Cheshire, Rice, & Nakagawa, 2013).

2.3.10 Transformational and Transactional Leadership Styles

Transformational leadership is a theory of behaviors and attributes (Avolio, Bass, & Jung, 1999). It is defined as a meaningful and creative exchange between leaders and followers with the aim to guide followers through a vision-driven change (Bass, 1985). Transformational leadership is defined as a leadership approach that causes change in individuals and social systems (Burns, 1978). It enhances the motivation, morale and the performance of followers through a variety of mechanisms. These include connecting the follower's sense of identity and self to the mission and the collective identity of the organization, being a role model for followers (Appelbaum, Degbe, MacDonald, & Nguyen-Quang, 2015). This theory is one of the broad categories of leadership styles which demonstrate the effectiveness of leaders in different contexts (Stewart, 2006).

Transformational leaders exhibit charismatic disposition as role models for the followers through inspirational motivation (Bass, 1985). This leadership style manifests in the extent to which a leader influences followers through trust, loyalty and respect to the leader. It may create significant change in the life of people and organizations (Appelbaum et al., 2015; Bass & Avolio, 1990). It is a process in which leaders and

followers help each other to advance to a higher level of morale and motivation (Burns, 1978). According to Burns (1978), there are two concepts: Transforming leadership and transactional leadership.

(a) Transformational Leadership style

Transforming leadership creates significant change in the lives of people and organizations. It redesigns perceptions and values, and changes expectations and inspirations of employees. It is based on leader's personality, traits and ability to make a change such as articulation of an energizing vision and challenging goal. These leaders are a moral exemplar of working towards the benefit of the team, organization and the community at large.

Transformational leadership style is multi-faceted and comprises four sub-dimensions (Avolio, Zhu, Koh, & Bhatia, 2004). These include idealized influence (attributed and behavior), inspirational motivation, intellectual stimulation, and individualized consideration.

i. Idealized Influence

Idealized influence attributed refers to followers' attributions of power and confidence, and their identification with their leader. Leaders consider the need of others over their own needs, and serve as charismatic role models for their followers, who respond with trust, confidence, and respect. Idealized influence behavior includes behaviors such as: expecting high performance standards; communicating values; and providing an attractive vision, an organizational mission, and purpose. A leader instills pride in followers and emphasizes collective mission by going beyond self interest for the benefit of the organization (Hughes, 2014).

ii. Inspirational Motivation

Inspirational motivation refers to offering meaning, showing optimism, encouraging team spirit and enthusiasm about goals and the future (Bass & Riggio, 2006). It entails the

leader's ability to inspire confidence, motivation and a sense of purpose in his followers. The transformational leader has to articulate a clear vision for the future, communicate expectations of the group and demonstrate a commitment to the goals that have been laid out.

iii. Intellectual stimulation

Intellectual stimulation includes behaviors that stimulate followers' critical reflection processes by questioning assumptions, reframing problems, rethinking routines, and approaching old situations in new ways (Ashforth, Schinoff, & Rogers, 2016). People admire leaders who awaken their curiosity. Compared with other transformational leadership dimensions, intellectual stimulation is more task focused. The leader challenge followers to think and learn and encourage openness to new inspiring ideas and alternatives. These ingredients can ensure team and organizational success. Leaders who exhibit intellectual stimulating behaviors motivate their followers to explore new ways to approach their jobs

iv. Individualized consideration

Individualized consideration characterizes leaders who are attentive to individuals' needs by providing empathy, a supportive climate, and training and learning opportunities. Research has repeatedly found that these sub-dimensions are highly interrelated (Epitropaki & Martin, 2013).

(b) Transactional Leadership style

Transactional leadership, on the other hand, is a style of leadership in which a leader promotes compliance mainly through rewards and punishment. It is based on “give and take” relationship between the leaders and the followers (Antonakis, Avolio, & Sivasubramaniam, 2003). The work of Burns (1978) was extended by Bass (1998) who explained the psychological mechanism that underlies transforming and transactional leadership. He also used the term “transformational” instead of “transforming” and posited that transforming and transactional leadership were mutually exclusive styles

(Bass, 1985, 1998). It was further explained how transformational leadership could be measured, its impact on followers' motivation and performance. The extent to which a leader is transformational is measured first, in terms of his influence on the followers. The followers express trust, admiration, loyalty and respect for the leader. In contrast to Burns (1978), Bass (1985) suggested that leadership can simultaneously display both transformational and transactional leadership styles.

2.3.11 Organization Support Theory

Organization Support Theory states that employees view their organization as having a disposition to view them favorably or unfavorably, as reflected in the treatment it provides them. The perception develops through multiple interactions between employees and their employers, operating at both a cognitive and an emotional level (Buchan, 2010). Employees reciprocate based on the perceived level of organizational support, which refers to an individual's perception regarding the degree to which an organization values their contributions and cares about their wellbeing (Coyle-Shapiro & Shore, 2007). Employees value organizational support partly because it meets their needs for approval, esteem and affiliation, and engagement (Eisenberger & Stinglhamber, 2011). When HRM practices lead to high perceived organizational support, employees are more satisfied with their jobs, feel more closely connected with the organization, and are likely to be more loyal and committed to the organization.

Based on the norm of reciprocity (i.e., the moral obligation to respond favorably to positive treatment (Eisenberger & Stinglhamber, 2011), employees with high perceived organizational support are more committed to work for the organization. This implies that favorable HRM practices and effective leadership influences will be perceived as organizational support. Recognition by management, peers, patients and the community creates a web of interpersonal relationships among employees. When employees view these actors as potential stakeholders in the organization, it enhances perceived organizational support and arouses greater commitment to stay.

2.3.12 Herzberg's Two Factor Theory of Work Motivation

The Motivation-Hygiene Theory is one of the behavioural theories of motivation. (Herzberg et al., 1959). The aim of Herzberg et al. (1959) research was to discover individual workers' attitudes towards their work and what it was that individual workers wanted from their jobs. The Motivation-Hygiene Theory, proposes that two sets of independent and distinctive factors exist which serve to motivate workers. Motivators/satisfiers' are intrinsic factors which relate with the content of the job. They contribute to personal growth and long lasting changes of attitudes and are more likely to contribute to increased job satisfaction. Consequently, motivating factors become a source of job 'satisfiers'. The motivating factors include achievement, recognition, work itself, responsibility, advancement and personal growth with the most important motivators being work itself, responsibility and advancement (Herzberg, 1968).

Hygiene factors or maintenance factors and dissatisfies, are extrinsic to the worker and relate with the context of the job. These factors are likely to be 'push factors' or reasons for leaving a job. They prevent dissatisfaction with the job but do not contribute to long term job satisfaction. Hygiene factors include: status, security, relationship with subordinates, personal life, relationship with peers, salary, work conditions, relationship with supervisor, company policy and administration and supervision. All factors are equally important, but some may become more important than others depending on circumstances (Herzberg, 2005). Hygiene factors are not in and of themselves motivators for work. Hygiene factors serve as a basis for a satisfied employee and are not themselves satisfiers. Positive changes in hygiene factors will only result in short term attitude changes. Herzberg et al. (1959) suggested that hygiene factors fail as satisfiers because they do not contribute to the workers' personal growth.

Herzberg's Two-Factor Theory of motivation posits that the factors that cause job satisfaction at work (i.e. motivators/intrinsic factors) are different from the ones that cause job dissatisfaction (which he calls hygiene/extrinsic factors). Herzberg uses hygiene to describe the job factors which are considered to be just the maintenance factors that are important to avoid dissatisfaction with work, but do not necessarily provide satisfaction or

positive motivation. Herzberg draws a qualitative difference between hygiene and motivating factors.

The second set of needs is growth needs. They refer to factors intrinsic within the work itself. These include recognition of a task completed, achievement, responsibility, advancement and work itself. These factors are according to Herzberg, the motivating factors, which implies that humans try to become all that they are capable of becoming and when satisfied they work as motivators (Herzberg et al., 1959). The job content (e.g. opportunities for responsibility and advancement) is the only way to increase satisfaction and thereby enhance work motivation. However, when the growth factors are missing this does not cause dissatisfaction, simply an absence of satisfaction (Herzberg, 1987).

However, if hygiene factors are met, they prevent only job dissatisfaction. According to this theory, the factors causing satisfaction are different from those causing dissatisfaction, hence the two feelings should not be treated as opposites of one another. The main distinction that Herzberg makes between hygiene and motivators is that hygiene factors are not directly related to work, so he calls them 'job context factors', whereas motivators are directly related to work, so he calls them 'job content factors'. According to Herzberg, motivators contribute to people's satisfaction (and development) in their jobs (Herzberg, 1968).

Following the preceding theoretical review, the next section attempts to explore empirical studies. The review focuses on the health crisis, migration intentions, remuneration and the role of HRM, career advancement and psychological contract.

2.4 Review of Empirical studies of migration decisions

2.4.1 Health crisis in Developing Countries

Migration of health professionals within and between countries has spurred wide concerns in the academia and public policy arena (Tankwanchi et al., 2013; WHO, 2006, 2010). Although efforts to address shortage of human resources in the health sector have

accelerated over recent years, these problems continue to hamper the goal of quality service delivery (Astor et al., 2005; Dieleman & Hilhorst, 2010) both globally and at the country level. A growing interest on the subject in recent years has been spurred by a number of factors including accelerated rate of emigration in the past 10 years from an estimated 150 million in 2000 to 214 million in 2011 (Chappell & Glennie, 2010; Sander, Holtzman, Pauly, & Cohn, 2015). These trends have exacerbated critical staff shortages of health staff worldwide (Refer to Appendix 10).

The health crisis transcending many developing countries has aroused great concerns on human resource gaps in the health sector. It has been noted that although Africa had 906 million (14 per cent) of the 6.5 billion inhabitants of the world in 2005, the region has 24 per cent of the global burden of disease (United Nations, 2005; WHO, 2006, 2010), the continent has only 1.3 per cent of the world's health staff (Wyss, 2004).

An even pessimistic scenario is the report that more than a quarter of all African countries (16 out of 53) had at least 50 percent of their doctors living overseas in 2000 (Clemens & Pettersson Gelande, 2008). The health crises manifest in an array of challenges. They include, inequalities (Chen et al., 2004), acute staff shortages (Connell, Zurn, Stilwell, Awases, & Braichet, 2007; Dumont & Zurn, 2007; Hagopian et al., 2005) and migration within and outside borders (Awases et al., 2004; Herfs, 2014; Moshi, 2010).

Studies on health worker staffing levels in Sub Saharan Africa unveils the fact that Sub Saharan Africa has the lowest health worker to population in the world due to migration of the few available workers (Maestad & Brehony, 2007; Sanders, 2003). The World Health Report 2006 estimated that the world lacks about 4 million health workers, if a minimum level of health outcomes is to be achieved (WHO, 2006). The report identified 57 "crisis" countries as being the most affected by this dearth in health personnel, predominantly in Sub-Saharan Africa and Asia. Estimates shows that about 20 percent of Uganda's doctors and 43 percent of Liberia's physicians were working in the US or Canada by 2002 (Hagopian et al., 2005).

Despite successful resolutions by the WHO regional committee for Africa to expand the continent's health workforce, for the last 20 years, Africa's regional human resource for health density declined between 2005 and 2010 (WHO, 2010, 2015).

Evidence abounds that there has been little attention to health resource issues in many developing countries (Jackson et al., 2011; Mullan et al., 2011; Omaswa, 2014; WHO, 2010). Migration of skilled health professionals is more acute in developing countries especially in Africa. It is unfortunate that the continent is losing its best doctors and nurses in the greatest numbers at a time when it needs them most (Stilwell et al., 2004). It has recently been predicted that Africa needs at least 167,000 additional physicians by 2015 (Astor et al., 2005) to attain the Millennium Development Goals.

2.4.2 Migration intentions

There is increased understanding that migration decisions are not made overnight (Burch et al., 2011). Extant literature has documented studies on migration intentions involving medical graduates who pursued postgraduate studies abroad. The study by Hagopian et al. (2005) portrays non-return of medical students who have studied abroad. They found that a culture of migration typifies success among West Africa's medical practitioners training and practicing abroad. Once such norms are established, the levels of pay and working conditions required to retain or encourage the return of *émigrés* is substantially higher. This signifies the role of networks in migration dynamics. While this research provides insights regarding health worker motivation, the full picture is still missing particularly enhanced understanding on how international opportunities affect entry into the profession.

It has been argued that increased awareness to reward differential triggers migration intentions (Manzi et al., 2012; Pemba, Macfarlane, Mpembeni, Goodell, & Kaaya, 2012). A study in six countries (Cameroon, Ghana, South Africa, Senegal, Uganda, and Zimbabwe) portrayed that intentions to migrate ranged from 26.1 percent in Uganda to 80 percent in Zimbabwe (Awases et al., 2004). A study of Nigerian medical graduates of one medical school for the period 1995 to 1997 found that 40 percent were living abroad

10 years after graduation (Ihekweazu, Anya, & Anosike, 2005). In a tracer study of the whereabouts of medical graduates of the then Muhimbili College of Health Sciences for the period 1961 to 2000, it was revealed that 6 percent were working abroad, 45.2 percent were working in the public sector and 25 percent were working in the private sector (Sirili et al., 2014).

The results of a research in 8 universities in South Africa which involved final year medical students showed that 55 percent had planned to work abroad for a period, 47 percent had made career choice and family medicine was unpopular (de Vries, Steinmetz, & Tijdens, 2016).

Table 2.5: Summary of Studies examining migration Intentions of students

Author and Date	Country	Sample	Data Collection Method	Key Findings
de Vries et al. (2016)	South Africa	Medical students	Questionnaire	55 % plan to work abroad for a period. 47 % intend to do some rural service. 47 % made career choice that family medicine not popular.
Sirili et al. (2014)	Tanzania	Graduates from 1961 to 2000 in Tanzania	Document review	6 % practicing abroad 45.2 % working in the public sector. 25 % working in the private sector
Muula (2006)	Malawi	252 Qualified Physicians	Document Review	64.3 percent trained abroad 46 percent of the graduates working in Malawi.
Ihekweazu et al. (2005)	Nigeria	416 of 468 graduates, 1995-1977, one school	Telephone interview and Questionnaires	40 % living abroad 10 years after graduation.
Dambisya (2004)	Uganda	77 graduates from one school in 1984 in Uganda	Document review	82.6 % specialists. 25 % of specialist in public health. 53.9 % working in the public sector.
Dambisya (2003)	South Africa	264 students of one rural medical school. In South Africa	Self-administered Questionnaire	49 % intended urban practice. 27 % intended rural practice. 90 % intended to do postgraduate training.

2.4.3 Remuneration

A considerable number of studies have addressed determinants of migration decisions of health workers. One of the reasons is better remuneration (Grignon, Owusu, & Sweetman, 2013; Vujicic, Zurn, Diallo, Adams, & Dal Poz, 2004). Drawing on (Oni, 2003, p. 13), Emeagwali (2003) highlights the causes of out-migration in Africa thus:

“The primary cause of external brain drain is the unreasonably low wages paid to African professionals. The contradiction is that we spend four billion dollars annually to recruit and pay 100,000 expatriates to work in Africa but we fail to spend a proportional amount to recruit the 250,000 African professionals now working outside Africa”

The migration literature invariably attributes reasons for professional mobility across organizations and countries to the search for greener pastures. Quoting Mandela, Hale (2003) notes:

“To this day we continue to lose the best among ourselves because the lights in the developed world shine brighter”.

Empirical studies have found that a good compensation system can be a potential source of competitive advantage (Guest, 2011). The compensation system enables an organization to attract more and better candidates and to retain essential employees for longer periods of time (Kasper & Bajunirwe, 2012).

It has been estimated that more than 20,000 African professionals leave the continent each year for better wages and career growth prospects overseas (Kerr, Kerr, Özden, & Parsons, 2016; Ozden & Parsons, 2016; United Nations, 2005).

Some researchers posit the pivotal role of salaries in the migration dynamics (Carrington, 2013; Vujicic et al., 2004). There is consensus among researchers that low wages play an important role in the migration of physicians. Some studies went as classifying remuneration as the most important factor for retaining health workers (Grogger & Hanson, 2015; Kossivi, Xu, & Kalgora, 2016).

It has been reported for example that an average medical doctor in the US earns close to \$200,000 annually, while a senior medical doctor in the Philippines cannot expect to earn more than around US \$40,000 (Astor et al., 2005, p. 2497). A similar scenario prevails in Tanzania where a medical specialist earns an annual salary of \$ 8,640 (Azevedo, 2017, p. 20). Arguably, one cannot lose sight of the purchasing power parity in comparative settings in which higher income in some locations may be eroded by the high standard of living. Despite disagreement on the importance of wages relative to other factors determining migration decisions, it appears there is fairly broad consensus that increasing salaries is an important strategy for slowing the migration of health professionals (Awases et al., 2004; Mensah, Mackintosh, & Henry, 2005).

A different sub set of studies on return migration lend support to the powerful role of remuneration in migration decisions. For example, Yang and Martinez (2006) shows that the return migration of Filipino workers abroad is sensitive to fluctuations in the exchange rate. Indeed, Pang et al. (2002) show that skilled workers appear to be more likely to return to their home countries after their home countries experience periods of sustained economic growth.

Dual practice (referred to as multiple job holding) which entails rendering service in both the public and private sectors among physicians (Ashmore & Gilson, 2015; Clemens & Pettersson Gelandar, 2008; Ferrinho, Van Lerberghe, Fronteira, Hipólito, & Biscaia, 2004) is said to be propelled by the financial gap between what doctors gain from the dual practice and what they earn in their formal employment. This form of practice is purported to help retain public health care workers in low and middle-income countries.

Informal payments have been proved to affect the quality of health care (Mæstad & Mwisongo, 2011). It has been found that health workers are involved in 'rent-seeking' activities, such as creating artificial shortages and deliberately lowering the quality of service, in order to extract extra payments from patients or to bargain for a higher share of the payments received by their colleagues.

A survey in Pakistan indicates that low remuneration and poor training and work environment influenced potential migrant physicians. Indeed increased awareness of differential rewards triggers the desire for migration (Zimmermann & Bauer, 2002).

Table 2.6: Summary of Studies examining Remuneration

Author and Date	Country	Sample	Data collection Methods	Findings
Grogger and Hanson (2015)	United States	Highly skilled professionals	Survey	Individuals with the highest skill levels tend to migrate to countries with higher earnings variance to receive the greatest wages. Among the many variables that influence migration decisions, wages have been shown to have an important impact
Sander et al. (2015)	Kenya	Physicians	Interviews and Task Diaries	Fair compensation is one of the crucial motivations for health professionals. Countries that attract the most significant number of skilled professionals tend to be wealthier and more mature economies since they offer higher incomes
Kasper and Bajunirwe (2012)	Sub Saharan Africa (SSA)	Health care Workers	Document Review	Thirty-two SSA countries do not meet the WHO minimum of 23 Health Care Workers per 10000 population. Contributing factors include insufficient supply, inadequate distribution and migration stemming from among other things, inadequate wages
Grignon et al. (2013)	Developing Countries	Health care professionals	Document Review	Health professionals migrate from low to middle and higher income countries. The mobility is primarily towards higher paying, more prestigious, more amenity – rich areas.
Ashmore and Gilson (2015)	South Africa	Medical Specialists	In-depth Interviews	Engagement of doctors in dual practice in both public and private hospitals enhances their retention in low and middle-income countries. Doctors earn more incomes from dual practice as compared to their income they earn in their formal employment.
Yang and Martinez (2006); Pang et al. (2002)	Philippine	Health workers	Survey	Skilled migrant in Philippine appear to be more likely to return to their home countries after their home countries experience periods of sustained economic growth.
Astor et al. (2005)	India, Nigeria, Pakistan, Colombia, and Philippines	Physicians	Questionnaire	Despite varied responses among the studied countries, a desire for increased income was among the primary motivating factors for physician migration
Mensah et al. (2005)	Ghana	Physicians	Interviews	There is widespread agreement that poor remuneration is one of the reasons why

Author and Date	Country	Sample	Data collection Methods	Findings
				medical doctors migrate from low income countries. All doctors attested that the search for a better pay in the UK where they could earn ten times as much as their salaries was a major driving force for their migration
Awases et al. (2004); Mensah et al. (2005)	Senegal, Uganda, Ghana, Cameroon, South Africa, , Zimbabwe	Health workers	Questionnaire	Despite disagreement on the importance of wages relative to other factors determining migration decisions, increasing salaries is an important strategy for slowing the migration of health professionals
Vujicic et al. (2004)	Sub Saharan Africa	Doctors and Nurses	Data set from source and receiving countries	Wage differentials are so large between low income and high income countries that no wage increases in, say, sub-Saharan Africa can reduce migration. Non-wage strategies might thus be more effective in altering migration flows.
Emeagwali (2003)	Sub Saharan Africa	Skilled professionals	Desk Review	The primary cause of external brain drain is the unreasonably low wages paid to African professional While a lot financial resources are spent to engage expatriates, the funds could be used to attract migrant professions to return to their home countries
Zimmermann and Bauer (2002)	Pakistan	Skilled health professionals	Document Review	Increased awareness of differential rewards triggers the desire for migration

2.4.4 The influence of HRM on migration decisions.

Studies on human resources for health workforce have gained currency in recent years (Guest, 2011). This is in part attributed to increased focus on the link between human resource issues and the effectiveness of health systems. There is a growing body of research that explores the pivotal role of HRM in achieving organizational objectives (Jansink, 2015). There is supportive evidence on the existence of positive relationships between at least one specific dimension of firms' economic performance and certain HRM practices (Brewster & Mayrhofer, 2012).

It has been reported that doctors' career preferences have multiple sources. It has been found that both pecuniary and non-pecuniary factors (salary, working conditions,

children's education, living conditions and safety) affect career preferences of health workers (Cox, Khan, & Armani, 2013).

Dovlo and Martineau (2004) attributes migration to factors such opportunities for intellectual growth, improved or better standard of living, health and productive working environment, improved or better research facilities and opportunity for professional growth and development. In a similar vein, Chandler et al. (2009) and Kolstad and Lindkvist (2013) found that offering continuing education, increased salaries and hardship allowances, provision of housing, good infrastructure and equipment are powerful recruitment strategies. Job satisfaction and intention to leave seem to depend on the context in which health workers operate. In their study, Blaauw et al. (2013) noted that 52.1 percent of health workers in South Africa were satisfied with their jobs compared to 71 percent from Malawi and 82.6 percent from Tanzania

According to Connell, Zurn, Stilwell, Awases, and Braichet (2010), health worker migration outflows in Sub Saharan Africa have increased in the last three decades, from a small number of sending countries to nearly all Sub Saharan African countries. It is noted that globalization and attendant active recruitment have played a part in increasing migration flows, but active recruitment policies in high-income countries are also considered an important contributor (WHO, 2010). It has been revealed that doctors from the African continent migrated to the United States in even bigger numbers compared to previous years, growing by 38 per cent between 2002 and 2011 (Tankwanchi et al., 2013).

In several African countries, both students as well as health professionals from various disciplines (medicine, nursing, pharmacy, etc.) have been questioned about migration intentions. Different push and pull factors have been identified. Push factors most often cited include lack of opportunity for professional development, unavailability of equipment and supplies, heavy workload, low wages, low job satisfaction, and the threat of political instability and conflict. Pull factors include better remuneration, better working conditions and opportunities for professional development (Luboga, Hagopian, Ndiku, Bancroft, & McQuide, 2011). In addition to these push and pull factors, Hagopian

et al. (2005) reported a well-developed culture of medical migration among physicians in sending countries, encouraging them to look for opportunities abroad.

Table 2. 7: Summary of Empirical studies on migration decisions

Author and Date	Focus	Methodology	Findings
Ashmore and Gilson (2015)	Medical Specialists in South Africa	In depth Interviews	Dual practice can impact both positively and negatively on specialists' intention to stay in the public sector
Tankwanchi et al. (2013)	Emigration of physicians from Sub Saharan Africa	Literature review	Doctors from the African continent migrated to the United States in even bigger numbers compared to previous years, growing by 38 per cent between 2002 and 2011,
Poppe et al. (2014)	Reasons for migration of health workers in Sub Saharan Africa	Semi Structured Interviews	Three principal reasons for migration were reported: 1) educational purposes; 2) political instability or insecurity in their country of origin; and 3) family reunification.
Mæstad and Mwisongo (2011)	Informal Payment in Tanzania	Literature review, Interviews	Informal payments can impact negatively on the quality of health care through rent seeking behaviours. Health workers are involved in 'rent-seeking' activities, such as creating artificial shortages and deliberately lowering the quality of service, in order to extract extra payments from patients or to bargain for a higher share of the payments received by their colleagues.
Ramani, Rao, Ryan, Vujicic, and Berman (2013)	Rural retention of Health personnel in India	in-depth interviews with students and in-service personnel	Both pecuniary and non-pecuniary factors (salary, working conditions, children's education, living conditions and safety) affect career preferences of health workers.
Patterson et al. (2010) Brewster and Mayrhofer (2012)	HRM and Performance	Interviews	There is supportive evidence on the existence of positive relationships between at least one specific dimension of firms economic performance and certain HRM practices
Songstad, Rekdal, Massay, and Blystad (2011)	Working Conditions	Qualitative Study design	Perceived unfairness in salary, promotion and recognition in Tanzania
Clemens (2010)	Sub Saharan Africa	Questionnaire	The impact of doctor migration on health service delivery.
Kolstad (2011)	How to make jobs in rural areas more attractive to newly educated clinical officers in Tanzania	Literature review, In-depth Interviews	Offering continuing education and provision of good infrastructure and equipment is an effective recruitment strategy

Author and Date	Focus	Methodology	Findings
Leshabari et al. (2008)	Quality of health care service and health worker motivation	Questionnaire	Little is known about the quality of health care services provided by existing few health workers and the level of motivation in their respective work stations
Willis-Shattuck et al. (2008)	Motivation	Desk Review	While motivational factors are country specific, financial incentives, career development and management issues are core factors.
Leonard, Masatu, and Vialou (2007)	The role of ability and motivation in health care Quality in Tanzania	Questionnaire	The structure of an organization can improve the motivation of doctors
Kireria and Ngowi (2007)	Career advancement in Sub Saharan Africa	Questionnaire	Lack of opportunities for career advancement is one of the major factors driving migration of doctors generally and newly graduated doctors in particular in many developing countries.
Bryan et al. (2006)	Shortages of medical doctors in Tanzania	Interviews	Critical shortages of medical doctors in the health sector.
Hagopian et al. (2005)	Non return of medical trainees in West Africa	Questionnaire	A culture of migration typifies success among West Africa's medical practitioners training and practicing abroad.
Maestad and Brehony (2007)	Tanzania	Interviews	Little is known on the doctors' migration and attrition rates and reasons thereof within and outside Tanzania
Mæstad (2006)	Sub Saharan Africa	Interviews	Despite the critical health crisis in developing countries. Researchers paid relatively little attention to the role of human resources in health crisis in developing countries.
Adepoju (2005)	HRM challenges in Sub Saharan Africa	Questionnaire and Interviews	Worsening human resource for health was one of the biggest challenges.
Pang et al. (2002), Stilwell et al. (2004);	West Africa	Survey	Postgraduate training is among the reason for emigration.
Dominick and Kurowski (2004)	Shortage of doctors in Tanzania	Survey	There were only 0.2 doctors per 1000 population with large variations across districts and regions in Tanzania
Sanders (2003)	Health worker staffing levels in Sub Saharan Africa	Interviews and in depth desk reviews	Sub Saharan Africa has the lowest health worker to population in the world due to migration of the few available workers.
Kiggundu (1989)	Sub Saharan Africa	Interviews	Developing countries lack realistic and accurate human resource policies and plans.

2.5 Research gaps

The preceding review which is summarized in Table 2.5, Table 2.6 and Table 2.7 show theoretical and empirical gaps. Despite a wide range of theories covered in the theoretical

review, there is no single, coherent theory that adequately explains the multi dimensional nature of the dynamics of migration decision making. Several literatures have attempted to explain the reasons why employees leave an organization. Surprisingly, less is known on why some organizations attract and retain doctors why others fail to do so. It would be insightful to explain the factors that make some skilled professionals stay in environments littered with potential push factors. The literature on human resource for health in Sub Saharan countries signal but do not adequately elaborate the link between human resource management practices and migration of doctors in diverse contexts.

Significant literature has been dedicated to explain the potential costs of doctor migration (Buchan, 2010; Chen et al., 2011). Other studies paid much attention on the impact of migration on health service delivery (Clemens, 2010), shortages (Bryan et al., 2006), inequality in distribution (Munga & Mwangi, 2013), health financing (Maestad & Brehony, 2007) and internal migration (Ishengoma & es Salaam, 2008)

The cited knowledge gaps have spurred calls for inquiry into the dynamics of internal and external doctor migration in Tanzania (Astor et al., 2005; Black, 2004; Hagopian et al., 2005; Manongi & Marchant, 2006; Moshi, 2010) and other developing countries (Blacklock et al., 2014; Mæstad, 2006; Maestad & Brehony, 2007). These indices echo a need for a study to explore factors that influence doctors' decisions to stay or leave. An inquiry of this domain can inform policy and decision makers on the possible interventions to ameliorate doctor migration and indeed enhance retention strategies. This study is an effort to fill these gaps.

2.6 Chapter Summary

This chapter has attempted to make theoretical and empirical reviews with regard to the phenomenon of migration. From the theoretical review, a variety of theories explain the dynamics of migration decisions. The HRM literature elevates the pivotal role of human resources and the critical need to properly manage this resource in order to attract, utilize and retain people. This review indicates that HRM policies and practices are multi-

faceted, and that they have a propensity to affect employee job satisfaction and organizational commitment in a variety of ways.

The career literature is a major contribution to how scholars conceptualize the evolution and development of a stable career identity in contrast to initial vocational choices. The career anchors in which professionals operate seem to be strong determinants of the pendulum of the employment relationship in work settings. It has been posited that persons ultimately settle on their particular careers for reasons as unique as the individuals themselves.

The psychological contract has emerged as a framework to understand the exchange nature of the employment relationship. It can be inferred that job satisfaction is more likely to occur when there is a degree of fit between the organization and individuals' expectations.

The Human Capital theory underscores the need for management and employees to have the right skill base and capabilities to address the challenges of an increasingly competitive global environment. Human capital is 'generally understood to consist of the individual's capabilities, knowledge, skills and experience of the company's employees and managers, as they are relevant to the task at hand, as well as the capacity to add to this reservoir of knowledge, skills, and experience through individual learning. The emphasis on human capital in organizations reflects the view that market value depends less on tangible resources, but rather on intangible ones, particularly human resources. Recruiting and retaining the best employees, however, is only part of the equation. The organization also has to leverage the skills and capabilities of its employees by encouraging individual and organizational learning and creating a supportive environment where knowledge can be created, shared and applied.

Social capital is generally considered an attribute of communities, whereas human capital is considered an attribute of individuals and comprises a stock of skills, qualifications and knowledge. The key indicators of social capital include social relations, formal and informal social networks, group membership, trust, reciprocity and civic engagement.

Social capital is generally understood as the property of the group rather than the property of the individual.

Social relationships and the social capital therein, are an important influence on the development of both human and intellectual capital. At the individual level, individuals with better social capital –and stronger contact networks - will ‘earn higher rates of return on their human capital.

The connections between human capital, social capital and organizational capital produce intellectual capital for better management of knowledge within the organization. Knowledge has long been recognized as a valuable resource by economists and has been a focus of significant attention in the human capital literature, in particular the issues of knowledge generation, leverage, transfer and integration

While Social Capital theory is concerned with the nature, structure, and resources embedded in a person’s network of relationships, Social Exchange theory is concerned with the quality of interactions within that network. From their review of the literature, the concept of social exchange seeks to examine the quality of social interactions that employees encounter within their employing organizations. Conditions for social exchange are strongly linked to the relational dimension of social capital, for example: actors share social bonds; they maintain high levels of trust; and they are known to one another through long-term dependent relationships.

The organizational support theory posits that employees form a generalized perception concerning the extent to which the organization values their contributions and cares about their well-being (perceived organizational support. The theory explains relationships between employers and employees based on social exchange.

The literature review highlights potential influence of human resource policies and practices on employee migration decisions. In sum, this study utilized these theories as a foundational framework to explain the dynamics of migration decisions and employee retention. A recurring theme in the above theories is the potential influence of human

resource policies and practices on employee migration decisions. The theories offer a theoretical platform for studying international mobility of skilled human resources

CHAPTER THREE: STUDY METHODOLOGY

3.1 Introduction

This chapter presents the philosophical premises underpinning this research through ontological and epistemological assumptions. It elaborates on the research strategy, presents the research design and argues for the rationale of the choice of the methodological approach. It clarifies on how data were collected, and analyzed through inductively.

3.2 Research philosophy

It is widely acknowledged in academia that embarking on a specific academic research should be preceded by the researcher's identification of personal understanding of the nature of knowledge since it paves way for an informed choice of the methods to be adopted (Denzin & Lincoln, 2011; Piekkari, Plakoyiannaki, & Welch, 2010). The quest for knowledge in education and social science studies has generated diverse philosophical orientations to guide the research practice. As stated in the introduction, the purpose of this study was to explore the role of HRM practices in the migration of doctors in Tanzania. In order to map how I embarked on the research journey, it is deemed necessary to give a rationale for the methodological decisions I made. In this section, I identify the philosophical stance of this study; postulate the implications for ontology, epistemology and the attendant methodology for this study.

Underlying any research agenda are assumptions and beliefs about the nature of the world, knowledge, role of the researcher and the relationship between theory and research. These fundamental considerations constitute a research paradigm. This is defined as:

"universally recognized scientific achievements that, for a time, provide model problems and solutions for a community of practitioners" (Kuhn & Hawkins, 1963, p. 10).

A research paradigm addresses three questions: (1) Ontological, “What is the nature of reality” (2) Epistemological, “What is the nature of knowledge and what can be known” and (3) Methodological; “How can the inquirer go about finding about knowledge?” (Lincoln, 2011; Neuman & Robson, 2011). It is widely documented in the literature that there are five prominent research paradigms in the social sciences research: Positivism, Post positivism, Critical theory, Constructivism and the participatory (Creswell, 1998). However, two major traditions can be discerned. These are Objectivists and Subjectivists’ (Cohen & Manion, 1994) and are also termed Positivist and Phenomenological (Miles & Huberman, 1994, p. 8). Although these perspectives are invariably viewed as simple dichotomies, they are indeed seen as continua since there is often a strong relationship between the positions adopted on each of the strands (Burrell & Morgan, 1979). These issues are examined within the context of the current research.

The positivists (Popper, 1959) believe that there is an objective physical and social world with objective reality. Positivists seek to obtain law-like generalizations, termed nomothetic (Neuman & Robson, 2011), by conducting value-free research to measure social phenomena. It is believed that different researchers observing the same factual problem will generate a similar result by carefully using statistical tests and applying a similar research process in investigating a large sample (Creswell, 2013, 2014; Creswell & Zhang, 2009)). Their common belief is the existence of a universal generalization that can be applied across contexts, which is now called naïve realism.

The aim of the researcher in knowledge generation is explanation, prediction and control and the researcher is seen as dis-interested, objective scientist (Lincoln & Guba, 2000; Neuman & Robson, 2011). The 19th century positivist movement pioneered by the founding fathers of social research, Comte and Durkheim posited that scientific study of society could be confined on collecting information about a phenomenon that can be objectively observed and clarified (Haralambos, Holborn, & Health, 2000, p. 966). Given that individuals’ feelings, emotions and internal meanings could neither be observed nor measured, they were considered not important (Bryman, 2015).

Modernist social scientists started questioning the validity of positivists’ laws of human behaviour (Popper, 1959; Popper, 1963). Underlying their line of thinking is the idea that

rigorous theory testing should involve a deductive approach that can disapprove or falsify the closely defined hypothesis and formulated predictions. While this can be achieved through controlled environment in the natural sciences, social theories can only be tested in the field where the phenomenon exists. In this vein, the postmodernist scholars challenged the testable approach to understanding human behaviour as they argued that individual and community subjective views stemming from experience, motivation and social conventions are reservoirs of knowledge (Layder, 1993). Postmodernists thus underscore that

“Knowledge claims must be set within the conditions of the world today and in the multiple perspectives of class, race, gender and other group affiliations (Creswell, 1998).

The constructivist paradigm maintains an interpretive stance and argue for the superiority of constructivism, idealism, relativism, humanism, hermeneutics and sometimes postmodernism (Denzin & Lincoln, 2011; Walsham, 1995). It is acknowledged that reality is constructed by social actors and people’s perceptions of it. They recognize that individuals with different backgrounds contribute to the on-going construction of reality existing in their broader social context due to the fact that the subjective nature of human perspectives and experiences, social reality may change and can have multiple perspectives (Hennink, Hutter, & Bailey, 2011).

The interpretivists reject objectivism and a single truth as proposed in post-positivism. To understand the social world from the experiences and subjective meanings that people attach to it, interpretivist researchers favour to interact and to have a dialogue with the studied participants. They also prefer to work with qualitative data which provides rich descriptions of social constructs. As opposed to generalization or the nomothetic approach adopted by post positivist researchers, interpretivists use a narrative form of analysis to describe specifics and highly detailed accounts of a particular social reality being studied, which is termed the idiographic approach (Neuman & Robson, 2011; Walsham, 2006).

Research is geared to unearth the inner perspectives or real meanings of social phenomena from its study participants as a good social knowledge. In terms of axiology, interpretivist take the stance of the emic or insider perspective, which means to study the

social reality from the perspective of the people themselves. The experiences and values of both research participants and researchers substantially influence data collection and analysis (Walsham, 1993; Yin, 1994). There is a strong belief that time and context free generalizations are neither desirable nor possible (Creswell, 1998, 2014), that research is value-bound (Walsham, 1995) and that one cannot assume that data simply waits discovery in an external world nor do impartial observers enter the research scene without an interpretive frame of reference (Charmaz, 2011). This is what Weber describes as *verstehen* that, inductively understands the meanings and motives placed on particular social actions and processes by those involved in them (Haralambos & Holborn, 2000). In support of this contention, it is argued that these meanings are only produced with reference to other meanings while knowledge is contextualized by its historical and cultural nature (Agger, 1991, p. 117).

After reflecting on the preceding discussion of the schools of thoughts, I deduced that the abstract, intangible nature of the role of HRM in doctor migration makes it unsuitable for a positivist, quantitative approach. This justifies the choice of a non-positivistic, qualitative approach that accommodates the view that all medical doctors studied offer a version of reality through a combination of mixed views and meanings. Pursuance of this stance implies an inductive, qualitative approach to determine common themes (Denzin & Lincoln, 2011). In this vein, multiple, value-laden realities must be inductively examined by the researcher to establish common themes which can be used to make claims about the reality of the phenomena under investigation (Creswell, 1998; Guba & Lincoln, 2003).

The positioning of this study under interpretive perspectives, is premised on the cognizance of the view that all individually constructed realities are valid and that by inductively examining the factors influencing doctors' migration decisions, it is possible to increase knowledge of the role of Human Resource Management practices in Tanzania hospitals. This is also justified by a number of scholars including Eisenhardt (1991), Walsham (2006) and (Yin, 2003, 2009) as they suggest that an interpretive research philosophy is more appropriate to exploratory studies as it provides a rich description of the phenomenon under investigation, thereby facilitating readers' understanding. This is

particularly so when the boundaries between phenomenon and context are not clearly evident (Yin, 2003, p. 13) and the idea that building theory from case studies is a research strategy that involves using one or more cases to create theoretical sensitivity (Eisenhardt, 1989b) Following the positioning of this study as interpretive, it is worth determining the research strategy.

3.3 Research strategy

Yin (2003) identifies five different research strategies: experiment, survey, archival analysis, history, and case study. The strategies are distinguished by three aspects namely type of research questions, the extent of behavioural control and the degree of focus on contemporary events. I take cognizant of the view that a research strategy should stem from the nature of the research problem (Eisenhardt, 1989a). Drawing on the established wisdom that that studying the dynamic, complex and context-dependent problems in hospital settings required wider methodological options (Mliga, 2003), and taking into account that this could not be reflected in quantitative hypothesis testing research in a positivist paradigm (Auerbach & Silverstein, 2003; Lincoln, 2011) and considering the contemporary nature of this explanatory study (Ghauri, 2004; Saunders, 2000; Saunders, 2011; Yin, 1994) , a case study strategy was considered appropriate.

This preference is further justified by the potential of case studies in producing rich insights. Pursuit of a qualitative study required attention to rich details of contextually rich data and the understanding of subjective experience of medical doctors (Walsham, 1995). This is indeed germane to a study that seeks to use an interpretive approach that gives a feeling of how participants create meanings and interpretations (Newman et al., 2011). The strategy is thus geared towards addressing the research gaps identified and articulated in the introduction. The overriding aim is to explain why doctors migrate to other employment arrangements and why other doctors stay.

I employed case study to enhance identification of patterns in relationships between actors and their environment and provision of depth and richness for constructing knowledge and building theory (Eisenhardt, 1989a; Suddaby, 2006). I subscribed to Bryman (2006)

emphasis on the need to overcome possible limitations of a single approach. I also took into account recommendations by Eisenhardt and Graebner (2007) that the stated ontological and epistemological stance and the research question merits an interpretive approach through employment of cases with diverse contexts.

3.4 Research design

A research design is defined as a framework for the collection and analysis of data (Myers, Well, & Lorch, 2010). It is a blueprint of the study (Creswell & Zhang, 2009). The choice of a research design, and subsequent processes: data collection and analysis approaches greatly depend on the research paradigm (Creswell, 2014; Denzin & Lincoln, 2011). A qualitative design was chosen to characterize participant perspectives. This choice was premised on the idea that this approach is optimal for capturing the essential aspects of a phenomenon from the perspectives of study participants. This is cognisant of the crucial need to strategise ways and means of addressing potentially sensitive subjects with possible fear of reprisals or repercussions (Kothari, 2014).

This study adoption of an interpretive rather than a positivist approach. As stated in sections 3.2 and 3.3, a study on the role of HRM practices in the migration of medical doctors in Tanzania which is a contemporary phenomenon with real-life events (Boeije, 2010) merit the adoption of a case study design.

3.4.1 Case study design

Case studies are an ideal research approach to generate in depth and contextualized data (Piekkari, Welch, & Paavilainen, 2009; Stake, 1995). A Case study is defined as:

‘An empirical study that investigates a contemporary phenomenon within its real-life context and in which multiple sources of evidence are used’ (Yin, 1994, p. 23).

While a researcher can either use a single or multiple cases, this study employs multiple cases. This choice is premised on the following considerations. First, consistent with Creswell (2013), case studies have emerged as an increasingly important approach in

many management disciplines. Second, case study design is a research strategy that involves using one or more cases to create theoretical constructs, propositions or midrange theory from case based, empirical evidence. I took into account that the stated research questions in chapter one could be suited to explain wider hospital contexts. The choice of the research sites is elaborated in the section that follows.

3.4.2 Selection of Cases

Social science scholars underscore careful attention to selection of cases. There is strong emphasis that case selection should be based on criteria that are consistent with the research problem (Truss et al., 2013). Scholars build knowledge by testing theory in incremental steps (Kuhn & Hawkins, 1963; Popper, 1959). However, qualitative school researchers have increasingly recognized the fact that theory must come from data rather than being forced to fit an existing framework (Stern, 2007). I conducted a pilot study with an increased awareness that quality data stems from careful sampling. The preliminary study was done in February 2008 to explore potential hospital cases which could be included in the study. I used convenience sampling (Richards & Morse, 2012) through familiarization with key informants in different hospitals who were well informed of personnel matters. I employed telephone contacts and visits in Morogoro, Moshi and Dar es Salaam regions. The information gathered was complemented by perusal of documents. Appendix 4 portrays that many doctors and private hospitals are concentrated in cities and some towns.

Leonard et al. (2007, p. 683) posits that the motivation of doctors can be affected by the organization for which they work, I selected the hospitals on the basis of their richness in explaining the factors affecting doctors' migration decisions. I noted that there were variations of the number and density of doctors in different regions. I therefore classified hospital variations in terms of the number and density of doctors, location (rural-urban), level and status (Tertiary, Regional, District), governance (Public- Private/NGO) and employee retention rate. Drawing on the preliminary information obtained from the pilot study in four hospitals (Two public hospitals (One rural and one urban); a private hospital (based in urban area), and a faith based hospital (in a rural setting). It emerged that some

cases captured more of internal migration than external. Taking cognizance of the international management foci of the PhD Programme at the University of Agder, I opted to drop two hospital cases and remain with two (i.e. a public referral hospital in an urban setting) and a faith based hospital (Non for profit in a rural area).

While hospital A exhibited high rates of doctor migration, hospital B managed to retain medical doctors. This contrast attracted my attention. Much as hospital B has ties to Norway, this was not my selection criteria. The choice of hospital B was inspired by its achievement in retaining doctors for a longer gestation period. Hospital B had no migrant doctors. I chose two case studies with inter and intra variation which is suited to the interpretive research approach (Silverman, 2016), in order to get a wide range of perspectives. Table 3 shows contrasts of the two hospitals.

Table 3.1: Main characteristics of Hospital A and Hospital B

Characteristics	Hospital A	Hospital B
Year of establishment	1953	1953
Governance	Public (Semi-Autonomous)	Private (not for profit/NGO)
Ownership	Government	Church
Location	Urban	Rural
Number of Employees	2700	526
Number of doctors	300	11
Population Catchment	5 Million people	2.1 Million People
Bed Capacity	1500	400

Source: Compiled from Records in hospital A and hospital B.

3.5 Methodological Approach

The choice of a proper research method in the conduct of research has been widely underscored in the literature (Ghauri, 2004; Patton, 2002). There are two main research methods namely Quantitative and Qualitative. Quantitative research seeks predictions, facts, statistics and generalizations (Babbie, 2011; Denzin & Lincoln, 2005). The 19th century positivist movement pioneered by the founding fathers of social research, Comte and Durkheim posited that scientific study of society could be confined on collecting information about a phenomenon that can be objectively observed and clarified (Miles, Huberman, & Saldana, 2013).

The study adopted an inductive research approach (Gioia, Corley, & Hamilton, 2013). I employ a phenomenon-driven, as opposed to theory-driven (Dries & De Gieter, 2014) approach. Whereas traditional, theory-driven research follows a process of developing hypotheses, a phenomenon-driven research starts with the generation of fact from participants to address identified research questions.

A qualitative approach offers the opportunity to identify the reasons for migration. It facilitates exploration of insights that cannot be captured through quantitative research method. Despite initial criticisms of the case study approach with reference to limited scientific generalization (Dubois & Gadde, 2002; Yin, 1994), advocate the use of systematic combining (i.e. abduction) as a suitable case study approach Since it relies on linguistic rather than numerical data, and employ meaning based rather than statistical forms of data analysis (Elliott, Timulak, Miles, & Gilbert, 2005; Yin, 2014). I thus attempted to give interpretations which are context specific in order to develop theory by utilizing insights from migration decisions.

3.5.1 Selection of Participants

It is acknowledged that sample selection hinges on the nature of the problem under investigation (Bryman, 2008; Patton, 2005). In qualitative studies, prior determination of sample size is unnecessary since one cannot determine the time data saturation will be attained Drawing on Guest, Bunce, and Johnson (2006, p. 61), I took cognizance of the fact that research that is not concerned with statistical generalization often uses non probabilistic samples. This research employed purposeful sampling to earmark participants whose roles were deemed closely linked to the research question (Marshall & Rossman, 2014; Truss et al., 2013).

I interviewed 22 doctors in hospital A. These were composed of 14 non migrant doctors obtained through purposive sampling using the sampling frame provided by the HRM department. I also held interviews with 8 migrants through snowball sampling (Bryman, 2008). This entailed requesting participants to earmark their fellow doctors who could

talk to the researcher. This was considered to be a good method of obtaining informants especially for populations that are neither well-confined nor well-enumerated (Sikika, 2010). This was facilitated by non migrant doctors in hospital A who linked me with fellow colleagues who had migrated outside Tanzania. Interviews in hospital A were concluded by a conversation with the Human Resource Director (A HRM professional). Interviews in hospital B focused on 5 doctors and the Managing Medical Director (who was also a medical doctor by profession). In order to get insights on national HRM policy formulation and implementation, I held conversations with 2 HRM officials at the Ministry of Health and Social Welfare. This sample size was considered adequate for an explanatory study underpinned by data saturation (Fusch & Ness, 2015; Guest et al., 2006). Table 3.2 shows a summary of all interviewees. Table 3.3, Table 3.4, Table 3.5 and Table 3.6 presents detailed information of respective participants.

Table 3.2: Summary of Interviewees

Category	Hospital A	Hospital B	Ministry of Health	Total
Hospital Directors	0	1	0	1
Human Resources Directors	1	0	0	2
Human Resource Officers	0	0	2	2
Doctors in Tanzania	14	5	0	18
Doctors in the Diaspora	8	0	0	8
Total	23	6	2	31

Source: Compiled by the Researcher, (2009).

Table 3.3 List of non migrant interviewees in Hospital A

Code	Date	Interviewee Designation	Gender	Time	Age (Years)	Duration
HM 1	04.09.2008	Medical Officer I (Paediatrician)	Male	12:30 PM-1:15PM	47	45 Minutes
HM 2	05.09.2008	Senior Medical Officer I (Psychiatrist)	Female	11:00 AM– 12:05 PM	51	65 Minutes
HM 3	05.09.2008	Medical Officer II (Internal Medicine)	Male	3:00 PM 3:40 PM	36	40 Minutes
HM 4	06.09.2008	Medical Officer II (ENT)	Male	11:30 AM – 12:35 PM	30	65 Minutes
HM 5	11.09.2008	Medical Officer I (Internal Medicine)	Male	3:20 PM – 4:20 PM	37	60 Minutes
HM 6	02.10.2008	Senior Medical	Male	2:30 PM – 3:15	30	45 Minutes

Code	Date	Interviewee Designation	Gender	Time	Age (Years)	Duration
		Officer I (Gynecologist)		PM		
HM 7	06.10.2008	Medical Officer II (Internal medicine)	Female	2:00 PM – 2:30 PM	28	30 Minutes
HM 8	15.10.2008	Medical Officer I (Orthopedics)	Male	1:00 PM – 1.45 PM	32	45 Minutes
HM 9	16.10.2008	Medical Specialists II (Pediatician)	Female	12:15 PM – 12:50 PM	50	35 Minutes
HM 10	17.10.2008	Senior Medical Officer I (Psychiatric an)	Female	4:55 PM – 5:30 PM	46	35 Minutes
HM 11	03.11.2008	HR Director (HR Specialist)	Male	2:30 PM – 10:00 PM	44	90 Minutes
HM 12	20.11.2008	Medical Officer I (Orthopedics)	Male	3:30 PM –10:05 PM	39	35 Minutes
HM 13	05.12.2008	Medical Specialist II (Pediatician)	Male	3:37 PM – 4:25 PM	51	33 Minutes
HM 14	08.12.2008	Medical Specialist II (Internal Medicine)	Male	4:15 PM – 4:55 PM	44	40 Minutes
HM 15	12.12.2008	Medical officer III (Internal medicine)	Female	5.00 PM – 5.5.0 PM	32	50 Minutes

Table 3.4: List of migrant interviewees from Hospital A

Code	Date	Interviewee Designation	Gender	Time	Age (Years)	Duration
BD1	21.3.2009	Senior Medical Officer II (Dermatologist)	Male	5:00 PM – 6:00 PM	39	60 Minutes
UK	29.4..2009	Senior Medical Officer I (Ophthalmologist)	Male	11:00 AM– 12:05 PM	42	65 Minutes
BD2	04.5.2009	Medical Officer I (Pathologist)	Male	1:30 PM – 2:35 PM	33	65 Minutes
CD	13.5.2009	Medical Officer I (Urologist)	Male	12:30 PM-1:15PM	35	45 Minutes
BD3	19.5.2009	Medical Officer II (Gynecologist)	Male	3:20 PM – 4:20 PM	38	60 Minutes
LS	22.5..2009	Medical Officer III (Internal medicine)	Female	2:00 PM – 2:30 PM	29	30 Minutes
BD4	10.6.2009	Medical Officer II (Urologist)	Male	2:30 PM – 3:15 PM	35	45 Minutes
NM	14.6.2009	Medical Officer I (Surgeon)	Male	1:00 PM – 1.45 PM	37	45 Minutes

Source: Compiled by the Researcher, (2009).

Table 3.5 List of Interviewees at the Ministry of Health and Social Welfare

Code	Date	Interviewee Designation	Gender	Time	Age (Years)	Duration
MN1	7.6.2009	Senior Human Resource Officer	Female	1:00 PM – 2:05 PM	38	65 Minutes
MN2	8.6.2009	Human Resource Officer 1	Male	12:30 PM- 1:20PM	32	50 Minutes

Source: Compiled by the Researcher, (2009)

Table 3.6: List of Interviewees in Hospital B

Code	Date	Interviewee Designation	Gender	Time	Age (Years)	Duration
HY1	13.2.2009	Hospital Director (Pediatrician)	Male	1:30 PM – 2:25 PM.	48	55 Minutes
HY2	13.2.2009	Medical Officer II (Internal Medicine)	Male	4:10 PM – 5:20 PM	31	70 Minutes
HY3	14.2.2009	Assistant Medical Director (Internal Medicine)	Male	1:00 PM – 2:00 PM	39	60 Minutes
HY4	15.2.2009	Medical Officer I (Surgeon)	Male	5:00 PM – 5:58 PM	34	58 Minutes
HY5	16.2.2009	Medical Officer I (Ophthalmology)	Male	3:15 PM– 4:00 PM	42	45 Minutes
HY6	17.2.2009	Medical Officer I (Gynecologist)	Male	6:05 PM – 6:50 PM	44	45 Minutes

Source: Compiled by the Researcher, (2009).

3.6 Data Collection

The nature of research instrument in a qualitative study hinges on the purpose of the study (Patton, 1987). As explained in section 3.2, this study is positioned within interpretive perspective. The study sought to understand the role of Human Resource Management practices in the migration of doctors in Tanzania. This explanatory study merited employing different means of collecting information to enhance validation (Kothari, 2014). Primary data (interview and observation) and secondary data (document review) were used to unearth answers to the research question (Kothari, 2014; Yin, 2014). These procedures are elaborated in the next section.

Data were collected in hospital A from 1st August to 31 December 2008 and in Hospital B from 13th February to 17th February 2009. Following the approval of my research

proposal by the Agder University, I submitted the Research Proposal to the Tanzania National Institute for Medical Research (NIMR), I was granted an ethical clearance certificate to conduct the study in specified health facilities (i.e. Hospital A and Hospital B). Access to hospital A began with my presentation of a research permit. I was well received by the Director of hospital services who introduced me to the Director of Human Resources. This created a smooth orientation in the hospital environment. I was also introduced to HRM officers who helped me to access hospital records which were useful in the identification of potential interviewees.

I targeted to talk to doctors from different specialties and experiences. I employed simple random sampling using departmental records. The HR officers helped me to get in touch with the doctors who were sampled. This aroused participants' greater confidence in the integrity of the researcher and enhanced their willingness to share their personal lived experiences during the interviews. After concluding interviews at hospital A, I held brief meetings with the middle management personnel to register my appreciation of the warm welcome and great support in my data collection. I also took contacts of the doctors with whom I held conversations so that I could extend a dialogue on issues I could later need classification. This forum helped me to adjust to my analysis and interpretation of the findings.

In hospital B, I presented the research permit to the Managing medical Director who gave me a warm reception. I was invited to participate in the morning prayers during the period of data collection. This helped me to get the feeling of how things are organized and I got a quick grasp of the organization culture. My introduction to church members (most of whom were hospital employees) made it easier for me to familiarize with the hospital community. Interviews in hospital B were concluded by meeting the Assistant Managing Medical Director on behalf of the management team. I also held individual conversations with the HR officer and medical doctors I had talked to in order to express my appreciation of the great support accorded to me for the whole period of data collection. These procedures are elaborated in the next section.

3.6.1 Primary Data

Primary data in hospital A and hospital B were gathered through interviews and observation. The process is elaborated below.

(a) Interviews

Interviews are widely used to access people's experiences and inner perceptions, attitudes and feelings of reality (Denzin & Lincoln, 2011). Interview guides are shown under Appendices 3A to 3C. Interviews were considered necessary in capturing detailed data, clarifying issues and cross-checking the reliability of data. I interviewed doctors who were working in hospital A and those who had migrated from the hospital to work abroad. These were regarded as the key actors with more knowledge and experience of their professional matters in the hospital contexts. Information was also collected from HRM officials from the hospital and the ministry of Health and Social welfare who are key decision makers on policy and HRM practices. Much as I talked to human resource Directors in the hospitals, I took cognizance of the fact that asking senior executives to indicate practices has less validity than asking employees themselves (Bryman, 2015).

The interviews were designed to probe for participants' feelings, perceptions, experiences, and opinions (Marschan-Piekkari & Welch, 2004; Stahl & Björkman, 2011). The questions were intentionally open ended and prompts were used to further arouse the participant' views and opinions (Creswell, 2014). The interviews lasted between 40 minutes to one hour. As advised by Richards and Morse (2012) I used the research clearance protocol, I explained to the participants the purpose of the study and the modus operandi which entailed voluntary participation. Issues of anonymity and confidentiality were re-affirmed as underscored in the research protocol. I assigned anonymous codes for each interviewee. The codes comprise interviewees in hospital A (HM 1-15), migrant doctors working in Botswana (BD1-BD4), Lesotho (LS); the United Kingdom (UK), Canada (CD) and, Namibia (NM).

I interviewed 22 doctors in hospital A. These were composed of 14 non migrant doctors obtained through simple random sampling using the sampling frame provided by the HRM department. I also held interviews with 8 migrants through snowball sampling (Bryman, 2008). This entailed requesting participants to earmark their fellow doctors who could talk to the researcher. This was considered to be a good method of obtaining informants especially for populations that are neither well-confined nor well-enumerated (Sikika, 2010). This was facilitated by non migrant doctors in hospital A who linked me with fellow colleagues who had migrated outside Tanzania. Interviews in hospital A were concluded by a conversation with the Human Resource Director (A HRM professional). Interviews in hospital B focused on 5 doctors and the Managing Medical Director (who was also a medical doctor by profession and an expatriate). There were no interviews for doctors who left because I didn't experience any case of doctor migration.

In order to get insights on national HRM policy formulation and implementation, I held conversations with 2 HRM officials at the Ministry of Health and Social Welfare. This sample size was considered adequate for an explanatory study underpinned by data saturation (Fusch & Ness, 2015; Guest et al., 2006). The researcher observed work practices in the hospital cases involved. However, this was done in the capacity of an external observer. Memoiring was insightful in the constant comparative benchmarks of incidences (Miles et al., 2013). Table 3.2 shows a summary of all interviewees. Table 3.3, Table 3.4, Table 3.5 and Table 3.6 presents detailed information of respective participants.

3.6.2 Secondary Data

Secondary data was gathered through document reviews. Documents reviewed in hospital A include, the Strategic Plan for the period 2007/08 – 2011/12, the Hospital Rolling Strategic Plan, 2005-2008; Hospital Annual Report for 2006/2007 and human resource records (MNH, 2007). National documents were also reviewed to get policy and implementation trends of human resource issues. The documents include the Health Sector Reform Programme of Work: July 1999 - June 2002, the Second Health Sector Strategic Plan (HSSP) (July 2003 - June 2008), the Health Sector Reform Plan of Action

(1996-1999) and the Human Resource for health Strategic Plan 2008 – 2013 (MOH, 2008; 2013). In the case of hospital B, document reviewed include annual reports (1996 to 2009), five year strategic plans, from 2002 to 2006, policy documents. and HRM records related to staffing levels, training, development, career development, and reward management. Much as organization researchers contend that official publications such as annual reports typically reflect only what a team of executives and public relation officers want to convey publicly (e.g. (Ott, 1989, p. 109), I took cognizance of the possibility that regime change might have happened in the course of time.

3.7 Data analysis

Social scientists underscore the importance of making explicit the techniques we use for data analysis (Eisenhardt, 1991). This study employs an inductive approach. It is an approach that primarily entails detailed reading of raw data to derive concept, themes through the researcher's interpretations of the raw data (Corbin & Strauss, 2008; Silverman, 2011). Data were analyzed through coding and memos. Data analysis is described through orderly steps adopted to move from raw data to a few themes which capture respondents socially constructed meaning. I wrote memos to keep track of the emerging thoughts from the data. These are part of the interview summaries which helped me to make reflections and inferences of what insights stemmed from constant iterations (Boeije, 2010).

Back and forth reflections proved useful in identifying convergences and contradictions of migration dynamics (Geertz, 1973; Strauss, 1998). It facilitated comparison of espoused and actual values (Pettigrew, 1985). The interview data were coded in words closely resembling those used by the participants in order to maintain the data semantics and easy reference. The coding procedure is elaborated in the next section.

3.7.1 Low level Categories

Data analysis began with coding relevant interview quotations depicting doctors' reasons for staying or leaving. A code is viewed as "the essential relationship between data and

theory (Hennink et al., 2011; Richards, 2014). There was no prior code book constructed. Data were coded using an open coding process. A label or code was assigned to selected text. Lower level categories are derived from the key words in the quotations. These statements were generated through examination of data in order to form an impression of the main idea of the datum. The process entails examination of data line by line or set of lines. Consistent with (Bryman, 2008, 2015), similar data were grouped and conceptually labelled. However, not every line qualified to form a code. Meaning units within the interviews were given open codes that capture the meaning of the selected text. The interview data were coded in words closely resembling those used by the participants in order to maintain the data semantics and easy reference (Babbie, 2011; Miles & Huberman, 1994, pp. 61 - 74; Strauss, 1990).

3.7.2 Higher level Categories

Higher-level categories were associated with major themes which entailed looking for commonality among the statements. I attempted to establish relationships between discrete codes according to conceptual categories (Bryant & Charmaz, 2010). (Charmaz, 2011). The fundamental question at this stage was: What insights do the statements infer to? The process entailed constant comparative method (analytic induction). Interview invariably signaled the need to make follow up clarifications from previous and future participants. I later realized that constant comparison was a very useful technique in the way some issues raised in previous interviews in same or different hospitals were confirmed or disapproved in subsequent interviews and document reviews. This back and forth follow ups enhanced reliability. The interviews I had conducted became pointers of necessary questions to probe as I talked to other participants. I was able to draw parallels between the doctors' experiences in different settings.

Consistent with Boyatzis (1998) and Braun and Clarke (2006), analysis was not a linear process of moving from Column 1 (quotations), through column 2 (Lower level categories) to Column 3 (Theme). It was rather more of a recursive process involving moving back and forth. In doing so, some statements and categories were invariably re-categorized after concluding that they fit to be under the respective columns or rows. In sum, it resembled a jig saw fit process. This facilitated creation of the main themes which

are subsequently used to write the story. The relevance of this approach stems from the view that the methodology embodies a set of flexible analytic guidelines that facilitate theory building rather than theory testing (Bryant & Charmaz, 2010).

I strived to search for important themes in describing the phenomenon of migration decisions of staying or leaving. I employed a data – driven inductive approach (Boyatzis, 1998; Creswell, 2013) to ensure that the themes emerged from the participants' expressions. I drew on Eisenhardt (1989b) emphasis on referring to literature review to enhance theoretical sensitivity. As advocated by Miles et al. (2013), the coding process is displayed in tables in order to clarify my analytic reflections. The coding process is summarized in chapter five under respective hospital cases (See Section 5.10, Table 5.2 for Hospital A and Section 5.26, Table 5.5 for Hospital B).

3.8 Reflexivity

In the attempt to understand the phenomenon of migration decision choices, I took into account that my role as a researcher entails construction of meanings and of lived experiences of the study subjects. I am aware that I am part of the social world that I studied (ackerly & True, 2010) and that my positionality does not exist independent of the research process (van der Riet, 2012). In this vein, I strived to study the dynamics of migration decision choices without the influence of personal values.

Literature review enhanced my theoretical sensitivity and helped me to minimize bias in interpretation. I drew on (Bourke, 2014; Creswell, 2013) to reflect on my values beliefs and interpretations by keeping a research diary and writing memoirs and reflective accounts to delineate the research process and my interpretation of the findings. This quest was enhanced by making inferences between the findings and the literature. I played a central role as a research instrument in data collection. This was in terms of recruiting the participants of the study, managing the interview process and analysing the data collected. In the course of these undertakings, I cannot rule out possibilities of biased perceptions and interpretations. I have elaborated this subject matter in the revised dissertation.

Memoing was insightful in the constant comparative benchmarks of incidences. Drawing on Patton (2005); Charmaz (2011) and Miles et al. (2013); I wrote a series of memos whenever I felt that there were issues I had to make a follow up, or which seemed ambiguous, and striking some similarity or differences with previous encounters with and between interviewees within a case or in previous cases. Memoirs are part of the interview summaries which helped me to make reflections and inferences of what insights stemmed from constant iterations.

My academic background with 26 years of experience in Human Resource Management studies at Mzumbe University gave me the impetus to undertake this research. Having been trained in English study programmes, I didn't experience any communication barrier in the research process. I was able to communicate with doctors and HRM officials involved in the study since they had adequate English language proficiency.

3.9 Ethical concerns

Many authors (including (Walsham, 1995) underscore the importance of adherence to ethical issues in research. This is particularly so regarding matters of confidentiality and anonymity. The National Institute of Medical research (NIMR) in Tanzania approved and granted Ethical clearance for the research (Ref. NIMR/HQ/R.8a/Vol. IX/863 dated 11th August 2009). A copy of the Clearance Certificate is attached as Appendix 1. Moreover, the Research Protocol was approved by the Research Committee of the Faculty of Economics and Social Sciences of the University of Agder, Norway and permission for the research was granted by the respective hospital management.

Participation in this study was entirely voluntary, and confidentiality and anonymity were assured. Prior to conducting conversations, I re-affirmed the participants who volunteered to talk to me that I would adhere to ethical principles. I reiterated the purpose, scope and format of the interviews before consent was obtained. All participants gave informed oral consent following being introduced to them by persons they were familiar. Consistent with what I had affirmed in the consent forms, interview notes were numerically coded and all the information which could denote participants' identity is not included in the final report.

Rather than using real names, the researcher allocated pseudonyms to ensure anonymity in the presentation and analysis of data.

3.10 Evaluation of the quality of this research

The quality of qualitative research tradition has been questioned in the literature (see, for example (Boeije, 2010; Denzin & Lincoln, 2005) The main criticisms levelled are mainly centered on issues of reliability and validity to ensure its replicability and generalizability. The findings of case study research are invariably challenged on the basis their reliance on retrospective accounts (internal validity), individual bias (construct validity and reliability), and the idiosyncrasy (external validity) of findings (Denzin & Lincoln, 2011; Yin, 2003).

Consistent with the study positioned as an interpretive study based on a different set of ontological and epistemological assumptions from functionally based research, it was considered plausible to use the trustworthiness criteria. This is a collective term focusing On four concepts namely credibility, transferability, dependability and conformability (Creswell, 2014). Trustworthiness and rigor are normally underscored in qualitative studies as opposed to the conventional positivistic criteria of internal and external validity, reliability, and objectivity. Social science researches have traditionally proved their worth through demonstration of validity and reliability concerns (Cook, Campbell, & Day, 1979; Patton, 2002). The applications of these criteria are summarized in Table 3.6 and elaborated.

Table 3.7: Techniques for evaluation of qualitative research.

Traditional criteria	Trustworthiness Criteria	Method for meeting trustworthiness criteria
Internal validity	Credibility	(1) Extended engagement in the field, (2) Triangulation of data types (3) Peer debriefing, (4) Member checks
External Validity	Transferability	Detailed (thick) descriptions of Concepts and categories, Structures and processes related to processes revealed in the data
Reliability	Dependability	(1) Purposive and theoretical sampling, (2) Informants' confidentiality protected (3) Inquiry audit of data collection, management and analysis process
Objectivity	Conformability	(1) Explicit separation of 1 st and 2 nd order findings (2) Meticulous data management and recording: Verbatim transcription of interviews. (3) Careful observation notes, Clear notes on theoretical and methodological decisions, (4) Accurate records of contacts and interviews.

Source: Based on (Lincoln & Guba, 1985)

3.10.1 Credibility

Credibility (internal validity) refers to the confidence one can have in the truth of the findings (Creswell & Poth, 2017). It deals with the accuracy of data to reflect the observed social phenomena and whether the study actually measures or tests what is intended. In this study, I strived to do the following. First, I used reflective accounts (Arber, 2006; Miles & Huberman, 1994; Rager, 2005; Strauss, 1998) through interview notes (showing detailed dialogue record and reflective summaries of each interview and diary (delineating the chronology of the research cum experiences) to enhance credibility. The interview process, analysis, and results of the study have been described in detail to show how the conclusions of this research are clearly based on its data. Second, member checks were assured by contacting the participants and requesting their feedback on my interpretations of the conversations. However, owing to e-mail hacking of my yahoo address, I lost the first round feedback and had to request the participants to re-affirm their feedback save for three interviewees who could not be traced after retirement and one interviewee who died.

3.10.2 Dependability

Dependability refers to the stability of the findings over time and conformability to the internal coherence of the data in relation to the findings, interpretations and recommendations (Denzin & Lincoln, 2011; Yin, 2009). In order to ensure a high degree of dependability, all the steps were carefully documented and shared with fellow faculty members at Mzumbe University in Tanzania as well as faculty members at the University of Agder in Norway who were well versed with the approach I had adopted. Their inputs were very valuable to my research roadmap. There was a low pace of interviews due to doctors' busy work schedules which invariably affected appointments. I recall that I had to wait for five hours to have an appointment with a medical doctor only to learn that it would not be possible. The researcher however sympathized with the situation taking into account of the big workload for medical doctors and unforeseen emergences a typical of hospital work setting.

3.10.3 Transferability

Transferability (external validity) refers to the level of applicability into other settings or situations is concerned with the extent to which the findings of one study can be applied to other situations (Denzin & Lincoln, 2011). In positivist work, the concern often lies in demonstrating that the results of the work at hand can be applied to a wider population. In this study, I drew on (Creswell & Zhang, 2009; Denzin & Lincoln, 2000a, 2000b); to present detailed contextual information about the study sites. Consistent with (Patton, 2002), I also strived to provide sufficient thick description of the migration dynamics so that readers can have a proper understanding of it, thereby enabling them to compare the instances of the phenomenon described in the study with their prior experiences. Moreover, study site profiles, participant profiles data collection methods employed and the time frame of data collection process are delineated to elaborate the boundaries of the study.

3.10.4 Conformability

Conformability (objectivity) refers to the extent to which others can confirm the findings in order to ensure that the results reflect the understandings and experiences from observed participants, rather than the researcher's own preferences. It entails a researcher striving to avoid subjectivity. In consideration that I was the main research tool, I took cognizance of possible subjectivity. I, therefore, used a diary to make self-reflections and keep an open mind. I wrote memoirs to delineate my conversation impressions whenever I engaged a participant. The records provide an audit trail which enables an examination of both the research process and research outputs.

The study utilized a number of recommended strategies to ensure rigour: First, study sites were carefully selected as elaborated in section 3.4.2. Second, I wrote detailed interview notes and summaries of each interview. Third, I composed a diary (delineating the chronology of the research cum experiences) to enhance credibility. The interview process, analysis, and results of the study have been described in detail to show how the conclusions of this research are clearly based on its data. Third, drawing on the emphasis by Miles et al. (2013), Patton (2005), member checks were done by seeking the feedback of the interviewees on my interpretations of the conversations. The feedback given was very valuable in refining my earlier interpretations. Fourth, consistent to Yin (2003); (Yin, 2013) advocacy, I conducted interviews, observations, and document analysis in two hospitals under diverse governance structures (i.e. public and private non for profit faith based).

3.11 Chapter Summary

This chapter describes the research methodology followed in this study in order to explain the role of HRM in the migration of medical doctors in Tanzania. It presents the research perspectives and the attendant research paradigm through ontological and epistemological assumptions. It elaborated the rationale for the choice of the adopted methodology. The research strategy and research design are delineated Exploratory case study design was considered appropriate. The choice of the methodological approach is justified and clarity

on how data were collection and analyzed. A qualitative study gave me the opportunity to explore the role of HRM practices in the migration of medical doctors. Although this phenomenon could be studied using other methodologies, an inductive approach appeared to be more appropriate for the desire to explore factors that influenced decisions to stay or leave. The chapter concludes by drawing on established criteria to assess the quality of the research.

CHAPTER FOUR: THE TANZANIA CONTEXT

4.1 Country Profile

This chapter commences with a presentation of basic information on Tanzania ranging from the geographic location, political governance and the economy. It describes the structure, evolution and growth of the Tanzanian Health system in terms of staffing and training levels, trends of doctor migration. It concludes with a summary.

4.1.1 Geography

The United Republic of Tanzania is one of the developing countries of sub-Saharan Africa. It is a Union of two former states Tanzania Mainland (formerly called Tanganyika) and Zanzibar that united in 1964. It is the largest country in East Africa; occupying an area of about 945,087 Sq. Km. Figure 4.1 on page 80 shows that Tanzania has common borders with 8 neighbouring countries. It borders with Kenya in the North, Uganda, Rwanda and Burundi in the North-West, Democratic Republic of Congo in the West, Zambia, Malawi, Mozambique in the South, and the Indian Ocean on the East. It borders to three of Africa's most important lakes: Lake Victoria in the North-West (Africa's largest lake), Lake Tanganyika in the West (Africa's deepest lake), and Lake Nyasa in the South. The northern part of Tanzania is mountainous, and Mount Kilimanjaro (Africa's highest and snow-capped mountain) is situated close to the border with Kenya. The central parts consist of plateaus, with big plains and arable land.

4.1.2 Political governance

The United Republic of Tanzania is a union of two former states, namely Tanganyika and Zanzibar that united in 1964. Both states were former colonies of first, Germany and later Britain Tanganyika became a sovereign state on 9th December, 1961 and a republic in 1962. Zanzibar became independent on 10th December, 1963. The Peoples' Republic of Zanzibar was established after the revolution of 12th January 1964. The two sovereign republics formed the United Republic of Tanzania on 26th April 1964. However, the

Government of the United Republic of Tanzania is a unitary republic consisting of the union Government and the Zanzibar Revolutionary Government. The state of Zanzibar includes the islands of Unguja and Pemba. The United Republic of Tanzania has 30 administrative regions which are divided into 169 districts. Each district is governed by a Council composed of both elected and non elected councillors. Out of the 169 districts, 34 are urban and 135 are rural. Dar es Salaam was the capital from independence in 1961 up to 1996 when the government moved the political capital to Dodoma. The legislative offices are in Dodoma, where the National Assembly meetings are held. Dar es Salaam is the commercial city.

Figure 4. 1: The Map of Tanzania



Tanzania is governed by a constitution with three governing bodies namely, the Executive (consisting of the President who is the Chief of State, a Vice-President and a Prime Minister), Legislative (consisting of the National Assembly for the Union and the House

of Representatives in Zanzibar), Judicial (in the Mainland consisting of Courts of Appeals, High Courts, Resident Magistrate Courts, District Courts and Primary Courts while in Zanzibar it consists of the High Court, Peoples District Courts and Islamic Courts).

Tanzania was under a one party system driven by a socialist economic model from 1961 until 1995 when it adopted a multi-party democracy. The first multi-party elections were held in 1995 and the ruling party, namely CCM (Chama Cha Mapinduzi- a Revolutionary Party) won. The elections are held after every five years. The CCM Party won in the 2000, 2005, 2010 and 2015 elections. Other Political Parties include CHADEMA, Civic United Front (CUF), the National Convention for Construction and Reform (NCCR-Mageuzi), the Tanzania Labour Party (TLP), the Democratic Party (DP), United Democratic Party (UDP), the Alliance for Change and Transparency (ACT), Democratic Party (DP); Party for Peoples Redemption (CHAUMA), Alliance for Democratic Change (ADC), Progressive Party of Tanzania (PPT), Tanzania Democratic Alliance (TADEA), National Reconstruction Alliance (NRA), National League for Democracy (NLD) and Union for Multiparty Democracy (UMD).

Tanzania has continued to enjoy political stability since it became independent in 1961. This has provided reassurance to foreign investors, compared to the more politically volatile neighbors (Deloitte, 2017).

4.1.3 Economic Overview

Tanzania has sustained relatively high economic growth over the last decade, averaging 6 to 7percent a year. This growth put it close to the top of the fastest growing economies in Sub-Saharan Africa (Bank, 2017). Tanzania's poverty rate fell from 60 percent in 2007 to an estimated 47 percent in 2016, based on the US\$1.90 per day global poverty line (Cluster, 2017). Universal education, and the waiving of fees for primary and secondary schools, has drastically increased primary school enrolment in Tanzania and Kenya(Orodho, 2014). These achievements are indeed not accidental. The country is

endowed with abundant natural resources ranging from minerals, oil and gas, arable land and an array of tourist attractions.

Tanzania is one of the least developed countries in the world ranking 151 out of 187 countries by the Human Development Index – a composite measure of indicators of life expectancy, educational attainment, and income. It is among the world's lowest-income nations with annual per capita GDP of US\$1500 and annual expenditure on health of US\$31 per person in 2010 (World Bank, 2012).

The per capita income of around US\$500, and an average life expectancy of 51 a third of the population lives below the poverty line. The infant mortality rate is around 51 per 1000 population (NBS, 2011, 2013). The current account deficit also declined to about US\$1.5 billion (equivalent to 3.1% of GDP) in June 2017, from about US\$1.9 billion (equivalent to 4.2% of GDP) in June 2016 (Haile, 2017).

The economy depends heavily on agriculture which accounts for almost 50 % of GDP and provides 85 % of the exports, employing about 80% of the population (NBS, 2011). The cash crops include Coffee, Tea, Cotton, Cashew nuts, Sisal, Pyrethrum, Tobacco and Cloves (in Zanzibar). The size of the formal sector is small (around 6%) of total employed persons. There are mineral reserves including Diamond, Gold and gemstones. Dar es Salaam is the commercial capital and major gate way to East and Central Africa. It serves neighbouring land-locked countries of Malawi, Zambia, Burundi, Rwanda, Uganda and the Democratic Republic of Congo. Other sea ports include Zanzibar, Tanga and Mtwara. Tanzania has the largest concentration of wild animals and is a home to the world's famous National Parks and Game Reserves.

Tanzania has a comparative advantage in its agricultural and mining potential. It is emerging as a potential middle income economy in the wake of discovery of rich gas and oil deposits and abundant mineral resources such as Gold, Diamond, and Tanzanite.

Tourism is one of our leading foreign exchange earners, a big source of trade and employment opportunities for Tanzanians and a key driver to economic growth and

development. It has a wide range of tourist attractions. These include Mount Kilimanjaro (the highest in Africa), Lake Victoria (the world’s second largest fresh water lake) in the north, Lake Tanganyika (the world’s second deepest) in the west. Its geographic location makes it a natural trading and logistic hub for East Africa. Tanzania consistently recorded a trade surplus in services, driven mostly by tourism receipts. Official statistics show that tourist arrivals reached 1,284,279 in 2016 up from 1,137,182 tourists in 2015, which is equivalent to an increase of 12.9 per cent. Earnings from the sector reached 2.0 billion US dollars in 2016 against 1.9 billion US dollars in 2015. For 2016/17 financial year, the sector contributed to 17.5 per cent to Tanzania’s GDP and 25 per cent foreign currency earning. During the same period, 500,000 people were directly employed in the tourism industry (IMF, 2017). Table 4.1 gives a summary of the demographic and socio economic profile of Tanzania.

Table 4.1: Tanzania Demographic and Socio-Economic Profile

Area (Sq. km)	945,087
Population (mill.)	49.4 (2012), 50 (2016)
Population growth rate	2.8 percent
Population below poverty line (%)	36.0
Inflation	5.2 percent (2016 est. World ranking 43)
Labour force (mill.)	26.9 (2016 est.) and world ranking was 21
Number of doctors per 10000 (2007-2013)	0.3
Life expectancy at birth (Years, both sexes)	64.3*
Public expenditure as % of total health expenditure (2015)	36.3
Population below poverty line (%)	36.0
Unemployment rate (%)	12.9
GDP per capita (current USD)	1,004

Sources: World Bank (2012); (WHO, 2010); URT (2013), CIA (2017)

4.2 Structure of the Tanzanian Health system

Health services are provided through a network of health facilities nationwide. Appreciable successes have been recorded in broadening the network of Health Centers, Dispensaries and Hospitals, from the grassroots to national level. The health sector comprises the public system, including the Ministry of Health and parastatal organizations

and the private sector, including facilities operated by private for-profit groups, non-governmental organizations, and faith-based organizations. There are five levels of facilities in the public health system. These include national referral hospitals, regional general hospitals, district hospitals, health centers, and dispensaries (MOH, 2008). Table 4.2 shows the cumulative growth.

Table : 4.2 Trend of Health facilities 2010 – July 2015

Year	Hospitals	Health Centers	Dispensaries	Total	Cumulative increase
2010	240	620	5,400	6,260	
2011	249	653	5,657	6,559	299
2012	249	693	5,822	6,764	504
2013	254	711	5,913	6,878	618
2014	257	716	5,960	6,933	673
July 2015	257	716	6,077	7,050	790

Source: Tanzania Annual Health Sector Performance Profile, 2015, p.90

The Tanzanian government is the main provider of health services. It owns approximately 64 percent of all health services. The Tanzanian faith based or voluntary sector is the second biggest health care provider in Tanzania (Boulenger & Criel, 2012). The government and faith based collaboration was formalized in 1972 following the adoption of the decentralized, pyramidal health system. The Christian faith based health sector is represented in the public health arena by a platform that enjoys official government recognition namely the Catholic Social Services Commission (CSSC). The private for profit was banned in 1997. It has however increased rapidly since the health reforms of the 1990s (Boulenger & Criel, 2012).

4.3 The evolution and growth of the Health workforce

At independence in 1961, Tanzania (by then Tanganyika), had a critical shortage of trained human resources to staff the new organizations or institutions. The enormity of the problem was indicated by the fact that institutional and human capacities were quantitatively and qualitatively atrocious by any standards (Yambesi, 2009). The post-independence periods in many African countries was characterized by underdeveloped

education and health systems. For example, Tanzania inherited a greatly under developed health service system (Tobias, 1963).

There was a considerable gap between the requirements of the economy and the existing stock of human resources to run different organizations and institutions. Senior and middle grade posts in Tanzania and indeed in the other East African countries were almost entirely occupied by foreigners (Samoff & Carrol, 2003). Tanganyika had only 21 University graduates in all disciplines and only 11 were indigenous Tanganyikans (Iliffe, 1998) including one woman (Legum, 1988). Out of 157 medical Officers and specialists, 56 were local officers. The stock of high level manpower on an occupational basis was thus alarming.

In response to the human resource capacity gaps, Tanzania gave priority to massive investment in education and health services and infrastructure at all levels (Mmari, 1979). The government assumed a prominent role of being a provider of education and health services (Mujinja, Urassa, & Mnyika, 1993; Munishi, 1995). Following concerted efforts by the government in the training of requisite human resources there were significant developments in increased number of medical doctors (Kwesigabo et al., 2012; Tibaijuka, 1998b).

In 2006, there were 1,339 doctors in Tanzania including 455 in the private sector. About half of all doctors were employed in the Dar e s Salaam region (52%), which had 2.5 doctors for every 10,000 people (TDHS, 2011). As shown in Appendix 4, 14 out of 26 regions had only 0.1 Doctor or less per 10,000 people. While Dispensaries and Rural Health Canters have low density of doctors, they have high numbers of patients which undermines the effectiveness and efficiency of the health sector (Manzi et al., 2012; Ndulu, 2004).

According to URT (2013), the Health Sector Performance Profile Report of 2011 shows that there were 52,637 workers in the entire health sector, for the reporting year. The report also indicates that the trends of healthcare workers prior to 2011 were 33,715 in

2005/2006; 38,527 in 2006/2007; 41,537 in 2007/2008; 44,547 in 2008/2009; and 48,637 in 2009/2010 (MOHSW/IHI/NIMR/WHO, 2013).

Table 4.3: Trends of Health Workforce Growth

Year	Number of health Workers
2005/2006	33,715
2006/2007	38,527
2007/2008	41,537
2008/2009	44,547
2009/2010	48,637

Source: MOHSW/IHI/NIMR/WHO (2013).

4.4 Training of Medical doctors

The Makerere University was education hub of East African countries during the colonial period and a decade after independence. East African medical students had been studying at the faculty of medicine at Makerere College in Uganda the since 1938. The University of Dar es Salaam was opened in 1961 as a constituent college of the University of London, and later the University of East Africa. It grew from the small beginning of 13 Law students to an institution of over 2000 students in the 1970s.

In response to the human resource capacity gaps, Tanzania gave priority to massive investment in education and health services and infrastructure at all levels (Ishumi, 1994). The government assumed a prominent role of being a provider of education. The medical faculty was established in 1968 and government bursaries targeted priority areas which included Medicine and Engineering (Mmari, 1979, p. 127).

Following concerted efforts by the government in the training of requisite human resources there were significant developments in increased number of medical doctors (Tibajuka, 1998; Harrington, 1999). In 2006, there were 1,339 doctors in Tanzania including 455 in the private sector (Ndulu, 2004).

Despite notable achievements in increased number of middle and high-level human resources, the target for self-sufficiency in human resources particularly in science specialties was not achieved owing to among other things, exodus of qualified local experts to other countries (Bryan et al., 2006; Rugumyamheto, 1985; Tibaijuka, 1998a; Yambesi, 2009). As put by Kwesigabo et al. (2012), it is a health system where the workforce numbers, in every category of auxiliary and professional, have not kept pace with a population that has quadrupled since 1961.

While the population in Tanzania has grown tremendously from about 10 million people in 1961 to more than 44 million in 2012 (NBS, 2013), studies in Tanzania (Bryan et al., 2006; Dominick & Kurowski, 2004; Kaaya et al., 2012; Maestad & Brehony, 2007) have established human resource gaps in the health sector. According to UNICEF (2012), Tanzania had approximately 5 physicians and 50 nurses and midwives per 100,000 population compared with the WHO minimum threshold of 228 health workers per 100,000 population. Shortages are 87.5 percent and 67 percent in private and public hospitals, respectively (WHO, 2014b).

Mal-distribution and brain drain compound the shortage (Sikika, 2013; Sirili et al., 2014). Appendices 4 portray the number and densities of Medical personnel per 10,000 population It portrays the Tanzania human resource crisis in terms of medical doctors and other health staff in all regions and presents the number of Doctors, Assistant medical doctors, and Clinical Officers working in both the public and private sectors in Mainland Tanzania and Zanzibar. Appendix 11 shows health worker distribution worldwide. It indicates that Tanzania is among the countries in the world with critical staff shortages.

4.5 Doctor Migration Trends

There is wider awareness that large numbers of trained health personnel have left African countries (Ndulu, 2004; Zurn, Dal Poz, Stilwell, & Adams, 2002). However, lack of a reliable data on out migration makes it difficult to get the magnitude of the problem (Awases et al., 2004; Black, 2004; Juma, Kangalawe, Dalrymple, & Kanyenda, 2012).

Almost all studies of physician migration from Africa provide data gathered by recipient countries (Hagopian et al., 2005; Mullan, 2005; Vujicic et al., 2004) . Given the lack of outmigration data from source countries, I gathered different data sources from receiving countries. Table 4.2, Appendices 5 to 8, and Appendix 11 give a wider picture that indicates Tanzania to be among the countries that have been losing many medical doctors through outmigration. Outmigration cases are difficult to establish due to the fact that there are no exit interviews which could established the number of employees who left. Hospital records simply indicate abscondment cases. The use of key informants to locate doctors who were working abroad was very insightful.

It has been reported that 170 trained medical doctors (26 %) left Tanzania in the 1980s (Kiwara, 1994, p. 282). The health workforce in Tanzania declined over 35% between 1994/1995 and 2005/2006 partly due to out-migration. The country had only 1,264 doctors working in the country and 1,356 doctors working abroad in 2006 (Clemens & Pettersson Gelandar, 2008; Kireria & Ngowi, 2007).

A study conducted by the Medical Association of Tanganyika had found that 342 trained medical workers, of whom 111 were doctors, had moved to Botswana, Lesotho, Namibia, Malawi, South Africa and Swaziland (MOH, 2008). In order to bridge this gap, it was extrapolated that Tanzania would need to triple its number of doctors if it is to achieve the Millennium Development Goals of reducing child mortality and improving maternal health. In 2013, about 8.2 % of trained doctors were outside the country (Sikika, 2013).

A study by Bryan et al. (2006) reported that worsening human resource for health was one of the biggest challenges in the Tanzania. Although deterioration of health care provision stemmed from different factors, out-migration was singled as a significant setback (Kanchanachitra et al., 2011). It was unearthed that 10 to 15 percent of doctors were estimated to migrate from Tanzania or work in non – health service delivery in Tanzania. Similar findings were reported by Black (2004); Stilwell et al. (2004) and Awases et al. (2004).

Available evidence shows that there is high out migration rate of doctors to countries in the region, notably Kenya, South Africa and Botswana (Bryan et al., 2006; Clemens, 2010; Tankwanchi et al., 2013). It has been reported that out 84 Tanzania doctors who were working in the Africa region, 51 were in Botswana (WHO, 2010). Out-migration of Doctor includes 17 teaching staff at the faculty of medicine at the University of Dar es Salaam who emigrated between 1990 and 2002 (Ishengoma, 2008).

Tanzania was reported to have one of the highest net emigration rates of doctors in sub Saharan Africa when it was established that 52 percent of Tanzania doctors were working outside the country in 2000 (Clemens & Pettersson Gelandar, 2006b, p. 10). The exodus of doctors has also been noted in terms of some specialty. For example, study established that 15 per cent of Tanzania Psychiatrists were working in UK and 5 per cent in the US by 2008 (Jenkins et al., 2010, p. 5). It has been indicated that Psychiatrists per 100,000 population in Tanzania is 0.04. Although some developing countries have experienced a higher volume of out migration in terms of sheer numbers than others, this magnitude for a country like Tanzania represents a large proportion of the total. The preceding scenario epitomizes Tanzania as one of the developing countries beset with a health crisis particularly in the wake of HIV/AIDS, Malaria, TB and high Maternal Mortality rate of 578 per 1000 births (New Africa, 2007, p. 17). Table 4.4 and Appendices 5 to 8 illustrate out migration trends.

Table 4.4 Location of medical doctors outside Tanzania by 2012.

Country/ Region	Female	Male	Total
Africa			
<i>Southern Africa</i>			
Botswana	3	6	9 (4.9 %)
Namibia	2	4	6 (3.3 %)
South Africa	6	6	12 (6.5 %)
Zimbabwe	-	3	3 (1.6 %)
Sub Total	11	19	30 (16.3 %)
<i>Eastern Africa</i>			
Kenya	5	11	16 (8.7 %)
Uganda	6	32	38 (20.7 %)
Rwanda	-	2	2 (1.1 %)
Sub Total	11	45	56 (30.5 %)
<i>Rest of Africa</i>			
Sudan	-	2	2 (1.1 %)

Country/ Region	Female	Male	Total
Sub Total Africa	22	66	88 (47.8 %)
Middle East and India	2	2	2 (1.1 %)
Far East (Japan, China, Korea and Singapore)	6	2	8 (4.3 %)
Europe (Germany, Netherlands, Sweden, Norway, UK and Russia)	8	19	27 (14.7 %)
North America (New Zealand)	11	27	38 (20.7 %)
Australia	3	3	6 (3.3 %)
Unknown Location	4	9	13 (7.1 %)
GRAND TOTAL	56	128	184

Source: (Sikika, 2013, p. 10)

Table 4.4 depicts the location of the tracked medical doctors who were abroad during data collection. A total of 88 (47.8 per cent) Tanzanian doctors who responded were operating in other African countries. Doctors that were operating in East African countries (other than Tanzania) accounted for 30.5 per cent; while more than one-third (35.4 per cent) were living in North America and Europe.

It is a pity for a developing country like Tanzania with a host of development challenges such as loss of investment on human resource capacity, lack of requisite health infrastructure to lose human capital highly needed to offer critical health services to the populace.

In the wake of a cultural change from extended family towards nuclear family, there are new demands on family welfare obligations in organizations which pose formidable employee retention challenges. These dynamics made it difficult for the health sector to respond to health system demands such as increased burden of diseases and attainment of Millennium Development Goals.

Loss of human capital in terms of highly skilled health workers and loss of investment in training in a health sector of a developing country like Tanzania is a significant obstacle to improving the health system in the wake of high population growth and limited resources. The indices make it necessary for an inquiry into the root causes of the mobility of talent within and outside the country

This scenario makes Tanzania to be a good case which merits a context specific study on the factors that influence migration decisions to stay or leave making. Understanding of

the factors that motivate doctors to stay in different work contexts can enhance design of retention interventions through reinforcement of the factors valued by employees in their work settings.

4.6 Chapter Summary

This chapter has focused on the context of the Tanzania health sector. The evolution and development of the health sector has been described in terms of staffing levels and human resource capacity. Tanzania had registered notable achievements in the expansion of the human resource training through public, and donor support. These efforts have been realized in the wake of public private partnership between the public and the public sector. It has been increasingly realized that the government financing and provision of health services is no longer feasible or indeed sustainable. The provision of health services requires all stake holders to complement each other rather than compete.

Despite notable achievements in staffing and training levels, the economic crisis and attendant health crisis plunged the sector into severe lack of equipment and supplies and doctor migration. The health sector challenges increasingly require not only workforce expansion but most importantly motivation for their continued service. This elevates the urgency of this study in exploring the role of human resource management practices in the quest to enhance retention of medical doctors.

CHAPTER FIVE: CASE PRESENTATIONS AND FINDINGS – HOSPITAL A

5.1 Introduction

The study set to explore the role of human resource management practices in the migration of medical doctors in Tanzania. Specifically, the focus was on what factors influence medical doctors to stay or migrate and what human resource practices were employed by hospital A to enhance retention of medical doctors. The chapter begins with a description of the organization profile, mission, structure, governance context. It presents the research findings and discusses theoretical underpinnings to the existing body of knowledge. The chapter is concluded by a summary of the key issues discerned.

5.2 Hospital A

5.2.1 Hospital Profile

Hospital A is a semi-autonomous main public referral and University teaching hospital that was established in 2000 following separation of the then Medical Centre from the hospital teaching college. It is providing specialized care to referral cases requiring advanced technology and highly skilled personnel. It has a long history dating back in 1920s. It became a Medical Centre in 1976. The new status paved way for the separation of the old medical centre. These changes were more of administrative arrangements as the hospital remains a university teaching hospital providing conducive teaching and research environment for medical students from many medical and research institutions. The hospital has 2,700 employees of whom 219 are Doctors and Specialists, 900 registered and enrolled Nurses and the rest are supporting staff. It has 1,500 bed facilities, attends 1,000 to 1,200 outpatients weekly, and admits 1,000 to 1,200 inpatients per day. .Table 5.1 shows an overview of the hospital profile.

Table 5.1: Hospital A Profile

Year of Establishment	1920, Previous Acts repealed in the latest Act No. 5 of 2000
Governance	A semi-autonomous hospital under the Board of Trustees.
Ownership	Wholly Government Owned.
Location	Capital City (Dar es Salaam)
Catchment area: Dar es Salaam and Upcountry referrals	4.5 million.
Number of Employees (2008)	2700
Number of Doctors	234
Number of Nurses	900
Number of Inpatients	43,486
Number of Outpatients	330,528
Number of Beds	1500

Source: Compiled by the Researcher drawing on Hospital A records, (2008)

5.2.2 Vision

The hospital vision is to be an internationally accredited tertiary level, teaching hospital offering high quality affordable medical care.

5.2.3 Mission

Pursuant to the vision, the mission of the hospital is to provide sustainable, effective, efficient and high quality tertiary specialist medical services for referred and other patients from all areas of Tanzania, while providing conducive environment for training and research.

5.2.4 Hospital structure

At the apex is the Board of Trustees whose Chairperson is appointed by the President of the United Republic of Tanzania upon recommendations by the ministry of Health and Social Welfare. The Board is constituted of members drawn from the Dar es Salaam City Council, the Muhimbili University College of Health, and Allied Sciences, representatives of Workers Union, Attorney Generals Chamber, appointees of the minister of Health, the Executive Director (who is secretary to the Board), and representatives from the hospital management team. The hospital is organized into eight Directorates.

These include Medical Services, Surgical Services, Clinical Support Services, Nursing Services, Human Resources, Finance and Planning, Information and Communication Services and Technical Services. It has 25 Departments and 106 Units.

5.3 Governance context

The hospital Board is the supreme organ vested with a wide range of powers and functions. It appoints senior members of the hospital management team and ensures the overall smooth running of the hospital. The tenure of office of the Board is three years and members of the board are eligible for re appointment Below the Board of Trustees there is the Executive Director who is the Chief Executive Officer (CEO) of the hospital. He/she is appointed by the ministry of health but accountable to the Board of Trustees. The CEO is responsible for the general conduct of the day to day operations, management of the hospital under the direction of the Board of Trustees. Under the Executive Director there are five divisions namely Surgical Services; Medical Services; Clinical support Services; Technical Services and Nursing Services Quality Division.

While the present study is about how human resource management practices can influence doctors' decision to stay or migrate, it should be noted that not all human resource policies are decided by the HRM directorate. Decision about the implementation of policies on salary levels and annual increments, issuance of recruitment approval, postgraduate training within and outside the country, promotion awards and payment of pensions are still centralized in the hands of the government. This is normally through tripartite agreement between the parent ministry (i.e. Ministry of Health and Social Welfare), the central establishment and the Ministry of Finance and Planning. I shall therefore first explain the distribution of responsibilities between the three institutional levels in implementing human resource practices in Hospital A. The government level, the corporate and the human resource management directorate level.

5.3.1 Government responsibilities

The government instituted some strategies through respective policies to ensure that public hospitals like hospital A attract and retain medical doctors. These include salary reviews, private practice policy, and scaling up enrolment levels in medical schools. These are presented below.

a) Salary Reviews

Salary reviews have been part of the wider civil service reforms geared towards improving governance and service delivery (URT, 2010). This policy aimed at attracting and retaining well qualified personnel, in the public service, as well as motivating employees by addressing equitable remunerations across the service. Appendix 10 portrays the trend of pay levels. Column one is the particular year refereed to. Column two shows the nature of the reward decision. Column three is the authority which endorsed the implementation of the reward. This ranges from a government department to a special commission formed by the President. Column four is the researcher's remark and reflection on a particular row.

b) Private Practice Policy

The combination of low salaries and poor working environment demoralized most of the medical doctors and in turn led to internal and external migration (Ishengoma, 2008). Owing to the government's inability to increase funding for the health care, a cost sharing policy (payment of user fees) in a hitherto socialist orientation of free education and health services was adopted in the early 1990s This marked the recognition of the pivotal role of the private sector in the provision of health services.

In 1996, the government of Tanzania introduced an Act empowering a public health institution to practice a public private mix. The funds generated from private practice were meant to subsidize worker's income and other hospital operations hence ameliorating limited government funding which affects many issues: low salary, poor

working tools, poor hospital infrastructure, and lack of equipment and medical supplies. The 1970s through 1980s to mid 1990s witnessed deterioration of health services. The government could meet only 10 to 20 per cent of the recurrent budget needs of its hospitals. In 1996 the government of Tanzania passed an act empowering public health institutions to practice private – public mix (i.e. attend private patients in addition to rendering services to the public). The hospital management has the responsibility for implementing and adapting these policies.

c) Educational Policies

The Ministry of Education and Vocational Training oversees nine universities that train medical doctors and other health professionals (Kwesigabo et al., 2012). Initially the government (through the Muhimbili University of Health and Allied Sciences - MUHAS) was the sole trainer of medical doctors until 1997. This activity is now implemented by private medical schools and Church owned schools. These include the Kilimanjaro Christian Medical Centre (KCMC), the Hurbert Kairuki Memorial University (HKMU); the International Medical Training University (IMTU), the Catholic University of Health and Allied Sciences (CUHAS) and St. Francis University College of Health and Allied Sciences (SFUCHAS).

While the average intake of medical students was 50 students per year in the 1970s, it reached about 100 students by 1997 (Manzi et al., 2012). Enrolment levels for specialist training in health training institutions increased the number of medical specialists from 46 in 2005 to 265 in 2009 (Kaaya et al., 2012). In order to ameliorate critical shortages of medical doctors and other health professionals exacerbated by, among other things, brain drain, the government directed universities to rapidly scale up their annual student intake to 200 (URT, 2008). Government scholarships (covering Tuition, Meal, Accommodation, practical training, Books, Stationery and Research). were accordingly granted to new medical students.

While in the previous years, the beneficiaries were required to refund the money after their graduation, the government has waived this condition so as to encourage more students to take science subjects because this is where there is high demand in Tanzania.

d) Infrastructure

The government strives to ensure that the hospital infrastructure is improved. These initiatives are complemented by donors through collaboration. For example, Abbot Fund and the Miracle Corners of the World- (all from US) entails among other things, construction of new buildings, rehabilitation works and purchase of laboratory equipment.

5.3.2 Corporate responsibilities

The quest to attract and retain doctors in hospital A has necessitated institutionalization of policies and strategies in consonance with wider government initiatives. The corporate management is involved in coordinating Intramural and Extramural Private Practice. The modus operandi of these policies is elaborated below.

a) Intramural private practice

Hospital A implements the adapted intramural private practice policy within the hospital in the realm of the government's private practice policy. Doctors combine salaried, public-sector clinical work with a fee for service for private patients. It is a Fast Track procedure in which private patients can arrange to meet specialists by paying a consultation fee of Tsh.15, 000 under the cost sharing arrangement. The specialist doctors who treat private patients earn 40 per cent of this fee per patient. This is a flexible work system meant to complement low public sector salary as well as under funding of hospital operations.

b) Extramural private practice

Following the re-introduction of the private practice policy, doctors got opportunities to render services to private health facilities through part time arrangements. The doctors are directly paid by the hospitals where they render services during their free time. The hospital Board had given clearance for doctors to be engaged in Extramural private practice (outside the hospital) after official working hours. The doctors are also engaged in entrepreneurial projects both within the domain of health services (e.g. pharmacy shops) and non health (e.g. petty businesses).

5.3.3 HRM responsibility

The Human Resources Directorate is responsible for formulation and implementation of the strategic plan and human resource policies of the hospital. It is organized as a strategic management function and contributes to the strategies of acquisition, development, and retention of human resources. It is responsible for administration and personnel management in the hospital and provides a wide range of support to the Board of Trustees, Management, and employees. In the process of carrying out its functions, the directorate also plays an interface role in the interactions between the hospital, the government, and other partners on administrative and human resource management issues.. The directorate is organized into three departments: recruitment and training, compensation and industrial relations. Each department has specific role to play in carrying out the functions of the directorate in consonance with the hospital corporate plan. In tandem with corporate initiatives, the role of each department is described below.

a) Recruitment and Selection

The Recruitment Department is responsible for determining vacant positions and filling new positions and seeking approval for employment permits from the government. It coordinates the selection process through advertising, short-listing, interviews, and hiring in accordance with the Recruitment Policy of the hospital and government policies and regulations.

Bilateral agreements between Tanzania and foreign countries paved way for foreign doctors to be posted to Hospital A to render health services. This arrangement gave Tanzanian doctors opportunities for knowledge exchange as they worked with specialists from the different countries. During the interview period, there were expatriate doctors from China (6), Cuba (6), Egypt (4), India (4), Britain (2), Korea (2), Russia (2), Japan (1) and Germany (1). The hospital benefited from their rich expertise in areas of Surgery and Ophthalmology. The staffing levels for doctors were at 75 capacity during the period of the study. While the standard hospital establishment required 336 doctors, there were only 203 in 2008. Efforts to increase recruitment levels awaited government approval.

b) Training and Development

The department of training has the overall function of coordinating training activities in the hospital. Training is a key strategic activity in furtherance of hospital mission. There is a training programme for doctors and other health staff. The Department coordinates identification of training needs, trainers and training programme, prepares training plans, coordinates in house training and workshops and facilitates induction programme. It solicits scholarship and sponsorship for various courses pursued by the hospital staff. The department also coordinates the rotations of interns in the Hospital from the period they are posted to the hospital by the Ministry of Health and Social Welfare until they complete their one year training and get certified as medical practitioners. According to hospital records (MNH, 2007), the number of doctors going through such training programs in respective years include 9 (2004), 9 (2005), 27 (2006), 33 (2007) and 35 (2008).

c) Reward Management

The reward strategy entails payment of staff salaries, benefits, and allowances. In this undertaking, the hospital maintains and updates salary particulars for each employee in the payroll for accurate payment of monthly salaries, allowances, and benefits. It provides different incentives. These include accommodation to entitled doctors in the form of a house rent. Cognizant of the fact that soft loan for construction and purchase of vehicles is

preferred by medical doctors the hospital coordinates staff loans arrangements with various financial institutions. The loans are recovered through staff salary deductions. The HRM department also manages some of the employees' benefits. It ensures that statutory contributions are deducted from each employee in the hospital and are timely remitted to the respective social security fund. It makes the necessary arrangements with the social security funds to facilitate the payment.

d) Industrial Relations

The hospital strives to maintain industrial harmony that is a prerequisite for smooth health service delivery. The department of Industrial relations is responsible for establishing and maintaining harmonious labour relations conducive for effective and efficient organizational performance between the Management on the one hand and employees on the other. The Department provides technical expertise and performs distinct functions. First, it interprets the provisions of the laws governing labour relations and labour agreements. Second, it handles employees' grievances and coordinates the resolution of labour disputes and conflicts. Third, it coordinates collective bargaining between the Management of the hospital and employees through their Trade Union.

The hospital Board of Trustees is linked with staff through a workers council. The two parties aim to establish harmonious relationships. While the employer aims at ensuring that there is quality health care provision to the populace, the Trade Union demands financial and non financial incentives for the health staff who provide health services through their technical expertise. Non adherence to the agreed formal employment contract attracts disagreements between the parties. Trade union disputes are resolved through dialogue between the representatives of the Trade Union Branch and the management team. However, lack of consensus on pay levels and working conditions between the parties triggers strikes and doctor migration which compromise health service delivery.

5.4 Findings in Hospital A

Detailed process of data collection and analysis has already been elaborated in chapter 3 (section 3.6). This section presents the findings from the interviews. It reveals the main reasons for decisions to either stay or leave. The factors are categorised under HRM and non-HRM factors. Discussions with the study participants elevated three major factors which were considered important for them to stay in hospital A. These factors include opportunities for competence building, income from dual practice, and sense of duty. Non-HRM factors which influenced doctors to stay include sense of duty to patients and the country, and obligation to the extended family. Under each major factor, sub factors are identified and elaborated.

5.4.1 Competence Building

The medical profession requires constant learning and development towards mastery of requisite skills in their specialties. The hospital coordinated different courses at different levels. These range from variety of work experience and training, postgraduate education, learning from expatriate and domestic specialist doctors. These are presented below.

(a) Variety of work experience and training

For the period July 2007 to June 2008, a total of 34 medical officers attended short courses and 17 medical officers participated in long course within Tanzania. A total of 94 medical officers and 37 medical specialists were engaged in quality improvement training and 48 medical doctors were trained in information and communication technology. The value attached to variety of work experience unfolded through the following statements:

*“I wanted to gain **experience** here given diverse referred cases” (HM2).*

*“This hospital provides better prospects for **training**” (HM3)*

*“I gain a lot of **experience** here. I am satisfied with the skills I am acquiring practically.” (HM5).*

*“There are opportunities for **further training** which will enable me to fulfil my ambition of developing my career to a specialization level” (HM8).*

(b) Postgraduate training

The government increased the number of postgraduate sponsorship from 68 in 2008 to 168 in 2009. The hospital had trained some of the doctors in specialized courses. For example, in 2007/2008, a total of 28 hospital staffs were trained in India and Israel on various aspects of Open Heart Surgery. One physiotherapist was in India for a three month training to complement the cardiac core team. This is indeed a good start for creating local capacity in this specialty. Open heart surgery services commenced in May 21, 2008 and by June 30, 2008, the hospital had treated a total of 13 patients. The hospital also sends staff outside Tanzania for Super Specialty training. In 2007/2008 eight specialists went for or continued with Super Specialization training.

The greater value attached to the opportunity for competence building: is illustrated by the following statements:

*“I will get the opportunity for **postgraduate training**”* (HM2).

*“I value the assurance of **further training** because it is a costly career if you don't have a sponsor”.*
(HM4).

*“It is easier to get **sponsorship for further studies**”* (HM6)

*“There are opportunities for **further training** which will enable me to fulfil my ambition of developing my career to a specialization level”* (HM8).

*“Guaranteed support in **postgraduate training** will help me to go for further studies.”* (HM12)

*“I am banking on the opportunity for **further studies**”* (HM13).

The human resource officer at the ministry of health clarifies career opportunities thus:

*“Doctors who have worked for at least 2 years in public hospitals after internship are eligible to pursue **specialization** degrees. They normally apply sponsorship at the ministry of Health through their employers*
(MN1).

(c) Learning from expatriate doctors

As we noted in section 5.3.3 (a), hospital A had recruited expatriate doctors on short-term periods of one to two years as part of its collaboration arrangements with foreign health institutions. Engagement of these expatriate doctors entails also ensuring that there are Tanzanian doctors who closely work with them to understudy the necessary skills and competences. The doctors cherished these opportunities as they note:

*“I value knowledge exchange with **expatriate doctors**” (HM2).*

*“I **learn a lot** from the foreign **doctors** I work with” (HM3).*

*“I am gaining **international experience** through **expatriate doctors** in my department” (HM4).*

*“I **value mentoring** from **expatriate doctors**” (HM6).*

*“Working with **expatriates** is like studying abroad because you **learn much**” (HM7).*

(d) Learning from domestic specialists

Some medical doctors in hospital A expressed the benefits they gained by working with domestic specialists. The specialists were regarded as mentors. Multi disciplinary teams enhance learning and knowledge exchange. The ward rounds through which referral cases were discussed became rich sources of learning. Opportunities for team work enhanced the capacity of doctors. Below are illustrative quotes:

*“Forums with **Specialist doctors** have been **rich sources of learning** and I am highly motivated to participate” (HM5)*

*“There are **different specialists** one can **learn from**” (HM7).*

*“I am eager to **develop my competence** from the **specialists** who work here “(HM8).*

*“There are **different specialists** who are my **mentors** “(HM10).*

*“Since I work with specialist doctors in different specializations, I stand to **acquire more competencies** “(HM15).*

5.4.2 Income

Income manifested in three sub categories. These include income from intramural dual practice in medicine, income from extramural dual practice in medicine and income from extramural private practice in other business. These items are presented in the section that follows.

(a) Income from intramural dual practice in medicine

The flexible work system presented in hospital A paved way for introduction of intramural private practice in hospital A. This flexible arrangement seems to have influenced attraction and retention of medical doctors. Conversations with some of senior doctors who were engaged in Intramural private practice showed that they were happy with the system. The following quotes illustrate the matter.

*“I am satisfied with the **bonus** I get when I give service to **private patients** in my **public office**” (HM13).*

*“Getting additional pay for rendering services to **private patients**” (HM14).*

*“Treating **private patients** here increases my income and saves my time I would have moonlighted in private clinics” (HM16).*

*“This arrangement is part of the hospital strategies of income generation which is expected to **motivate doctors** to serve private patients while **working in the public hospital.**” (HM 11).*

The human resource manager describes how the system should work.

*“We have **contractual agreement** with doctors in which a specific clause stipulates that they have to work for the hospital for 8 hours a day. The number of hours may increase in case of emergency situations. They can as well be called to work a night shift and they are normally remunerated for that. So if doctors happen to work elsewhere within their official working hours, that is a matter of poor supervision.” (HM11).*

The importance of this arrangement is further clarified thus:

*“This arrangement is part of the hospital strategies of **income generation** which is expected to **motivate doctors** to serve private patients **while working in the public hospital**” (HM 11).*

In a similar vein, an official from the Ministry of health and Social welfare had this to say:

*“The government introduced this policy in a bid to ensure **availability of health services** to many people as well as a way **to retain doctors**” (MIN1).*

(b) Income from extramural private practice in medicine

Following the re-introduction of the governments private practice policy in the growing private health sector, doctors got opportunities to render services to private health facilities through part time arrangements. The doctors are directly paid by the hospitals where they render services during their free time. Other doctors owned health facilities, pharmacy shops, and employ professional colleagues. Some of the interviewees acknowledged being engaged in extramural private practice as they note:

*“I work in two **private clinics** at least twice a week” (HM2).*

*“**Extramural Private Practice** is one of the strategies to bridge the gap between my financial expectations and what the public sector can offer. (HM6).*

*“I complement my income through **Dual practice** (HM10).*

*“I opted to engage in **dual practice** after realizing that there are high chances of **earning much money** by rendering services in the private sector” (HM12).*

“I work in private clinics” (HM15).

One interviewee describes the process and benefits of extramural private practice of medicine through the following excerpts:

Interviewer: What pressing problems do you face in your job?

HM9: If I am to rank the problems, low pay comes on top. Others include lack of working tools and necessary medical supplies.

Interviewer: How do you complement your incomes?

HM9: I practice in private clinics.

Interviewer: Under what terms do you render service in a private hospital?

HM9: Terms are negotiable. In many cases, I am paid consultation fees according to the number of patients I attend. This varies from one hospital to another. On average Consultation fees amounts to TZS20, 000 per patient. I earn a lot during weekends when I am not on duty.

Interviewer: How many patients do you attend in private hospitals during working days and weekends respectively?

HM9: On working days, I may attend 15 to 20 patients. During weekends, I attend an average of 20 to 35 patients.

Interviewer: Does this imply that you earn more income in private practice than your formal employment in the public hospital?

HM9: That is true.

Interviewer: Do you envy doctors who work outside Tanzania?

HM9: Not at all. The cumulative income from diverse sources makes me better than those who migrated. As I am investing in Tanzania I reap much more benefits than what they will be able to accomplish when they return. They may earn higher salaries but when you consider the cost of living in western countries, they may end up with little savings”

(c) Income from extramural private practice in other business

Doctors were also engaged in entrepreneurial projects in different businesses. These opportunities have augmented low salaries and reduced temptations to migrate. Below are illustrative remarks on the value attached to moonlighting.

*“I complement my income through a **shop and Taxi businesses** because it is better than totally depending on salary” (HM1).*

*“I engage in **farming and animal husbandry** in order to augment my low pay” (HM4).*

*“I had to find ways of **bridging the gap**. I run **small businesses** like small-scale **farming**” (HM5).*

“I have opted to do large scale farming.” (HM13)

*“I have been **forced to engage in business activities** in order to supplement my income and I am earning three times as much as my public salary” (HM14).*

“I have established a shop” (HM15)

5.4.3 Sense of duty to patients and the country

Some of the doctors who had vowed to continue working in hospital A exhibited a sense of duty. Dedication to a cause for staying was expressed through the following remarks:

*“If I had migrated, I could always feel guilty of not **servicing my fellow citizens** (HM2).*

*“**Helping people that suffer** gives me satisfaction (HM5).*

*“I work here for **passion**. (HM6).*

*“It is gratifying to exercise your medical skills and **demonstrate your expertise to the needy** (HM14).*

5.4.4 Obligation to extended family and relatives

For the doctors who decided to stay, the value attached to family (i.e. Family bond) overshadowed migration temptations. The following quotes illustrate this issue.

*“Our culture entails maintaining strong **links with other extended families**. I am only educated in our clan and have many commitments to support my family and other relative. (HM 7)*

*“It becomes **difficult to leave dependants**” (HM10).*

*“I have no plans to migrate because the majority of **my relatives depend on my assistance**” (HM12)*

*“I am **hesitant to leave my family** because they can be uncomfortable with my long absence” (HM14).*

5.5 HRM factors which influenced doctors to leave Hospital A

Hospital A lost some doctors due to outmigration. Appendix 7 shows the patterns of migration. Discussions with doctors who migrated indicated they left for a combination of factors. Major factors include desire to specialize and gain international experience, income, leadership, administrative system, tools, equipment and working conditions and obligation to nuclear family. The factors are presented below.

5.5.1 Desire to specialize and gain international experience

The desire to specialization and gain international experience was cited as one of the reasons for doctors to leave. The interviewees noted:

*“I sought opportunities for greater **specialization** and **intellectual growth** “(CD).*

*“I sought employment in Lesotho in order to gain **international experience**” (LS).*

I had an ambition of gaining international experience which would give me professional satisfaction (BD1)

*“There was no assurance of **further training** in the shortest possible time” (BD2).*

5.5.2 Income

Income levels in the health sector emerged as one of the factors that influenced doctors to leave. In this study, four income levels were identified. These include, level of Income (by international comparison), level of Income and Fringe Benefits (by international comparison), level of Income and Fringe Benefits relative to other sectors and professions in Tanzania and Regularity of payment. These are described below.

a) Level of income (by international comparison

Many of the doctors who left to work abroad remarked on their displeasure with low income levels as they note:

*“Low pay made me **feel inferior** to colleagues. working in international NGOs or abroad “(LS).*

*“Low **pay** made it difficult for me to cope with life in Tanzania” (BD4).*

*“My salary **income** in Tanzania was hand to mouth “(UK).*

*“Low **pay** in Tanzania complicated my life. I had to leave for Canada” (CD).*

*“I was frustrated by **low salary earnings in Tanzania** “(BD3).*

“Whilst in Tanzania I was getting equivalent of \$500, in Botswana it is \$2700” (BD2).

Some migrant interviewee expressed the benefits of out-migration as they note:

“If I had persevered to work in the country, I don’t think I should have been where I am now” (NM)

“I am now able to handle my financial obligations “(LS).

The Human Resource Manager confirms complaints on salary when he said:

*“The staffs are **poorly paid** at all levels. Workers **morale is low** and **incentives** are inadequate due to the low institutional capacity (HM11).*

b) Level of income and fringe benefits (by international comparison)

Income and fringe benefits and incentives were one of the concerns by doctors who migrated. Some of the doctors commented thus:

*“I could not have left had the government paid me a living **salary, and fringe benefits**”* (BD4)

*“Many doctors who left the country were attracted by **lucrative salaries and incentives** they would earn”* (NM).

*“I was frustrated by **low salary and incentives** I had to emigrate to Lesotho”* (LS).

c) Level of income and fringe benefits relative to other sectors in Tanzania

Many of the interviewees raised concerns on inequity in salary and other rewards. Below are illustrative quotes:

*“Although I had studied medicine for five years I **felt inferior** to other professions in Tanzania due to low economic power”* (BD2).

*“**Other workers in government agencies** were getting good pay and incentives than our profession”* (UK).

*“There are significant **salary differences** within the country”* (NM)

*“It was very disheartening to see that a doctor could not **manage** to fuel his/her vehicle”* (UK).

Doctors benchmarked between local and expatriate doctors in hospital A. One of the thorny issues that came to the fore was the concern that expatriate doctors who were by then working in this hospital were getting higher pay than Tanzania doctors. The Human Resource Director clarified this matter thus:

“We do not pay them salaries because they are paid by their own governments. The Memorandum of Understanding spells out that the Tanzania Government will only pay them upkeep allowances. This covers items like Utility, Housing and Telephone bills” (HM11).

Internal migration trends also underscore the importance attached to salary. This is signalled by a positive response by doctors to work in rural areas in donor-funded projects. The trend had been towards managerial jobs and international health institutions including WHO, UNICEF, AMREF, and donor supported projects like TACAIDS and Mkapa Foundation that offer highly competitive salaries and incentives and better working environments for doctors who agree to be posted in distant district hospitals.

d) Regularity of payment

The efficient and effective service delivery by doctors hinges on among other things, timely payment of salaries and incentives they are entitled to. Doctors in hospital A raised complaints on frequent delays in the payment of their salaries. The following remarks reflect these concerns.

“My salary could not sustain me until the next pay” (BD1).

*“While we were **poorly paid**, even the little pay was paid late. How could my family and I survive with the rising cost of living?”(BD2).*

“It took four months before I was paid my first salary” (BD4).

5.5.3 Leadership

Effective hospital leadership is crucial for realization of quality health care provision. It requires close cooperation between different leadership levels. These range from the Ministry of Health and Social Welfare, the Governing Board, the Hospital Director and Heads of Departments. Leadership is presented through three lenses namely Role model leadership, Recognition and Participation and Communication.

a) Role model leadership

Hospital leaders are supposed to be role models for the rest of the staff. They are expected to set some standards of work culture. Exhibiting a behavior not expected of a leader lowers credibility and tarnish organization image in the internal and external environment. The following comments cast doubt on the role model of leaders in the hospital and the health sector.

*“If the head of department has left, what do you expect of junior members?”
(HM 15).*

“I had to guarantee a patient for TSHS 150,000 before being operated following management refusal for such a consideration” (HM1).

b) Recognition

Some doctors who migrated had a feeling that the hospital management did not recognize and appreciated their role and expertise. This was expressed through the following comments:

*“I deserved **recognition** from the management but I could not see that happening” (NM).*

*“My skills and efforts were not being **recognised**” (BD4)*

*“Doctors would also **appreciate being appreciated** for their role in society “(BD1).*

c) Participation and two way Communication

A well-functioning and effective feedback mechanism between workers and management is one of the backbones of good leadership Employee participation in decision making creates a sense of ownership of decisions and enhances compliance of agreed work targets. Despite a few opportunities to participate in various decisions, doctors noted that there was less feedback mechanism on the pace of implementation of the agreed decision. Doctors gave these sentiments through the following remarks:

“Management is mono direction. There is no two way communication in the decision making process” (HM 10).

*“The hospital Director was not willing to **listen to doctors concerns**” (UK).*

5.5.4 Administrative system

Some of the interviewees who migrated from hospital A levelled complaints on the administrative system. They felt that there was poor management system. This was expressed through dishonoured promises and breaches of psychological/ formal employment contract and contractual agreement.

a) Dishonored promises

Medical doctors are employed through a contract stipulating duties and responsibilities of each party. Although the HRM department re-affirmed its commitment to ensure that the health staff get their entitled payments, this commitment was in some cases not fulfilled.

This problem was raised by some doctors who noted:

*“Dishonoured promises for further studies made me leave “(UK).
“We resorted to strikes when we realized that government **promises** were partially fulfilled or they were sometimes not implemented as **agreed** “
(HM 3).*

b) Breach of employment contract and psychological contract expectations

In the domain of employment contract, the employer spells out duties and responsibilities that have to be performed by the employer as well as the employees. Drawing on standing orders for the public service (URT, 2009), the employment contracts stipulated that doctors were entitled to be paid leave, risk and housing allowances and eligibility for further training and promotion rights. However, there were delays and at times non enforcement of these rights. Disagreements on these matters invariably triggers doctors’ strike when they realize that government promises are partially fulfilled or sometimes they are not implemented as agreed. Unfulfilled promised is one of the factors which prompted some doctors to seek jobs outside the country. Echoing their concerns, interviewees gave the following comments:

*“Many **allowances** which complemented my salary income were **withdrawn**. I decided to find a job in Gaborone” (BD3).
“I had **expected** that I could have pursued a **specialization** course within three years of working experience. Unmanageable workload exacerbated by scarcity of doctors shattered my dreams” (LS).*

c) Contractual agreement

The government of Tanzania through the Ministry of Health, Community Development, Gender, Children and the Elderly clearly states the importance of recruitment of a well-trained health workforce for realization of Global and National Development Goals (MOH, 2008). According to (URT, 2008), between the years 1993 and 2005, 23,474 health staff graduated from different training institutions. However, due to the employment freeze, only 3,836 (16%) were absorbed into the public workforce (Kwesigabo et al., 2012). In spite of the high demand of medical doctors, the pace of recruitment in hospital A was very slow. For the period July 2007 to June 2008, the hospital recruited 30 Medical Officers and 10 medical specialists. The policy on

recruitment freeze paved way for contractual rather than permanent employment terms. Contractual recruitment terms plunged the health sector into brain drain. (MOHSW/IHI/NIMR/WHO, 2013). Interviewees who migrated gave the following remarks:

*“I felt **insecure** because of **contract terms**. I secure a job in Botswana ” (BD4).
“There is an urgent need to revisit the contract system. I had to seek employment in Namibia because I found myself at the cross roads for not having **reliable employment expectations**” (NM).*

5.5.5 Tools, Equipment and working conditions

a) Tools and Equipment

The doctors who left give accounts of how lack of working tools and equipment affected their work:

*“I was deeply touched to see myself helpless to a patient who had come from a far to Hospital A and yet not getting the expected service due to **inadequate diagnostic tools**” (LS).
“I was frustrated by lack of working tools. I felt that my skills were depreciating rather than gaining value in the course of my practice” (BD2).*

b) Hospital facilities and working conditions

Working conditions are a prerequisite in ensuring quality health care delivery. Some of the doctors who migrated expressed concerns on poor facilities and working conditions in hospital A

*“I was frustrated by among other things, poor working conditions” (BD3).
“Many of the facilities required for day to day practice were lacking in the hospital” (NM.).*

5.6 Non HRM factors which influenced doctors to leave Hospital A

Family welfare came to the fore in migration decisions. Obligations to nuclear family (children and spouse) entail provision of a decent living for one’s family
Concerns on children’s education were cited as one of the reasons which made doctors to leave. The following accounts illustrate this matter

*“It was a last resort due to the failure of the system in terms of **prospects for children’s education.**” (BD1)*
*“The **children are getting high quality education** in South Africa. Working here in Lesotho makes it easier for me to **sponsor my children’s education.**” (LS).*
*“I was eager to ensure that my **children get the opportunity to study** in Canada where I believed in high quality education” (CD).*
*“My **fear on children’s education** was precipitated by the deteriorating standards of education.” (BD3).*
*“I left Tanzania to **ensure that the children get better education** “(UK).*

5.7 Summary of Findings

The findings show that doctors’ decisions to stay or leave are influenced by a confluence of factors. The factors range from HRM to non-HRM. HRM factors which influenced doctors to stay included the following. First, is competence building. This featured through variety of work experience and training, postgraduate education, learning from expatriates and domestic Specialists. Second, income matters. This featured in different sources. They include intramural dual practice in medicine, extramural dual practice in medicine, and, extramural dual practice in business. Non HRM factors which influenced doctors to stay were found to be sense of duty to patients and the country, which was exhibited through patriotism and obligation to the extended family.

HRM factors that influenced doctors to leave included the following. First, is Income levels. This encompassed level of income (by international comparison); level of income and fringe benefits (by international comparison); level of income and fringe benefits relative to other sectors and professionals in Tanzania, and, regularity of payment. Second, Leadership. This covers matters on role model, recognition, participation and communication. Third, Administrative system which covers dishonored promises, breach of psychological contract expectations, and contractual agreement, Fourth, tools, equipment and working conditions. Fifth, is obligation to nuclear family and children.

5.8 Analysis and Discussion – Hospital A

Drawing on the findings presented in section 5.4, attempt is made to closely establish links between the findings and the initial review of literature in chapter 2 to analyze major themes that seem relevant to the findings. The themes that explain the influence of migration decisions surfaced in both HRM and non HRM factors.

5.8.1 Competence building

The efficiency and effectiveness of a hospital hinges on its capacity to deliver quality health care. Like other health care facilities, hospital A has shown dedication to high levels of technical and professional expertise to enable doctors to cope with a wide range of health challenges that interferes with their occupation. Training is a key strategic activity in furtherance of hospital mission. Training was viewed as a capacity building process for the medical doctors and other health staff. The hospital organized both short and long courses within and outside the country. The selection of trainees was based on the relevance of the courses to doctors' specialties. Workshops were used as avenues for knowledge exchange. This is a useful approach in a domain like health, which is at the interface of fast changing technology. Staff capacity building in the hospital was geared towards imparting technical expertise to the doctors. It transcends different organization functions. The main issues which came to the fore include, variety of work experience and training, postgraduate education, learning from expatriates, learning from domestic specialists and learning environment. These are elaborated in the section that follows.

(a) Variety of work experience and training

Continuing education (having the opportunity to participate in workshops was highly valued by the doctors who stayed. The variety of work experience and training demonstrate the role of career in a learning organization atypical of hospital A. The findings presented in section 5.10 show that there were multiple career anchors among the doctors involved in the study.

The findings highlight the fact that medical doctors are not homogeneous. They have different needs and aspirations in specific work contexts. While some valued technical competence, others were motivated by entrepreneurial orientation and family welfare. Still others gave credence to a combination of different careers. The findings indicate that a *one-size fits all* approach to careers is no longer sustainable. This study supports the boundarless career literature in chapter 2 (section 2.7) as permanent employment arrangements increasingly pave way to cross border mobility of skilled professionals. It also corroborate with studies which have questioned the concept of one-dimensional

dominance (Lounsbury et al., 2012) which found that some individuals internalize several strong anchors. This is sharp contrast to the theory of career anchors (Schein, 1978) which rests on the dominance of a single career anchor.

(b) Postgraduate education

The high value attached to postgraduate specialization was vivid in this study. The doctors who stayed cherished hospital A in terms of guaranteed opportunities for postgraduate training. This is reinforced by government sponsorship of medical doctors in postgraduate training within the country. Underlying these views was the idea that it would help them to keep abreast of new developments in health care delivery. The medical doctors highlighted the fact that workshops were good incentives for professional advancement as it was important to update their knowledge in order to cope with the tide of developments in the medical profession.

While the expectation of sponsored formal training opportunities in hospital A was an incentive for some doctors to stay, other doctors perceived training offers as inadequate. This is due to the fact that the offers did not commensurate with the number of eligible trainees. The slow pace of training was perceived by the doctors who migrated as posing the dangers of being deskilled. Some of the doctors who migrated pointed out emphatically that their migration was inspired by the desire to continue their education; seeking to specialize, gain international experience and access to the best facilities and technologies.

The quest for specialization was enhanced by perceived difference in western and developing country education. The doctors felt that a degree obtained abroad would be internationally recognized and could offer more opportunities worldwide. Indeed, in some cases, the attainment of specialization status became a stepping stone to other employment opportunities. Taking into account of the established motivation phrase a satisfied need is no longer a motivator; a challenge to the human resource management is to motivate the doctors to stay in the long term perspective after the completion of their specialty training. As we noted in chapter two (section 2.3.1, b), staff training posses

challenges as individuals possess different values and career aspirations. It emerges that delayed training often pave way for skill obsolescence in a fast changing domain like medicine. This lend support to other studies that show the influence of postgraduate training on employee job satisfaction and retention (Leppel, Brucker, & Cochran, 2012; Mowday, Porter, & Steers, 2013).

(c) Learning from expatriate doctors

Doctors in hospital A have been working with expatriate doctors recruited on renewable short-term contracts of two to three years. The value attached to tapping the rich experience of specialists attracted doctors who were oriented to the technical (functional) expertise career anchor to stay. Teaming up with expatriate doctors in ward rounds and conduct of major operations ushered in avenues for greater competence building in medical skills and use of modern equipments. By extension, these twinning arrangements enhanced cross-cultural learning. This rekindles the importance of employee training presented in chapter 2 (section 2.3.1, b). This is consistent with the findings of Riviello et al. (2010) and Mowday et al. (2013) who note that collaborative professional partnerships that adapt locally expressed needs increase local capacity.

(d) Learning from domestic doctors

I order to deliver quality health care; hospitals have to acquire state of the art technology. This calls for doctors' continuous education and training. Doctors who stayed were motivated by avenues for lifelong learning in order to improve their competencies. Continuous learning featured as one of the issues valued by the doctors who stayed in hospital A. They alluded that their access to mentorship by diverse specialists greatly enhanced their knowledge and competence in different medical domains. Domestic specialists were rich sources of accumulated knowledge. They learnt diagnostic and prescription skills during clinical meetings of addressing referral cases. This greatly enhanced their knowledge and competence in different medical domains. The technical (functional) career anchor described in chapter two (section 2.3.5) seems to influence the desire to enhance education and training opportunities. This finding elevates a learning

culture as a powerful influence on doctors who stayed in hospital A. This corroborates with the findings of Busse, Aboneh, and Tefera (2014) who found that professionally and personally meaningful learning happens often during meetings of professional teams between junior and senior medical specialists. Understanding this impact has important policy, economic, and programmatic implications.

5.8.2 Income from dual practice

Dual practice in hospital A can be viewed through three lenses. These include intramural private practice in medicine, extramural private practice in medicine and extramural private practice in business. The first one is within the hospital premises; the second type is practiced outside the hospital but within the health sector and the third is in the business and informal sectors. These income sources are discussed below.

(a) Income from intramural private practice of medicine

This is a fast track arrangement through which private patients can arrange to meet specialists in a public hospital by paying consultation fee under the cost sharing arrangement. Private patients who use fast track to access health services in the public hospital referral process targeted to be attended by medical specialists. Income from intramural private practice in medicine is one of the internally generated sources of hospital revenue for motivating workers as well as improving patients care. The hospital has managed to retain some of the specialists through this modus operandi. However, low hourly intramural rates in hospital A compared to high hourly rates paid in the private hospitals have ushered in inequity concerns.

As noted in the findings, hospital A services have on numerous occasions been interrupted with doctors' strikes in 2008 and 2012 in demand of better pay and improved working conditions. The influence of economic factors like salary is vivid even with doctors who stayed within the country. They tended to diversify their careers from clinical to research roles and politics. This manifested through decisions to specialize in matters hitherto unrelated to doctors' specialty domains. This elevated the Equity theory (Adams, 1965) as being applicable in this setting. It also reflects the relevance of the reward

management literature presented in chapter 2 (section 2.3.1 d). However, Tanzania can hardly benchmark pay levels to those applied in other countries. Low pay can arguably be compensated by non financial incentives in the form of recognition and supply of requisite working tools. This lends support to Lambrou, Kontodimopoulos, and Niakas (2010) who underscored the complementality between financial and non financial rewards.

(b) Income from extramural dual practice of medicine

Medical doctors in hospital A pursue simultaneous careers by combining formal employment in hospital A and engaging in private health facilities during their private time. As doctors render services in both the public and private hospitals, their income levels are improved. To this effect, extramural dual practice of medicine emerges as a successful retention strategy for doctors to continue working in hospital A. This finding underscore the role of dual practice in integrating career and reward management interventions hitherto pronounced in the retention literature.

(c) Income from extramural dual practice in other business

The location of hospital A in the country's business city with a population of 5 million has made it easier the flourishing of different businesses. The doctors engaged in non-health businesses such as groceries, taxi, farming and cattle keeping. as individual coping mechanism to augment low salary. As we noted in section 5.5.3, some acknowledged that these activities enabled them to earn higher incomes than their salaries. However, in the absence of close supervision, this detracted doctors' commitment from formal work to businesses. One can hardly rule out the tendency of some medical doctors' abusing the policy by rendering services to private hospitals during official working time.

Through dual practice, some doctors in hospital A exhibited entrepreneurship orientation career anchor. This unfolded through moonlighting. As we noted in chapter 2 (section 2.3.5), lifelong employment by a single employer seems to be paving way for flexible work arrangement. The career preferences are changing over time and the notion of a full time civil servant exclusively dedicated to the public sector is disappearing. It transpires

from our study that dual practice is a means through which medical doctors meet their survival needs owing to the inability of the government to provide adequate salaries and working conditions.

Dual practice seems to be contextual. Its demand varies in terms of location and specialty. In the light of the preceding discussion, treating doctors as a unified professional group may be insensitive to the different contexts in which doctors render their services. In this vein, employing a unified retention strategy seems to have limited outcomes. This study provides evidence about the extent to which medical doctors' resort to dual practice, the motives for doing so, and the outcome of this engagement which had hitherto been under studied in Tanzania. These arguments are shared by Frenk et al. (2010) who view dual practice policies as a retention strategy of the public sector in developing countries.

5.8.3 Sense of duty

The sense of duty in this study manifested through exposition of patriotic values to the profession and the country, and obligation to the extended family. These are discussed below.

(a) Patriotism

The doctors who stayed demonstrated their quest to help the needy. Some of the medical doctors showed high dedication to render services regardless of the forces that rose temptations to leave the country. A sense of guilty consciousness of not serving fellow nationals in case of leaving mitigated decisions to migrate. This is reminiscent of the service/dedication to a cause career anchor described in chapter 2 (section 2.3.5). It underscores valuing others welfare. This illustrates the high degree of doctors' patriotism to the country. Such commitment need to be nurtured through greater value and appreciation of their devotion. Other scholars also underscored patriotic professionalism by trainees who return to serve their countries (Hoffman, 2010; Wen, 2011).

(b) Obligation to extended family

Despite an conducive work environment and career ambitions that influence their colleagues to leave, some doctors chose to stay and continue to work in hospital A. Social Cultural factors created family bond. to parents, the extended family and the community at large. Family-related factors featured as both facilitators and barriers to doctor migration dynamics. Welfare concerns for the extended family made it difficult for some doctors to leave. These values are rooted in one's culture. Loyalty and feeling responsible to take care of the elderly parents and other relatives seem to have influenced decisions of staying. The doctors who stayed expressed their initial willingness to leave. However, family bond and cultural orientation of extended family obligations made them stay. A common expression was "If I leave, who will take care of my family and parents?"

5.8.4 Income levels

Income levels emerged as one of the factors influencing migration dynamics. In this study, four categories of income were identified. These include Level of Income (by international comparison); Level of Income and fringe benefits (by international comparison); Level of Income and fringe benefits relative to other sectors and professions in Tanzania and, Regularity of payments. These are discussed below.

(a) Level of income (by international comparison)

High levels of salary income differentials between Tanzania and other countries have been attractive to many medical doctors. These differential incomes erode the tenets of reward management literature presented in chapter 2 (section 2.3.1, d). Evidence abounds that there has been a high out-migration rate of doctors to countries in the region, mainly Kenya, Uganda, South Africa and Botswana as these countries are able to offer 3 to 9 times the salary offered in Tanzania (Bryan et al., 2006; Vujicic et al., 2004). Arguably, it is untenable for Tanzania to make such adjustments.

(b) Level of income and fringe benefits (by international comparison)

Low salaries and incentives in Tanzania cause doctors to view their future as uncertain. While lucrative incentives like good pension package in other countries compensate for low salary income, doctors in Tanzania have little hopes with pension levels upon retirement. In the wake of globalization, there is increased awareness of available opportunities in terms of salary income and incentives for skilled professionals in different economic settings. This underscores the primacy of better pension in a developing country context with limited social welfare benefits.

(c) Level of income and fringe benefits relative to other sectors in Tanzania

Salary disparities have widened in the wake of Public Sector Liberalization policies in which Executive Agencies were delegated powers to determine sector rewards for their employees in the light of their economic capacity. Much as this flexibility was geared at revitalizing work morale and increased productivity in specific sectors, it ushered in disillusionment of professionals in sectors with limited income sources. In this regard, hospital A is no exception. Income differentials between sectors emerged as one of the factors which influenced doctors to leave. Doctors who migrated questioned the rationale for varied pay levels among different sectors with little regard to qualifications and experience. The doctors narrated great concerns on Inequity in salary levels between the health sector and other sectors. Doctors' low economic power compared to professions like Engineers and Accountancy created some inferiority complex and diminished their work morale.

Owing to very attractive fringe benefits and incentives for members of Parliament, some high level medical specialists vied for political posts. A few won Parliamentary elections and some were appointed as ministers at times in the health sector and in other cases in non-health sectors (Ishengoma, 2008). Even those who won but were not given ministerial posts, they were motivated to work as members of Parliament rather than doing clinical roles. This had an impact on the capacity of the hospital to deliver the expected services. In this vein, pay disparities among sectors for professionals with more

or less the same qualifications and high pay and incentives of some political posts demotivated medical doctors and aroused internal and external migration. Even those who stayed waged strikes in demand of better fringe benefits and incentives.

There has been a noticeable trend of doctors' shunning from pursuing specialized training in their specialty by diversifying from clinical to non administrative/research activities. Underlying this trend was increased awareness that administrative health roles had better incentive packages compared to clinical roles. This has a far reaching implication in that the hospital experience scarcities in some key specialized areas. This signals a need for closer attention to specialty work contexts. This study signals the need to offer doctors in stressful specialties additional incentives over and above other specialists in order to attract and retain them.

(d) Regularity of payment

While the hospital is expected to ensure consistent administration of staff salaries and other entitlements like timely promotion, it surfaced in the findings that delays in receiving salaries were commonly mentioned. Doctors who migrated from hospital A recounted the way they were saddled with making the ends to meet. This problem necessitated individual coping strategies of dual practice discussed in section 5.8.2. This strategy ameliorates income gaps and has turned to be an effective retention intervention. However, delays in payment of salaries and incentives attracted strikes which have been plunging the hospital into crises which had serious impact on the service delivery. This is yet another manifestation of contract breach against employment contract which pave way for mistrust between the employer and employees.

The preceding discussion on an array of income levels underscores the role of equity theory (Adams, 1963, 1965) in the context of this study. The theory draws from exchange, dissonance and social comparison theories. The theory posits that individuals engage in a process of comparing contributions to outcomes in any particular interaction. It provides a behavioral approach based on comparisons of "persons" inputs and outcomes to "relative others" inputs and outcomes. Differences in pay and incentives between the health sector

and other sectors within the country as well as abroad forced some doctors to seek better opportunities elsewhere.

5.8.5 Leadership

The management style has an influence on the level of trust between the employer and employees. Leadership featured as an important factor influencing doctors to leave. This factor is discussed under two levels namely role model leadership, recognition, and participation and communication. These are discussed below.

(a) Role Model Leadership

Invariably an organization which treats its employees well in terms of meeting their individual and professional needs tend to attract new recruits as the positive image of portraying a caring organization culture. The reverse is equally true that a bad image is not within the confines of the organization boundaries but go beyond its internal environment and spreads into the labour market. While doctors acknowledged that good leadership is not divorced from challenges, there were concerns on associated with the support and willingness offered by management to ensure that personal and occupational matters were addressed. As Frenk et al. (2010) notes, leaders are expected to show the way (i.e. lead through good examples) to arouse followers to emulate a course of action toward a set organizational goal. The migration of a Head of department to work in an international health organization set a bad precedence for the other doctors. In a similar vein, poor leadership role model is exemplified by an account in which the then Deputy Minister of Health and Social Welfare was quoted in Parliament as saying:

“The government cannot force a doctor or any other employee to maintain his or her career because they had willingly chosen their careers. You cannot force a goat to drink water. In a similar vein, you can’t force a doctor to continue working in his or her career. Even if we dare to do so, the doctor will render no quality service to the nation. At most he or she will cause problems” to our patients” (Mwananchi, 2011, p. 12).

In the wake of shortages of skilled professionals like medical doctors, the above quote signals little concern to strategize ways and means of attracting and retaining doctors in the health sector.

(b) Recognition

Some doctors cited lack of recognition in spite of rendering their professional services to their best. This study rekindles the fact that medical doctors have a range of different social needs beyond high pay. Economic interventions skewed to financial rewards seem to be necessary but not sufficient. The hospital management can institute non-financial incentives like employee appreciation and recognition through praise, letters of award for exemplary performance and appropriate timing of promotion. While Tanzania can hardly benchmark her pay levels with those in countries where the doctors migrated to, it may still be possible to have some good HRM practices that will to some extent compensate for low wages and retain doctors in the health sector. Indeed, praise for a job well done can make a medical doctor feel that he/she is being valued and in turn arouse the commitment to continue rendering health services. Poor leadership manifesting through lack of recognition is also underscored by other studies (Dickson et al., 2014; Lehmann, 2008; Songstad et al., 2011).

(c) Participation and two way communication

Industrial harmony is a cornerstone to smooth delivery of health services in a health facility. Staff participation through involvement in decision making is an important HRM tool which can be enhanced through periodic meetings to inform employees on the pace of policy implementation as well as addressing pressing employment matters. Despite the presence of management and union representatives forums described in section 5.3, some doctors noted that there was passive staff involvement in matters related to their job. The hospital management style was predominantly top down with a tone of instructions rather than stakeholder consultation. In this regard, employee involvement appeared to be a passive undertaking. The use of ad hoc measures and top-down approaches in the communication process lowered the morale of doctors. This is yet another manifestation of a breach of psychological contract expectation presented in chapter 2 (section 2.3.6) which invariably disrupts work place harmony and hence triggering doctors to leave. This is consistent with other studies which showed the crucial role of participative leadership

in increasing job satisfaction and organizational commitment (Angelis, Conti, Cooper, & Gill, 2011; Han, Chiang, & Chang, 2010)

5.8.6 Administrative system

Like other organizations, hospital A requires an efficient and effective system to ensure that formulated policies and programmes are implemented in the light of the strategic plan. It was revealed the presentation of findings that the modus operandi of the hospital administration system exhibited cases of dishonoured promises, breach of psychological contract expectations and contractual arrangement that influenced doctors to leave. These issues are discussed below.

(a) Dishonoured promises

Despite the fact that hospital A policy is expressed as striving to ensure equitable and fair determination and administration of staff salaries, incentives, and benefits, espoused commitments were not adequately honored. As noted in chapter two (sections 2.3.6, c), non-adherence to agreed employment terms and policies created disequilibrium in the psychological contract for medical doctors. For example, withdrawal of risk allowances greatly lowered work morale of the doctors given the risky nature of their job particularly in the wake of HIV/AIDS. While employment records showed categorically that a doctor was eligible for promotion from one career ladder to another after every three years, this policy was not timely honored. Taking into account that the three-year gestation period of promotion was considered a basic right, delayed promotion was seen as a violation of the contract between the employer and the doctors. Such promotion delays further raised fears on doctors' career growth. In such circumstances of breaches of the employment contract, it ushers in talent retention challenges. This corroborates with the findings by Farndale, Scullion, and Sparrow (2010) that the HR function has a crucial role in talent management.

(b) Breach of Psychological/Formal contract expectations

The perception of unfairness took several forms. In some cases, doctors were of the view that they did not get what they deserve in relation to their work load. In other cases, there were perceived differences between their salary and incentives and those of other professions within the country. As we noted in section 5.8.4 (c), these sentiments connote irresponsibility on the part of the employer. This brings to the fore the view that justice delayed is justice denied. Theoretically, issues of distributive justice seem to be a relevant explanation of the factors influencing doctors to leave. This scenario echo findings from a study of health worker motivation in Kenya and Benin (Mathauer & Imhoff, 2006). Failing to keep basic promises on matters affecting doctors' performance precipitates their departure from the health system and the country.

(c) Contractual arrangement

In response to the employment freeze, hospital A recruited doctors on contract rather than on permanent employment terms. The expectations of doctors upon completion of their medical studies are availability of employment opportunities. These opportunities are highly valued given the fact that they are the reservoir of income sources to sustain livelihood and support of family members and relatives. For junior doctors, any offer for them to go to other countries is viewed as golden chance. This implies further depletion of the stock of trained doctors who would have bridged the gap between required and actual number of doctors working in hospital A.

5.8.7 Tools, Equipment and Working conditions

A well functioning health system requires availability of diagnostic tools and equipment and good working conditions. These are elaborated below.

(a) Working Tools and Equipment

In the course of discharging their duties and responsibilities, medical doctors need requisite tools and equipment. Lack of diagnostic equipment is a stumbling block in the

provision of health services. It created doctors fear of skill obsolescence because they are not able to put their knowledge and skills into practice. Doctors who left cited severe resource constraints in terms of equipment as one of the reasons which influenced their migration. This finding underscores the primacy of equipment in health service delivery. The finding underscores the crucial role of equipment in health service delivery. This corroborates with past research on health worker's motivation and retention which indicated that the improvement of working tools could increase retention (WHO, 2010; Willis-Shattuck et al., 2008).

(b) Hospital facilities and Working conditions

The need for good working conditions in a hospital setting cannot be overemphasized. Scarce health facilities impair provision of health services to satisfactory levels. Some of the doctors who left expressed complaints on poor working conditions. This scenario lowered their work morale and made it difficult to unleash their potential. This invariably causes frustration and a search for alternative employment elsewhere. The findings in hospital A corroborates with other studies (Iiping, Hofnie, van der Westhuizen, & Pendukeni, 2006; Lu, Barriball, Zhang, & While, 2012).

5.8.8 Obligation to the nuclear family

The findings in hospital A shows that out migration was also influenced by unfulfilled family welfare requirements. This was particularly with regard to getting doctor's children into good schools abroad. Poor standard of education in schools was perceived as a potential risk on the future academic achievements of doctors' nuclear family. Emigration to other countries was seen as an avenue to enable them to finance education and other social economic needs of the nuclear families.

5.8.9 Summary - Hospital A

The study set to explore the factors influencing migration decisions to stay or leave hospital A. It was noted that hospital A managed to attract some medical doctors but

failed to retain others. The dynamics of doctor migration in hospital A. is summarized in Table 5.3 It delineates the factors for staying and leaving and attendant remarks along specific themes and sub themes

Table 5.2: Summary of factors influencing migration decision in Hospital A.

Theme (with sub themes underneath)	Reasons for staying	Reasons for leaving	Remarks
Competence Building			
Variety of work experience and training,	Continuous training and development in Short and Long Courses attracted doctors to stay. Doctors cherish the heterogeneity of Hospital A in terms of diverse specialties as it enhances knowledge sharing.	Slow pace of training is one of the factors that aroused some doctors to leave as it was perceived as posing the danger of being deskilled.	The quest for advanced knowledge aroused outmigration in the absence of adequate local opportunities for competence building.
Postgraduate education,	Opportunities for postgraduate training are one of the factors influencing doctors to stay.	Desire for super specialization and international experience prompts some doctors to leave.	Although there were opportunities for career development, the supply outweighed the demand. The pace was also slowed down by the scarcity of doctors whose workload could not be compromised with training approval
	Few doctors with opportunities to work with expatriate doctors and local specialists are motivated to stay.	Despite increased opportunities in a variety of work experience and training, the quest for advanced training and international experience makes some doctors to leave	Trained super specialists can at times not return after completion of studies. Concerted efforts have to be made through improved health system within the country to arouse return of doctors after training.
Learning from expatriate Doctors	Doctors were motivated to stay because of valuing mentorship from Expatriate doctors	The opportunity is limited by the few number of expatriates and their short durations of stay	Expatriates are specialists with great experience. Being attached to such professionals enhances the acquisition of skills which would not be available locally.
Learning from domestic specialists	This is an opportunity attracting doctors to stay	It is not all doctors who get this opportunity.	The scarcity of domestic specialists hamper the pace of junior doctors to learn from them
Income from Dual Practice			
Income from Intramural Dual practice of medicine	Attracting Specialists and Super Specialists. It mitigates outmigration	Taking into account that Intramural Dual Practice targets Specialists and Super Specialists, Junior doctors seize this opportunity in private clinics. Some are tempted to leave for Specialized training abroad	This is an emerging strategy to retain medical specialists in hospital A.

Theme (with sub themes underneath)	Reasons for staying	Reasons for leaving	Remarks
Income from Extramural Dual Practice of medicine	The flexible system of rendering service in both public and private hospitals attracting doctors to stay	Super Specialists leave public employment and establishes their own health facilities since their skills and experience are marketable	This is a retention strategy attracting doctors at all levels. In the absence of this policy, outmigration levels would have been higher.
Income from Extramural Dual practice of other business	Income from Extramural Dual practice of other business complements other sources of income and mitigate temptations to leave	.	Although it is an additional income source, dual commitment or divided loyalty is a challenge.
Sense of Duty			
Patriotism	Doctors who stayed exhibited strong affiliation with the organization and the country	Although this was expected to be one of the values for a medical profession. However, doctors who left could not persevere.	Doctors with a strong sense of duty need encouragement, support, and respect.
Obligation to extended family	This is one of the factors that influenced some of the doctors to stay. Doctors role in supporting the immediate and extended family overshadowed migration temptations		The responsibility for the welfare of the extended family is part of the African Culture
Income levels			
Level of Income by (international comparison)	Low levels of salary income aroused complaints and at times strikes. However, Dual practice opportunities augmented low salary and attract doctors to stay	Low pay levels was a catalyst for doctors to leave	Payment is seen as unsatisfactory It is arguably difficult for the government to pay salary scales comparable to middle and high-income countries where doctors migrate to
Level of Income and Fringe benefits (by international comparison)	The government find it difficult to make adjustments along these comparisons since it is untenable	Potentially attractive for doctors to leave	Employment of expatriates ushering complaints by local doctors.
Level of Income and Fringe benefits relative to other sectors and professions in Tanzania	Concerns on inequity in terms of salary and fringe benefits caused complaints by doctors in hospital A.	Quest for equity raised great concerns and precipitate doctors to leave	Disparities in income levels were perceived as signaling that the doctors were not valued. This led to migration. Of some doctors.
Regularity of payment	Despite staying, some doctors raised concerns on delays in payment of salaries and promotion arrears	Delays were pronounced during revised scales	Uncertainties caused by pat irregularity precipitate migration.
Leadership			
Role model Leadership	Although an effective motivation strategy which is less costly, it is seldom applied.	One of the reasons cited by doctors who migrated	Inefficient and unfair organizational practices frustrate and demotivate medical doctors Ineffective leaderships frustrate doctors and lower their morale

Theme (with sub themes underneath)	Reasons for staying	Reasons for leaving	Remarks
Recognition	Lack of recognition is a recurring complaint by doctors who stayed.	One of the reasons cited by doctors who left.	This is arguably an area where active HRM could do much to make people stay at no extra cost. For example, letters of recognition and positive remarks for a job well done.
Participation and Two way Communication	Doctors who stayed raised concerns on little participation of doctors in decision making process. It culminated into periodic strikes	Rated low by doctors who migrated.	Workers participation in decision making is instituted in the hospital governance structure. However, the problem has been non implementation of the required procedure. Good industrial harmony is a backbone of efficient and effective health service delivery. There were complaints of infrequent meetings
Administrative System			
Dishonored Promises	This may set a bad precedence for doctors who stayed and erode their commitment.	Unfulfilled promises made some doctors to leave	Psychological contract breach compromises retention interventions.
Breach of Psychological/Formal contract (expectations)	Even those who stayed waged strikes in response to non enforcement of contract terms and conditions	One of the factors which cause doctors to leave	Despite formulated policies on different entitlements to pay leave, risk allowances, and timely promotions, they were not enforced. At times, the promises were abolished. Psychological/Formal contract breach Compromises retention interventions
Contractual arrangement	Complaints levelled against the hospital by doctors who stayed.	Fears on employment prospects made some doctors to leave.	Doctors expressed worries on contract terms instead of being employed on permanent terms. For sensitive sectors like health, employment freeze should have been waived. The pace of recruitment is slowed by the lengthy procedure in seeking permits
Tools, Equipment and Working conditions			
Tools and Equipment	Even doctors who stayed raised concerns on inadequate equipment. Referral cases are sometimes not addressed due to lack of requisite diagnostic tools and equipment	Cited by some doctors as one of the factors which influenced them to leave	The government is striving to retool hospital facilities. However, the pace is slow to meet increasing demand.
Hospital facilities and working conditions	In some departments, doctors are attracted to stay given great improvements in the wake of hospital reforms.	This is one of the factors which precipitated outmigration	In the absence of requisite facilities and good working conditions, doctors are tempted to seek alternative employment where they can utilize their skills.

Theme (with sub themes underneath)	Reasons for staying	Reasons for leaving	Remarks
Obligation to nuclear family	Obligation to nuclear family overshadowed the high demand of medical doctors' service.	This is one of the reasons cited by some of the doctors who left Deteriorating quality of education precipitated doctors' migration in the quest to ensure a bright future for their children	Retention interventions for doctors need to be holistic and take on board nuclear family welfare matters. Although it would have been the responsibility of the HR department to offer educational support to staff, limited resources made it difficult for hospital A to implement this. These are beyond the powers and ability of the hospital.

The finding unravels economic, professional and social factors that influence migration decisions in hospital A. Although many of the factors causing doctors to leave (and also causing trouble for the ones who decide to stay) can be attributed to limited funding, salary increase is a necessary but not sufficient motivation strategy. Although Tanzania has been increasing salary levels with a view of attracting and retaining doctors and other health staff in the public sector generally and hospital; A in particular, these initiatives have had no positive outcomes. This may in part be attributed to the prevalence of financial rewards with no corresponding attention to non financial rewards in employee motivation. Indeed, factors such as lack of recognition (e.g. praise and appreciation of one's role and establishment of cordial working relationship), two way communication between the hospital management and employees, ensuring equity among professionals in different sectors, breaches on both formal/legal contracts, unfulfilled promises can be addressed at no cost through improved HRM in hospital A.

In this vein, non-financial incentives can have a beneficial effect on motivation, even under adverse conditions of low salary. It is thus crucial that the human resource management at the hospital should consider a combination of financial and non financial rewards in the quest to motivate doctors to stay. This signals a need to go deeper into non financial aspects of motivational aspects of hospital management. It also emerged that medical doctors are motivated by among other things, an environment which facilitated attainment of career development goals. Lack of equipment and frequent shortages of medical supplies frustrated doctors and lowered work morale and commitment to offer quality health care services.

CHAPTER SIX: CASE PRESENTATION AND FINDINGS – HOSPITAL B

6.1 Introduction

The study sought to explore the reasons why doctors stay or leave in hospital B. The hospital is generally perceived as being successful in terms of health service provision. It is of interest to explain the factors which enhanced retention and whether the reasons are comparable to those of hospital A.

6.2 Hospital Profile

Hospital B is located in the Mbulu District in the South-West area of the Manyara Region, about 120 km. from the Regional Headquarters in Babati and 300 km from Arusha City. The immediate catchment area has about 300 000 residents and in the referral area there are about 2 million residents in 7 districts and 4 regions of Manyara, Arusha, Singida and Shinyanga (HLH, 2009). It was originally founded by the Norwegian Lutheran Mission and opened in 1955 to offer primary health care. In 1963 the management of the hospital was handed over to the Evangelical Church of Tanzania in Mbulu Synod. It is registered as a private hospital under the Private Hospitals (Regulation) Act No.6 of 1977 as amended by Act.26 of 1991.

The hospital has been part of the Tanzanian central health plan since 1967 and has the status of Referral Hospital at the Regional level since 2010. It offers Obstetric, Surgical and Medicine services. It has 420 beds and 580 staff and provides care to an average of 16,000 Inpatients and 60,000 Outpatients yearly. It plays a substantial role in the provision of health care in Tanzania. It serves around one million people in its direct catchment area. and a population of 3 million for its secondary (referral) functions. The hospital is mainly financed by the Royal Norwegian Embassy in Tanzania. It also receives grants from various Christian medical Associations (e.g. Finland) as well as friends. Table 5.4 gives an overview of the hospital profile.

Table 6.1 Hospital B Profile

Year of Establishment	1955
Status	Faith Based Organization (Private Non for Profit) Hospital
Governance	Under the Diocese.
Ownership	Under the Church
Catchment area Population served: Immediate catchment Greater reference	300,000 People 2.1 mills.
Total number of Staff	580
Number of Tanzanian Doctors	6
Number of Expatriate Doctors	6
Number of In Patients (2008)	16,635
Number of Outpatients (2008)	60,508
Number of Beds (2008)	420

Source: Hospital Records (2009)

6.3 Vision

The vision is *“To cater for all physical, mental and spiritual needs of its patients.”* The vision is implemented through core activities including reducing the burden of disease, poverty alleviation, building and maintaining institutional capacity of both the hospital and its partners and improved collaboration with likeminded institutions.

6.4 Mission

The hospital mission combines clinical care, community service, outreach activities and education and training schools. These key areas are implemented in a mutually supportive fashion. Although this mission reflects multiple objectives which are formidable challenges to be spearheaded, good leadership and team work has enabled the hospital to achieve good outcomes.

6.5 Structure

The hospital consists of eleven clinical departments. These include Surgical, Pediatrics HIV/Aids, Diabetes, Maternity and Gynecology, Dental, Physiotherapy, Internal Medicine, Outreach, Out Patient, and Psychiatry.

The central mission of the hospital is maintenance of a high quality of medical care. The medical care incorporates a close link between the curative, preventive and palliative care. In addition to this, because of the remote location of the hospital, adequate physical support services are periodically taken care.

6.6 Governance

Hospital B is owned by the Evangelical Lutheran Church in Tanzania. It is governed by a Board which is elected by the General Assembly of the Evangelical Lutheran Church of Tanzania, Mbulu Synod. Board Members include Church officials, Representatives of the Ministry of Health and Social Welfare, the Regional Administrative Secretary and Medical Doctors. Hospital operations are guided by the Lutheran Church Board. It has to adhere to national guidelines from the Ministry of health and Social Welfare.

The hospital management philosophy is translated through a new organization structure. Unlike conventional hierarchical organization structures with top Management Team at the apex, followed by Middle Management and responsibility units and Patients at the bottom, the new hospital structure has Patients at the apex and the Top Management at the bottom. I learnt from the management that the structure entailed a different management philosophy, signaling that the management was geared towards serving the rest of the stakeholders. Governance is described at different levels namely Government, Corporate and HRM responsibilities. These are presented below.

6.6.1 Government responsibilities

Government responsibilities are twofold namely Service Agreement and Secondment of Staff. These are described below.

a) Service agreement

The quest to attain the Millennium Development Goals, National Development Vision 2025 and the National Strategy for Growth and Reduction of Poverty goals has brought to the fore the urgency of Public Private Partnership. At independence, the government assumed primary responsibility for the provision of health care to its people and made progress in developing a comprehensively structured health care delivery system from the national to the village level. Government health services have, however, been supplemented by private health services. Initially, not-for-profit health care providers, particularly church-owned facilities, dominated this sub-sector. However, subsequent to the 1991 amendment of the 1977 Act that had banned for-Profit practitioners from providing health care, there has been a rapid increase of for-profit health care facilities. About 46% of the Private for-Profit health facilities were established after 1990 (Munishi, 1995). The Private Hospital Amended Act of 1991 states that the Minister for Health has the power to check and regulate the fees structure and remuneration paid by private providers. The Minister responsible for Health is empowered to fix the maximum price to charge on medical services rendered by private health care providers.

The government developed a Service Agreement in 2007 that provided a contractual arrangement for private providers of health services to render health services on behalf of the government. The government (through the Ministry of Health and Social Welfare) supports the hospital with basket funds, Staff Grants and Bed Grants. The hospital has good collaboration with both district and regional authorities through outbreaks control as well as vaccinations, medicine and medical supplies for outreach, tuberculosis and HIV services. There are several benefits from this contractual arrangement. First, the government can determine and monitor the use of funds disbursed to the private sector. Second, private providers of health services receive government funds and hence a

reliable means of income. Third, the Ministry of Health and Social Welfare gives opportunities for private providers to access public sector trainings (e.g. seminars and workshops).

b) Staff Secondment

Secondment of health staff entails assigning them to work for another organization within the public service or in private not for profit health facilities. According to the Tanzania Public Service Regulations of 2003 (Clause 99 (1), a public servant can apply or can be requested to take a leave without pay to work in another public or private organization for a two year renewable contract. Secondment approval hinges on establishing that it is in the public interest to do so. Hospital B is one of the hospitals with a window of opportunity for government seconded health staff. The aim of the government is to ameliorate staff shortages in organizations with high staff demand. The government is responsible to pay salaries for the seconded staff. The secondment of doctors doesn't affect their continuity of employment and initial employment contract rights. Medical Specialists employed through secondment arrangements qualify for government grants. The recipient hospital only pays extra allowances on top of the basic salary. This arrangement is indeed a win-win situation for both the government and the host hospital as it ameliorates critical shortages of medical specialists in rural settings like hospital B which increasingly offer specialist services

6.6.2 Corporate responsibility

Corporate responsibilities are three fold: Public Private Partnership, Institutional Partnership, Research and Income generation. These are presented below.

a) Public Private Partnership

In 1996 the Ministry of Health and Social Welfare introduced guidelines and standard for health facilities, obliging private health facility to register and fulfill certain requirements. This was aimed at assuring that private health services complement health care services

provided by the government in efforts to narrow the gap in demand and supply. Contractual arrangements between the Government and Faith Based Organizations were carried out in terms of subsidies (Grant in Aid) arrangements whereby the Government provided according to a formula bed and staff grants to Faith Based Organizations (FBO) hospitals that are providing affordable health service to their surrounding communities. In districts without any governmental hospital the Government designated FBO Hospitals to serve as Council Designated Hospital (formerly also known as District Designated Hospital) whereby the government supports the operational costs of the private hospitals.

Hospital B adheres to national guidelines and standards for private health facilities stipulated in the public private partnership. This is largely in the domains of health service provision, education and training. Curriculum and student admission is regulated by the National Accreditation of Technical Education (NACTE) Board as part of quality assurance. These partnerships are windows of various opportunities (e.g. staff secondment, joint training and resource sharing in terms of basket funds, medical supplies and drugs) .These create a conducive working environment which arouses doctors' motivation to stay.

b) Institutional collaboration

Hospital B has established collaborative programs with different institutions within and outside the country. It cooperates with the ministry of Health and Social Welfare and the church. It has twinning arrangements with other institutions engaged in capacity building and training activities outside Tanzania. The hospital has strong partnership with the Royal Norwegian Embassy and international health organizations such as AMREF and flying doctors. Twinning arrangement with institutions abroad includes the department of health of the University of Agder, Kristiansand regional hospital, the Sørlandet hospital, the Fredskorpset (Peace Corps), Norwegian Lutheran mission, Tweega Foundation, North Trøndelag University College, University of Bergen, University of Oslo, Ullevål Hospital, Agder University, and University of Virginia.

The partnership with Madaktari Africa, a US based organization, has brought about national and international accreditation for a training programme of neurosurgeons and nurses at the hospital. It is now included as a neurosurgical training site in Tanzania. The capacity building of both surgeons and nurses has increased the capacity of the hospital to perform complicated procedures as well as improved the pre-, intra and post operative care. These partnerships increase competence building through engagement of expatriate doctors. These networks bring resources like medical equipment and training offers which enhance skill utilization valued by doctors who stay.

c) Research

Research is one of the core strategic activities in hospital B. It is related to both the capacity building of human resources and the national and international collaborative linkages. The hospital conducts clinical research to ensure that clinical services are improved over time. A number of highly relevant international studies are pursued through collaboration with international partners. Integration of research into the hospitals strategy creates a strong synergy with clinical work and training. This activity attracts medical professionals to work in hospital B as it enhances career opportunities in international health research.

Research activities have been funded by the Gates Foundation through the Foundation for the National Institute of Health USA, the University of Virginia and the Royal Norwegian Embassy in Tanzania and various universities in different countries. The hospital has formal research collaboration agreements and research candidates from several institutions: These includes the National Institute for Medical Research in Tanzania, the Centre for Educational Development in Health Arusha, Tanzania, the Centre for International Health at the University of Bergen, Norway, the Sørlandet Sykehus Helseforetak, Kristiansand, Norway, Ullevål University Hospital, Oslo, Norway, Ohio State University, USA, and Umeå International School of Public Health, Sweden.

d) Income generation

Provision of high quality services to the poor requires among other things adequate sources of income. Hospital B relies on external support from the government and other donors. During the study period, there were three main sources: The government of Tanzania, the Royal Norwegian Embassy in Tanzania and foreign private donors (individuals or institutions).

6.6.3 HRM responsibility

The growth and success of the hospital hinges on ensuring the HRM department facilitate and promote talent of hospital staff. The HRM department is responsible for the formulation and implementation of policies on three main functions namely recruitment, competence building (i.e. Training) and Reward Management.

a) Recruitment and Selection

Drawing on its short and long term objectives, hospital B formulates policies on identification and selection of candidates to fill vacant posts that arise over time. Prospective employees are selected on the basis of predetermined attributes and skills which evolve from job analysis. The hospital puts premium on requisite qualifications as well as rural background. In order to relive medical doctors from heavy workload, Hospital B employs substitute cadres (a system commonly known as Task Shifting). This is a medical cadre (i.e. Clinical Officers) who perform many roles meant for qualified doctors. They are trained in a Three-Year Medical Course. After working at that level for a minimum of five or more years, mostly in rural health centres or District hospitals, they are eligible for two more years of medical training which qualifies them to be Assistant Medical Officers. Although they are not internationally recognized, the government accords them the same status as doctors. The substitute cadre have the opportunity to pursue specializations courses within medical training institutions in Tanzania. The doctors interviewed in this study have a regular medical background.

b) Training and Development

The hospital put emphasis on building the competence of the population it serves. It develops capacity building programmes for staff. This is in terms of on the job training, short courses and seminars and long term courses. There are career development opportunities which ensure continuous education and training through scholarships within and outside the country. It promotes capacity building for other health institutions in Tanzania through its Nurses Training School, and the research cooperation with foreign and local institutions. Moreover, the close co-operation with the government of Tanzania has also made it possible for the hospital to participate in health policy discussions in the country. Hospital B is a training institution aspiring to attain the status of a Teaching hospital. The new status attracts highly skilled staff vying for a combination of clinical and teaching roles. Moreover, this is a recruitment reservoir of qualified graduates hence self sufficiency in staffing levels and a source of human resource supply for other health facilities.

c) Reward Management

The hospital devises motivational programmes to reward employees. It implements policy directives emanating from labor legislations at the national level. Private hospitals are required to adhere to the stipulated minimum wage and are free to make any additional pay in the light of their financial ability. Hospital B provides financial and non financial rewards to motivate the health staff. Financial rewards include basic salary which is the same as public sector pay applicable in hospital A. Whenever the central government increases salaries, the hospital management has to make corresponding increases in respect of prevailing government scales. This is in accordance with central government regulations governing the operations of both the public and private health facilities. Taking into account that doctors in hospital B have limited opportunities for dual practice in medicine, the hospital pays them top up allowances (i.e. 30% of their basic pay). Given the low cost of living in the rural setting of hospital B, their salary income is comparatively sufficient as compared to doctors in hospital A located in the capital City. Non financial rewards offered to employees include promotions in line with the appraisal

process. There are also internal career advancement opportunities which motivate doctors to pursue training at different levels with corresponding rewards for accomplishments.

6.7 Findings in Hospital B

The factors that influence attraction of medical doctors to stay in hospital B can be grouped into HRM and non HRM factors. HRM factors which aroused doctors to stay. These include recruitment of candidates of rural background, competence building (i.e. variety of experiences and training, postgraduate training, learning from expatriate doctors), income (salary top ups, extramural dual practice in business), leadership (recognition by management, colleagues, community and patients) and administrative system (equipment). These factors are presented below.

6.7.1 Recruitment of candidates with a rural background

The hospital recruits candidates who hail from areas proximity to its location. This practice capitalizes on the fact that the hospital has trained and developed them in areas which tally with its mission. Hospital records show impressive durations of doctors stay ranging from 10 years to 38 years. This in part, stems from a recruitment strategy in which doctors are recruited from areas close to hospital location. This created mutual trust and organizational identification. Interviewees gave the following comments:

*"We managed to **retain** doctors because we largely employ **staff exposed to rural environment**" (HY2).*

*"I **grew and got secondary education in this village**. I also **did my internship** in this hospital". (HY5).*

*"I volunteered to be **seconded** here because I **come from this area**" (HY4)*

*"This is **my home village**" (HY3).*

*"We **employ** staff who share **hospital values**" (HY1)*

6.7.2 Competence building

The findings indicate that various education programs ranging from experience and training, postgraduate training and learning from the expatriate doctors attracted doctors to stay. These are presented below.

(a) Variety of experience and training

The hospital has been committed in training employees in order to increase their competence to deliver quality health care. There are different training opportunities ranging from on the job training, short and long courses and seminars. The targeted occupations include Medical Officers, Medical Assistants, Laboratory Assistants and Accountants. The staffs are further developed through skill development in different professional levels. This strategy cements the bondage of staff to the organization. For example, six doctors were trained in 2004. One doctor had completed Masters and proceeded for a PhD at Bergen University in Norway. This is a big incentive for a doctor and very few doctors have had such an opportunity apart from hospitals with synergy with higher learning medical training where doctors are also involved in teaching.

In cherishing access to competence building opportunities, interviewees gave the following comments:

“Hospital sponsoring staff in upgrading courses” (HY3).

“I have benefited in many upgrading programmes” (HY4).

“The hospital is committed to ensure staff advancement” (HY5).

I am getting regular professional development opportunities (HY6).

(b) Postgraduate Training

The hospital provides opportunities for staff advancement. This is done through Scholarships within or outside the country. Medical doctors noted that there were various opportunities for education and training which developed their knowledge and skills.

“Postgraduate training abroad exposed me to different medical experiences” (HY5).

“The hospital has supported my postgraduate training in the UK and Norway (HY4).

“We offer the doctors opportunities for specialization within the country or abroad” (HY1).

“The hospital is committed to ensure staff advancement” (HY2).

(c) Learning from Expatriate doctors

The collaboration between Hospital B and hospitals abroad has paved way for recruitment of expatriate doctors. The collaboration included international health organizations like

AMREF and hospitals in Norway, Europe and UK. Doctors come for short visits and research which ranges from few weeks to a maximum of two years. During the study period in February 2009, there were 8 expatriate doctors working in the hospital. These came from Norway, The Netherlands and the United Kingdom. This arrangement provides hospital B doctors the opportunities for professional development through joint medical research, seminars and workshops. There were monthly visits from specialists through the services of flying doctors. This ushered in invaluable experiences which are very useful in improving medical skills and competences. Hospital B doctors embrace and appreciate such avenues which are a platform for cross cultural learning.

The following remarks describe the value attached to working with expatriate doctors:

“As I work closely with different expatriates, I get a wide range of medical skills” (YH5).

“I appreciate opportunities to do joint researches with expatriate doctors because it enriches my competence (HY4).

“I gain from knowledge exchange with Expatriate doctors” (HY3).

“It’s very stimulating to work in a collegial work setting with Expatriate doctors” (HY6).

“Team work creates the bondage of local and expatriate doctors (HY1).

Expatriate doctors were commended for their unreserved commitment to work in a rural setting like hospital B. This appreciation is illustrated in the narratives below:

“Engagement of Expatriate doctors increase quality health service provision” (HY4).

“Expatriate doctors are prepared to work in a new culture” (HY1)

“Expatriate doctors have greatly contributed to the achievement of the hospital mission.” (HY2).

6.7.3 Income

Income in hospital B is categorised into two sources namely salary and eextramural dual private practice in other business. These factors were cited by some doctors as factors which ameliorated their widening income gap between urban and rural areas.

(a) Salary Top up

Like other public sector employees in Tanzania both public and private, income levels for doctors in Hospital B is low. The hospital adheres to government pay rates in the light of employee qualifications and experience. In order to ameliorate inadequate salaries, the

hospital pays the doctors salary supplements (i.e. top up). This policy motivated doctors as it helps them to meet many of the basic needs. The following quotes attests

*“I am well paid. I get **additional 30 %** on top of my **basic salary**”* (HY3).

*“I **appreciate the Salary Top Up as a complement** to non engagement in Intramural and Extramural Private Practice “(HY6).*

*“The hospital is paying **Salary top up** to doctors to **motivate** them (HY1).*

*“The **salary is reasonable and same as government scale** “(HY4).*

(b) Extramural dual practice in business

The faith based nature of hospital B is geared towards provision of high quality health services. These services are provided with the tone of serving the people rather than profit creation. This orientation and the rural location rules out doctors’ engagement in intramural private practice (within the hospital) and extramural private practice in medicine (in private hospitals). Doctors in hospital B augment low salary income by doing extramural private practice in other business (I.e. Cattle keeping and Farming). Doctors underscored proximity to their business projects as it simplified business supervision because distant locations invariably have high agency costs. The statements below mirror the perceived gains from this income source.

*“**Farming** relieves me from food purchase”* (HY5).

*“I am **getting rental income** from a Guest House I built”* (HY6).

*“I **engaged in Agriculture and Cattle** keeping to increase my **income**”* (HY3).

*“I have to **be closer to my farm** which enables me to **sustain my family needs**”* (HY4).

6.7.4 Leadership

The efficiency and effectiveness of a health facility hinges on among other things Leadership. The Vision, Mission and Strategies are formulated by stakeholders through the direction of the entrusted leaders. Leadership manifested in two major prisms namely role model and recognition. Under recognition, four dimensions were noted. These are management, colleagues, community and patients. These levels are presented and elaborated below.

(a) Role model Leadership

Good Leadership was cited as a motivation for doctors to stay. Interviewees commended the hospital leadership through the following comments:

“Doctors are actively involved in the management of the hospital operations” (HY5).

“I am impressed that our colleague was appointed as Assistant Medical Director (HY3)

“I am inspired by the willingness of the hospital management to listen to our concerns” (HY4).

“The hospital leadership leads by example” (HY6).

(b) Recognition by management

The hospital leaders were praised for showing their empathy to the big workload the doctors were shouldering. This was seen as a symbol of being respected and acknowledgement of their valuable service to the hospital.

In response to this kind of treatment, the doctors expressed their appreciation of being recognized through the following remarks:

*“Praises like **well done** inspire greater commitment to work in the hospital” (HY6)*

*“I am **being valued** by **management**” (HY4).*

*“The management **involves doctors in decision making** of hospital matters” (HY2).*

(c) Recognition by colleagues

Most of the interviewees in hospital B said that they highly valued team work spirit which was espoused through collegiality and camaraderie. This was expressed through the following statements:

“I am happy with the high Team spirit among doctors here” (HY3).

“I enjoy my cooperation with peers in this hospital” (HY6).

“Team spirit among medical doctors increases hospital efficiency” (HY2).

“There is high respect among doctors in this hospital” (HY1).

“I am being valued by Colleagues” (HY4).

(d) Recognition by patients

The hospital attracts many patients from the community and distant regions. This trend has been caused by perceived high quality health services. This image attracts patients

from afar because of their value to quality service. The patients vindicate their recognition of the services rendered by doctors. Doctors expressed their pleasure on the way patients have been appreciating their services. As reciprocity to being recognized by the patients, some interviewee said:

*“I get **positive remarks** from **many patients**” (HY6)*

*“My **happiness** is **among patients**.” (HY5).*

*“Our **dedicated service** attracts **many patients to seek treatment here**” (HY4).*

*“Recognition by the patients is the **biggest inspiration** for me (HY3)*

In assessing the quality of the health care services, the Managing Medical Director notes:

*“We do **make a difference** in the **lives of thousands**. The hospital has the lowest maternal mortality rate in sub-Saharan Africa and the infant mortality is also very low” (HY1).*

6.7.5 Administrative system

An administrative system which provides requisite equipment and medical supplies enhances job satisfaction. The doctors in hospital B expressed their admiration of the availability of adequate equipment. This was expressed through the following comments:

*“Adequate **equipment** enables me to provide quality service to the patients” (HY3)..*

*“I am excited by working in a hospital setting where **equipment** is available hence easier to utilize my skills” (HY6).*

*“I discharge my duties much smoothly because I am **provided with the equipment** I need” (HY5).*

“The Hospital has adequate equipment” (HY4)..

*“The hospital is **well equipped**” (HY2).*

6.8 Non HRM factors which influence medical doctors to stay in Hospital B

Non HRM factors which influenced doctors to stay encompass a sense of duty to patients and the country (Moral Obligation), family bond, community bond stemming from recognition by the community, religious affiliation, recognition by the patients, and, organization culture. These factors are hereby presented and elaborated.

6.8.1 Sense of duty to Patients and the Country

Sense of duty emerged as a reason why some medical doctors remained in hospital B. This attitude seems to be reinforced by their passion. Expressing a sense of devotion, doctors gave the following remarks:

“I feel proud to serve patients who would hardly get quality health care in such a rural setting” (HY5).

“Tanzania needs a health professional of my kind to serve patients in a village setting” (HY3).

“This hospital is a good place to offer health services with love drive than money oriented service” (HY4)

6.8.2 Societal traditions and customs

Culture defined as *“the way we do things here”* (Deal & Kennedy, 1982) appear to influence doctors to stay in hospital B. This is mirrored in three lenses namely family, community, and moral satisfaction. These are presented below.

(a) Family bond

Doctors expressed family ties which created a strong bondage to continue working in hospital B. These ties were expressed through the following comments:

“I am managing to look after my aged relatives” (HY5).

“I am the overseer of the welfare of my clan. There is no way I can be tempted to leave” (HY4).

“I avoided social isolation from my family which could be stressful to me had I left to work elsewhere” (HY6).

“I can't leave my parents who solely depend on my support” (HY 3).

(b) Community bond

The doctors reported having good relationships with community members. They noted that they had developed a sense of belonging in the community. They expressed their devotion to render health services in a rural setting arguing that the community appreciation of their role motivated them to stay. This bondage is illustrated by the following comments:

“I am delighted to work in a health facility located near my home” (HY5).

*“It is nice to be in a community where there is **recognition of your role**” (HY3).*

*“When you work in an environment where people **value what you do**, it **inspires** you to work much harder. I am motivated by **recognition by the community.**”(HY4).*

(c) Moral satisfaction

Drawing on the hospital profile in Section 5.19.2, hospital B is a faith based hospital with a religious culture. Religious affiliation (exhibited through moral satisfaction) fostered institutional loyalty and arouses the commitment of doctors to stay and spearhead the hospital mission. The doctors expressed strong affiliation with the hospital which operates under the church governance. The following quotes attests to this

“Being a Christian, this is where I am serving God” (HY5).

*“I am glad that I have lived up to my **religious conviction of serving patients** in remote location” (HY6).*

*“I for one **value Christian values**. I believe that God sent me to work here and **serve the people**. I wish to **serve the church**” (HY4).*

*“I have **a moral desire to help patients** in hard to reach environments in Tanzania” (HY4).*

*“I provide **physical and spiritual services** to the patients” (HY3).*

*“Our **Christian faith** is important to the hospital” (HY1).*

6.8.3 Migration intentions

Some interviewees raised concerns that the pension fund they belong to had unfavorable terms compared to other pension funds in public hospitals where members would get hefty payments. This created a strong sense of exclusion and dissatisfaction. These sentiments were expressed through the following remarks:

*“I will not gain **substantial pension upon retirement** because the National Social Security Fund I belong to **pays little compared to other pension funds**. If these differences persist, **I may opt to work in hospitals where pension funds pay high**” (HY6).*

*“My **contributions are not recognized as collateral** which can enable me to **access a loan** in the financial institutions. This is **unfair and unjustified.**” (HY4).*

*“The hospital will be unattractive if it fails to spearhead **harmonization of pension scheme** for all pension funds” (HY5).*

These concerns were supported by some Ministry officials who noted:

“Retirees in the National Social Security Fund where hospital B belongs receive little pension compared to those in the public sector (MN2).

“Whilst some pension funds allow their members to withdraw 25 % of retirement benefits while still in employment, others are yet to adopt this system”(MN1).

6.8.4 Summary of Findings – Hospital B

The ability of hospital B to attract and retain medical doctors makes it to be an interesting case for comparison with hospital A. This success stemmed from many factors. The findings discern two major strands of factors namely HRM and non HRM factors. HRM Factors influencing doctors to stay included Recruitment of candidates with rural background. Most of the doctors grew up in districts close to the hospital. This is arguably necessary but not sufficient. The hospital devised an array of competence building scenes. These encompass a variety of experience and training; postgraduate training and opportunities to learn from expatriate doctors from different countries and international health organizations who visited the hospital. These career development avenues developed the capacity of doctors and were highly motivating. It surfaced that the doctors cherished an administrative system which provided requisite equipment to ensure that doctors properly utilize their skills and competences.

In order to mitigate low remuneration, the hospital introduced salary supplements to doctors on top of the basic salary pegged to government prevailing rates. It also emerged that doctors at individual level engage in Extramural Private Practice in Business as alternative sources of income.

Good leadership which valued doctors through recognition at management, colleagues and patient levels seem to influence doctors to stay. There is participative management and employee involvement which actively involves doctors in the management of the hospital operations. The doctors were impressed by the appointment of their colleague as the Assistant Medical Director. The doctors were also motivated by the way the hospital leadership paid close attention to their concerns. This demonstrated that the hospital leadership led by example. Recognition by the management, colleague, community and

patient assured the doctors that they had a pivotal role in the delivery of health services in the hospital and beyond. These are indeed less costly interventions which seem to be a powerful retention strategy as doctors give credence to their being valued.

The hospital culture seems to be an important factor which fostered doctor retention. It features in four dimensions namely Family bond, Community bond, and Moral Satisfaction stemming from religious affiliation. In the context of the African culture, some individuals have core obligations for the welfare of family members, parents and other relatives. This culture cements strong bondage which make it difficult for the doctors to seek employment opportunities in other settings..

Although no doctor migration was experienced in hospital B, there were concerns on pension which increased dissatisfaction that signalled migration intentions.

6.9 Analysis and Discussion – Hospital B

In spite of working in a rural location littered with an array of problems: excessive workload, and poor social infrastructure which stand out to be potential factors that could reduce morale and indeed arouse temptations to migrate, doctors in hospital B stayed. This hospital achievement is not accidental. Drawing on the findings presented, the factors which influence migration decisions in hospital B include recruitment of candidates with rural background, opportunities for competence building, (i.e. variety of experience and training, learning from expatriates, income (salary top ups and extramural dual practice in business), leadership (role model, recognition by management, colleagues and patients), administrative system (equipment). Non HRM factors which influence doctors to stay are sense of duty (family and the country), culture family and community bonds) and moral Satisfaction. These are presented and analyzed in the sections that follow.

6.9.1 Recruitment of candidates with rural background

The recruitment process in hospital B underscores ones background, qualifications and behaviour. There is careful selection and transparent communication of the expectations

from both the employer and employees. This creates congruence of employer and employee expectations and ensures psychological contract fulfilment. The doctors had an extensive experience of the lifestyle in the rural area. This transcends their primary and secondary educational levels.

The career literature in chapter 2 (section 2.3.5 attests that longer gestation period in pursuit of an occupation is important in decisions concerning ones career (Schein, 1990). This finding resonates with a growing evidence of the importance of matching a candidate's own background to the setting in which they are recruited to work. It has been indicated that personal characteristics that influence perceptions and intentions for rural practice include values, beliefs and social background (Frehywot, Mullan, Payne, & Ross, 2010; Lisam et al., 2013).

6.9.2 Opportunities for competence building

The training of medical doctors plays an important role in shaping their interests and ultimate choice of workplace after graduation. Hospital B seems to have won the hearts of doctors through exposure to different experience and training, postgraduate training and working with expatriate doctors.

(a) Variety of experience and training

The findings revealed that there was a strong organization support for doctors' continuing education. Hospital B instituted strategic retention initiatives through provision of professional and personal support to employee needs. This culture fostered an environment of long term engagement of the doctors. The doctors cherished a variety of experience and training ranging from short courses, on-the-job training and off the job training in health institutions. This was perceived as a motivating factor as it was seen to help improve career prospects. The doctors and other health staff are periodically developed through skill development in different professional levels. This strategy cements the bondage of staff to the organization since it ensures that there are adequate

career development prospects. The doctors valued the opportunities for building their competences.

As we noted in chapter 2 (section 2.3.6) the psychological contract is characterized as a match between the expectations the organization has of its employees, the expectations the employees hold of their organization and what the organization is able to offer in return (Rossouw et al., 2010). While violation of the formal and psychological contract exacerbates migration of employees, lifelong employment can be attained when an organization strives to meet job related employee concerns. A noteworthy hospital commitment is exhibited in the findings presented in section 6.8.1 (sub section a). The decision of the hospital to sponsor a medical doctor at PhD level in Norway is a clear demonstration of its great value in staff development and hence a great inspiration for other doctors to stay.

This finding lends support to previous studies which underscore competence building initiatives as a long term development goal (Maestad & Brehony, 2007; Mæstad & Mwisongo, 2011; Nouri & Parker, 2013). This brings to the fore the relevance of the human capital theory (Becker & Gerhart, 1996) showing that economic success of individuals depends on investment in education and training. While studies like Mubyazi et al. (2012) in Tanzania revealed that health workers expressed strong feelings about limited training opportunities in rural areas, the experience in hospital B demonstrates great commitment in utilizing the available resource to expose the doctors to diverse learning avenues in the motto of building staff competence. The difference may in part be attributed to a faith based as opposed to a public health facility which has different resource bases for competence building of staff.

This seems to suggest that the context in which a hospital operates matters. Other studies have reported that opportunities for career progression and further training are structured to favor those working in big cities (Darkwa, Newman, Kawkab, & Chowdhury, 2015). However, the finding in hospital B show that this cannot be generalized with little consideration of the context generally and governance in particular.

(b) Postgraduate training

As we noted in the career literature in chapter 2 (section 2.3.5), several surveys of doctors living outside their countries of training confirm that postgraduate training was one of the reasons for emigration (Bonenberger et al., 2014; Stilwell et al., 2004). Research has demonstrated that doctors who are provided regular training and development opportunities are more likely to remain in the organization (Bernsen et al., 2009). While training inculcates requisite employee knowledge, skills and competences, it also signals employer's commitment to their workforce (Newman et al., 2011). Indeed Rodriguez (2008) argues that once employees feel that they are not growing; they begin to look externally for new job opportunities. Hospital B managed to avoid such a risk by offering an array of opportunities for continuous training and development. In a similar vein, past studies (e.g. Ahmad and Schroeder (2003), Pfeffer, 2000) found that employees that receive more training display low levels of intention to leave the organization than those who receive no training.

(c) Learning from expatriates

The doctors were continuously developed and actively involved in multi-disciplinary teams of experts through collaboration arrangements with expatriates living in Tanzania (e.g. Flying doctors) residing in the East and Central Africa region) and those visiting the hospital on short term contracts. The hospital management had created a working environment where Tanzanian and international doctors work cooperatively. Collaboration with research organizations within and outside Tanzania has created opportunities for enhancing doctor's research skills. For example, during the time of the study the hospital had links with the University of Virginia in the US and Laerdal in Norway.

The hospital management and staff expressed an appreciation of their experience with hard working, highly motivated and committed expatriate volunteers. These learning avenues are one of the factors that attracted and retained doctors in hospital B. The role of expatriates has been instrumental in terms of mentoring and knowledge exchange. Doctors in hospital B appreciated working with expatriate specialists as it enhanced

knowledge and experience sharing. This finding lends support to career literature in chapter 2 (section 2.3.5). The technical (functional) career expertise emerged as a motivator for doctors to stay in this hospital. This study confirms earlier findings which revealed that the availability of career development opportunities within an organization tends to promote a higher degree of organizational commitment among employees (Wils et al., 2010). Moreover, a study by Burch et al. (2011) found that lack of opportunities for career advancement is one of the major factors driving migration of doctors in particular in many developing countries.

6.9.3 Income

Pay levels have long been acknowledged as important factors which influence staff retention. As we noted in the findings (section 6.7.3, (i)), hospital B keeps pace with prevailing salary scales in the public sector and pay the doctors additional allowances of 30 percent. This is in cognisance of the reward literature in chapter 2 (section 2.3.1, d) and previous research in the context of least developed countries which suggests that salary increases and other improvements in compensation may contribute to employee retention (Chappell & Glennie, 2010).

While doctors in hospital A (located in urban areas) engage in 'dual practice', or hold multiple jobs in both the public and private sectors, there were limited opportunities for doctors in Hospital B. In response to this limitation, they engaged in alternative sources of income for their survival (i.e. extramural private practice in other business). These include farming. Cattle keeping and construction of guest houses which are on high demand by patient relatives. Non financial incentives like recognition by the management, colleagues, the community and patients overshadowed economic rewards in hospital B. This study lends support to previous studies which found that sustainable intervention combines financial and non financial incentive (Adzei & Atinga, 2012; Chandler et al., 2009; Kolstad & Lindkvist, 2013).

6.9.4 Leadership

As we noted in the findings (sections 6.7.1), recognition from the management, colleagues the community and patients was viewed as one of the most important motivating factors for doctors to stay. These are discussed and analysed below.

a) Participative management

The hospital ability to attract and retains qualified medical doctors in a rural low resource setting elevate it as a show case not only to other private hospitals but also to the public sector. Leadership in Hospital B exhibited how setting policy and overseeing strategic direction, managing resource allocation, and monitoring policy targets and outcomes through stakeholder involvement is an effective retention intervention in a rural setting. As noted in section 6.7.1d strong leadership and managerial practices foster organizational capacity and sustains higher-quality services. Doctors were inspired by the hospital leadership. Their positive remarks were associated with the management support and willingness to ensure that personal and occupational matters were addressed.

In spite of its rural location which makes it difficult to attract medical doctors, the hospital has managed to attract and retain doctors. The hospital has demonstrated how leadership can enhance employee morale and commitment to stay in an organization. The appointment of one of the medical doctors to be the Assistant Medical Director is a potential motivating factor for the appointee as well as colleagues. Underlying this view is the idea that such recognition signals the value the hospital attaches to the internal experts and can attract more specialists to seek employment in hospital B.

The leadership style at the hospital is termed *Inclusion A approach*. This is a management phrase formulated by the hospital management team meant to ensure that all staff work together as a team and include each other's experience and input to decisions being made in a good spirit and with constructive and kind communication. This does not however replace the authority of the leaders when making final decisions, but it improves the decision making process and the feeling of being included and useful to the hospital for

all workers. This participatory management enhances commitment in pursuit of organization activities.

Hospital B leadership developed good relationships with local and national health authorities (at district, regional and ministry levels) and international donors, particularly the Royal Norwegian Embassy and the Friends in Norway which have been of great importance both for funding and capacity building objectives. Good leadership and team work has enabled the hospital to achieve good outcomes.

The findings in hospital B echo the fact that psychological contract fulfillment presented in chapter 2 (section 2.3.6 c) enhances employee retention. This is stark contrast to a catalogue of complaints leveled against poor leadership in many rural and urban healthcare institutions in many developing countries where the root causes that affect retention of medical doctors emanate from the HRM system and work organization process (Ferrinho et al., 2004; Lindelow & Serneels, 2006).

b) Recognition by management

The good relationship between the management and the doctors nurtured religious affiliation and built a culture of institutional loyalty. The hospital management rewards doctors through recognition, appreciation and encouragement for a well done job. This is premised on the recognition of the limitations of money as a motivator. Drawing on reward management literature in chapter 2 (section 2.3.1, d), integrated financial and non financial rewards complement each other and boosted doctors morale and commitment. A *“fair day’s work for a fair days pay”* may have little relevance in the absence of demonstrating how the employer values the employee. The hospital ability to address problems besetting doctor performance inspires them to stay. It is thus crucial to recognize employee expectations relating to the social exchange which may assist in promises fulfillment. This confirms previous studies which indicated that employee recognition enhances their loyalty to the organization and hence high commitment to stay (Fu & Cheng, 2014; Khuong & Tien, 2013).

c) Recognition by colleagues.

Professionals like medical doctors work in teams along their specialties. Hospital environments with dedicated work teams increase job satisfaction and commitment. When one perceives that he or she is being valued by peers, it is a motivation. This is supported by the reward literature in chapter 2 (section 2.3.1, d) which indicates that employees deserve intrinsic rewards as a complement of extrinsic rewards. The hospital has a strong cohesion among all hospital employees. From the inspiration of good leadership, all employees identify themselves with a common organization culture of collegiality. The doctors acknowledged the collegiality atmosphere in which they worked in teams. As we discussed in section 6.8.4 above, this array of recognition and appreciation by the community, management, patients and colleagues is a powerful factor which arouse doctors' work morale and commitment to their continued stay.

d) Recognition by patients

Doctors dedicated service attracts many patients to seek treatment in hospital B. When doctors get positive remarks from patients, it is inspiring. Despite its location in a rural area, hospital B is visited by patients from distant Districts and Regions. This is largely attributed to high quality service exemplified by good staff attitude and dedication to render quality patient care. The hospital is renowned for its high quality medical services. The hospital performance has been so good to the extent of registering the lowest Maternal Mortality Rate in Sub-Saharan Africa. The good image is not accidental. It stems from among other things, good leadership, high level investment in human capital and other hospital resources. As Fritzen (2007) note, health workers are the most important resource for producing good health services and ultimately influence the success or failure of the health system.

6.9.5 Administrative system

Doctors and other health staff require adequate equipment to do their jobs properly. The supportive management role was perceived as one of the factors which create an enabling work environment for quality patient care. Doctors in hospital B commended the

availability of adequate equipment. They underscored the primacy of requisite equipment in their quest for rendering quality health care services. They gladly acknowledged that availability of equipments enhanced their utilization of knowledge and skills.

The curative services offered at the hospital have been described as being of very high quality nationally and internationally. Because of its medical expertise and well functioning equipment it attracts patients and receives referral cases from all over northern Tanzania. It relies on its competent staff and basic equipment to provide quality care. This finding lend support to previous studies (Ssenkooba et al., 2007) *which* suggests that having the requisite equipment in a health facility can have significant impact on attracting health care providers working in the rural areas.

6.9.6 Sense of duty to Patients and the Country

A Sense of duty is one of the reasons which motivated doctors to stay in Hospital B. The doctors categorized their jobs as acts of service, rather than just work which they were hired to do. The long serving culture hinges on doctors' dedication to whole heartedly work in a rural setting with knowledge of the alternative opportunities elsewhere. Their accumulated skills and experience could have prompted them to seek employment opportunities elsewhere. The doctors in hospital B serve beyond their call of duty. The retention of doctors for long periods of time builds an institutional memory which in turn influences new recruits since doctors who have stayed for a long time period are role models to the newly recruited. Doctors iterated that having "a *calling*" was one of the reasons for their continued stay in hospital B. This seemed to be closely associated with their religious conviction which cemented moral obligation. Most importantly, this commitment should never be taken for granted. Hospital leadership has to demonstrate recognition of such devotion as a positive reinforcement.

6.9.7 Societal tradition and customs.

Culture is discussed and analysed through four lenses namely family bond, community bond, and moral satisfaction. The culture of nurturing and continued support of the community members has to a great degree worn the hearts of the doctors and indeed all

the staff. The hospital culture treats the staff as members of one family. It has indeed demonstrated how an organization can integrate HRM functions cohesively towards a holistic management philosophy and transformational leadership. This has helped to nurture, develop and maintain a committed and dedicated workforce which collectively associates contract fulfillment literature in section 2.3.6, c).

a) Family bond

The findings show that one of the factors which motivated doctors to stay was strong family ties. While some interviewees pointed out that they had the responsibility to look after their aged parents and relatives, others indicated that they were obliged to take care of the welfare of their extended families. These roles make it difficult for doctors to leave. This scenario mirrors the career literature in chapter 2 (section 2.3.5) as the lifestyle integration career anchor in which supports people value the importance of balancing work and family responsibilities (Oosthuizen et al., 2014).

b) Community bond

This study found that doctors in hospital B (most of whom were originating from the nearby districts) continued to work in the hospital. This commitment stemmed from community bond (affection to help the community). The doctors rendered health services in response to greater appreciation and recognition by the community. Working in a hospital located near one's home is an opportunity to render health services to the community members.

In the African culture, people tend to establish strong ties with their communities. The ties become stronger when an employee is given some recognition by the community. Doctors stated that the appreciation that they felt from the community was a strong motivating factor which cemented their commitment to continue working in hospital B. This study underscores the importance of recognizing doctors in their work context as it seems to be a powerful influence in winning the hearts of professionals in a rural setting like hospital B. This echoes findings on past studies which found that respect and support from the

community enhanced retention of health workers (Couper, Hugo, Conradie, & Mfenyana, 2007).

c) Moral satisfaction

The moral satisfaction derived from their religious orientations seems to have aroused their quest for contributing to the greater good of the hospital. Pursuit of daily workload is preceded by brief morning prayers involving all employees and the visitors. This organization culture enhanced staff punctuality and enhanced employee loyalty and commitment to provide physical and spiritual services to the patients.

As we noted the findings in section 6.7.1, the recruitment strategy of combining qualification and behaviour which involves church leaders among the selection committee spearhead the availability of professionals with religious values which commensurate with the hospital motto. This culture typifies the psychological contract literature in chapter 2 (section 2.3.6). The doctors render professional health services as well as religious services. The loyalties seem to be directed to serving God through the church and the hospital. This perception is in part attributed to their Christian values and beliefs. These values are further translated into job location preferences where patients in remote locations are given high priority.

6.9.8 Migration intentions stemming from inequity in pension

Membership to pension funds has traditionally been determined by specific sectors in which employees were saving. While profit health facilities and nonprofit NGO hospitals belong to the National Social Security Fund, health staff whose employment jurisdiction fall under state –owned organization (Parastatals) contribute to the Parastatal Pension Fund, and other government employees belong to the Public Sector Pension Fund. Disparity between different pension payments among pension funds in Tanzania aroused inequity concerns in hospital B with doctors calling for a freedom to choose which pension fund they could belong to. This garners the importance of Equity theory (Adams,

1965). Double standards in employee welfare matters negate the quest for attracting and retaining talent.

6.9.9 Summary Hospital B

This study sought to explore the factors that influence migration decisions to stay or leave hospital B. The hospital had managed to attract and retain doctors recruited. There was no doctor who migrated from the hospital during the period of the study. This is a rare case in the context of hospitals in rural locations in developing countries. Hospital B is in this respect an exemplary model of successful doctor retention interventions. The factors influencing doctors to stay are summarized in Table 5.6 It delineates the factors for staying and factors which signaled migration intentions.

Table 6.2 Summary of Factors influencing doctors to stay at Hospital B.

Major Theme	HRM practices and initiatives	Reasons for staying	Comments and Questions
Recruitment strategy		Exposure to rural environment influences choice of job location	Recruitment from a rural setting seems to be a positive retention catalyst. Doctors expressed their unreserved commitment to serve community members.
Competence building	Variety of experience and training	The hospital provides various career development opportunities	The hospital management is committed to create better career prospects for medical doctors. This is in both continuous training and development to highest levels of qualification possible. For example, by the time of the study, one doctor was pursuing a PhD in medicine in Norway. This is a rare opportunity in non university settings.
	Postgraduate training	Provision of opportunities for specialization attracted doctors to stay	Pursuit of postgraduate training helps doctors to specialize
	Learning from expatriates	Learning from the expatriates who are mostly super specialists is highly valued as it enhances greater competence	There are opportunities for doctors to understudy expatriate doctors who often visit the hospital to render specialized services at low costs
Income	Salary Supplement	Ameliorate economic hardships and creates a piece of mind.	Salary complements take into account the low pay and absence of opportunities for Intramural Private Practice in a rural setting with Faith Based NGO hospital where patients are satisfied with the level of health care rules out the demand for private clinics

Major Theme	HRM practices and initiatives	Reasons for staying	Comments and Questions
	Extramural Dual Practice in business	Complements salary gap and helps doctors to afford rising living costs	Doctors engagement in Extramural business complement the lost opportunity for Intramural Private Practice which is nonexistent in the context of a Faith Based hospital with a different culture
Leadership	Recognition by the Management	Highly valued by doctors who get a sense of importance	Praises like well done were a common management style. This is a strong motivation which reinforces doctors' perception that their work is valued.
Administrative system	Equipment	Valued since they pave way for proper utilization of skills	Management support manifest through provision of equipment. This inspires doctors to stay.
Sense of duty to patients and the country	Sense of duty to patients and the country	Doctors provide services through passion regardless of the challenges encountered.	The doctors exhibit a sense of duty. This may be stemming from religious devotion to render quality services to the needy.
Societal traditions and Customs	Family bond	Strong family ties mitigate migration temptations	The commitment to fulfil family obligations make it difficult for doctors to leave
	Community bond	This is multifaceted as it transcends hospital and church boundaries	Family bond is rooted in the community culture
	Moral Satisfaction	A faith based hospital elicit moral satisfaction and commitment to stay	The moral satisfaction derived from doctors' religious orientations seems to have aroused their commitment to stay. The doctors' loyalties seem to be directed to serving God through the Church and the Hospital. These values influence rural job location preferences.
		Reasons for Migration Intentions	
Pension		Concerns on differential pension payments between public and private hospitals	In the absence of Pension harmonization in the employment scene, inequity concerns erode employee motivation and precipitate migration intentions
Obligation to nuclear family		Concerns on Children's education in a rural area	Some doctors were not satisfied with the standard of education in the rural setting. This triggered migration intentions

The study set to explore the factors which influence doctors to stay or leave hospital B. It has been found that the hospital managed to attract and successfully retain medical doctors. There was no experience of doctor migration. The success in the retention of the doctors stems from a number of factors.

The recruitment and selection system practices are closely alignment with professional qualification and rural upbringing which are reinforced throughout the organizational culture.

There is multiple competence building opportunities. The doctors are continuously developed and actively involved in multi-disciplinary teams of experts through collaboration arrangements with expatriates from other countries. The management has created a working environment where Tanzanian and international doctors work cooperatively. The hospital has been committed in training the staff in order to increase efficiency and capacity. The hospital nurture and develop students from the community in secondary and professional training and employs them upon completion of their studies. The courses include Medical Officers, Medical Assistants, Laboratory Assistants and Accountants. The staffs are further developed through skill development in different professional levels. This strategy cements the bondage of staff to the organization.

The organization culture exhibited by hospital B is a vivid example of the fact that when an organization views an employee as a whole person, it devises multiple retention interventions. Underlying this view is the idea that there are diverse reasons for the mobility of skilled human resources. Attempt to attract and retain this resource requires multiple dimensions. The hospital has a strong cohesion among all hospital employees. All employees identify themselves with a common organization culture of collegiality. The hospital mission which transcends multiple objectives has created many opportunities for jobs in the community. The doctors have also demonstrated high devotion for work for the hospital despite the awareness of the alternative opportunities elsewhere.

The reward system which combines both financial and non-financial incentives has boosted staff morale and commitment. On top of the government salary scales, medical doctors are offered top up allowances, housing and free medical care. In recognition of the limitations of money as a motivator, the hospital management rewards staff through recognition, appreciation and indeed encouragement of good work done. This study reveals that doctors accord much weight not only on good pay but also professional and social needs. The need for recognition and praise of doctors for their crucial role and complex work context is arguably a costless endeavor. It transpires from the findings that apart from salaries, opportunities for periodic training career development prospects, and a good work environment with adequate equipment motivate doctors.

The findings support the premise that both financial and non-financial factors are important retention interventions. Hospital B implemented HRM functions as means to an end rather than being ends in themselves. Thus far, it can be concluded that attraction and retention of skilled employees greatly requires good human resource management practices.

Hospital B signals the pivotal role of leadership as it provides visionary direction which motivated doctors through recognition of their role in furtherance of the hospital mission. The findings echo the importance of good human resource management practices which can arouse employees' commitment to deliver quality service and most importantly to stay within the organization. The hospital demonstrates that HRM has to take a holistic view of employees and to underscore human capital principles to ensure that employees keep abreast of changes besetting their occupations.

Overall, dominant factors which seem to influence rural retention seem to be intrinsic motivation, rural background, religious affiliation, leadership and organizational culture. Much as hospital B had been spared of doctor migration during the period of the study, some doctors expressed intentions to leave due to dissatisfaction with low pension offered by the National Social Security Fund. This concern had negative implications on retention.

CHAPTER SEVEN: CROSS CASE ANALYSIS AND INTERPRETATION

7.1 Introduction

In studying patterns of doctor migration in two Tanzanian hospitals, one being a small hospital in a distant rural area, and another one being the main hospital of the country, located in the capital, one might at the outset expect to find doctors leaving the small, rural hospital to seek greener pastures in the main hospital or outside the country. Reasons for this would partly be about location. For well-educated people it is generally seen as more attractive to live and work in a bigger city, with better opportunities for career advancement, children's education, employment and income for spouses, living conditions such as good housing services. Moreover, the opportunity to work in a large hospital with a wide scope of disciplines, surrounded by experts in many specialized fields and also associated with high prestige (being a super specialist whose expertise is on high demand) would seem like important reasons to work in hospital A.

On the other hand, working in a smaller hospital in a distant, rural setting would probably be seen as a negative owing to perceived lack of social services like electricity and water, poor working and living conditions, inadequate transport and communication facilities, concern over quality of education for staff children stemming from poor quality of schools with acute lack of qualified teachers and scarcity of class rooms. As we shall see, these assumptions – often taken for granted – did not seem to hold up in the present study. It emerged that the decision to stay or leave is not only dependent on the scores on the various variables (such as income level), but mainly on which variables or factors are subjectively most important to the individual doctor.

In my study, doctors in both hospitals (and also doctors who had left hospital A) were asked about a number of issues listed in the interview guide (See Appendices 3A – 3 C) believed to be relevant to the decision to stay or leave. This included questions about competence building opportunities derived from domestic and expatriate specialists, income from dual practice and salary top ups, sense of duty (to patients and the country,

societal tradition and customs, extended and nuclear family, and community bonds, recruitment practices, leadership style, recognition, and administrative system.

What appears to be the case is that the real differences in such areas as economic income from dual practice and moonlighting opportunities were not always favoring the larger hospital. Furthermore, what seems to be most important for the doctors, was not always factors such as income and facilities, but rather – as we shall see – things like leadership style, duties to family and society, and – in the case of hospital B – what I have called “moral satisfaction” – which is a combination of religious devotion, and passion for doing “God’s work” by serving people in a local community. These dynamics are presented and analyzed in the sections that follow.

7.2 Factors influencing doctors’ migration decisions in Hospital A and Hospital B

This section first identifies convergences and divergences between the main findings in the two hospitals, factor by factor. The issues discerned are then interpreted in view of established theories (see chapter 2), and alternative theoretical perspectives that emerge.

7.2.1 Opportunities for competence building

Competence building featured as an important factor influencing migration decisions in this study. Both hospitals employed a range of competence building initiatives to attract and retain doctors. These ranged from a variety of experience and training, postgraduate training, learning from domestic specialists and expatriate doctors. This array of competence building opportunities is analyzed below.

a) Variety of work experience and training

Doctors in both hospitals who decided to stay were motivated by an array of work experience and Training. Periodic training and development was valued as a necessity in their quest for mastery of requisite skills and competences in their desired medical specialties. Both hospitals had collaborative research with foreign health institutions

which enhanced skill development and enable them to keep pace with the tide of technological changes in the medical profession. The doctors perceived these arrangements as demonstration of the hospital commitment to create a conducive learning environment equip them with requisite skills and competences required to perform their jobs and meet career aspirations. Continuous staff training and development features as an indispensable strategy for motivating doctors to stay in both hospitals.

However, some doctors in hospital A expressed dissatisfaction with the pace of training and development, exhibiting fears of career retardation due to the long gestation period they had to wait to seize training opportunities. This could be in part attributed to the fact that hospital A had comparatively more doctors than hospital B. Given that the medical career requires periodic skill upgrading to be in line with the changing technological environment in their profession and specialties in particular, some doctors mentioned this as a reason why they had to leave.

The findings lend support to the career literature presented in chapter 2 (section 2.3.5) that established a significant relationship between career development opportunities and employee retention. The extent to which health workers are exposed to opportunities for continuous professional development, such as sponsorship to attend both short and advanced courses in their areas of specialization, has a strong motivational effect on retention (Adzei & Atinga, 2012; Chen, 2014). It has been found that worker support strategies that give access to in-service training, contributes to confidence in practicing in rural and remote areas, and they strongly alleviates professional isolation, and improves retention (Moran et al., 2014).

Other studies have reported that opportunities for career progression and further training are structured to favor those working in big cities (Darkwa et al., 2015), However, the finding in this study show that this cannot be generalized with little consideration of the organization context generally and hospital governance in particular. Hospital B demonstrated commitment to nurture, develop and maintain a committed and dedicated workforce in accordance with the psychological contract fulfillment literature in chapter 2 (section 2.3.6, d).

The findings are consistent with the human capital theory (Becker, 1975; Schultz, 1961). The theory underpins the importance of human resource strategies that exceed financial motivation. It stresses that continuous professional development is integral in increasing professional workers' production capacity. There is a need for large investments in human capital development, whereby the education that workers receive would increase their productivity and efficiency, and motivation. As Rose (2005) notes, it is the human element, and not capital or material resources that determines the success of economic and social development.

Similarly, the psychological contract literature in chapter 2 (section 2.3.6) justifies why organizations invest in employees' training and development. The rationale is that it offers requisite competences in response to changing job requirements. These practices are expected to arouse employee commitment to stay. Psychological contract breach, on the other hand, can be defined as instances when employees perceive their organization to have failed to meet its reciprocal contractual obligations (Bal et al., 2010).

b) Postgraduate training

In both hospitals, postgraduate Training is offered to doctors who completed a medical degree and worked for a defined time period. The two hospitals offered scholarships to doctors within and outside Tanzania. They were trained in specialized programmes as a way of building local capacity in different specialty domains. The motivation to stay was reinforced by the expectation that doctors would pursue postgraduate training. Given the high training costs at the postgraduate level, the doctors were glad to seize such opportunities because they enabled them to specialize hence gaining greater competence and better delivery of high quality health care. However, perceived better medical technology abroad induced doctors in hospital A to migrate to the UK and Canada. Decisions to leave were premised on the hope that training abroad would yield much in terms of knowledge, experience and international exposure to state of the art medical technologies. The Quest for advanced training abroad was also necessitated by non availability of the desired specialty and the fact that medical training institutions are beset with lack of super specialists.

My findings confirms the idea that it is essential for doctors to continually update their medical knowledge taking into account that clinical practices change rapidly, doctors should remain receptive to new ideas, technologies and work practices in order to enhance the quality of their services. This confirms the career literature in chapter 2 (section 2.3.5). For example, Rodriguez, (2008) argues that once employees feel that they are not growing; they begin to look externally for new job opportunities. In addition, other studies (Bonenberger et al., 2014) found that employees that receive more training display lower levels of intention to leave the organization than those who receive no training. From the perspective of human capital management, people are considered as intangible assets (human capital) whose future value can be enhanced through investment (Shaw et al., 2013). Arguably, much as career development avenues increase doctors' knowledge, skills and competences, the motivation for career advancement can hardly be disentangled from the quest for an increased salary level upon completion of studies or the quest for self-actualization.

c) Learning from domestic specialist doctors

Mentoring refers to a close interpersonal relationship between a senior more experienced colleague (the mentor) and a less experienced junior colleague (the protégé) in which the mentor provides support, direction, and feedback regarding career plans and personal development to the protégé (Park, Newman, Zhang, Wu, & Hooke, 2016, p. 1173). The technical nature of the medical profession creates a compelling need for doctors to work in teams. The referral status of the two hospitals was cherished by the doctors who stayed in both hospitals as it provided avenues for knowledge sharing through diverse specialty teams in which junior doctors learnt from senior doctors.

The specialists in both hospitals offer career-related and psychosocial mentoring services to junior doctors. While career related mentoring help the junior doctors to advance their career in the hospitals, the psychosocial mentoring entail coaching (i.e. sharing of ideas, giving feedback and exposing them to challenging work roles). They are also role models to juniors (conveying appropriate attitudes, values, and behavior). The doctors were couched through Ward rounds to discuss referral cases and joint researches were

conducted through specialty teams. These forums were highly valued as a rich source of gaining experience and acquisition of practical skills. Doctors who stayed in both hospitals alluded to the fact that they got satisfaction from working with domestic specialists. Hospital A had comparatively more specialists compared to hospital B.

It surfaced that provision of mentoring opportunities in both hospitals motivated doctors to stay because they were perceived as valuable in terms of means of skill acquisition. As the Social Exchange theory (Blau, 1964) posits, employees feel obligated to reciprocate organizational support by their willingness to stay. This finding resonates with recent studies which showed that provision of effective mentoring by organizations limit employee turnover intentions (Baranik, Roling, & Eby, 2010). Taking into account that knowledge sharing is done through professional teams; social capital plays a central role in employees' professional development and mentoring. The findings increase understanding on how social capital and HRM practices influence knowledge sharing. This corroborates with findings by (Cabello-Medina, López-Cabrales, & Valle-Cabrera, 2011; Kikuchi & Coleman, 2012) which emphasized the synergy evolving from team work.

My study also highlights perceived organizational support as a possible mechanism that explains the positive effects of mentoring functions on employee attitudes in the workplace. This study illuminates the importance of mentoring services in enhancing employee retention. The findings garner the relevance of Social exchange theory. In this vein, HRM professionals in the health sector should take heed of the diverse experiences and approaches of their staff in designing staff development programmes, in order to provide opportunities for them to learn from one another. This study also makes an empirical contribution to the mentoring literature by showing the role of mentoring in the context of health care sector in a developing country context.

d) Learning from expatriate doctors

The collaboration with foreign governments and health institutions facilitated engagement of expatriate doctors in both hospitals. Expatriate doctors were engaged on short term

contracts. Doctors who stayed in both hospitals garnered the idea that working with expatriate doctors gave them the opportunity to share knowledge and gain international experience. Forums with expatriate doctors were acknowledged as rich sources of learning and doctors were highly motivated to participate. These partnerships focused on among other things, joint medical research and delivery of health care services. The cultural diversity between expatriate doctors and Tanzanian doctors in both hospitals created a window of opportunity for gaining international experience and the cross cultural learning between the collaboration partners. Expatriate doctors were also often mentors of the local doctors in their specialties. Doctors in hospital B had a comparative advantage on this aspect over those in hospital A because of an array of frequent expatriate visits. This trend is enhanced by its religious orientation with many collaboration networks abroad.

This finding lends support to the career literature in chapter 2 (section 2.3.6). My study confirms earlier findings which revealed that the availability of career development opportunities within an organization tends to promote a higher degree of organizational commitment among employees (Patterson et al., 2010). These findings also lend support to other studies which have found that worker support strategies that give access to in-service training, contributes to confidence in practicing in rural and remote areas, and that they strongly alleviates professional isolation, and improves retention (Moran et al., 2014).

7.2.2 Income

Income levels are closely associated with diverse sources of earnings available for the doctors in the Tanzania health sector. In this section, it is delineated into four sub themes. These include income from Salary and incentives, income from intramural dual practice in medicine, income from extramural dual practice in medicine and income from extramural dual practice in business. These are presented and analyzed below.

a) Income from salary and incentives

In response to low salary and incentive incomes, both hospitals instituted financial incentives to augment doctors' earnings. Hospital A made periodic salary reviews (Refer to Appendix 9). Hospital B adheres to prevailing government salary scales and paid doctors 30 percent top up allowance of the basic salary in order to complement lost opportunities for engagement in intramural and extramural dual practice in medicine which are not included in the hospital B policy and work culture.

Higher salary incomes in the financial sector compared to the health sector under which hospital A doctors worked. These differentials created dissatisfaction and lowered the work morale of doctors in hospital A. Concerns on low and irregular pay precipitated doctor migration in hospital A. Income differential between rural and urban locations is arguably offset by indices of the low cost of living in a rural setting in respect of the purchasing power parity.

Satisfaction with pay levels is not only based on absolute levels, but even more on relative levels. It surfaced that doctors in hospital A drew parallels between pay levels of the health sector and other sectors within Tanzania as well as between Tanzanian levels and pay levels outside the country. Also concerns with pension differentials featured as one of the factors which influenced decisions to leave in both hospitals. It is a pity that public sector employees belong to different pension funds with differentiated pension schemes according to respective sectors.

Concerns with pension differentials also featured as one of the factors which influenced decisions to leave in both hospitals. It is a pity that public sector employees belong to different pension funds with differentiated pension schemes according to respective sectors. The pension scheme offered to public sector employees (e.g. hospital A) were better than that offered in faith based hospitals (e.g. hospital B).

However, there were also differences in pension schemes among different pension funds serving public sector employees since some pension funds provided favorable pension

scheme than others. For example, the pension paid by the Local Authorities Pension Fund (LAPF) was higher than that offered by the National Social Security Fund (NSSF).

These differences which precipitate high levels of dissatisfaction in both hospitals are further compounded by lack of coordination between the social security funds (Songstad, Moland, Massay, & Blystad, 2012). This is in part attributed to the fact that each fund reports to a different parent ministry with different operational rules and procedures. This created differences in terms of contribution rates, benefit structures as well as plans and priorities between the pension funds. In the absence of a harmonized pension scheme, doctors expressed great concerns about inequity in pension between the public and faith based hospitals. These differences are one of the causes of migration in Hospital A and some doctors in hospital B expressed intentions to leave. Evidence from literature confirms that turnover intention is the best predictor of actual leaving and therefore can be used as proxy for turnover as well as a pointer that employees may not contribute to organization at their full potentials (Cho & Lewis, 2012).

Much as economic factors – salaries in particular, have largely influenced doctor migration in hospital A, hospital B managed to retain the doctors through integration of financial and non financial rewards. Unlike hospital A where incentive packages were largely financial (i.e. salary, allowances and fringe benefits), hospital B employed both financial and non-financial incentives. These encompassed valuing the work done by doctors through a demonstrated recognition of their clinical role in health care provision.

Inequity concerns elevated in this study underscores the applicability of Equity theory (Adams, 1965). The theory is concerned with the perception people have about how they are being treated as compared with others. Adams theory points out that there are two components in the employer-employee exchange, that is, inputs and outputs. Inputs are what the employee expects to get in return for their participation and sharing of information including education, experience or training. The outputs are the outcomes the organization provides, such as pay, benefits and recognition.

Motivation is influenced by an individual's subjective judgment about fairness of the reward one gets in relation to the relative input (which includes factors like effort, experience, and educational qualifications) compared with the reward of others. When an individual perceives the reward as equitable, he or she may increase the level of output and continue working. In contrast, when an individual perceives that he/she is inequitably rewarded, one may be dissatisfied and hence reduce the quality and quantity of output or may leave the organization.

Equity theory underscores the need to develop equitable reward and employment practices. In the eyes of employees, equity is translated into being treated fairly in comparison with another group of people (i.e. a reference group). In contrast, employees are de-motivated if they are treated inequitably. In this study, this theory ushers some relevance particularly on differential salary payment within the country and outside the country. The theory explains why pay and conditions alone do not determine motivation. Moreover, it mirrors the notion that granting pay rise or promotion to an employee can have a de-motivating effect on others. When employees feel fairly paid, they are more likely to be motivated.

Conversely, when employees feel that they are unfairly treated, they are likely to be dissatisfied and de-motivated. Doctors in both hospitals sought to gain equity by tallying the inputs they bring to a hospital and the outcome that they receive from it against the perceived inputs and outputs of others. In the context of this study, input encompasses the quality and quantity of doctors' contributions in the delivery of health care services. Examples of inputs include time, effort, loyalty, commitment, specialty skills, flexibility, tolerance, enthusiasm, trust in supervisors, and support from peers. Outputs can either be tangible or intangible. They range from recognition, to salary and benefits. Equity theory also contends that different employees ascribe personal values to different inputs and outcomes. In this vein, holistic interventions may have limited outcomes.

Although hospital B is comparatively successful in retaining doctors through employment of non-monetary incentives like recognition and credence to staff training and

development, differences in terms of pension packages between the public and private hospitals aroused migration intentions.

Some professionals in other sectors of the economy whose qualifications were perceived to be inferior compared to those of doctors earned higher pay than doctors. Such pay differentials precipitated a state of dissatisfaction and fuelled outmigration of doctors in hospital A. As noted in chapter 2 (section 2.4.3), awareness of different rewards triggers the desire for migration (Zimmermann & Bauer, 2002).

This elevates the applicability of Equity theory and illustrates the influence of economic factors in migration decisions in low income countries. Past studies in the reward literature in chapter 2 (section 2.4.4) suggests that salary increases and other improvements in compensation may contribute to employee retention (Chandler et al., 2009; Songstad et al., 2012). However, even for those doctors whose main migration motive was economic gain, professional factors such as the quest to specialize came to the fore.

It emerges that doctors are not only motivated by financial incentives but also non-financial incentives such as recognition by the management, the community, peers and patients. This lends support to others studies that underscore the fact that non-financial incentives can be highly effective, especially for the attraction and retention of doctors in rural areas (Kolstad & Lindkvist, 2013). Moreover, the findings juxtapose a combination of financial and non-financial rewards in enhancing work morale and greater commitment in pursuit of organization goal and objectives. It is in this context that hospital leaders have a critical role in establishing a work environment which nurtures recognition. In the case of hospital B, non-financial incentives like recognition by the management, colleagues, the community and patients overshadowed economic rewards. This resonates with past studies that underscore bundles of interventions in order to address multiple factors (Adzei & Atinga, 2012; Buchan, 2010; Buchan et al., 2013; Dolea et al., 2010; Lehmann, Dieleman, & Martineau, 2008; Wils et al., 2010).

b) Income from intramural dual practice in medicine

This is a flexible work system enshrined in the Private Practice Policy which allows patients to seek appointments in a public referral so that they get direct access to services provided by medical specialists. This system attracts patients who can afford to pay consultation fees for medical specialists and hospital diagnostic and prescribed medical supplies. Most of the doctors who stayed in hospital A were attracted by opportunities for Intramural private practice in medicine during official working hours. This arrangement allows doctors involved to gain additional income on top of their salaries. The doctors are paid 40 percent of the consultation fees. Arguably, this policy favours specialists and super specialists whose skills and competences are highly demanded by referred patients. Most importantly, this system minimizes the time they would otherwise moonlight in private hospitals. In contrast, doctors in hospital B have no flexibility of intramural dual practice in medicine since it provides subsidized health services to rural populations.

Intramural dual practice in medicine is part of hospital A strategies of income generation which is expected to motivate doctors to serve private patients while working in public hospitals. The system is highly valued by doctors in hospital A as they acknowledge that it substantially complement their low public sector pay. This policy has indeed enhanced doctor retention particularly for those motivated by financial rewards as they regard outmigration as no longer attractive.

The finding illustrates the limitation of dual practice in the retention literature presented in chapter 2 (section 2.3.2). Owing to scarcity of specialists in different clinical disciplines in the local market coupled with brain drain to other countries (Mwangu, Mbembati, Muhondwa, & Leshabari, 2008), junior doctors shoulder higher workloads of a general nature while the few specialists and super specialists attend referral cases from private patients. In this vein, the junior doctors do normally not benefit from this arrangement. The envisaged retention is thus compromised as inequity concerns come to the fore.

c) Income from extramural dual practice in other business

In order to expand income sources and hence augment low salary incomes, doctors in both hospitals were engaged in entrepreneurial projects. While doctors in hospital A established Shops and petty businesses, doctors in hospital B owned small Farms and kept Cattle. Taking into account that Intramural and Extramural private practice is inapplicable in the faith based hospital set up, doctors in hospital B also found it important to do extramural dual practice in non health business (i.e. moonlighting).

Hospital A doctors were comparatively better-off in increased financial earnings compared to hospital B doctors in terms of moonlighting due to the fact that businesses flourish more in towns and cities with a wider market from the bigger population as opposed to a rural setting with low demand. Additional sources of income substantially increased the incomes of doctors in hospital A and mitigated temptations to migrate. However, higher incomes did not emerge as imperative for doctors in hospital B whose strong sense of service in a rural setting overshadowed financial inducements.

The finding indicates the relevance of moonlighting literature. The study points to the need for improved regulation of moonlighting in Tanzania. This finding lends support to the reward literature presented in chapter 2 (section 2.3.1, c). In resource limited environments characterized by persistent low levels of salary and incentives, financial rewards seem to be highly valued by employees. Revelations by doctors engaged in moonlighting in this study are rich insights which have hitherto been under researched in the Tanzania health sector. Formalization of these opportunities has mitigated outmigration of doctors. The predominance of this practice in urban areas like hospital A premises elevate salary as one of the major factors which influence migration decisions to leave.

7.2.3 Sense of duty

According to Wikipedia, sense of duty is a motivating awareness of ethical responsibility deriving logically from ethical or moral principles that govern a person's thoughts and

actions. It conveys a sense of moral commitment or obligation to someone or something. At a county level, it manifests through patriotism expressed through re-affirmed love of a country. It entails placing the welfare of a country above the individual. Sense of duty manifests in five lenses namely patients and the country, the extended family, the nuclear family, the community and religious affiliation. These are presented and analysed below.

a) Duty to the extended family (Family bond)

The term extended family is used here to broadly refer to any form of blood relationship encompassing very proximate and very distant ones. Extended family includes the parents (e.g. Father, Mother), Grandparents, Aunts, Uncles, Cousins, and other kin. Family ties are rooted in African tribal traditions and customs. The idea of a family extends beyond its conjugal members. A lineage, or extended family, is thus a far larger web of relationships among different family members. One's relationship with members of the extended family may be as important as, and in some cases, more important than, one's relationship with spouses and children. This chain of close and distant relatives invariably creates financial and social obligations for members with relatively higher economic power. This is particularly so in the wake of non-existence of national social welfare in which the country could take responsibility.

The families were originally often living in close proximity. However, job opportunities have necessitated employed family members living in distant locations both within and outside the country. While being employed is acceptable and indeed cherished by other family members, emigration to other countries raises concern for members who are left behind. While not all doctors have such strong ties to the extended family, doctors who had strong ties with their families could only leave the country if they got the concert of their parents and relatives. Aged parents often discourage their sons and daughters from migration in fear of losing close care.

Duty to extended family influenced migration decisions of staying in both hospitals. In both cases, involvement of the family into an individual's life appeared to be more important. This stems from the tradition of maintaining strong links with other extended

family members. The doctors expressed fears as to the negative impact of leaving dependants with no reliable means of support. They vindicated having close family ties with their extended family and relatives who made it difficult to leave the country in search of alternative employment. Family members with higher economic and social power are often bread earners for their extended families. This is even more pronounced for cadres like medical doctors who are perceived by the community as having more economic power even if it is different in the real situation. There is a widespread misconception that highly educated persons have more financial power than the uneducated. This creates high expectations for offering financial support to the economically disadvantaged family members and generates a dependency syndrome hence eroding self reliance initiatives.

The findings in this study revealed that family bonds (rooted in societal traditions and customs) influence migration decisions to stay or leave. They featured as both barriers and facilitators to doctor migration decisions. Doctors' obligation to the extended family and relatives seem to overshadow migration temptations. This inspired them to continue working in their respective hospitals. The obligation to the extended family was demonstrated through stated obligations to the extended family (i.e. the elderly parents and relatives). Family ties stemming from a doctor being the bread earner deterred him or her from leaving.

Some doctors who stayed found it difficult to leave elderly parents and extended family members because their departure could have been social costs of migration. Other doctors who had less family commitments felt free to leave. Individual differences rooted in personal values and cultural orientation creates binding forces for some doctors to stay and freedom to other doctors to migrate. It transpires from this study that in collectivist cultures like Tanzania, the family is accorded a higher priority in migration decisions. This finding re-affirms the career literature in chapter 2 (section 2.3.5) in which Life style integration Career Anchor underpin the importance of balancing work and family responsibilities (Schein, 1987b). In a similar vein, it has been established that the cultural background of employees' (individualism–collectivism) determines the extent to which they rely on help from family members.

b) Duty to the nuclear family

Obligation to nuclear family is focused on immediate family (i.e. Spouse and Children). It is associated with great concerns for their welfare in terms of education and living conditions. The difficulty in fulfilling obligations to the nuclear family in Tanzania made some doctors to migrate from hospital A and exerted some temptations to migrate (in hospital B). The urgency of fulfilling the needs of the nuclear family in the wake of competitive pressures in modern sectors of Tanzania have elevated duty to the nuclear family and great concerns for children's education to become more important than the traditional duties to extended family and society, causing some doctors to leave hospital A and some to express migration intentions in hospital B. Emigration to other countries was perceived as a window of opportunity to fulfill these obligations. The findings underscore the need to treat professionals like medical doctors in a holistic manner by going beyond their individual status to include family welfare matters. The findings underscore the fact that provision of social services for doctors' families seems to be a potential retention strategy. The findings indicate the relevance of career literature presented in chapter 2 (section 2.3.5) in which the need based career anchor of life style integration underpin balancing work and family roles.

c) Duty to patients and the country

A sense of duty either to patients and the country is one of the reasons which motivated some of the doctors to stay in both hospitals. They articulated a strong sense of responsibility to provide health services to fellow citizens with high demand of health services. This signifies a strong passion and patriotism to serve the country. Invariably, doctors who migrated have always been labeled as unpatriotic to the country which invested in their education. The doctors demonstrated their sense of duty through resounding expressions of professional ethics and patriotic values to serve the citizenry irrespective of the push factor such lower salaries and poor living and working conditions that rose temptations to leave the country. They would feel guilty in terms of the lost opportunity to offer health services to fellow citizens should they migrate. This connotes selfless devotion to humanity at its best. Most importantly, this commitment needs to be

nurtured through management's appreciation of doctors' devotion. The findings show the relevance of the career literature in chapter 2 (section 2.3.5) which identifies service/dedication to a cause career as one of the influential career anchors in the employment scene. This lends support to past studies which identified personal values of service to poor as important motivating factors for medical doctors to work in rural health-care service. (Purohit & Martineau, 2016).

d) Duty to Community (Community bond)

Community bond stems from strong community ties between the doctors and the community surrounding hospital premises. The doctors in both hospitals developed a sense of belonging. In the course of their medical practice they created social capital which evolved from the appreciation of their health services rendered to the community. This is also part and parcel of the traditional African collectivist culture to operate in close ties with community members as a vindication of the value attached to their importance in one's life. Doctors appreciated the respect they received from the community. Provision of high quality health service garnered a high degree of respect and recognition of the doctors in both hospitals. While doctors in hospital A cemented community bonds with patient networks in hospitals they work during extramural dual practice in medicine, doctors in hospital B developed this bond as most of them hailed from communities in close proximity to the hospital.

The findings indicate that community bonds influences doctors to stay in their work settings. Strong community ties evolve from the perceived quality of health services rendered. Specialized health services are popularized by patient feedback. Community bond was built through business networks of Intramural and extramural dual practice in medicine in the case of hospital A. In contrast, doctors in hospital B exhibited affective commitment stemming from their strong ties with the community as they were mostly originating from the nearby villages and districts. Their commitment was further reinforced by the acknowledged appreciation and recognition by community members. It surfaced that the working relationship between doctors and the patients cement community bond when the services offered are perceived to be of better quality. The

study underscores the urgency of community respect of professionals like medical doctors. It lends support to past studies which found that respect and support from the community enhanced retention of health workers (Lumley, Coetzee, Tladinyane, & Ferreira, 2011; Songstad et al., 2012).

e) Duty to religion (Moral satisfaction)

Although spirituality and religion are often used interchangeably, there seem to be some differences. According to Gupta, Kumar, and Singh (2014), spirituality is about personal beliefs, while religion relates to behavior. They further note that spirituality is flexible and applicable whereas religion is fixed and based on customs. Dew et al. (2010) notes that that workplace spirituality is a central variable in developing the culture of trust, inclusion and innovation within various work places.

Management scholars have investigated workplace spirituality and its relation to organizational commitment, employee satisfaction and employee engagement (Gupta et al., 2014; Vandenberghe, 2011). Scherer, Allen, and Harp (2016) demonstrated a growing interest in spirituality in many modern business organizations. Workplace spirituality includes many aspects like meaningful work, sense of community, and organizational value. Workplace spirituality is intended to interconnect past experiences and develop trust among employees in a way that would lead the organization into a better and productive environment.

Religion can affect an organization, not only from the ‘top down’ (e.g., via the founder’s values), but also from the ‘bottom up’ through employees’ cognition, emotions, and behaviour. Work place spirituality has many benefits for the organization. These include enhanced trust among people, increased interconnectedness, and assisted to create more motivated organizational culture which would lead the organizational performance (Humphries, Jamil, & Jordan, 2016). Recent Organizational studies have strengthened the notion of workplace spirituality for creating meaningful job, delight, contentment and hope at work that generate employee engagement, and organizational commitment (Zhang, 2015).

The insights emerging from this study show that religious commitment influence employees' sense of work obligation. Employees perceive their work as a calling. This impact might be particularly significant in the case of health workers employees who are in the business of great challenges to save peoples' lives. A religiously motivated calling inspires an employee to *do good for others*. This alludes to the rising importance of both organizational culture and workplace spirituality in employee retention. Workplace spirituality has the potential to generate trust within employees. This lend support to previous studies which showed significant interaction between workplace spirituality and positive task output and job satisfaction (Van der Walt & de Klerk, 2014).

Moral satisfaction as defined here, is derived from an individual's religious orientation. Whereas doctors who stayed in hospital A expressed duty to patients and the country as their primary motivation to continue providing health services, doctors in hospital B demonstrated a strong religious affiliation. They underscored the importance of the religious dimension of their work. This emerged as an important factor influencing their decisions to continue working in the hospital. The doctors expressed compassion for providing help to those who need health care. They had deep concerns for the sick. An underlying motivation to stay was an urge to care for the patients in the hospital setting. The doctors were motivated by the sense of religious obligation and felt that a spin-off could be a reciprocal act of *blessings* from God: Their work motto was a fulfillment of their religious ethos and obligations to help others.

Taking care of the sick was heeding to a religious call. Provision of health services to patients in a rural setting demonstrated God's love and care for others. Religious affiliation is demonstrated trough compassion for the sick. The doctors exhibited altruistic motivation in the context of a developing country through great concerns for others and the community. The findings illuminate the fact that quality service doesn't always stem from provision of financial rewards..

A strong belief in God and adherence to religious obligations of service to others can increase the job satisfaction of doctors and other professionals. Moral satisfaction fostered institutional loyalty and creates strong conviction to stay and offer health services within

the hospital setting. The findings revealed that for these doctors, loyalty is not only to the employer but most importantly to the church and ultimately to God. The study showed that religious orientation characterized by spiritual values directed to serving God and mankind motivated doctors to stay. These values were reinforced by the hospital and church leaders in hospital B.

Management scholars have investigated workplace spirituality and its relation to organizational commitment, employee satisfaction and employee engagement (Saks, 2011). There is a growing interest in spirituality in many modern business organizations. Workplace spirituality includes many aspects like meaningful work, sense of community, and organizational value. Workplace spirituality is intended to interconnect past experiences and develop trust among employees in a way that would lead the organization into a better and productive environment

Religion can affect an organization, not only from the ‘top down’ (e.g., via the founder’s values), but also from the ‘bottom up’ through employees’ cognition, emotions, and behaviour. Work place spirituality has many benefits for the organization. These include enhanced trust among employees and increased interconnectedness (Petchsawang & Duchon, 2012).

Recent Organizational studies have strengthened the notion of workplace spirituality for creating meaningful job, delight, contentment and hope at work that generate employee engagement, and organizational commitment (Kumar, 2016, Vandenberghe, 2011)

The findings confirmed the notion that the leadership of an organization influences work practices. Specifically, spirit –centered leadership also influences migration decisions. It featured that a great sense of spirituality which stemmed from moral satisfaction enhanced the commitment of medical doctors to stay. The culture of morning prayers involving all employees and the visitors reinforced spiritual values in health service provision It emerged that an organizations that practice workplace spirituality go beyond being supportive of learning and development by helping employees develop a sense of “altruistic calling” (i.e. a conscious choice to serve others) or identification of passion

about their lives and their work. The spiritual element may be part of the psychological contract literature in chapter 2 (section 2.3.6) which shows that when an organization fulfils employee expectations, it reinforces their desire to continue rendering services.

The insights emerging from this study show that religious commitment influence employees' sense of work obligation. Employees perceive their work as a calling. This impact might be particularly significant in the case of health workers employees who are in the business of great challenges to save peoples' lives. A religiously motivated calling inspires an employee to *do good for others*. This alludes to the rising importance of both organizational culture and workplace spirituality in employee retention. Workplace spirituality has the potential to generate trust within employees. This lends support to previous studies which showed significant interaction between workplace spirituality and positive task output and job satisfaction (Van der Walt & de Klerk, 2014, Afsar & Rehman, 2015).

The role of spirituality and religion in the work place and in the management literature is a relatively new area of inquiry also with regard to developing countries. Interest in this domain in the work place has emerged over the last few decades (Van Dierendonck, 2011). The antecedents of today's interest in spirituality and religion at work dates back to the late 19th century in Europe and the United States and the interest in the Protestant Work Ethic (Weber, 1905) which rose in response to a perceived lack of interest on the part of the church toward lay people's experiences in the secular workplace (Buchholz & Rosenthal, 2003).

My findings are congruent with other studies of spirituality in the workplace which have established a relationship between spirituality and organizational commitment (Benefield & Holtzclaw, 2014; Marschke, Preziosi, & Harrington, 2011; Weber, 1905). Scholars have linked spirituality and religion in the workplace to a wide variety of organizational functions and practices. The major emphasis so far has been on its positive impact on organizational reality and leadership practices (Chen et al., 2011).

7.2.4 Recruitment practices

Like other professionals, medical doctors expect employment offers upon successful completion of their training in order to practice their profession. Recruitment practices featured as one of the factors that influenced migration decisions in both hospitals. The hospitals employ general and specialists doctors to ensure that they offer quality and specialized health services. However, there were notable differences in the recruitment practices of the two hospitals. The recruitment freeze in the public sector in the 1990s raised concerns on job security. Doctors were subjected to contractual employment instead of the previous employment terms on permanent and pensionable terms. This practice prompted some doctors to migrate from hospital A. In contrast, hospital B had better employment terms as doctors were employed on permanent and pensionable terms. Most importantly, hospital B enforced a recruitment strategy of hiring doctors from areas close to hospital location enhanced attraction and retention of doctors since they are committed to offer their services to relatives and the community.

Recruitment practices also tended to illuminate the organization's image to internal and external stakeholders. The findings indicate that employee's initial posting is a crucial stage of an employment cycle which can play an important role in influencing migration. Contractual employments in the wake of the employment freeze in hospital A precipitated job insecurity and dissatisfaction with employment terms. This resulted in internal and external migration of doctors from hospital A. This alludes to the career literature in chapter 2 (section 2.3.5) which delineates need based career anchors as crucial aspects in ensuring job security. In addition, the findings mirrors the retention literature presented in chapter 2 (section 2.3.2) which underscore the importance of retaining talent in a developing country context where the demand of doctors far exceeds the supply. The findings lend support to growing evidence that delay and slowness in public systems relating to HRM functions such as slow recruitment can lead to poor motivation and turnovers (Purohit & Martineau, 2016).

In contrast, it transpired from the findings in hospital B that recruitment strategies in which doctors are recruited from areas close to hospital location created mutual trust

between doctors and the hospital and facilitated their retention. Recruitment and selection in both hospitals is done on the basis of applicants ' potential competencies and skills. However, taking into account that hospital B has a strategy of attracting candidates with a rural background who happen to belong to the local church; it arouses greater devotion and commitment cemented by religious ethos. The finding lend support to the career literature in chapter 2 (section 2.3.5) which posits that longer gestation period in pursuit of an occupation is important in decisions concerning ones career (Schein, 2010). This resonates with a growing evidence of the importance of matching a candidate's own background to the setting in which they are recruited to work. Some studies indicate that staff that grew up in a rural environment are more likely to assume duties in these settings (Cohen, 2012; Honda & Vio, 2015; Walker et al., 2012; WHO, 2010). The findings of this study brings to the fore the rationale for selective staffing in the context of the location context.

7.2.5 Leadership

Leadership is the ability of the organization's manager to make good decisions and encourage other organizational members to perform their duties properly. Effective leadership entails encouraging certain behaviors in others via force of personality, persuasion and eloquent communication. Leaders inspire their followers to attain a stated vision or goal. Important aspects of good leadership include delegation of responsibility to subordinates and the ability to effectively communicate with organization members on matters affecting their work roles.

The efficiency and effectiveness of an organization (whether public or private) hinges on among other things visionary and committed leadership at different levels including the Ministry, Governing Board, the Hospital, and Departments down to sections or Units within the hospital. Leaders at all the levels are supposed to be role models for the rest of the staff. They are expected to set standards of work culture. Both hospitals were directed by leaders with a medical background. Although the professional medical background enhances their role of overseeing clinical dimensions of health care, their managerial roles to some degree distracts them from the core clinical roles in health service delivery. This

is a challenge in understaffed hospitals or in the wake of highly demanded specialty services. Also their medical training does not prepare them for leadership roles.

a) Leadership style

Leadership and leadership style featured as an important factor influencing migration decisions in both hospitals. Hospital A leaders tended to employ a paternalistic style (i.e. high power posture) which resulted into high levels of dissatisfaction stemming from little involvement of doctors in decision making and poor communication in matters affecting their professional work. In contrast, leaders in hospital B exhibited both participatory (equal power) and servant styles (low power) postures as they led through missions, values and intellectual inspiration. The participatory and servant leadership style is centered on servant hood, caring for others, and team building.

Migration decisions for doctors to stay or leave are in part related to leadership practices in both hospitals. The migration of the head of department in hospital A exhibited a behavior not expected of a leader. It lowered the hospital credibility and tarnished its image. As a role model, a leader's departure from an organization prompts subordinates to emulate and thwarts retention initiatives. Whereas doctors who migrated in hospital A leveled concerns on authoritarian management style with minimal involvement of doctors in matters affecting their profession, the participatory management in hospital B enhanced the commitment of doctors and was one of the factors which motivated them to stay. It fostered a sense of belonging to the organization and influenced work satisfaction and organizational commitment.

It transpired from this study that employees are more likely to stay with an organization when they feel that the leader values their role and contribution. This lends support to the psychological contract literature in chapter 2 (section 2.3.6) which shows that fulfilment of employee expectations increases work morale and desire to stay. It has been noted that,

“When the practicing leadership style is felt as unfavorable by workforce intentions to leave increases and when it is palpated as favorable, intention to leave decreases, hence heightens employee retention” (Chitra, 2013, p. 73).

The findings in both hospitals indicated the pivotal role of leadership in employee motivation. It brings to light the fact that leadership has to ensure that the expectations of both parties at the work place are fulfilled hence enhancing job satisfaction and employee retention. While a transactional leadership style was exhibited to a great extent in hospital A, where financial rewards were predominantly used to motivate employees, a transformational leadership style (a role model exhibiting inspirational motivation) was more predominant in hospital B, and it enhanced high work morale and commitment to stay. It surfaces that the tendency to migrate may be reversed with good leadership exhibited through recognition and participative management. It can never be over emphasized that Hospital B offers a nest of good governance because of its success story of managing to attract and retain medical doctors in a rural setting very often shunned by skilled professionals in many developing countries. The study provides some insights into the relationship between good HRM practices and employee work outcomes in the Tanzania health sector.

b) Recognition

Employee recognition entails demonstrated value and appreciation of the work done by the management, peers, the community and patients. The social work environment (i.e. Recognition by the hospital management, peers, patients and the community came to the fore as having a great influence in decisions to stay and leave. These were sub themes which permeated the findings in both hospitals. My findings from both hospitals elevate doctors' recognition by management, colleagues, patients and the community as strong factors that influences migration decisions to stay or leave. These sub themes are presented and analyzed below.

i) Recognition by the management

While acknowledging job satisfaction derived from patient recognition, some of the doctors who migrated from hospital A expressed strong concerns with regard to lack of management recognition. The doctors cited lack of recognition as one of the factors that aroused their migration. In contrast, doctors in hospital B were inspired by the

management recognition accorded to them. This was associated with reinforcement of positive remarks with regard to their good work performance. These manifested through inspiring praises like *well done* .which fostered work morale and greater commitment to work in the hospital. In this vein, doctors appreciate whenever hospital leaders demonstrate great value on their role in health service provision.

This study underscores the fact that medical doctors have a range of different social needs beyond high pay. It transpires from the findings that some of the things that doctors appreciate are not necessarily related to financial incentives (e.g. high pay). It was noted that there are a number of other initiatives to arouse employee commitment to stay in the organization even in the face of limited budget. Interventions which featured to motivate doctors to stay in hospital B include compliments such as praise for a well done job. The doctors acknowledged that they were satisfied with their job whenever they were valued or when they contributed to societal wellbeing. The finding exemplifies the power of vision, and importance of inspiring professionals to render health services with high degree of affection to the welfare of the community and fellow citizens.

Recognition is not only a cost effective measure to inspire an employee but also a very simple initiative to implement. A simple phrase like *thank you* can be very inspirational. This finding corroborates with a study by Ashmore (2013) which supported the idea that higher salaries may not always serve as the best satisfiers for medical specialists. This study rekindles the view that economic interventions skewed to financial rewards seem to be necessary but not sufficient motivators. Much as Tanzania can hardly afford to pay doctors comparable pay levels with those in countries where the doctors migrated to, some good HRM practices could to some extent compensate for low wages and retain doctors in the health sector. In this study, it has been revealed that non-financial incentives like employee appreciation and recognition through praise can enhance employee motivation. The findings underpin the fact that recognition of professionals like medical doctors influences their migration decisions.

This study underscores the importance of recognizing doctors in their work context as it seems to be a powerful influence in arousing their motivation. A pat on the back can

indicate management's value and appreciation befitting doctors' crucial role and status. It is a pity that such leadership behavior is not more common in the public sector. As stated in chapter 2 (section 2.3.6), research has established that psychological contracts are twofold: Transactional and Relational While a transactional contract can be defined as the kind of contract which contains the expected terms of exchange given in monetary value (for example, a bonus), relational contract is one which constitutes expectations about the relationship between employee and the organization, including such factors as trust and organizational commitment (Rousseau, 2001; Van Dyk, Coetzee, & Tebele, 2013).

My findings underscore the crucial role of relational contracts in employee retention. This corroborates with some previous studies which showed that doctors remain loyal when they perceive that they have a sense of value and a sense of pride; thus, they have low or no intention to leave the organization (Ineson, Benke, & László, 2013). The study further lends support to past studies which underscored that poor leadership was exemplified by lack of recognition (Faye et al., 2013; Munga & Mbilinyi, 2008).

ii) Recognition by colleagues

Provision of health services in both the public and private hospitals engage doctors and other health professionals through team work. Doctors in both hospitals expressed the satisfaction they garnered by being recognized by peers. In both hospitals there was close cooperation between Tanzanian doctors and expatriate doctors in research and health service provision. This was one of the important factors that influenced them to stay. The reward literature in chapter 2 (section 2.3.1. d) indicates that employees deserve intrinsic rewards as a complement of extrinsic rewards. This corroborates with findings by (Boxall, 2012) which underscore the synergy evolving from team work.

iii) Recognition by patients

Patients exhibit recognition of doctors whenever they get quality health services. The presence of specialized health services in both hospitals attracts patients who use referral avenues. Doctors in both hospitals who decided to stay gladly acknowledged that they

were highly motivated by the positive feedback they got from the patients whom they had treated. The study portrays recognition by patients as an important factor which motivated doctors to stay in both hospitals. This finding corroborates with several other recent studies in the health-care sector, such as in North Vietnam and Mali (Henderson & Tulloch, 2008) and Bangladesh (Rahman et al., 2010). These studies have demonstrated the importance of recognition by patients as an important intrinsic factor of motivation for health-care workers.

In spite of hospital A being popular compared to hospital B in terms of having many specialists in different domains, there was low patient satisfaction due to scarce and malfunctioning equipment, lengthy duration to get medical health services (e.g. diagnostic services). This was in part attributed to high doctor patient ratio stemming from the inability of lower level hospitals to render quality services in their locality. In contrast, hospital B has tended to attract many patients. This is attributed to among other things, provision of quality health care services with adequate equipment and medical supplies.

c) Participative management

Participative management entails closer involvement of employees in day to day matters in the workplace. It creates a sense of ownership of decisions and enhances compliance of agreed work targets. Despite the presence of management and union representative forums in hospital A, some doctors who migrated from hospital A complained that there was passive staff involvement in matters related to their job. They stated their dissatisfaction of a top down leadership style with minimal employee involvement. This often affected work morale and aroused doctors to leave. In contrast, hospital B exhibited high levels of workers participation through periodic meetings to deliberate on important hospital matters affecting their work roles. Here, the management was praised for listening to staff concerns and doctors expressed their joy in respect of the appointment of one of their colleagues as the Deputy Hospital Managing Director.

Workers participation in management featured as an influential factor in migration decisions. The findings indicated that employee involvement is an effective retention

strategy since it arouses high levels of commitment in the implementation of the organization mission and objectives. Participation creates a sense of ownership of decisions and enhances compliance with agreed upon work targets. Workers involvement in decision making signals management recognition of the technical expertise of medical doctors.

This lends support to the past studies which found that lack of involvement in decision making and inadequate communication were some of the issues that caused employees to leave organizations (Bonenberger et al., 2014; Patterson et al., 2010). Indeed, it has been argued that employees leave leaders and not organization (Gwavuya, 2011). Moreover, it was found that working in an environment clouded by negative influence from the leader cause employee dissatisfaction (Morris, 2011). The findings underpin the fact that psychological contract fulfillment presented in chapter 2 (section 2.3.6, c) influences employee retention. These dynamics resonates with a study which showed that poor leadership in many healthcare institutions in many developing countries eroded retention initiatives (McCoy et al., 2008).

7.2.6 Administrative system

The administration system is meant to ensure that formulated policies and programmes are implemented in the light of the strategic plan. Administrative system featured as important factors that influenced migration decisions in mainly two ways – either in terms of breaches of employment contract or psychological contract expectations or lack of equipment. These issues are presented below.

(a) Breach of employment contract and psychological contract expectations

Employment contract and psychological contract expectations are major criteria that employees use to evaluate the pendulum of employment relationship at a work place. Unfulfilled promised is one of the factors which prompted some doctors in hospital A to wage strikes and others sought jobs outside the country. Concerns were raised with respect to delays and at times non enforcement of rights like Risk insurance and housing

allowances and promotions. Government promises were partially fulfilled or sometimes they were not implemented as agreed. Some of the doctors in hospital A felt that the administrative practices were wanting. In contrast, there were harmonious relations between the hospital management and medical doctors in hospital B. The hospital honoured its promises and whenever there were implementation delays, timely communication was made to re-affirm its commitment to staff welfare.

(b) Equipment

Efficient and effective health service provision requires a well-functioning administrative system characterized by availability of requisite resources in terms of working tools and necessary supplies. Doctors in hospital A were provided with far less equipment than required. This is one of the factors which precipitated some of them to leave. However, doctors in hospital B expressed their gladness to have access to requisite resources which facilitated utilization of their skills. In severe resource constraints with far less equipment and drugs than required, doctors find it difficult to provide the services expected. Availability of equipment and medical supplies influences migration decisions in both hospitals. Lack of equipment was a de-motivator to doctors who migrated from hospital A as they felt that their knowledge was being under-utilized. In contrast, doctors who stayed in hospital B expressed their joy in having the requisite working tools which enabled them to offer good health services to patients.

Some doctors who migrated in Hospital A attributed their departure to dissatisfaction with poor working conditions in terms of inadequate supplies of medical equipment and drugs. The fear of skills underutilization ushered in dissatisfaction because it made it difficult to unleash their potential hence hampering their work efficiency as they could not properly diagnose patients' illnesses. Such a work environment aggravated frustration and at worse migration. Conversely, it surfaced that availability of adequate equipment in hospital B enhanced utilization of knowledge and skills and hence the motivation to stay. This study reaffirms the fact that the working environment has a strong influence on job satisfaction.

The findings mirror a close association between the administrative system and the career phenomena presented in chapter 2. (Section 2.3.5). Lack of working tools raised fears of career retardation and skill obsolescence due to a denial of an appropriate working environment to put their skills into practice. It also depicts the relevance of the psychological contract literature described in chapter 2 (section 2.3.6). This finding resonates with past studies which indicated that the availability of appropriate tools is a key factor of satisfaction (Ebuehi & Campbell, 2011; Leshabari et al., 2008) Thus inadequate equipment can be seen as one of the major causes of outmigration(Dolea et al., 2010; Mackintosh & Mujinja, 2010).

Table 7.1 : Summary of Findings in Hospital A and Hospital B

Theme (with sub themes underneath)	Reasons for staying	Reasons for leaving/Migration intentions	Remarks
Opportunity for competence building			
Variety of experience training	Periodic long and short course training and development attracted many doctors in both hospitals to stay.	Delays in access to training opportunities in hospital A was perceived as posing the danger of being deskilled. This prompted some doctors to leave.	While the bigger number of doctors in hospital A made it difficult to get opportunities to specialize, doctors in hospital B periodically secured scholarships for advanced medical training within the country and abroad. In addition to adequate trainin resources, the small number of doctors also facilitated smooth implementation of the training and development programme.
Postgraduate training	Provision of opportunities for specialization through postgraduate training attracted doctors in both hospitals to stay.	Desire for super specialization and international experience prompts some doctors in hospital A to leave.	The higher number of doctors in hospital A slowed the pace of training. This prompted some of the doctors to seek opportunities to specialize outside the country. In contrast, the small number of doctors in hospital B gave them a comparative advantage to access opportunities for postgraduate training. Trained super specialists can at times not return to Tanzania after completion of their studies. Concerted efforts have to be made by improving health systems within the country to motivate doctors to return after training abroad

Theme (with sub themes underneath)	Reasons for staying	Reasons for leaving/Migration intentions	Remarks
Learning from domestic specialists	The opportunity to learn from domestic specialists motivates doctors in both hospitals to stay.	The quest to gain international experience and advanced medical technology prompted some doctors in hospital A to seek opportunities outside the country.	Doctors in both hospital A and hospital B benefitted from learning from medical specialists. However, these opportunities were better in hospital A than in hospital B since the former had many specialists doctors than the latter. Owing to few domestic specialists and high workload to offer specialized services, it is not all doctors in both hospitals who geo the opportunity to work with domestic specialists.
Learning from expatriate doctors	Opportunities for mentoring by expatriate doctors motivated doctors to stay in both hospital A and hospital B.	The few number of expatriate doctors and their short duration of stay limits learning opportunities	Doctors in hospital A and hospital B were engaged to closely work with expatriate doctors. This enhanced acquisition of knowledge, skills and experiences. However, given the big number of doctors in hospital A, only some seized this opportunity.
Income			
Income from intramural dual practice of medicine	Engagement of doctors in intramural dual practice of medicine ameliorates economic hardships and motivates doctors in hospital A to stay.	The demand for dual practice in medicine is high for specialists and super specialists as compared to junior doctors. Some junior doctors are tempted to leave.	This private practice policy has ushered in the opportunity to complement low salary income in hospital A. However, owing to its faith based orientation (a nonprofit hospital) intramural dual practice of medicine is not implemented in hospital B. Doctors in hospital B are given salary top ups to augment the lost opportunity for intramural dual practice

Income from extramural dual practice of medicine	The flexible system of rendering service in both public and private hospitals is perceived as complementary to low salaries. This motivates them to stay.		<p>While the policy of extramural dual practice in medicine is implemented in public hospitals like hospital A, it is inapplicable in hospital B. This is in large part, attributed to its rural location where the demand for private health services is low due to affordability.</p> <p>This practice ushers in challenges of dual commitment and divided loyalty between the formal employer (Public sector) and part time employer (the private health sector).</p> <p>Doctors in hospital B stay for reasons beyond economic motives. It stems from sense of duty</p>
Income from extramural dual practice of other business	Extramural dual practice of other business motivates doctors in both hospital A and hospital B.	Engagement of doctors in extramural dual practice of other business ameliorate economic hardships and mitigated temptations to leave	Doctors in both hospital A and hospital B complemented low salaries by engaging in extramural dual practice of other business. This includes economic projects like farming and shops.
Sense of duty			
Duty to the nuclear family	Concerns on poor standard of education for the children negate the commitment to stay.	<p>Some doctors in hospital A found it difficult to stay in the wake of poor welfare services for their nuclear family</p> <p>A few doctors in hospital B expressed migration intentions due to dissatisfaction with the education system in the local schools</p>	<p>HRM officials in both the public and private hospitals should ensure that employee welfare matters are periodically addressed.</p> <p>Employee retention interventions need to give credence to family welfare matters. Arguably, limited resources made it difficult for both hospitals to have modern education facilities</p>
Duty to extended family (Family Bond)	This is one of the factors that influenced some of the doctors in both hospitals to stay.	The role and obligation of doctors in supporting the immediate and extended family overshadowed migration temptations.	The responsibility for the welfare of the extended family is part of the African Culture.
Duty to patients and the country	Doctors in both hospital A and hospital B provide services through passion regardless of the challenges encountered.	High levels of duty to patients and the country by some doctors in both hospital A and hospital B made migration unattractive	<p>Despite limited resources and low pay levels compared to other professions within and outside Tanzania, some doctors in hospital A worked very hard to serve peoples' lives.</p> <p>Doctors in hospital B rendered quality health services in a rural setting shunned by other professionals. This was sense of duty at its best. This may be stemming from their religious devotion to render quality services to the needy.</p>

Theme (with sub themes underneath)	Reasons for staying	Reasons for leaving/Migration intentions	Remarks
			The sense of duty exhibited by doctors in both hospital A and hospital B need encouragement, support and recognition
Duty to the community (Community bond)	Doctors who stayed in both hospitals offered clinical services with high commitment	A combination of family and community bonds overshadowed the desire to migrate	Family bond is rooted in the community values and culture.
Duty to Religion (Moral satisfaction)	The faith based orientation of hospital B elicit employee moral satisfaction and commitment to stay	Duty to religion mitigated out migration in hospital B	The moral satisfaction derived from doctors' religious orientations in hospital B seems to have aroused their commitment to stay. The doctors' loyalties seem to be directed to serving God through the Church and the Hospital. These values influence rural job location preferences.
Recruitment practices	Exposure to a rural environment for extended period of time influences employee attraction and retention in hospital B	Recruitment delays and contract terms in hospital A created job insecurity and caused outmigration of some doctors	Recruitment from a rural setting seems to be a positive retention catalyst. Employment terms seem to influence employee job satisfaction and commitment to stay employment prospects
Leadership			
Role model leadership style	Role model leaders inspire employees to stay and emulate perceived good values and attributes	Some doctors who migrated from hospital A expressed great concerns on autocratic leadership style.	Inefficient and unfair organizational practices frustrate and demotivate medical doctors, lower their work morale and arouse some of them to leave.
Participative management	Doctors in hospital B were highly motivated by being actively involved in decision making process of hospital affairs, there were complaints on little involvement in hospital A.	Some of the doctors who migrated from hospital A expressed high concerns on lack of participation in decision making.	Although hospital A had employee participation forums, representatives seem to have been ineffective owing to lack of periodic feedback on matters discussed at higher level decision making bodies. Involvement concerns in hospital A seem to have been addressed to a wrong level while representatives were accountable.
Recognition			
Recognition by the management	Recognition by the management motivated doctors in both hospitals to stay.	Lack of recognition featured as a recurring concern by both some doctors who stayed and those who migrated from hospital A. Due to authoritarian leadership style.	This is arguably an area where active HRM could do much to make people stay at no extra cost. For example, letters of recognition and positive remarks for a job well done.

Theme (with sub themes underneath)	Reasons for staying	Reasons for leaving/Migration intentions	Remarks
Administrative System			
Dishonored promises	Fulfilled promises by the employer motivated doctors in hospital B to stay	Unfulfilled promises made some doctors in hospital A to leave	Much as all doctors in hospital A were affected by unfulfilled promises in employee rights, some doctors stayed for reasons of their sense of duty and patriotism. Dishonored promises compromises employee retention interventions
Tools and Equipment	Doctors in both hospitals expressed the value attached to working tools and hospital facilities.	Inadequate equipment and poor health facilities created fears of skill obsolescence and is cited by some doctors in hospital A as one of the factors which influenced them to leave	The government is striving to retool hospital facilities. However, the pace is slow to meet increasing demand.

7.3 Chapter Summary

The study sought to explore the factors that influence doctors' migration decisions to stay or leave in hospital A and hospital B. This chapter attempts to compare and contrast the two hospitals through the prism of the findings presented in chapter 5 and the literature review in chapter 2.

The cross case analysis in this chapter has brought to the fore an array of themes and sub themes that influenced decisions to stay and leave an organization. Under the theme of competence building, the findings identified variety of work experience and training, access to postgraduate training, learning from domestic specialists and from expatriate doctors). The theme of income showed different income and incentive sources ranging from intramural, extramural to moonlighting. The theme of sense of duty emerged with several measures of obligations. Various expressions of leadership style and participative management, and many forms of recognition: by management, peers, patients and society, and also several aspects of administrative practice and resource provision recurred in the cross case analysis.

Taking into account that the array of themes and sub themes may be untenable in theory modification or theory building in chapter 7, I have opted to identify the main themes which seem to be more important to decision making in the dynamics of doctor migration. These include 1) Organizational Environment and HRM practices, 2) Professional development and mentoring, 3) the Income factor, 4) the Administrative system and resource availability, 5) Leadership and recognition, and 6) Sense of duty.

In sum, cross case analysis in this study revealed cross cutting themes which explain the dynamics of migration decisions in both hospitals. It emerged that avenues for competence building (Professional development), Social factors, and participative leadership seem to be effective retention strategies practiced in both hospitals. The degree of success however differed owing to contextual factors including leadership, and organizational culture.

CHAPTER EIGHT: DISCUSSION OF RESULTS AND FINDINGS

8.1 Introduction

The present study set to identify reasons why some doctors decide to stay while others decide to leave Tanzanian hospitals. The study attempts to explain key factors that make doctors stay even when salary is low, and what makes them leave – beyond low income. This chapter discusses the results and positions them in the extant body of research. Based on the presentation of findings from hospital A (in Chapter 5), hospital B (in Chapter 6) and the preceding cross case comparison (in Chapter 7), I have identified some main themes for further analysis and discussion. These are themes that appear to be particularly important in order to understand doctors' migration decisions, and also to explain the difference between the two hospitals. In the sections that follow, I first present summaries of reasons for choosing these as main themes and a model outlining the overall analytical approach. I then will deal with each of the themes, discussing the main findings in relation to my original theoretical platform (in chapter 2), and in relation to other relevant theories, also indicating occasions for theory development. Finally, these themes are discussed in the light of three main lenses for interpreting the results, 1) the Psychological contract lens, 2) the (Hertzberg type) Dual Factor lens, and 3) a Meaning-seeking lens. Finally, there is a summary of the chapter.

8.2 Selection of themes from the findings.

In the preceding cross case analysis (chapter 7) a great number of factors and issues were covered, including several determinants of professional development (variety of work experience and training, access to postgraduate training, learning from domestic specialists and from expatriate doctors), several measures of income, several measures and varieties of dual income and other incentives, several measures of duty and felt obligations, issues of recruitment practices and educational capacity, various expressions of leadership style and participative management, and many forms of recognition, both by management, peers, patients and society, and also several aspects of administrative practice and resource provision.

The objective of the present chapter is to restate inductively the links between what I consider the most important findings (i.e. findings that surprised me, or that I found striking) and the theoretical framework that I built upon when starting the study. I will also seek to bring in other theoretical considerations that were not considered in chapter 2, that have been made relevant by my findings in the study. Finally, I shall also discuss opportunities for theory development or theory refinement as a result of my findings.

In order to carry out such an analysis, it is necessary to limit the number of issues to a manageable level. As I stated in my concluding remarks in chapter seven, the six themes that I have ended up with include 1) Organizational Environment and HRM practices, 2) Professional development and mentoring, 3) the Income factor, 4) the Administrative system and resource availability, 5) Leadership and recognition, and 6) Sense of duty. In the following, I shall first briefly summarize some findings related to each of these themes, and explain why I find them worth further examination, before presenting an overall framework in Figure 8.1.

8.2.1 Organizational Environment and HRM practices

A general finding is that formal HRM departments do not always play a decisive role in creating the conditions for increased retention of doctors. However, HRM may play a significant role in improving the factors that lead to increased retention rates, in particular by influencing administrative practices and leadership styles.

While local control of personnel, and a high level of flexibility and responsiveness, has had positive impacts on motivation and retention of doctors in hospital B, my findings show that the quality of service delivery in hospital A is compromised by lack of hospital HRM autonomy. Although the government has an array of human resource policies, plans and programmes and regulations, they are sometimes not implemented, or are enforced late, and they are not always aligned. As a result, there is a gap between theory and practice, to a large extent due to delayed decision making and bureaucratic red tape. Implementation of human resource policies and regulations in hospital A depend to a large extent on many institutions. These include the President's Office (Public Service

and Good Governance), the Ministry of Finance and Planning, and the Ministry of Health, Community Development, Gender, Children and the Elderly. This modus operandi of limited autonomy makes it difficult for hospital management to respond to the changing demands of the human resource requirements. Many of the causes of dissatisfaction (and the choice of leaving) in hospital A can be traced to such HRM inefficiencies that can again be traced to lack of autonomy, responsiveness, and alignment of HRM practice – also undermining the level of mutual trust in the organization.

8.2.2 Professional Development and Mentoring

The quest for doctors to attain career development goals appear to be an important influence on migration decisions. Professional development opportunity on the job (e.g. mentoring by specialists and expatriate doctors), and off the job training geared to skill development and competence building, were commonly cited by doctors in both hospital A and hospital B as contributing to feeling valued at work, hence arousing their desire to stay. Mentoring by senior specialists gave the doctors professional satisfaction arising from meeting career aspirations since they worked in a rich learning environment that facilitated professional advancement. Doctors frequently learn through ward rounds together with seniors and expatriates. Such practices seem to be a major learning opportunity of many aspects of patient care. These include clinical reasoning, diagnostic skills through cost effective tests and appropriate treatment. This enabled them to keep abreast of professional and technological developments.

The findings illustrate that periodic offers of opportunities for competence building such as postgraduate training are an essential prerequisite for career advancement of medical doctors. These arrangements enable the doctors to acquire new skills and take on new challenges. Slow pace of enforcing career expectations prompted some doctors in hospital A to seek better career opportunities outside the country. This study provides indications that good quality continuous professional development is a very positive incentive and enhances doctor retention.

8.2.3 The Income factor

My findings show that financial rewards (e.g. high salary and fringe benefits) seem to be highly valued by employees in resource limited environments characterized by persistent low levels of salary and incentives. Despite periodic salary reviews in the Tanzanian public sector, inequity concerns with respect to salary differentials among public sectors within Tanzania (there was dissatisfaction with the pay level compared to other professional groups in the state sector), as well as between Tanzanian levels and pay levels outside the country, prompted some doctors in hospital A to migrate. In contrast, doctors in hospital B were fairly satisfied with the pay, despite the fact that they were not typically highly paid, save for salary top up to ensure that wages were commensurate with pay levels in the public health sector. In the case of Hospital B, differences in pension schemes between the public and private health sector signalled migration intentions by some doctors.

Moonlighting in non-health related businesses such as groceries, farming and cattle keeping enable doctors in both hospitals to earn higher incomes than their salaries. However, the findings revealed that in some cases in hospital A, dual income schemes created problems of divided loyalty. Also, the opportunity for intra-mural dual practice may have led to abuse by some doctors, who render services to private hospitals during official working time. The system of intramural dual practice also seems to favor senior specialist more than junior doctors, even as these juniors often shoulder higher workloads.

Nevertheless, in spite of the overall importance of income, higher salaries may not always serve as the best satisfiers for medical doctors who have multiple values and social needs in non-financial domains. A satisfying job environment which provides intrinsic needs of employees (e.g. recognition) may act as a compensating factor, making extrinsic factors like salary to be secondary.

8.2.4 The Administrative system and resource availability

While the hospital administration system is meant to ensure that formulated policies and programmes are implemented in the light of the strategic plan, it featured in my case studies as an important factor that influenced decisions to stay or leave in both hospitals. Doctors who migrated from hospital A raised concerns with respect to delays and inequities, and at times non-enforcement of rights, like risk insurance, housing allowance, promotions, and lack of medical supplies and equipment. Such delays and inequities undermined doctors' trust in the organization. By contrast, doctors in hospital B cherished the way the management honoured agreed promises and in cases of delays provided feedback to re-affirm its commitment to address employee concerns. This created harmonious relations between the hospital management and employees hence enhanced their commitment to stay. The findings show that management support through demonstrated concern with employment work problems and provision of requisite equipment and medical supplies enhance employee retention.

8.2.5 Leadership and Recognition

The study shows that leadership can have a positive or negative influence on the behavior of followers. Working in an environment clouded by poor leadership can lower the morale and commitment of followers and may have a negative impact on employee retention, while an inspiring leader can win the hearts of followers.

While it is widely acknowledged that employee participation in decision making creates a sense of ownership of decisions and enhances commitment to achieve set work targets, doctors who migrated from hospital A raised concerns about poor hospital leadership, which manifested through lack of recognition and feedback and slow pace of implementation of agreed decisions on employee rights. By contrast, doctors in hospital B were satisfied with participatory management form of leadership, which is one of the factors that influenced their continued stay. The supportive leadership style made employees feel that they were cared for. Here, the leaders' strong moral values exhibited the ethos of transformational leadership which garnered high levels of trust relationships

between hospital leaders and employees. The vision and mission of the organization resonates with the followers' beliefs and values. This was expressed through periodic interaction and feedback. Management support and commitment to address personal and occupational matters created positive perceptions on the role model leadership style.

This study elevate recognition, both from management and from colleagues, patients, or the community, as an important factor that influence migration decisions for doctors. Simple treatments like a pat on the back and phrases like *thank you for a well-done job* can inspire employees to do their best for the organization. Whilst such recognition is common in hospital B, it rarely manifest in hospital A. This is an often overlooked yet vital strategy to arouse employee morale and commitment to stay.

8.2.6 Sense of duty

The finding portrays duty to the extended family, patients and patriotic values to the country as a primary cause for doctors who stayed in both hospitals. While a sense of duty to the nuclear family caused some doctors to leave from hospital A in order to seek a better educational environment for their children, a sense of duty to religion and to the hospital mission caused doctors to stay in hospital B.

Strong collectivist cultural values in the country manifesting through an array of duty attributes. They ranged from a service ethic to nuclear family, extended family, the community, patients, country and religious orientation in the case of hospital B. Although doctors are normally reluctant to work in rural areas, where opportunities for career development are typically less than in urban areas, some doctors vowed to stay in hospital B because of the inspiration of high sense of duty stemming from the family, community, and patriotic or religious values.

8.3 Description of the Conceptual Framework

As stated in the methodology chapter, I adopted an inductive research approach in order to explain the dynamics of migration decisions in a developing country context. My

interpretive approach focuses on uncovering participants' perceived meaning rather than going for hypothesis testing and falsification. Thus, the "truth" about migration decisions that I have sought, is viewed as relative, and I acknowledge multiple realities in the context studied. As an active agent in the research process, I have strived to understand participants' subjective experiences. This being an interpretive study, I seek to integrate the findings and extant literatures to build, modify, refine and develop theory that can better explain the factors that influence employee decisions to stay or leave the organization.

The section below presents and describes the proposed conceptual framework (i.e. Figure 8.1). It suggests a pattern of relationships arising from the findings. The framework encompasses different aspects. As a background context, the national health care system (the overall health care system of Tanzania, and the hospital governance structure in the two case hospitals) is included. These have been described in some detail earlier in Chapter 4 of this dissertation and will not be dealt with more in the present chapter.

However, behind the analyses that follow, it should be kept in mind that the Tanzania national health care system operates through both public and private or NGO hospitals. The public health sector collaborates with faith-based providers through provision of subsidies and secondment of staff, and with private for profit hospitals through public private partnership. Also, it should be kept in mind that health services in Tanzania are delivered through a decentralized system, whereby local governments (under the Prime Minister's Office–Regional Administration and Local Government), are responsible for service delivery through dispensaries, health centers, and district hospitals.

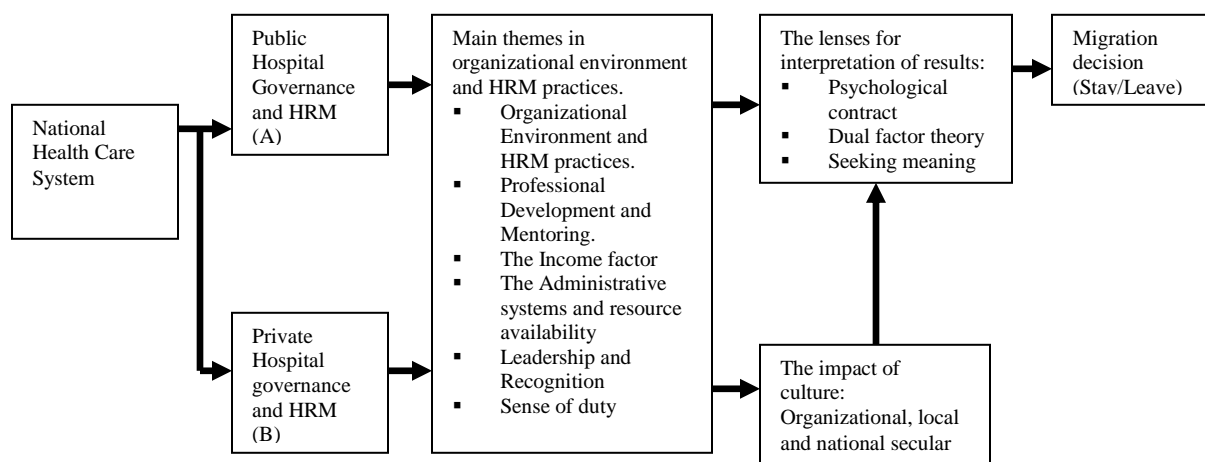
Under the decentralized structure, the Ministry of Health, Community Development, Gender, Children and the Elderly is responsible for policy formulation, regulation, resource mobilization and allocation, coordination, and inter-sectoral linkages, management support to level-three hospitals, including national, referral, and special hospitals and training key professional health cadres. Also, in addition to working with local government authorities, the Ministry of Health, Community Development, Gender, Children and the Elderly collaborates with several other ministries. These include the

Ministry of Finance and Planning (to provide funding,) and the Ministry of Education, Science and Technology (to train pre service and in-service health workers).

The Ministry of Health, Community Development, Gender, Children and the Elderly is responsible for recruitment and distribution of health staff throughout the public sector. Hospital A is directly under the ministry of health and social welfare, whereas hospital B operates under the Evangelical Lutheran Church of Tanzania. Private sector partners are coordinated by two major umbrella organizations. These include the Christian Social Service Commission which represents a large number of Faith Based Organizations, and the Association of Private Health Facilities in Tanzania. Despite its religious orientation, hospital B adheres to national guidelines promulgated in Tanzania labour laws on all employment matters. For example, it has to pay employees the minimum salary level or above, according to its financial ability. Moreover, all statutory pension deductions have to be remitted to the pension funds, and all labour disputes are resolved through national guidelines.

The overall Tanzanian health care system will not be further analyzed, but one of the themes, i.e. organizational environment and HRM practices, is greatly influenced by this national system. The main focus of the framework in Figure 8.1 is the six themes, already mentioned. These will be analyzed and discussed in greater detail in the following section, and links to theory pointed out. These themes turn out, according to my interpretation of findings, to be the main factors behind decisions to stay or leave the organization.

Figure 8.1 Conceptual Framework of the study



After examining the six themes in terms of theoretical significance, and also comment on the cultural element, influencing in particular, the sense of duty theme and the ways doctors construct meaning, I shall use three “lenses” to seek an understanding of impact.

8.3.1 Psychological contract lens

The psychological contract lens has been referred to several times in this dissertation. In a sense, it calls for a calculative understanding of the decision to stay or leave – adding up the gaps between expectations and real outcomes in terms of the benefits of working in Tanzania against the costs.

8.3.2 Dual Factor theory lens

The Herzberg’s Two factor theory described in chapter 2 (section 2.3.11) suggest that some of the themes may have a strong motivating effect, and in the present case also motivating doctors to stay, while other themes are about “hygiene” satisfaction and dissatisfaction, that when unsatisfied may subvert attempts to motivate employees, and in the present case attempts to increase retention.

8.3.3 Meaning seeking lens

Finally, the meaning-seeking lens cuts across both the psychological contract calculus and the motivation/dissatisfaction factors, and seek out – in overall terms – how doctors come to decide to stay or leave. The phenomenological method in organizational studies is closely linked both to grounded theory and inductive research, and the main target of a phenomenological investigation is to uncover how individuals seek and find meaning. Thus, this part brings in phenomenological perspectives linked to organizational support theory and trust.

8.4. Analyses of the themes

Among the six themes, the first one (the role of HRM department and position in the organization) brings in a contextual perspective. It asks whether the way HRM practice is organized in the institution is a sound one. The following four themes are influenced by the way HRM is organized, and each of these themes cover areas of expectation and fulfilment – questions of whether or not doctors are satisfied or not satisfied, motivated to stay or motivated to leave the organization – in terms of professional development opportunities, income, quality of administration and resource availability, and leadership style and recognition. Finally, the sixth lens is about what doctors bring to their job in terms of inner demands on themselves expressed as a sense of duty. The sense of duty is again strongly influenced by the surrounding culture.

8.4.1. Organizational Environment and HRM practices

HRM policies, practices and processes are composed of activities that put HRM policies into place. Practices try to ensure that policies are implemented as intended. A variety of practices may be used to implement a given policy. While HRM policies are broad in describing what an organization wishes to accomplish, HRM practices are specific in describing how an organization desires to achieve intended goals. HRM processes characterize employees' experiences and perceptions of HRM practices.

According to my findings, Hospital A exhibited considerable gaps between management rhetoric (e.g. official policies) and reality (e.g. enacted and implemented practices). HR practices affect organizational outcomes by shaping employee behaviour and attitudes. They determine the recruitment, training and reward strategies which can increase job satisfaction, boost work morale and enhance retention. While good HRM practices (such as employee recognition and appreciation) tend to attract and retain employees, poor HRM practices (e.g. non provision of requisite working tools) de-motivates staff and increases the probability of leaving.

The HRM literature in chapter 2 underscores the crucial role of HRM in improving the factors that lead to increased retention rates (Armstrong & Taylor, 2014; Buchan, 2010; Dieleman et al., 2011; Guest, 2011; Khan, 2010). While hospital B features as an interesting case for employee retention, a general finding of this study is that formal HRM departments in hospital A do not play a decisive, positive role in creating the conditions for enhancing retention of doctors. What needs to be explained, then, is why there is this discrepancy.

(a) Hospital autonomy

Hospital A has a semi autonomous status in which the government delegated operational responsibility to the hospital governing board. While literature on hospital autonomy suggests that it may lead to enhanced efficiency, improved responsiveness to local needs and better health outcomes (London, 2013), there are indications that there has been limited or partial implementation of intended autonomy in hospital A. In spite of having considerable latitude in running its affairs in comparison to other public sector hospitals, hospital A had limited autonomy in formulation of HRM policies exacerbated by prerogative powers of the central government which created inefficiencies in HRM implementation.

By contrast, hospital B is a non-for-profit faith based, non-governmental organization. It provides health services as promulgated in the national health policy framework. While it has full autonomy to offer health services in its rural setting, it is subject to government health policies and regulations. It has to adhere to standards set for quality assurance in health care provision. These policies are adopted by executive council of the church and by extension the hospital board. However, the hospital is given full autonomy to implement the public private partnership in training, research and outreach programmes within its catchment area, and in all matters of internal HRM. The findings corroborate with a study by Munga, Songstad, Blystad, and Mæstad (2009) which underscored the importance of decentralized decision making systems. Despite the limitations which manifest in hospital A, the HRM department can still employ internal resources to respond to critical concerns which demoralize employees and create inefficiency – but it does not always follow through.

(b) HRM responsiveness

Employee involvement in matters related to their job in hospital A appeared to be a passive undertaking irrespective of the presence of management and union representative forums. This illuminates non-adherence to agreed employment terms and policies which created disequilibrium in the psychological contract as presented in chapter 2 (section 2.3.6). It has been noted that fulfillment of expectations lead to positive attitudes of the employees and higher levels of commitment. This facilitates retention management which is described as a beneficial process to both the origination and employees as it encourages staff to remain with the organization for a maximum period (Ineson et al., 2013; Khuong & Tien, 2013; Sandhya & Kumar, 2011).

Responsiveness to doctors' needs, on the other hand, showed up in the ability of hospital B to recruit doctors from areas close to hospital location. Such local recruitment created mutual trust between doctors and the hospital and facilitated their retention. The finding is consistent with the career literature in chapter 2 (section 2.3.5) which posits that longer gestation period in pursuit of an occupation is important in decisions concerning ones career (Schein, 1978). However, violation and breach of a psychological contract often results in a decline in employees' willingness to stay in an organization (Dhanpat & Parumasur, 2014). As noted in section 8.4.1 (sub section b), lack of responsiveness – or the ability to act in time – was also seen in the area of recruitment. In contrast, doctors in hospital B felt affiliate and had a sense of belonging which enhanced their loyalty to the employer. This signals that retention strategies have to be aligned with what employees' value as being important to their work. Cognizance of the fact that employees highly valued being treated with respect for their work roles, it is imperative to honor employees' expectations.

It transpires from my findings that the HRM department in hospital A should revitalize social relations between the management and employees through collaborative HRM practices which featured in hospital B. There seem to be a need to move away from control or calculative HRM practices towards commitment based and trust-based, collaborative HRM practices. While control approaches to HRM seeks to improve efficiency by enforcing employee compliance by for example, basing employee rewards

on measurable criteria (Armstrong & Taylor, 2014), trust-based commitment approaches to HRM aim to shape employee attitudes by forging psychological links between organizational and employee goals (Guest, 1997). Such changes would give credence to more fruitful exchanges between the organization and employees and promote transformational leadership styles and greater autonomy. Different degrees of responsiveness between hospital A and B may be attributed to differences in governance structures arising from organizational culture.

(c) Cohesion and alignment of HRM practices

The overall quality of the HRM efforts in Hospital B was according to my findings, clearly superior to that of Hospital A. In Hospital B the HRM responsibility was aligned with general line management responsibilities, and marked by responsiveness to doctors need and pro-active attempts to meet expectations. In Hospital A the quality of the HRM practice suffered from lack of responsiveness, that may be partly due to the quality of the work of the hospital's HRM department itself, but also to problems associated with too many governmental influences, both at the policy and the practice level. These problems were reinforced by a lack of delegation and autonomy, which in the end led to non-aligned practice. An example of such lack of alignment and responsiveness, due in part to lack of autonomy, was found in the recruitment strategy of Hospital A.

The employment freeze instituted by the government led to recruitment delays, and the hospital had to subject doctors who applied for jobs to contractual employment terms. Contract renewal was subjected to government issuance of permits. Delays in employment permit renewals instilled job insecurity, and undermined the mutual trust between employer and employees, and prompted some doctors to migrate from hospital A. This alludes to the career literature in chapter 2 (section 2.3.5) which delineates need based career anchors as crucial aspects in ensuring job security. The findings also lend support to growing evidence that delays and slowness in public systems relating to HRM functions, such as slow recruitment, can lead to poor motivation and turnover (Purohit & Martineau, 2016).

As a contrast, the findings in hospital B show that recruiting doctors from areas close to hospital location created mutual trust between doctors and the hospital and facilitated their retention. This resonates with a growing evidence of the importance of matching a candidate's own background to the setting in which they are recruited to work. Some studies indicate that staff that grew up in a rural environment are more likely to assume duties in these settings (Cohen, 2012; Rose & van Rensburg-Bonthuyzen, 2015; Walker et al., 2012; WHO, 2010). The findings of this study bring to the fore the rationale for selective staffing in the context of employee location context.

The HRM literature demonstrates how a strategic approach to HRM can be translated into a set of coherent HR processes and practices. While the HRM strategy ought to be people centered and aligned with stakeholder needs and priorities, the findings in hospital A showed that the unitary system characterized by centralized prerogative powers in HRM functions cannot bring positive health outcomes. This is due to the fact that the HRM strategy in the health sector undermines decentralized decision making which can build a HRM strategy appropriate to the specific organizational context.

The way an organization aligns different practices in a strategic architecture creates synergy. Public sector organizations like hospital A need to recruit, develop and train employees, set conditions of employment through a coherent set of employment policies. This requires HRM functions (i.e. recruitment and selection, skill development and training, career progression, employment conditions and reward management) have to be means to an end rather than being ends in themselves. The public health sector needs to be more flexible and responsive to issues of selective recruitment, training and development interventions that can harness and attract talent. These practices echoed the urgency to move from a rule bound culture to operational efficiency culture which can enhance quality health care outcomes. There is need for devolution of authority and decentralization of activities in order to establish flexible structure and processes which ensure greater responsibility of line management in addressing employment matters.

8.4.2. Professional development and mentoring

While Shemdoe et al. (2016); and Mloka et al. (2012) revealed that health workers expressed strong feelings about limited training opportunities in rural areas, hospital B (located in a remote rural setting) seem to have offered doctors adequate opportunities for further training and career advancement. The hospital demonstrated great commitment in utilizing the available resources to expose the doctors to diverse learning opportunities in the motto of building staff competences. The findings revealed that availability of learning opportunities is one of the factors that influenced doctors to stay in both hospitals.

The findings are in agreement with the career literature presented in chapter 2 (section 2.3.5). The career literature established a significant relationship between career development opportunities and employee retention as it promotes a higher degree of organizational commitment among employees (Chen et al., 2011; Moran et al., 2014; Nouri & Parker, 2013). The findings contribute to the mentoring literature which indicates that provision of mentoring services enhances employee commitment to stay in an organization as they value career advancement.

The findings lend support to the human capital theory presented in chapter 2 (section 2.7). Training is a key strategic activity in furtherance of hospital missions in hospital A and hospital B. Both hospitals implemented training and development programmes to ensure attainment of employee career development goals. The hospitals organized periodic skill enhancement workshops, mentoring by specialists and postgraduate training in specialized courses to build clinical competence. The hospitals forged collaboration with local and international health institutions. This increased opportunities for joint research which ushered in avenues for availability of modern equipment and cross-cultural learning in tropical diseases. These career development opportunities motivated doctors to stay.

However, in spite of the fact that availability of career development opportunities in hospital A motivated doctors to stay, the pace of training and development was slow due

to high demand as compared to the supply of training resources in the ministry of Health, Community Development, Gender, Children and the Elderly. Many collaboration links with foreign institutions gave hospital B an added advantage over hospital A in terms of resources for career development opportunities.

In spite of huge investments in employee training and development, non availability of working tools and medical supplies in hospital A made it difficult for the hospital to realize return on investment in capacity development due to skill under utilization. Owing to these concerns, some doctors in hospital A migrated to other countries. Investment in human capital sharpens the capacity of the hospital to deliver quality health care as long as the organization manages to utilize and most importantly retain the trained employees. Migration of trained and developed employees has no return on investment. The ability of hospital B to retain all doctors spearheaded achievement of its mission. In this vein, the failure of hospital A to retain some of the doctors affected its achievement of the goal set in its training programme. The findings echo the need to ensure that investment in human capital goes in tandem with interventions to retain talent.

The findings elevate the relevance of Social Exchange theory presented in chapter 2 (section 2.3.9). Social behavior often involves social exchanges where people are motivated to attain some valued reward for which they must forfeit something of value (cost). Employees seek profits in exchanges such that rewards are greater than the costs. There is disillusionment when there is perception of inequity or where others are rewarded more for the same costs incurred. Social exchange theory can be used to explain the development and management of interpersonal relationships. It influences the relationships among members of groups and organizations. The leadership style exhibited in hospital B was geared to build collegial linkages between hospital leaders and the employees. This enhanced employee work morale and greater commitment to stay.

Social capital theory seems to be an important link between doctors and patients in both public and private hospitals. The social capital of doctors evolves from the perceived quality of health services rendered. Doctors in Hospital A had greater access to networks

and social capital through business networks of intramural and extramural dual practice in medicine.

Despite operating in a rural setting, doctors in hospital B garnered strong social capital in the nearby community and beyond because of high quality health services. Doctors who work and live in a rural community like hospital B have close interactions with community members and are actively engaged in community affairs. Much as doctors in both hospitals utilized their human capital (knowledge, skills and competencies) to create social capital with the patients, the geographic proximity of hospital B to the communities in neighbouring villages and districts and the shared religious values enhanced their social capital within the hospital and in the community. Doctors in hospital B built social capital through good relationships with the management, colleagues and community members. The strong bondage largely stems from the strong ties as most of the doctors came from nearby districts. In the African culture, people tend to establish strong ties with their extended family and communities.

The findings in hospital B indicate a potential advantage of strengthening social capital between doctors and stakeholders: management, peers, patients and the community. It emerged that professional norms, obligations and trust embedded in social relations enable doctors to provide quality health care services. This can be done by building trust through establishing common values and mutual trust among employees and team building workshops. Organizational social capital came to the fore as doctors appreciated and valued multiple hospital projects which contributed to the welfare of their families. The projects have created employment opportunities in the community and hence a strong incentive which ameliorates poverty levels. The cumulative social capital built strong trusting relationship between doctors and the management on the one hand and doctors and the community on the other hand. This social and work environment has inspired doctors and reinforcing bonds of loyalty to stay.

The psychological contract theory seem to be relevant in the way doctors accorded high value to learning opportunities offered by both hospitals. As stated in chapter 2 (section 2.3.6) when mutual expectations between the employer and employees are fulfilled,

employee's desire to stay is enhanced (Van Vuuren, 2010). The theory justifies why organizations invest in employees' training and development. The rationale is that it offers requisite competences in response to changing job requirements. These practices are expected to arouse employee commitment to stay. Psychological contract breach, on the other hand, can be defined as instances when employees perceive their organization to have failed to meet its reciprocal contractual obligations (McDermott, Conway, Rousseau, & Flood, 2013) hence arousing employees to leave.

8.4.3. The Income factor

Overall, the income factor seems to be less important than previously assumed. While low pay and inadequate incentives are cited in the reward literature by Vujcic et al. (2004); Chappell and Glennie (2010); and Tabatabai (2012) as push factors to employee migration, the findings in this study shows that higher incomes did not emerge as imperative for doctors, particularly in hospital B, whose strong sense of service in a rural setting overshadowed financial inducements.

A satisfying job environment which provides intrinsic needs of employees (e.g. recognition) may act as a compensating factor making extrinsic factors like salary to be secondary. Employees also value flexible work systems and recognition for their professional and social roles. Had money been a decisive motivator, hospital B, in particular, would not have managed to attract and retain the doctors. Despite being quite aware of employers who pay high salaries and the economic potentials of urban and city settings, doctors in hospital B persevered to work in the rural area beyond the call of duty. In this vein, some of the things that doctors appreciate most are not necessarily related to financial incentives (e.g. high pay).

There were differences in the way income opportunities worked in the two hospitals. Hospital A has a location advantage with many private hospitals as opposed to the rural setting of hospital B which was the sole health facility in its catchment area. While high living costs in a city setting made doctors in hospital A to accord high value to dual income, low cost of living and duty to religion and the high quality health care offered in hospital B made private practice unattractive.

Dual practice in hospital B is untenable on two grounds. First, the faith based nature of hospital B is geared to offering high quality health care at low costs rather than profit creation. The rural location of hospital B makes it difficult for the majority of the people to afford high pay for health services. Second, patient satisfaction influences their choice of medical services. In the case of hospital B, health services offered are of good quality and subsidized and have garnered high patient satisfaction. These factors rules out doctors' engagement in intramural private practice (within the hospital) and extramural private practice in medicine (in private health facilities). The doctors in hospital B augment low salary income by doing extramural private practice in other business (i.e. cattle keeping and farming) when they are off duty.

8.4.4. The administrative system and resource availability

While the literature underscore requisite equipment and medical supplies for effective delivery of health services, some of the doctors who migrated from hospital A cited severe resource constraints in terms of inadequate equipment and medical supplies as one of the reasons which influenced them to leave. The fear of skills underutilization made it difficult to unleash their potential, hence hampering their work efficiency as they could not properly diagnose patients' illnesses. The findings show that doctors find it difficult to provide the services expected in environments of severe resource constraints with far less equipment and drugs than required.

In contrast, the supportive management in hospital B creates an enabling work environment for quality patient care. Doctors in hospital B commended the primacy of requisite equipment as it enhanced their utilization of knowledge and skills. This study reaffirms the fact that the working environment has a strong influence on job satisfaction. My finding underscores the primacy of clinical and diagnostic equipment in the delivery of quality health care. This mirrors a close association between the administrative system and the career literature presented in chapter 2 (section 2.3.5). Lack of working tools raised fears of career retardation and skill obsolescence due to a denial of an appropriate working environment to put their skills into practice. It also depicts the relevance of the psychological contract literature described in chapter 2 (section 2.3.6). This finding

resonates with past studies which indicated that the availability of appropriate tools is a key factor of job satisfaction (Ebuehi & Campbell, 2011). It has been noted that inadequate equipment is one of the major causes of outmigration (Dolea et al., 2010).

8.4.5. Leadership and Recognition

In spite of the fact that economic factors – salaries in particular, have influenced doctor migration in hospital A and migration intentions in hospital B, salary reviews in the public sector seem to have little impact in attracting and retaining doctors. By employing non-financial rewards in the form of recognition and appreciation of the crucial role played by doctors, hospital B succeeded to attract and retain doctors. Compliments such as praise for a well-done job inspire employee to stay in the organization even in the face of a limited budget. This is not only a cost-effective measure to inspire an employee to stay and perform well, but also a very simple initiative to implement.

Consistent with the reward literature in chapter 2 (section 2.3.1, d), this study underpins the relevance of recognition (by management, peers and the community) in employee attraction and retention. When employers express respect to their employees and acknowledge their achievements and contributions to the organization's success, it builds employee loyalty (Fu & Cheng, 2014). Recognition is thus a strong factor which is highly valued as it enhances work morale and commitment to stay in an organization.

This study lends support to other studies which underscore combined rather than isolated incentives (i.e. Bundles) as they enhance employee morale and commitment. As the findings illustrate, various non-financial incentives that could be combined with financial incentives include recognition, availability of requisite equipment, family welfare, and professional development opportunities. The findings corroborate with previous studies which indicated that employee recognition enhances their loyalty to the organization and hence high commitment to stay (Carr et al., 2011; Fu & Cheng, 2014; Ramani et al., 2013).

My findings also revealed that operational leadership and line management can influence employee decisions to stay or leave, among others through participate and consultative leadership styles. It surfaces that employees are more likely to stay with an organization when they feel that the leader values their role and contribution. These insights garner the influence of Social exchange theory described in chapter 2 (section 2.3.9) and Transformational-and Transactional leadership. Styles described in chapter 2 (section 2.3.10). Transformational leadership focuses on increasing organizational members' commitment, capacity and engagement in meeting goals (Moolenaar, Daly, & Slegers, 2010).

There is considerable evidence that transformational leadership relates positively to employees' affective states and well-being (Montano, Reeske, Franke, & Hüffmeier, 2017) and employees' learning-related goals and outcomes (Hamstra, Van Yperen, Wisse, & Sassenberg, 2014). The positive effects of this type of leadership on numerous individual and organizational outcomes have been validated across many industries, occupations and cultures (Derue, Nahrgang, Wellman, & Humphrey, 2011; Northouse, 2015). It is thus crucial that organizations recognize the role that HRM has to play in managing their workforce, and that they employ methods that suit the specific needs of their employees and the contexts in which they operate.

8.4.6. Sense of duty

Organizational, local national, secular and religious culture featured as important determinants of employee decisions to stay or leave. These are analysed and discussed through the prism of sense of duty which in some cases motivated doctors to stay, irrespective of the potential forces driving employees to leave. A strong sense of duty was seen in the relationships to both nuclear family, extended family, patients, religion, community and the country. The sense of duty-factor was not covered in chapter 2 and was not anticipated when preparing for the study. However, it emerged as an important factor which influenced decision to stay or leave. In particular, the strong sense of duty found in hospital B, based on religious conviction and hospital mission seemed surprising – as revealed by the interpretive approach.

(a) Duty to nuclear family

Concerns about better education for the children caused some doctors in hospital A to leave and some doctors in hospital B to express migration intentions. Thus, the sense of duty did not always influence doctors to stay. This is consistent with the career literature in chapter 2 (section 2.3.5) which showed that the life style integration career anchor influences employees' value in balancing work and family responsibilities (Hofstede, 1980; Oosthuizen et al., 2014). Cultural dimension is also relevant in duty to nuclear family. While national cultures had previously been geared towards collectivist cultures, increasing individualism in Tanzania today is emerging in some cases in response to societal obligations. As mentioned, the individualism – collectivism cultural dimension is defined as “the degree to which people in a country prefer to act as individuals rather than as members of groups (Hofstede, 2001). Individualism here means that concern for the nuclear family is rated as more important than concern for extended family and broader environment. All other dimensions of sense of duty in my findings, except for duty to the nuclear family, influenced doctors to stay.

(b) Duty to extended family

Duty to the extended family calls for doctors to stay, and is rooted in the obligation to fulfill family roles which in turn stem from cultural orientation. This finding re-affirms the career literature in chapter 2 (section 2.3.5) in which a Life style integration career anchor underpin the importance of balancing work and family responsibilities (Schein, 1987b). The findings also corroborate with (Hofstede, 1984, 1991) cultural dimensions. Duty to extended family in collectivist societies like Tanzania garner high value as it is associated with social achievement and good interpersonal relations among members in a family. Duty to extended family typifies the collectivist cultures in which many societies in developing countries identify themselves. An important finding in my study was that a sense of duty to extended family in many cases influenced doctors to stay, even when they were otherwise inclined to leave.

(c) Duty to patients and the country

A sense of duty to patients and the country also were cited as reasons to stay in both hospitals. The doctors re-affirmed their sense of duty through resounding expressions of professional ethics and patriotic values to serve the citizenry irrespective of the push factor such lower salaries and poor living and working conditions that rose temptations to leave the country. This signifies a strong passion and patriotism to serve the country. The findings indicate the relevance of the career literature in chapter 2 (section 2.3.5) which identifies service/dedication to a cause as one of the influential career anchors in decisions to stay. This is consistent with past studies which identified personal values of service to poor as important motivating factors for medical doctors to work in rural health-care services (Purohit & Martineau, 2016).

(d) Duty to religion and hospital mission

Religion seems to influence doctors to stay in hospital B even in the wake of problems besetting their work setting. This may extend our knowledge on the role of religiosity in work behavior in developing countries. The vision of hospital B is to cater for all physical, mental and spiritual needs of its patients. The organization culture evolving from employees' deep spiritual orientation appears to have ushered in deep commitment to patient care. Arguably, spirituality alone is not a panacea to ensure employee retention.

My findings underscore close relationship between work place spirituality and employee commitment to stay in the organizations in developing countries that hitherto have not been extensively explored in western HRM literature. The study lends support to other studies of spirituality in the workplace which have established a relationship between spirituality and organizational commitment (Benefield & Holtzclaw, 2014). Scholars have also linked spirituality and religion in the workplace to leadership practices (Chen & Yang, 2012).

(e) Duty to community and the country

Specialist doctors who stayed in hospital A provide outreach services to regions and districts. The communities visited accord high value to such services. The services are offered with increased understanding that specialized health services are on high demand by the populace in the wake of acute scarcity of doctors. Similarly, doctors in hospital B had positive perceptions of being valued by the community. Doctors provide health services in a rural setting with un-reserved commitment to help patients from different communities and regions. The services included admitted and out patients as well as outreach visits in distant villages and districts. This created pride and a sense of achievement hence increased commitment to stay. My findings are consistent with the findings of previous research on the sense of community respect and working relations (Greenspan et al., 2013; Ineson et al., 2013; Khuong & Tien, 2013) These studies in unison show that employees remain loyal when they perceive that they have a sense of value and a sense of pride; thus, they have low or no intention to leave the organization.

8.5. The impact of Culture

In Figure 8.1, the cultural impact element is shown as an exogenous force, influencing both the sense of duty theme and the meaningfulness lens in the framework. Thus, while the HRM literature often seem to take American or European main cultural patterns more or less for granted, my findings clearly underscore the need to incorporate the cultural factor when studying HRM phenomena in Non-Western societies. Hofstede (1984) originally identified four cultural values. These included Power distance (large versus small), Individualism versus collectivism (strong versus weak), Uncertainty avoidance (strong versus weak), Masculinity versus femininity. He later added a fifth value, Long term orientation versus short term orientation.

The identification of cultural values helps us understand the priorities of people in that culture, and how values relate to behavior – such as staying or leaving. In the context of my findings, the dimension of individualism vs. collectivism is perhaps the most important, illuminating the relationships between individuals and groups in the society.

Collectivism is characterized by a tight social framework in which people distinguish between in-groups and out-groups. Family members expect their in- groups to take care of them (Hofstede, 1980, p. 45) while people in individualist societies to a greater extent are expected to take care of themselves. Doctors who stayed in both hospitals exhibited high commitment that stemmed from community bond (affection to help the community) and extended family bonds. This stems from a tradition in the African culture in which people tend to establish strong ties with their communities and extended families. It is also an expression of a collectivist cultural value (Hofstede, 2001).

The psychological affection with the community, the extended family, and the country also builds a form of patriotism. This is reminiscent of the service/dedication to a cause career anchor described in chapter 2 (section 2.3.5) which seems to be relevant in employee affiliation to the community. The findings illuminate the saying: *East West Home is best*. It is also expressed by persons who exhibit patriotic values by vowing to serve fellow citizens rather than seeking greener pastures in other organizations or countries.

8.6. Three lenses

My analysis has so far brought attention to the Tanzanian health care system as a “macro” context, and to six themes that seem to explain much of the difference between the two hospitals. One of these themes has dealt with the “micro” context of HRM in the two hospitals. Four of the themes are indicative of satisfaction or dissatisfaction as reasons for leaving or staying. And one theme is focused on individual doctors’ sense of duty – in multiple directions. We have also briefly commented on the impact of culture in influencing both a sense of duty and meaning seeking

Some of the findings appear to be more surprising than others. The income theme was expected to be more important than our results so far have shown it to be. Overall leadership style and leadership quality, as well as the effectiveness and fairness of the administrative system have been shown to be more important than anticipated. The opportunity for professional development has also been shown to be of very high

significance. Furthermore, the sense of duty-theme came out strongly, and the very strong sense of duty to hospital mission and religion in hospital B was found to be surprising.

The question now to be raised is about how to interpret our findings so far. Is there some way to come up with an overall assessment, and answer the question of what it is that ultimately lead doctors to stay or leave? I do not believe that the phenomenon of staying or leaving is one that lends itself to very precise prediction and to one particular perspective. I therefore suggest viewing the findings through three theoretical lenses – the psychological contract lens, the two-factor lens, and the meaning-seeking lens.

8.6.1. The Psychological Contract lens

Both in my initial theory chapter (chapter 2, section 2.3.6), in my presentation of results (chapters 5, 6 and 7), and in my analysis (in this chapter 8), I have referred several times to the Psychological contract theory. This theory is about the relationship between expectations and experience. It should be noted that psychological contract theory implicitly presupposes a formal contract theory between employer and employees, specifying the terms of work and rewards, and subject to legal trials in the case of breaches. The Psychological contract theory is in essence about all aspect of work-related exchanges of inducements and contribution that are not subject to legal examination, but that are still part of the expectations held by the two parties about inducements and contributions, about ways employees will be treated and about proper behavior in the workplace.

If employees have been led to have high expectations for such factors (themes) as overall HRM quality, leadership and recognition, administration and resource availability, and they later experience that the quality is not up to expectations, this may be a rational reason for migration. Ffulfilment of psychological contracts, on the other hand, may be expected to increases work morale and influences employee retention. The conceptual framework vindicates that unmet employee expectations can affect the relationship between HRM practices and decisions to stay or leave. For example, concerns about poor working conditions in Hospital A at one time attracted strikes which plunged the hospital

into a crisis which had a serious impact on the service delivery. The strikes were a manifestation of contract breach against employment contract which also paved the way for mistrust between the employer and employees. This illuminates non-adherence to agreed employment terms and policies which created disequilibrium in the psychological contract.

The psychological contract literature notes that fulfillment of expectations lead to positive attitudes of the employees and higher levels of commitment. This facilitates retention management, which is described as a beneficial process to both the origination and employees as it encourages staff to remain with the organization for a maximum period (Ineson et al., 2013; Khuong & Tien, 2013; Sandhya & Kumar, 2011). However, violation and breach of a psychological contract often results in a decline in employees' willingness to stay in an organization (Dhanpat & Parumasur, 2014)

In contrast, doctors in hospital B felt affiliate and had a sense of belonging which enhanced their loyalty to the employer. This signals that retention strategies have to be aligned with what employees' value as being important to their work. Cognizance of the fact that employees highly value being treated with respect for their work roles, it is imperative to honor employees' expectations.

The psychological contract theory has identified two types of psychological contracts. These are transactional and relational contracts. The difference between these contracts is clarified below.

(a) Transactional contracts

A transactional contract can be defined as the kind of contract which contains the expected terms of exchange given in a monetary value such as a bonus (Rousseau, 1995; Rousseau, 2004). Transactional psychological contract: focuses more on the explicit elements of the contract without accounting much for intrinsic qualities of workers. These are more common in organizations with authoritative management styles and hierarchal control. These contracts are found to be related to careerism, lack of trust in employer,

and greater resistance to change. They tend to be shorter term in nature and keep people working for extrinsic rewards.

(b) Relational contracts

A relational contract is one which constitutes expectations about the relationship between employee and the organization. It includes such factors as trust and organizational commitment (Rousseau, 1990; Van Dyk et al., 2013). Relational contracts can be considered as socio-emotional relationships concerned with the more social and emotional elements of the employment relationship. They are characterized by a high level of member and affective commitment, identification, and stability in the relationship (Rousseau, 1995). Relational psychological contract: stresses interdependence of the organization and level of social exchange. These psychological contracts tend to be longer term in nature. It underscores participative management and emphasizes commitment and belief in the intrinsic values of people to want to work for something beyond monetary rewards. Relational contracts are found to be associated with trust and increased acceptance of change.

Transactional contract in hospital A featured in HRM functions of reward and career development. Salary and promotion delays and withdrawal of risk allowance in hospital A were more severe breaches of psychological contract in hospital A. Despite the fact there were agreed employment terms and policies, they were not adequately honored. Doctors had concerns on perceived differences between their salary and the salary levels of other professions within the country. Risk allowance was withdrawn with little regard to the risky nature of health service provision particularly in the wake of HIV/AIDS. This had an impact on the psychological contract for medical doctors. Delayed promotion was seen as a violation of the contract between the employer and the doctors. Such promotion delays further raised fears on doctors' career growth. The failure of the hospital to keep basic promises on matters affecting doctors' employment rights influenced some of the doctors to leave.

In contrast, hospital B adhered to government salary levels in order to benchmark public sector pay levels. This is not a common practice in other private hospitals which have their own pay levels provided that it is not below the stipulated minimum wage. In addition, doctors are paid salary supplements (i.e. top up) of 30 percent of the basic salary. This policy motivated doctors as it helped them to meet many of the basic needs. This in some way seem to be a complement to non engagement in intramural and extramural private practice However, the pension fund in which hospital B doctors belonged to had unfavorable terms compared to other pension funds in public hospitals where members would get hefty payments. Such huge differences of the pension package between hospital B and hospital A created a strong sense of exclusion and dissatisfaction to the extent of some expressing migration intentions.

The findings attest that hospital A did not fare well with relational contract. While relational contracts would have complemented challenges in transactional contracts, the findings in hospital A showed that one of the factors that caused low job dissatisfaction of doctors was lack of management recognition. It emerged that doctors have a range of different social needs beyond high pay. While the government cannot afford to pay doctors comparable pay levels as those in countries where the doctors migrated to, the hospital management could feasibly employ relational contracts through praise for exemplary performance to signal that the role of doctors is valued. Hospital B builds relational contract by forging long term trust relationships between employees and the management. Its success lies in mutual respect, trust, shared values and increased availability and quality of health services.

The psychological contract lens presents my main research issue as a balance sheet type of issue adding up psychological costs and benefits (in terms of met and unmet expectations). While a surplus (fully met expectations) will lead to retention, a deficit will lead to migration. However, the theory itself does not stipulate which items in the balance sheet are more or less important to individual decision-makers, or here more important to individual doctors.

We shall now turn to another lens, the Two-factor lens, which may possibly help us pick out some balance sheet items that are more important than others in causing migration.

8.6.2. Herzberg's Two-Factor lens

The two-factor theory of motivation (Herzberg et al., 1959) was designed to predict employee performance motivation – not motivation to stay or leave. The theory separates motivation and job satisfaction into two groups of factors: Hygiene factors and motivators. Hygiene factors include salaries/wages/fringe benefits, company policy and administrative systems, inter-personal relationship, quality of supervision, job security, working conditions and work/life balance – leading, according to Herzberg, at best to general satisfaction and the prevention of dissatisfaction. Herzberg also called these “maintenance factors”. They are extrinsic to the job itself.

Herzberg's new insight was that the satisfaction of such “hygiene” factors, does not lead to higher performance motivation – only the elimination of dissatisfaction. Herzberg therefore concluded that the dissatisfaction with hygiene factors first had to be eliminated, before it would pay to work with the motivator factors. The motivator factors, on the other hand, cover such factors as sense of personal achievement, status, recognition, challenging work, responsibility, and opportunity for learning, advancement, promotion and personal growth. These lead at best to high motivation for performance and strong commitment.

Herzberg recognized that an increase of satisfaction in an area where the individual was already satisfied, would not lead to a higher level of motivation. Thus, if the level of pay was clearly unsatisfactory, a pay increase would reduce the level of dissatisfaction. But a further increase of the level of pay, would not lead to a higher performance motivation. Only factors that contributed to make the job itself, or aspects directly associated with the job, more interesting, would be truly motivating for higher performance.

Since Herzberg first published his theory and the result of an empirical study (of engineers' motivation), there has been some disagreement of where to exactly draw the

line between motivators and hygiene factors. This is not, however, of great concern in the present study. The main question raised by the two-factor lens, is whether or not we can go beyond the psychological contract type balance sheet calculus, and point to one set of themes that are more likely to lead to migration while another set is more likely to lead to retention.

Among the six themes, professional development and mentoring clearly belong to the motivator type of factors in Herzberg's scheme. Leadership and recognition, would also count as motivator factors, while the income factor and the quality of the administrative system and resource availability would belong among hygiene factors. Is a decision to migrate a result of too little motivation, due to lack of professional development and recognition, or is it a result of too much dissatisfaction with income or resource availability?

My findings seem to indicate that both hygiene factors and motivators influence employee decisions to leave or stay. Remuneration, a hygiene factor cited by Herzberg et al. (1959) as an important factor influencing employees' job satisfaction) was, it seems, overshadowed by good interpersonal relations nurtured through personal and team recognition, as well as a flexible work design. Conversely, achievement, recognition, advancement and growth (i.e. motivators) appeared to be highly influential in employee attraction and retention. The theory put much premium on achievement and recognition as motivating factors for employees. This is arguably an area where active HRM could do much to make people stay, through overall recognition and positive remarks for a job well done.

One of my themes, the organizational environment and HRM practices, does not fit in with neither the psychological contract lens nor the Herzberg's Two-Factor lens. Structural problems related to HRM are not of direct concern to employees. The issue is not part of the psychological contract, and it cannot be classified as a motivator or hygiene issue. Only the consequences of such (structural) problems can be accounted for. The consequences of poor HRM appear to materialize both in relation to motivators and hygiene factors.

Also, it is difficult to link sense of duty to both the psychological contract lens and the dual factor lens. The sense of duty stems from culture and personal obligations, and is not easily influenced by HRM. In the case of Hospital B, however, the strong missionary spirit seems to have installed a very strong sense of duty that is part of the overall psychological contract calculus and that may also be counted as a motivator in Herzberg an terms, influencing the rate of retention positively.

Generally, it seems that problems of retention of doctors in less developed nations, are often blamed on lack of funding (I. e. on hygiene factors such as low income and lack of resources), it should be noted that both hospitals have a relatively strong performance when it comes to professional development (motivator), and that Hospital B also scores high on leadership and recognition (motivators), whereas Hospital A scores much worse on leadership, recognition and involvement. This also means that it probably would cost much less to improve on the motivator factors, in order to increase retention, as compared to significantly increase wage levels and resource availability. Thus, my findings revealed that factors which precipitate employee desire to leave hospital A were sometimes mitigated by job satisfaction stemming from fulfilled professional development opportunities, or from sense of duty arising from family and community bonds which are rooted in societal culture.

Although it is not the same to motivate for higher performance as compared to motivating for (retention, my findings seem to be congruent with Herzberg's two factor theory in the sense that investing in motivator factors will offer a good payoff in terms of retention.

8.6.3. The meaning-seeking lens

The complexity of individual decisions to stay or leave takes us beyond both the Psychological Contract Theory and the Two-Factor Theory. Of course, some of my informants could give concise answers to why they would stay or leave, but in most cases the reasons offered for the choices made, were quite complex and many-facets featured around what they overall found meaningful. Creation of meaningful conditions for work

minimizes migration temptations. The meaningfulness of work is pervasive. It goes beyond good pay and includes employee values and beliefs within the social context.

In phenomenological research methodology, the objective is to disclose how informants construct meaning during their everyday navigations in life – and also how they think of meaning during critical phases of important decision-making (Smith, Dixon, Trevena, Nutbeam, & McCaffery, 2009). While my ambition in the present study was not to contribute to phenomenology, there is a close link between grounded theory type research, interpretive research, and phenomenological research. The interpretive approach allows for both establishing a theoretical base before conducting the study (which is played down in grounded theory research), and for adding theories and perspectives as the study unfolds (including adding phenomenological perspectives). Although my objective was not so much to delve into the deeper meanings of the choices made, the use of in-depth interviews also lends itself to phenomenological interpretation.

Job satisfaction and motivation arise from affective orientations and from how a person feels about the job. Satisfaction is high when an employee has a pleasurable perception of the job. The magnitude of perceived job value hinges on among other things the organization environment and HRM practices. Doctors who stayed in both hospitals were motivated by among other things, intrinsic values of the medical profession. Poor HRM practices, exhibited in hospital A (e.g. breach of psychological contract terms) ushered in high levels of job dissatisfaction as compared to hospital B, where doctors more generally had a feeling of working in a friendly and supportive work atmosphere, which induced high work morale and greater employee commitment to stay.

The perception of overall organizational support can also be interpreted in the light of trust and trusting relationships. Some of the concerns which influenced decisions to stay or leave are related to trust. The recruitment freeze and the introduction of contract work in Hospital A, which to a considerable extent undermined employee trust in the organization – compared to the local recruitment policies, and tenure offerings of Hospital B, which fostered trust throughout the organization.

(a) The role of Trust

The essence of trust is to be willing to rely on the integrity, surety, care of the competence of another person, or of an institution, and act accordingly (here: to decide to stay and “give it a chance”) – even in a situation where there can be no guarantee of not ending up feeling hurt or “trapped” or “betrayed”.

In spite of a host of tedious medical activities (e.g. high workload which at times involves working day and night, frustration due to scarcity of supplies and equipment) doctors who stayed in both hospital A and B persevered to provide health care services. The doctors expressed sympathy with patients who had high expectations from the perceived competence of doctors. Committed doctors viewed their role as a gratifying experience to serve patients. They felt satisfied by saving patients’ *lives*. For some, commitment was reinforced by some sense of patriotism (a desire to reciprocate to the citizenry whose taxes were invested in their medical training which they could not have afforded to pay on their own. For others, commitment stemmed from the appreciation and respect by the community which signaled the high value attached to the health services rendered. In this vein, the desire for meaning may be superimposed upon the psychological contract lens as an overriding imperative, where the concern is not with item by item expectations but with the overall picture.

The foregoing work culture corroborates with the findings by (Kahneman, 2011) in his seminal work titled ‘Thinking Fast and Slow’. Drawing on his research on hedonic psychology (i.e. the science of happiness), he explored people’s daily experience in terms of incidences of likes and dislikes, It was found that happiness is not a net result of having more likes than dislikes during the day, but rather to look upon life overall as being meaningful, fulfilling, and satisfactory, in terms of our own values. These dynamics lend support to a study on trust. Trust is viewed as:

“the willingness of a party to be vulnerable to the actions of another party based on the expectations that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party” (Mayer et al., 1995, p. 712).

Interpersonal trust is essential to the functioning of any organization and determines whether it achieves its objectives (De Jong & Elfring, 2010). The degree of interdependence created between the management and employees requires trusting relationship through among other things teamwork, commitment and personal fulfillment (Wangombe, Wambui, & Kamau, 2014).

(b) Ability, benevolence and integrity trust

Studies on trust have attempted to address the trust formation process. They describe the elements that people base their decisions on regarding whether to trust others: the antecedents of trust Lleó de Nalda, Guillén, and Gil Pechuán (2016) delineates three antecedents of trust: the ability, benevolence, and integrity of the person in whom trust is placed (trustee). His model identified factors that influence the formation of trust both in the trustee (the person in whom trust is placed) and the trustor (the person who places the trust).

Ability refers to the knowledge and technical skill of the trustee. Benevolence covers the trustee's motives and intentions, in that an assessment will be made of whether the trustee is concerned with the trustor's interests as well as his own, and not just his own gain. Finally, integrity includes the principles governing the trustee's behavior. Specifically, in order to assess this, the trustor will assess whether the trustee shares his principles (Mayer et al., 1995, pp. 717 - 720)..

A positive trust relationship with the management is associated with perceived capability to deliver quality services without controls. The autonomy and involvement in decision making in hospital B engendered trust relationships between doctors and the hospital management was considered a motivating factor. This lend support to other studies which showed that good trust relationship with management motivated employees This indicates that workers' degree of control and ability to make informed decisions influenced positive trust relationships with management and boosted employee morale and commitment to stay. However, the findings in hospital A showed that lack of appreciation and

recognition generated stressful relationships between the doctors and the management and triggered strikes which affected work place harmony and service provision.

The perceived medical competences influence patient choices of where they should seek services. Good patient care reinforces the demand for services. The quality of healthcare services mainly hinges on doctors' competence in terms of knowledge and technical skills. In order to ensure quality health care, hospitals have to ensure that they have competent health staff. This can be through provision of education and professional development opportunities for the healthcare workforce. This requires employees to have adequate practical education and training (Mayer & Gavin, 2005).

Benevolence is the extent to which a trustee is believed to want to do good to the trustee, aside from an egocentric profit motive. It is expected that the trustee has some specific attachment to the trustor (Mayer et al., 1995, p. 718). Management's trust in doctors in terms of benevolence (believing they will do their best manifested in particular in Hospital B). It has been established that people with different developmental experiences, personality types and cultural backgrounds vary in their propensity to trust (Hofstede, 1980).

Integrity connotes value congruence. It is the compatibility of an employee's beliefs and values with the organizational cultural values. Doctors' trust in peers enhanced job satisfaction. Collegial working relationships and trust among doctors is a strong motivational factor in work settings (Sirili et al., 2014). This trust arises from support from colleagues, professionalism, high levels of teamwork and respect.

A recurring consensus is that the influence of the antecedents of trust (the ability, benevolence, and integrity of the trustee) is affected by the kind of relationship involved. The relative weight of each of the antecedents varies, depending on whether one is trusting in a manager, a subordinate, or a coworker (Knoll & Gill, 2011; Wasti, Tan, & Erdil, 2011). Trust is also strongly connected to psychological contract theory and social exchange theory. Trust is based on the expectations of how another person will behave based on that person's current and previous implicit and explicit claim (Good, 1988).

In terms of the two-factor theory, it seems that meaning is more dependent on the (positive) motivation factors and the opportunity to do what one intended to do, than on the (negative) hygiene factors and what is lacking. But when the negative experiences from lack of fair wages and fair treatment, and lack of resources to do one's job, are too strong, this undermines the experience of meaningfulness.

There seem to be job related aspects which make employees to perceive their job as more meaningful. The findings elevated management style, recognition, opportunities for professional development in terms of career advancement, Spiritual satisfaction. It emerges that a work environment in which employees are praised for well done tasks or appreciation of their greater job roles in the organization increases their job satisfaction and enhances their desire to stay.

A common thread that typifies a meaningful job environment is interpersonal trusting relations among employees and between the management and employees. Employee perception of a meaningful job makes them to even devote private time to work without coercion. As we noted in the findings, this work culture is reinforced by supportive and inspirational organizational leadership.

8.7. Reflections on Discussion

The preceding analysis and discussion brought to the fore an array of theories which seem to increase understanding of the factors that influence migration decisions to stay or leave. Theories which are included in chapter 2 include the career anchor and the psychological contract theories. Theories that had not featured in the literature review chapter but appeared to be relevant to the findings include human capital, organizational support, social capital, leader member exchange, social exchange, social identity, Hofstede's cultural dimensions and Herzberg's two factor theory.

The study discerns three lenses which enhance understanding of the dynamics of migration decisions to stay or leave hospital settings. These include the Psychological contract, the Two Factor theory and the meaning seeking. The psychological contract

theory presented in chapter 2 (section 2.3.6) underpins the relationship between expectations and experience between the employer and employees. It specifies work related duties and obligations of both parties. While met expectations arouse job satisfaction and increased employee retention, breaches of the contract can create job dissatisfaction and desire to leave. Alignment of retention strategies to employee values appears to be very important intervention to enhance employee work morale and motivation. While transactional contracts (financial incentives) have dominated reward interventions in hospital A, the findings in hospital B show that relational have a strong influence on employee motivation to stay in an organization.

Although the two-factor theory of motivation (Herzberg et al., 1959) was designed to predict employee performance motivation – not motivation to stay or leave, it seem to have some relevance to the findings. Among the six themes, professional development and mentoring seem to belong to the motivator type of factors in Herzberg's scheme. Leadership and recognition, would also count as motivator factors, while the income factor and the quality of the administrative system and resource availability would belong among hygiene factors.

It transpires from my findings that both hygiene factors and motivators influence employee decisions to leave or stay in the two hospitals. While remuneration (a hygiene factor cited by Herzberg et al. (1959) is viewed in western HRM literature as an important factor influencing employees' job satisfaction), it was overshadowed by good interpersonal relations nurtured through personal and team recognition, as well as by a flexible work design in hospital B.

In spite of there being no close association between the sense of duty to both the psychological contract lens and the dual factor lens, the strong missionary spirit in hospital B seem to have created a strong bondage between employees and the organization which fostered retention.

Drawing on the inductive nature of this study, I attempted to distill how participants made sense of their lived experiences in migration decisions. I employ the organization support and social exchange theories to explore the meaning seeking phenomenon. Both theories

subscribe to the idea of reciprocity between the employer and employees in the employment scene. The theories entail trusting work relationships whose propensity influence decisions to stay or leave.

In attempting to reconstruct these theories in the context of my findings, it seems to me that there is a common thread among these lenses. A fundamental theoretical premise is that social relations within the realm of professional identity have a significant influence on job location preferences. The conceptual framework in Figure 8.1 postulates the impact of the cultural element which influence the sense of duty and the meaningfulness lens. It transpires from the analysis that cultural factors influence decisions to stay or leave work place settings. The social capital appears to influence decisions to stay. This stems from the pride and a sense of belonging associated with social groups. The groups range from professional teams, community clubs to religious affiliations.

Social relations seem to be a link pin between employees, the management and external stakeholders in an organization. This is premised on my considered view that investment in human and social capital would not have great value if doctors leave the organization. It appears that the value of human capital is closely associated with social capital and resultant network of relationships built through the stepping stone of mutual trust espoused in the organization and societal culture. In this line of reasoning, it may thus be imperative for an organization to invest in the development of social capital which can be a conduit for knowledge sharing and hence creating potential synergies between human capital and social capital. Networks of relationships between doctors on the one hand and the management, peers, patients and the community on the other hand can thus be potential attraction and retention interventions in the context of developing countries.

Promotion of interpersonal trust building in the organization can be attained if there is a relationship oriented culture. Social networks are potential sources of interpersonal relations. This to a large measure explains the high job satisfaction derived from mentoring and team assignments. My finding contributes to the literature on social capital presented in chapter 2 (section 2.3.8). Social capital within an organization seems to be a prerequisite for organizational learning which can attract and retain talent. In particular,

bonding social capital offers an understanding of the influence of community bond on employee retention in developing countries. It surfaced that leadership styles, and flexible work systems exhibited in hospital B facilitated the development of human and social capital. It appears that HRM practices can positively or negatively influence migration decisions. Interpersonal trust can foster collegiality and social bond within an organization. However, if the relationships between organizational members dissolve, it can lead to lack of belongingness and hence non attainment of the intended objectives. This study provides the pivot between HRM and social psychological theories towards greater understanding of the key factors influencing employee decisions to stay or leave an organization. Previous studies were predominantly skewed towards reasons for leaving and scanty attention was given to reasons why some doctors stay irrespective of the driving forces.

Despite the fact that faith and religiosity have featured as having a strong influence on employee's desire to stay, this doesn't justify that it can be exported to the public health sector. However, certain organizational attributes of faith based hospitals such as developing a sense of community within the organization, exhibiting a work environment in which employees feel sense of being valued by the management, peers, patients and the community can be modeled in other health facilities to arouse high levels of commitment to remain in the organization. This study contributes to increased understanding of the relationship between work place spirituality and employee commitment to stay in organizations in developing countries where there has been limited knowledge in western HRM literature. Hospital B exhibits a higher form of duty to God which is associated to a passion to serve fellow community members. Religion influences commitment to offer quality health services to serve patients. Health workers with moral satisfaction closely align work with the organization mission.

The study has contributions to theory development and implications for management practice which will be dealt with in detail in chapter 8. Potential contributions seem to be anchored to the following dimensions. First, is the crucial role of selective staffing in the context of candidates' background. Second, is the influence of mentoring services on employee attraction and retention. Third is the limitation of financial rewards in employee

motivation. This is premised on the crucial role of relational contracts in employee commitment and loyalty to the organization. Fourth, the urgency of employers to fulfill formal and psychological contract expectations and provision of requisite equipment to ensure quality health care delivery. These are used by employees as yardsticks of the extent to which the employer values them. Fifth, greater influence of operational leadership and line management on employee retention. Sixth, the influence of organizational culture and societal traditions on employee retention. This is closely aligned to trusting relationship formation and development within an organization which builds commitment values that marginalizes the desire to leave an organization.

8.8. Chapter Summary

The study set to identify reasons why some doctors decide to stay while others decide to leave Tanzanian hospitals. An underlying issue is to what extent the decision to stay or leave is a consequence of HRM policies, and practices and whether improved HRM lead to greater retention and improved practices. This chapter draws on the findings in chapter 5, and cross case analysis in chapter 6 alongside literature to build theory. The proposed conceptual framework exhibited in Figure 8.1 depicts the context in which doctors in Tanzania hospitals make migration decisions to stay or leave. The analysis focuses on the main themes discerned from the findings. These are the themes considered to influence decisions to stay or leave an organization. These include organizational environment and HRM practices, professional development and mentoring, Income factor, the administrative system and resource availability, leadership and recognition and sense of duty.

The findings are interpreted through three lenses namely the psychological contract, the dual factor and the meaning seeking. The lenses have been juxtaposed to make sense of the results. An emerging focus is the crucial role of leadership to forge interpersonal relations in work and social settings in building trust and increased employee commitment. The chapter presents and describes perceived pattern of relationships arising from the findings. The main themes appear to influence migration dynamics in the two hospitals in terms of motivation and job satisfaction.

Recruitment practices featured as one of the factors that influenced migration decisions in both hospitals. There were notable differences in the recruitment practices of the two hospitals. The recruitment freeze in the public sector raised concerns on job security in hospital A. Doctors were subjected to contractual employment instead of the previous employment terms on permanent and pensionable terms. This practice prompted some doctors to migrate from hospital A. In contrast, hospital B had better employment terms as doctors were employed on permanent and pensionable terms. Most importantly, hospital B enforced a recruitment strategy of hiring doctors from areas close to hospital location enhanced attraction and retention of doctors since they are committed to offer their services to relatives and the community. The findings in hospital B showed that recruitment strategies in which doctors are recruited from areas close to hospital location created mutual trust between doctors and the hospital and facilitated their retention.

The study showed that the opportunity to learn from senior doctors and from visiting experts (i.e. expatriate doctors) is an important driver for professional development in both hospital A and B. Both hospitals organized regular departmental presentations to ensure that doctors share interesting medical findings and knowledge sharing attained from conferences. Doctors in both hospitals highly valued access to mentorship by medical specialist as it enhanced their knowledge and competence in different medical domains. Working with expatriate doctors in ward rounds and conduct of major operations and health researches ushered in avenues for greater competence building in medical skills.

On the one hand, doctors in hospital B had a comparative advantage on the aspect of expatriate doctors over those in hospital A because of an array of frequent expatriate visits given its religious orientation with many collaboration networks abroad. On the other hand, doctors in hospital A had more opportunities to learn from the many specialists as compared to those in hospital B which had fewer specialists. These forums were highly valued as a rich source of gaining experience and acquisition of practical skills. Doctors who stayed in both hospitals alluded to the fact that they got satisfaction from working with domestic and expatriate specialists because it facilitated attainment of technical and professional career goals.

Past theories attributed migration decisions to economic factors. However, cognizance of the fact that there are doctors living in the same conditions as migrant doctors in hospital A who decide to stay, economic motives were not expressed as emphatically as social cultural factors like trust and meaningfulness. Relative to other aspects of the job, income is not the primary motive to continue working in the hospitals as generally thought. Much as economic factors – salaries in particular, have largely influenced doctor migration in hospital A, hospital B managed to retain the doctors through integration of financial and non financial rewards. Unlike hospital A where incentive packages were largely financial (i.e. salary, allowances and fringe benefits), hospital B employed both financial and non-financial incentives. These encompassed valuing the work done by doctors through a demonstrated recognition of their clinical role in health care provision. There is need to widen the focus from individual to societal perspectives of migration. Doctors' decision to stay or leave different work settings seem to be influenced by social and cultural factors

The administrative system and resource availability featured as important factors that influenced decisions to stay or leave. This is particularly with regard to breaches of employment contract, psychological contract expectations and equipment. Breach of employment contract and psychological contract expectations manifested through unfulfilled promised in terms of delays and at times non enforcement of rights like risk and housing allowances and promotions. Government promises were partially fulfilled or sometimes they were not implemented as agreed. By contrast, there were harmonious relations between the hospital management and medical doctors in hospital B. The hospital honored its promises and whenever there were implementation delays, timely communication was made to re-affirm its commitment to staff welfare.

Whereas efficient and effective health service provision requires a well-functioning administrative system characterized by availability of requisite resources in terms of working tools and necessary supplies, doctors in hospital A were provided with far less equipment than required. Lack of equipment was a de-motivator to doctors who migrated from hospital A as they felt that their knowledge was being under-utilized. However, doctors in hospital B acknowledged having the requisite working tools which enabled

them to offer good health services to patients. This enhanced their utilization of knowledge and skills and hence the motivation to stay.

The study show that leadership style influences employee retention. When leadership style is perceived by employees as unfavorable, employee intention to leave increases and when it is felt as favorable, intention to leave decreases. It surfaced that employees are not motivated as powerfully by material rewards as widely thought. Even in the wake of limited autonomy and resources, good HRM practices like employee recognition and provision of mentoring services can enhance retention. Professional and social values can instill intrinsic motivation to stay and deliver services in an organization.

The study indicated that even under limited financial resources and hard working conditions in a rural setting like hospital B location, application of soft HRM version (I.e. good leadership, employee recognition and supportive management) play an important role in enhancing employee attraction and retention.

Social relations appear to influence employee decisions to stay or leave. These were prevalent at different levels: management, peers, family, patients and the community. Strong bonds with extended family also influence employee commitment to stay. However, duty to nuclear family necessitates migration in search of educational opportunities for children and spouse. Factors such as family welfare, organizational culture and societal traditions and customs and religious orientation seem to be important elements in employee decisions to stay or leave. The findings also ravel the pivotal role of HRM practices that facilitates creation of conditions for increased employee retention rates. The variation in employee retention between hospital A and B may in part be attributed to organizational culture values which influence HRM strategies. It emerged from the findings that different HRM strategies result in psychological environments that foster varying levels of employee commitment and retention.

A sense of duty either to nuclear family, extended family, patients, community and the country featured as having a strong influence on employee attraction and retention. The study illuminates national, organizational culture as a determinant of employee decisions

to stay or leave an organization. It signifies a strong passion and patriotism to offer patient care irrespective of the push factor such lower salaries and poor living and working conditions that invariably raise employee temptations to leave an organization or the country. It emerged that factors related to sense of duty to extended family, patients, the community and the country, recognition by the management, peers and patients were predominant recounts for doctors' decisions to stay in both hospitals. Environments that make employee develop a sense of belonging and commitment to the organization make the desire to quite unattractive.

CHAPTER NINE: CONCLUSIONS AND IMPLICATIONS

9.1 Introduction

The study sought to explore the role of HRM practices on the migration of medical doctors in Tanzania. The aim was to gain insight into the reasons that influence medical doctors to stay or migrate to other employment arrangements. Data were collected in two hospitals (a public and a private faith based) in urban and rural settings respectively.

This concluding chapter presents a resume of the findings, identifies the limitations of the study, presents theoretical contributions and highlights managerial implications. It concludes by showing implications for future research.

9.2 A Resume of Findings

The HRM department in hospital A do not play a decisive, positive role in creating the conditions for enhancing retention of doctors. Limited HRM role in employee retention stems from lack of autonomy, low HRM responsiveness and lack of cohesion and alignment of HRM practices. Centralized decision making in the public sector have had a negative impact on timely recruitment and reward management in hospital A. This created high levels of dissatisfaction and low work morale which increased employee desire to leave the organization. By contrast, hospital B was able to recruit doctors from areas close to hospital location which created mutual trust between doctors and the hospital and facilitated their retention. Different degrees of responsiveness between hospital A and B may in part be attributed to differences in governance structures and organizational culture.

The quest for doctors to attain career development goals appear to be an important influence on migration decisions. This study provides indications that good quality continuous professional development is a very positive incentive and enhances doctor retention. The medical profession requires skill upgrading in order to keep abreast of rapid technological developments.

While the income factor was expected to strongly influence migration decisions to leave in environments of resource constraints, a surprising result is that it was less important. This is in part attributed to the salience of professional development and mentoring, leadership and recognition as strong motivators. Much as the two-factor theory of motivation (Herzberg et al., 1959) was designed to predict employee performance motivation – not motivation to stay or leave, my findings seem to indicate that both hygiene factors and motivators influence employee decisions to leave or stay. While professional development and mentoring, leadership and recognition can be anchored to motivator factors, the income factor and the quality of the administrative system and resource availability featured as hygiene factors.

Remuneration, a hygiene factor cited by Herzberg (1968) and Herzberg et al. (1959) as an important factor influencing employees' job satisfaction) was, it seems, overshadowed by good interpersonal relations nurtured through personal and team recognition, as well as by a flexible work design. Conversely, achievement, recognition, advancement and growth (i.e. motivators) appeared to be highly influential in employee attraction and retention. This study lends support to Herzberg's two factor theory in the sense that investing in motivator factors seems to offer a good payoff in terms of retention.

Initial expectations would be that urban based organizations are more able to retain employees as compared to rural based organizations in terms of better employment terms and diverse income sources. However, a surprising finding is that hospital B (a small hospital in a rural setting) managed to retain doctors while hospital A (a bigger hospital in a city location) lost some doctors to migration. It emerged that factors such as mentoring, opportunities for training and development, selective recruitment, recognition and provision of adequate equipment and working tools, good governance through participative leadership style seem to influence decisions to stay. In this vein, employees value not only good pay but also professional and social needs.

The study shows that employees are more likely to stay in an organization if they strongly feel that the management shows concerns for their welfare through high recognition and when their roles commensurate with their competences, trust and management support. It

emerged that transformational leadership style is crucial for achieving organizational goals. Inappropriate leadership styles can negatively affect employee retention. It emerged that management styles are regarded as repugnant as they undermine employee performance and instigate their propensity to leave the organization and vice versa. This study showed that employee retention can be achieved through the adoption of appropriate styles that aligns business strategies with employee motivation and morale. The study depicts leadership from the perspectives of the exchange of power and its utilization to secure desired outcomes. This research add support for the idea that there should be in addition to common types of rewards such as high salaries and incentives, a simple approach like verbal praise to employees that can remarkably improve their motivation and by extension desire to stay in an organization.

Culture seems to have a strong influence on doctors' sense of duty in multiple directions: family, community, patients and their inherent perceptions of their professional roles (i.e. meaning seeking). Despite the fact that problems of retention of doctors in less developed nations, are often attributed to funding (I. e. on hygiene factors such as low income and lack of resources), my findings revealed that factors which precipitate employee desire to leave hospital A were sometimes mitigated by job satisfaction stemming from fulfilled professional development opportunities, or from sense of duty arising from family and community bonds which are rooted in societal culture.

While the HRM literature often seems to take American or European main cultural patterns more or less for granted, my findings clearly underscore the need to incorporate the cultural factor when studying HRM phenomena in Non-Western societies. The findings underscore the relevance of Hofstede (2001) and Hofstede and Bond (1988) cultural dimensions (i.e. individualism vs. collectivism) which influence values and decisions to stay or leave.

The sense of duty (stemming from societal culture) is reinforced by strong family and community bonds. In the case of hospital B, the strong missionary spirit seems to have created moral satisfaction. This is a salient manifestation of Herzberg's motivators and is

closely associated with the psychological contract fulfilment which positively influences high employee retention rates.

The study contributes to the psychological contract literature in the context of developing countries. The psychological contract through the prism of relationship between expectations and experience in work related exchanges between the employer and employees seem to have a strong influence on decisions to stay and leave.

My findings illustrate the relevance of Kahneman (2011) who underscore sense making arising from a person's values irrespective of a catalogue of displeasure experiences. It also resonates with the issue of trusting relationship through among other things teamwork, commitment and personal fulfillment as postulated by Mayer et al. (1995). Reminiscent of the tenets of organizational support theory, perceived organizational support in terms of career development and involvement develops trusting relationships evolving from ability (the trustee's knowledge and skills) or benevolence (the trustee's motives and intentions) and integrity (value congruence) between employee's beliefs and values with the organizational cultural values.

My findings integrate organizational support theory and trust relationships to explain the meaning seeking process in migration decisions to stay or leave an organization. It emerges that when HRM practices lead to high perceived organizational support, employees are more satisfied with their jobs, feel more closely connected with the organization, and are likely to be more loyal and committed to stay in the organization. Trust seems to be embedded in social relations among employees. Professional teams create common values and mutual trust among employees. Trusting relationship between doctors and the management on the one hand and doctors and the community on the other hand reinforce bonds of loyalty to stay. Provision of challenging and meaningful work (i.e. job content) was highly valued by doctors. This stems from the assumption that employees do not just work for money but they would also like to create purpose and satisfaction in what they do.

The study provides the pivot which juxtaposes HRM, human and social capital theories which usher in greater understanding of the key factors that influence employee decisions to stay or leave an organization. Previous studies were predominantly skewed towards reasons for leaving and scanty attention was given to reasons why some doctors stay irrespective of the driving forces which could potentially make them leave.

9.3 Limitations

The findings should be viewed in the light of some limitations. The exploratory nature of this study makes it difficult to generalize the conclusions. The findings should therefore be tested in wider settings. The study focused on the medical doctor cadre. There is no comparison to determine whether the factors that attract doctors to stay or factors that precipitate doctors' decisions to leave are applicable to other medical cadres like nurses or other health professionals in developing countries. This understanding could enhance retention interventions.

Beyond the limitations associated with case studies and qualitative research in general – in terms of limited opportunities for generalization, and also beyond the deliberate narrowness of the sample (focusing on medical doctors in two hospitals), I am also aware of the potential weaknesses associated with the research design and the process of carrying out the research.

I take cognizance of the fact that qualitative, interpretive research being generally vulnerable to researcher biases in the recording and interpretation of information. In the context of such a qualitative PhD study, there is a possibility of personal biases in the selection of quotations for coding and the presentation of findings and for further analysis; for the interpretation of these quotations and the search for the meaning behind. In order to ensure inter-rater reliability (Eisenhardt, 1991; Morse, 1997; Yin, 2013), I strived to share interview summary reports with the participants and engage peer groups (e.g. faculty members in the School of Public Administration and Management at Mzumbe University, and PhD candidates at Agder University in Norway (other than the advisor) in helping me to check out the coding and interpretations of the data.

9.4 Theoretical contributions

The previous chapter delineated a number of themes which emerged from the analysis and discussion of the findings. These include organizational environment and HRM practices, professional development and mentoring, the income factor, the administrative system and resource availability, leadership and recognition, and sense of duty. Analysis of the findings brought to the fore an array of theories which exhibited some influence on migration decisions to stay or leave. These include career and psychological contract theories which emerged from the initial theoretical platform, human and social capital, social exchange, social identity, Hofstede's cultural dimensions and the two factor theory. Reconstruction of these theories yields three main theoretical lenses: psychological contract, Herzberg's Two Factor and the meaning seeking. These lenses are cornerstones which discern increase understanding of the dynamics of migration decisions in different hospital settings. In the section that follows, I present the main theoretical contributions.

9.4.1 Contribution to the career and mentoring literature

The study underscores the primacy of continuous training and development of doctors. The study demonstrates that doctors are attracted to stay in an organization when they have access to professional development and mentoring opportunities. This expands the mentoring literature in the context of health care sector in developing countries. It increases understanding of the crucial role of mentoring relationships in employee retention. A mentoring relationship in both hospital A and B developed career related competences for medical doctors. This enhanced organizational learning and knowledge creation and aroused employee commitment to stay. The study underpins the fact that organizational factors, such as top management support in the provision of opportunities for on the job and off the job facilitates more effective mentoring results. This finding juxtaposes the relevance of human capital, social capital, social exchange and organization support theories. In unison, they concretize the importance of developing employee competences in the quest to enhance their retention in both urban and rural areas.

The study underscores the heterogeneity of medical doctors in their different specialties and work teams. It demonstrates that doctors are attracted to stay in an organization when they have access to professional development and mentoring opportunities. HRM managers may aid in fostering social capital between employees by developing their abilities, opportunities and motivation in order to enhance knowledge sharing through flexible work systems and professional teams. Social capital can be built and developing through design of work processes that promote team work Cognizance of the fact that human and social capital requires constant investment in specific HRM practices, HRM managers should provide employees with the opportunity to interact in teams as this can enhance interpersonal relationships which garnered high value in this study. Furthermore, they should take heed of the diverse experiences and approaches of their staff in designing staff development programmes, in order to provide opportunities for them to learn from one another.

Engagement of expatriate doctors created a mentoring relationship between local and expatriate doctors who were perceived as professional role models. The findings show that mentoring fosters organizational retention in part because the emotional bond established between a mentor (local specialists and expatriates) and a protégé (medical doctors) in both hospital A and hospital B) may contribute to higher levels of organizational commitment

Mentoring relationships may operate through a dual pathway to impact organizational retention by assisting in the transfer of organizational knowledge while simultaneously developing the high-quality interpersonal relationships that strengthen a protégé's commitment to an organization. This corroborates with studies by Okurame (2012) and Amuakwa-Mensah and Nelson (2014) which indicated that learning in the workplace occurs both formally (through on and off site courses) and informally, where people learn within work teams. The learning atmosphere is enhanced by social relations trust levels in the organization. The expressions of doctors in both hospital A and hospital B with regard to cherishing career development opportunities testifies that employees learn best when they are supported, stimulated and challenged in both formal provision and workplace development. Much as mentoring benefits trainees and organizations, greater benefits can

be realized when social capital processes and goals (involving investment in the learner as more than a capital resource), are developed.

9.4.2 Contribution to moonlighting literature

Moonlighting is understood as holding a second job outside of normal working hours. Numerous members of labor force contribute to the secondary market by working additional hours either through additional jobs or through self-employment. The reasons behind moonlighting are thought to be financial, intellectual or social domains. My findings illustrate the extent to medical doctors' resort to dual practice, the motives for doing so, and the outcome of this engagement which had hitherto been under studied in the Tanzania generally and the health sector in particular.

The notion of a full time civil servant exclusively dedicated to the public sector is disappearing. Doctors in urban settings are engagement of doctors in health and non health businesses through intramural and extramural private practice. Moonlighting stems from the quest to complement low salary and incentive levels. Although the introduction of the private practice policy has enhanced the government's quest to mitigate outmigration of medical doctors, divided loyalty seem to have affected the quality of health services in the public sector.

9.4.3 Contribution to Leadership and Organizational Culture

The critical role of leadership and leadership style in employee motivation and retention is brought to limelight. It emerged from the findings that skilled professionals like medical doctors prefer an organization which offer them the opportunity for knowledge creation and sharing. The participative leadership featured as an effective retention strategy as it entailed close involvement of employees in decision making process of the organization.

The findings elevate the strategic importance of organizational culture and societal traditions on employee retention. It demonstrates variations of cultural values between

public and private hospitals in the context of developing countries. While the HRM literature often seems to take American or European main cultural patterns more or less for granted, my findings clearly underscore the need to incorporate the cultural factor when studying HRM phenomena in non-western societies. These insights underscore the relevance of Hofstede (1984) cultural dimensions (i.e. individualism vs. collectivism) which influence values and by extension decisions to stay or leave. It determines employees' sense of engagement, identification and belonging to the organization, and team work spirit. Committed employees were ready to stay in the two hospitals irrespective of whether there was favorable or unfavorable work environment. This illuminates the influence of social relations in the retention literature. Family and community bonds (rooted in societal traditions and customs) create important obligations which act as barriers or facilitators of decisions to stay or leave. The work environment and the social ties feature as strong retention factors.

9.4.4 Contribution to the role of spirituality in employee retention

The role of spirituality and religion in the work place and in the management literature is a relatively new area of inquiry with regard to developing countries. This study integrates spirituality and retention literature and vindicates their relationship with employee motivation and commitment to stay in an organization. A strong organization culture reinforced by religious orientation appears to be an asset in employee retention as it created moral satisfaction.

There has been a plethora of research on the predictors of organizational commitment, such as organizational culture (Schwartz, 2012) and leadership styles (Baruch, 2004). However, a very few researcher has focused on the association between organizational commitment and religiosity (Neubert & Halbesleben, 2015; Tracey, 2012). Taking into account that religion is one of the most universal and influential social institutions that has a significant influence on people's attitudes, values, and behaviors at both the individual and societal levels (Berger, 2011), it is an important cultural factor which merit a scholarly inquiry.

Furthermore, in spite of the fact that religious diversity has been accommodated in work places through fair recruitment policies in the public sector, the influence of moral satisfaction in employee retention noted in hospital B has been largely under theorized in western HRM literature.

This study increases the understanding of the relationship between work place spirituality and employee commitment to stay in an organizations in developing countries where there has been limited knowledge in western HRM literature. Hospital B exhibits a higher form of duty to God which is associated to a passion to serve fellow community members. Religion influences commitment to offer quality health services. Health workers with moral satisfaction closely align work with the organization mission. The strong missionary spirit in hospital B seems to have created a strong bondage between employees and the organization which fostered retention.

9.4.5 Contribution to psychological contract and trust literature.

The study underscores the urgency of employers to fulfill formal and psychological contract expectations through among other things, provision of requisite equipment. It surfaced that trusting relationships enhance work morale and commitment to deliver quality health care. Drawing on the inductive approach of this study, I employ the meaning-seeking lens. It pervades both the psychological contract calculus and the motivation/dissatisfaction factors, and distils the dynamics in which doctors come to decide to stay or leave. It emerges that organizational support theory and trust unearths lived experiences of doctors in different work settings.

These insights illustrate the relevance of Kahneman (2011) who underscore sense making arising from a person's values irrespective of a catalogue of displeasure experiences. It also resonates with the issue of trusting relationship through among other things, team work, commitment and personal fulfillment as postulated by Mayer et al. (1995). Reminiscent of the tenets of organizational support theory, perceived organizational support in terms of career development and involvement develops trusting relationships evolving from ability (the trustees knowledge and skills) or benevolence (the trustee's

motives and intentions) and integrity (value congruence) between employee's beliefs and values with the organizational cultural values.

I have attempted to integrate organizational support theory and trust relationships to explain the meaning seeking process in migration decisions to stay or leave an organization. It emerges that when HRM practices lead to high perceived organizational support, employees are more satisfied with their jobs, feel more closely connected with the organization, and are likely to be more loyal and committed to stay in the organization. Thus far, the proposed conceptual framework (i.e. Figure 8.1 in chapter 8) postulates theoretical linkages of the three lenses and illustrates their impact on employee decisions to stay or leave. The model can be examined in other organization environments using other theoretical and methodological approaches for the development of more insights into the factors that may enhance retention strategies.

A strong bond of trust between the management and employees influences employee loyalty and enhance retention. Trusting relationships increase job satisfaction and enhances employee and organizational social capital. The findings in both hospital A and hospital B show that trusting relationship among work teams and the management has a strong influence on employee migration decisions. Retention strategies have to build trusting relationships between the employer and employees.

The leadership style influences employee organizational trust. Although trust seems to be very important in a workplace, it is not just a matter of management trusting employees more and they will work far better; equally important is that managers behave in ways that allow their staff to trust them. As Wei, Wong, and Lai (2012) note, trust between work teams on the one hand and the management has a positive impact on mutual support, teamwork, attitude, communication, innovation, psychological contract, knowledge transfer and organizational citizenship behavior. This study shows that an increase in the trust levels of employees motivate employees to truly care about the organization they are employed by.

9.5 Implications for management practice

Drawing on the preceding theoretical contributions, the study has implications for management practice. These are focused on HRM decentralization, Recruitment practice, Leadership and Leadership style, Trusting relationships, Employee job satisfaction and retention and Employee moral satisfaction and retention. These are presented in the sections below.

9.5.1 Implications for HRM decentralization

Decentralization for human resources in the health sector is greatly influenced by the degree to which political and/or administrative power is transferred and what administrative linkages exist between the different management levels, and between the ministry of health and other central government offices that influence resource allocation such as ministries of Finance and Planning and Public Service.

It has surfaced that too many government controls at policy and practice levels have a negative impact on organisational capacity to respond to plan and implement desired human resource outcomes with high levels of responsiveness and flexibility. This underpins the importance of decentralization of HRM functions from the central government to semi autonomous organizations in achieving a more equitable distribution of health care and better management practices, aligned with local priorities and needs. Despite operating under centralized HRM systems, public sector organizations can embark on proactive mobilization of internal resources and application of participative management style to respond to doctors need and expectations with minimum dependency on the government. One of the possible sources of income might be intramural dual practice in medicine which has gained currency in the wake of implementation of the private practice policy.

The findings echo the importance of good human resource management practices which can arouse employees' commitment to deliver quality service and most importantly to stay within the organization. It is imperative for the government to minimize centralized decision making powers and authority in order to establish flexible structure and work

systems that can enhance greater sectoral and organizational responsiveness in the implementation of HRM policies.

9.5.2 Implications for Recruitment practices

It emerged that slow recruitment lead to increased job dissatisfaction, low work morale and migration of medical doctors. This signals that attraction and retention strategies have to be aligned with what employees' value as being important to their work. Cognizance of the fact that employees highly valued pursuit of career goals in their professional practice, expectations such as seizure of employment opportunities have to be fulfilled. The government should increase the magnitude of decision making powers to autonomous organizations to ensure increased responsiveness in the implementation of policies addressing HRM demands.

Policy-makers seeking to address employee retention challenges need to also take into account supply side factors, such as employee preferences. There is a need to shift from compulsory rural service, which is difficult to manage and enforce, to providing non-wage job attributes, such as a calling to serve the poor, training opportunities, career development prospects, and living and working conditions, play a role in what health workers choose.

Drawing on the heterogeneity in employee preferences and orientation, it is important for HRM managers to develop targeted recruitment programmes that identify employees who have a calling to work in specific work environments. In view of an emerging influence of rural background on retention which surfaced in this study, recruitment practices in the public sector should go beyond qualifications to include close reference to contextual factors such as environments in which candidates grew up. Espoused organizational values have to be clearly stated during the recruitment and selection stage to spell out espoused work values.

Much as the government has increasingly opened up employment opportunities, recruitment process is still contingent on application for recruitment permits. Owing to

delays associated with this procedure, skilled employees like medical doctors opt to seek employment elsewhere. There is a need for the government to review the recruitment policy which imposes recruitment freeze. For a developing country like Tanzania with acute shortages of medical doctors, the policy has paved way for outmigration of doctors to other countries while their internal demand still outweighs their supply.

9.5.3 Implications for Leadership and Leadership Style

The findings showed that some leadership practices play a critical role in creating a work place environment characterized by high levels of employee job satisfaction. It emerged that employees are more likely to stay in an organization when they perceive that their leaders exhibit interest and concern of their welfare, involves them in decision making and gives regular positive feedback and recognition.

Leadership research has shown that leaders are perceived as role models who set norms and expectations for appropriate conduct. A work environment with positive psychological support has been shown to influence critical variables for employee motivation and retention. Examples include job satisfaction, organizational commitment and turn over intention. The transformational leadership style (associated with altruistic ethic and focused on values) enhances employee job satisfaction and increases retention rates. The findings of this study indicate the need for HRM managers to understand how their leadership styles are perceived by employees and how varying leadership styles affect the level of job satisfaction. The study echoes the need for the HRM managers to understand and apply appropriate leadership styles which would spur employees' commitment to stay in the organization. Examples include employee engagement in decision making and regular communication and feedback on concerns within the work environment. The findings have implications for employee mentoring in leadership career paths since perceived role model leadership inspires positive work attitudes.

The limitations of financial rewards on employee motivation in this study imply that when designing retention strategies, HRM managers should focus on intangible rewards

such as leadership styles, learning and development opportunities which can create a sense of psychological satisfaction and enhance employee commitment to stay.

9.5.4 Implications for trusting relationships

Interpersonal and institutional trust seems to have a positive influence on employee job satisfaction and desire to stay in an organization. HRM managers can strengthen work place trust and relationships between the management and employees through sound HRM practices such as collegial recognition, supportive team work and respect and good communication in the organization. Social contacts between colleagues within specialty departments are an important factor in retaining talent. Organizations can thus contribute to the creation of a positive social atmosphere by stimulating interaction and mutual cooperation among peers and through open communication between management and employees.

This garners the urgency of HRM managers to capitalize on organizational culture and societal traditions in designing retention interventions. Human resource managers should therefore make concerted efforts in building positive social relations among members of the hospital communities. Public and private sector hospitals can strengthen work place trust through positive social interactions through sound HRM practices such as collegial recognition, supportive team work and respect and good communication in the organization that unleash trust, obligations, loyalty and commitment among employees. Retention interventions could thus capitalize on these factors in order to arouse employee motivation and commitment to continue offering quality health care services in an organization.

9.5.5 Implications for employee job satisfaction and retention

The findings show that opportunities for professional development (e.g. mentorship and continuous training), recognition and appreciation of employee roles, supportive management, sense of duty, and resource availability increased work morale and job satisfaction. This underscore the fact that fulfillment of employee psychological contract

enhances employee motivation and retention. Attempts to develop human and social capital may fail if employees lack job satisfaction. Alignment of retention strategies with things that employees value as being important to their work is crucial. It is therefore important for an organization to conduct periodic job satisfaction surveys. This can unearth strong factors to be reinforced as well as weak factors to be addressed. Employee retention practices are successful if they are in tandem with what employees value and consider when deciding to stay or leave the organization.

9.5.6 Implications for employee moral satisfaction and retention

Despite the fact that faith and religiosity have featured as having a strong influence on employee's desire to stay, this doesn't justify that it can be exported to the public health sector. However, certain organizational attributes of faith based hospitals such as developing a sense of community within the organization, exhibiting a work environment in which employees feel sense of being valued by the management, peers, patients and the community can be modeled in other health facilities to enhance employee retention.

Taking into account that moral values are pervasive in a wide range of organizational contexts, there is a need for the public sector organizations to unlock high levels of employee commitment to remain in the organization by nurturing moral values. Retention interventions can thus be enhanced through provision of a work culture and environment that give room for religious accommodation.

In the light of the preceding implications for management practice, development of employee retention strategies and interventions hinges on whether HRM managers in both hospitals have a clear understanding of the key factors that influence employee decisions to stay or leave an organization. In this regard, it is imperative for HRM managers to identify factors that employees value and which consequently influence their desire to continue working for an organization. This can facilitate identification of appropriate interventions that can facilitate design of appropriate interventions that can contribute to employee attraction and retention.

9.6 Implications for future research

Following my research on medical doctors' migration decisions in Tanzania, I feel that there are many areas in need of more research in this domain. However, I recommend four major areas. These include problems with data, conflict of interest in private practice, optimization of a retention strategy and the need for conceptual or empirical development on the role of religion in the retention literature. The focus and considered approach are proposed in the sections that follow.

9.6.1 Lack of data

There has been and still there is lack of adequate data on the magnitude of outmigration of doctors in Tanzania hospitals. Data on employee migration is sought in respective organizations where they were employed before they left the country. However, the difficulty with access to information on outmigration is compounded by the fact that there are no exit interviews which could establish the number of employees who left. Hospital records simply indicate cases of abscondment, leave without pay or secondment to other organizations. In the wake of employment freeze, graduates leave the country to seek employment and business opportunities abroad. Such cohorts cannot easily be traced as they are not engaged with any employing institutions.

The researcher recommends additional studies involving other Tanzanian professionals in the Diaspora. Updated databases on Diaspora in the Ministries of Home Affairs and Foreign Affairs can be informative. An inquiry into the capital inflows in the form of remittances may increase our understanding of the role of the Diaspora in the development of the national economy. Tanzania can as well utilize the Diaspora in short term assignments in areas with low skill base within the country like telemedicine in the health sector. The government has been doing concerted efforts to coordinate Diaspora forums through its foreign embassies. However, some migrant employees are not actively engaged with these forums. This is arguably an emerging income source for the country which merit close involvement of nationals working and doing business abroad to respond to calls for investment within Tanzania.

9.6.2 Conflict of interest in dual practice

While it is increasingly documented that health professionals in developing countries engage in health and non health activities (Ferrinho et al., 2004; Kiwanuka et al., 2011) as an alternative source of income to supplement inadequate salaries, there is little knowledge on the impact of dual practice on the quality of health services in resource poor settings (Socha & Bech, 2011). This is particularly important in the wake of the current crisis relating to global human resources for health mirrored through limited supply, maladministration and migration of human resources.

This may include a closer examination of the impact of divided loyalty in serving the public and private hospitals. The opportunity for intra-mural dual practice may lead to abuse by some doctors, who may render services to private hospitals during official working time. Moreover, there is possibility for dual practice to enhance inequity as the system of intramural dual practice invariably seem to favor senior specialist more than junior doctors, even as these juniors often shoulder higher workloads in the public hospital. These issues call for more research which could provide important guidance for policy makers and health planners in developing countries. This knowledge is particularly important in the wake of liberalized market environment in the health sector and increased currency of public private partnership. The studies may also have implications for career and reward management practices.

9.6.3 Work motivation and meaningfulness

Research has demonstrated that employees are motivated by a variety of factors. While some are motivated by material benefits from work (Armstrong & Taylor, 2014), others get satisfaction from career advancement (Coetzee & Schreuder, 2014). Still, others view their jobs as socially valuable through fulfillment gained from doing the work since it is perceived as being highly meaningful (i.e. sanctification of work) (Rossouw et al., 2010; Wrzesniewski, McCauley, Rozin, & Schwartz, 1997).

The findings showed that monetary rewards are necessary but not sufficient motivators. Attempts to motivate employees require a shift from addressing material needs (monetary rewards) to how people seek meaning in their work place. This domain is under researched in developing countries.

While studies in the industrialized world have shown that the presence of a calling and career development are closely related (Dobrow & TOSTI-KHARAS, 2011; Hirschi & Herrmann, 2013), the nature of and reason for this relationship have not been thoroughly investigated in the context of developing countries. Research on the influence of calling on career development might advance the theoretical understanding of the influence of calling on career choices. Taking into account that notions of occupational callings are not universal across cultures (Berg, Dutton, & Wrzesniewski, 2013), further studies should investigate whether the experience of a calling is relevant in other cultures and explore the role of cultural norms and values. Increased knowledge on career decidedness and planning can inform career counseling policies.

9.6.4 How to optimize Retention Strategy

While the motivation literature advocate use financial reward systems in the form of money to attract and retain employees (Budhwar & Debrah, 2013; Mathauer & Imhoff, 2006; WHO, 2006), this study has revealed that psychological satisfaction, opportunities for career advancement and organizational leadership which nurtures trusting social relations increase job satisfaction and motivation and hence their intention to stay in the organization. Indices of an emerging greater role of duty to nuclear family in the modern sector of Tanzania postulates the need for HRM managers to treat medical doctors in a holistic manner by going beyond their individual status to include family welfare matters as it seems to be a potential retention strategy. The findings suggest that successful retention practices have to be aligned with what employees' value in their job context.

While a wide range of retention strategies have been introduced to address employee migration (Smitz et al., 2016; WHO, 2010), there is little evidence to demonstrate the effectiveness of any specific strategy. Taking into account that health environments are

varied (Blaauw et al., 2010), it is important to discern context specific interventions in order to formulate appropriate HRM retention policies.

While there have been numerous studies on retention management and psychological contract in the western HRM literature, there has been scanty attention of this domain in developing countries, Studies which integrate retention management and psychological contract can advance knowledge of the factors that can enhance employee retention rates. Other studies can examine whether the reasons for quitting or staying are the same for the different health occupations and institutions or not. Moreover, studies focusing on doctors and health practitioners in private hospitals can bring insights on the effectiveness of dual practice policy.

9.6.4 Conceptual development of the role of religion in retention.

Despite considerable attention of expanding international literature on calling (Duffy & Dik, 2013), there is lack of research on religion, self control and self regulation (McCullough & Willoughby, 2009; Vohs & Baumeister, 2011) which seem to influence employee commitment to stay in an organization. Research is needed to understand the influence of calling on career outcomes in the context of developing countries where there is limited conceptual or empirical development of the role of religion in the retention literature. Increased understanding of such perspectives of relationships between work activity and religious attitudes, and in the present study, between religious attitudes and migration decisions can inform retention interventions.

9.7 Conclusion

The study set to identify reasons why some doctors decide to stay while others decide to leave Tanzanian hospitals. I strived to explore to what extent employee decision to stay or leave an organization emanates from HRM policies and practices and whether improved HRM can enhance retention rates.

Interpretation of the findings brought to the fore a number of key themes that influence employee decisions to stay or leave an organization. It emerged that organizational environment and HRM practices, professional development and mentoring, income factor, the administrative system and resource availability, leadership and recognition and sense of duty were prevalent determinants of employee decisions to stay or leave an organization. I employed three lenses namely the psychological contract, the Two Factor theory and the meaning seeking lens to interpret the findings.

Contrary to the widely acknowledged influence of financial incentives in migration decisions, my findings elevated interpersonal relations nurtured through a collaborative organizational culture (i.e. participative leadership style, knowledge sharing through professional mentoring create trusting relationships which are a cornerstone in building employee loyalty and commitment to render quality services. It transpires from this study that low cost interventions such as employee recognition and appreciation have a strong influence on attributes such as organization citizenship behavior.

The study vindicate that when HRM practices lead to high perceived organizational support, employees are more satisfied with their jobs, they feel more closely connected with the organization, and are likely to be more loyal and committed to stay in the organization. The main message we derive from this study is that employee retention in an organization is a strategic HRM priority. It is imperative for HRM managers to have insights of the factors that increase job satisfaction and motivation to stay in an organization. They have a greater role in spearheading interpersonal relations in work and social settings in order to build trust and increased employee commitment that has a positive retention outcome.

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Appendices

Appendix 1: Clearance Certificate



THE UNITED REPUBLIC OF
TANZANIA



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11th August 2009

Mr David E Ndikumana
Senior Lecturer
Faculty of Public Administration and Management
Mzumbe University
P o Box 84, MZUMBE
MOROGORO

CLEARANCE CERTIFICATE FOR CONDUCTING MEDICAL RESEARCH IN TANZANIA

This is to certify that the research entitled: Migration of Doctors in Tanzania Hospitals: Do Human Resource Management Policies and Practices Make a Difference? (Ndikumana D E *et al*), has been granted ethics clearance to be conducted in Tanzania.

The Principal Investigator of the study must ensure that the following conditions are fulfilled:

1. Progress report is made available to the Ministry of Health and the National Institute for Medical Research, Regional and District Medical Officers after every six months.
2. Permission to publish the results is obtained from National Institute for Medical Research.
3. Copies of final publications are made available to the Ministry of Health and the National Institute for Medical Research.
4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine.
5. Approval is for one year: 11th August 2009 to 10th August 2010.

Name: Dr Mwelecele N Malecela


Signature

ACTING CHAIRPERSON
MEDICAL RESEARCH
COORDINATING COMMITTEE

CC: RMO
DMO

Name: Dr Deo M Mtasiwa


Signature

CHIEF MEDICAL OFFICER
MINISTRY OF HEALTH, SOCIAL
WELFARE

Appendix 2: Informed Consent

Dear Respondent,

I am Mr. Ndikumana David Emmanuel, a Senior Lecturer at Mzumbe University. I am currently a PhD candidate at the University of Agder, Norway. I am researching on the topic titled:

“The Role of Human Resource Management Practices in the Migration of Medical Doctors in Developing Countries – The Case of Tanzania”

The aim of this research is to explore whether Human resource management practices in Tanzania hospitals are responsible for decisions of doctors to stay or migrate.

Kindly go through the following clarifications so as to decide whether you will participate or not.

- a) Participation in this study is voluntary. You are free to withdraw from the study whenever you wish to do so.
- b) Your views are highly valued and every response is correct.
- c) Please rest assured that your responses will be treated with the highest anonymity. The data will be used by the researcher for scientific purposes. The results of this study may be published in whatever forum without showing your particulars.
- d) Please indicate in the appropriate box below your final decision regarding participation in this study

I agree

I disagree

Name of Respondent:.....

Signature:

Date:

THE PROPOSAL FOR THIS STUDY HAS BEEN APPROVED BY THE RESEARCH COMMITTEE OF THE FACULTY OF ECONOMICS AND SOCIAL SCIENCE, UNIVERSITY OF AGDER, NORWAY

Appendix 3A: Interview Protocol for Doctors working in Tanzania

A. Preamble

I would like to begin by thanking you for allotting your precious time to serve patients to have a conversation with me. The aim of this research is to explore the role of HRM practices in doctor migration in developing countries. The study focuses on Tanzania. Your input is highly valued. The outcome of the research is increased understanding of the factors that determine doctors' migration decisions to stay or migrate. Furthermore, the study seeks to unearth hospital strategies to cope with doctors' migration. Please note that the views and experiences shared will only be used for academic purposes and will remain anonymous.

B. Informed Consent

The modus operandi is detailed in Appendix 1.

C. Main Questions

1. Would you like to tell me a little bit about yourself?
2. How long have you been at this hospital?
3. In which department do you belong?
4. What is your specialty?
5. What is your previous work experience?
6. What motivated you to become a medical doctor?
7. What motivated you to pursue your specialization?
8. In which training institution did you pursue your studies?
9. What motivated you to work at this hospital?
10. Does this hospital meet your career expectations?
11. How would you describe the working conditions at this hospital?
12. What rewards (both financial and non-financial) do you get at this hospital?
13. What rewards (both financial and non-financial) do you perceive to be important for your job satisfaction but are currently not given to you?
14. In spite of the temptation for some health professionals to migrate to other organizations both within and outside Tanzania, you decided to stay at this hospital. What are the factors that encouraged you do so?

D. Concluding Questions

15. What do you recommend to the government in the quest to attract and retain medical doctors?
16. Is there anything that you might not have thought about before, that occurred to you during this conversation? Can I contact you again?

Thank you for your time, commitment and cooperation

Appendix 3B: Interview Protocol for Doctors working outside Tanzania

A. Preamble

I would like to begin by thanking you for accepting to participate in this study.

The aim of this research is to explore the role of HRM practices in doctor migration in developing countries. The study focuses on Tanzania. Your input is highly valued. The outcome of the research is increased understanding of the factors that determine doctors' migration decisions to stay, migrate or return. Kindly note that the views and experiences shared will only be used for academic purposes and will remain anonymous.

B. Informed Consent

The modus operandi is detailed in Appendix 1.

C. Main Questions

1. Would you like to tell me a little bit about yourself?
2. What motivated you to pursue a medical career?
3. What is your specialty?
4. Where trained?
5. Who financed your training?
6. During your employment in Tanzania, in what type of hospital were you employed?
7. For how long did you work in the respective hospitals?
8. How did you seize the opportunity to work abroad?
9. When did you migrate?
10. What do you consider to be the major reasons which made you to leave Tanzania to work abroad?
11. In which countries have you been working since you migrated? What attracted you to work in those countries and not others?
12. How smooth or difficult is it to secure employment in the country you are working?
13. How do you compare the remuneration and incentives offered to you and the situation in Tanzania before you left?
14. Tanzania stands to gain from her professionals working abroad. Has Tanzania utilize your knowledge, skills and experiences?
15. What can the government do to attract you back?

D. Concluding Questions

16. Is there anything that you might not have thought about before, that occurred to you during this conversation?

Thank you for your time, commitment and cooperation

Appendix 3C: Interview Guide for Human Resource Directors and Managers

A. Preamble

I would like to begin by thanking you on behalf of the hospital administration for allowing me to conduct this study in your hospital. By extension, may I thank you for allotting your precious time to talk to me. The aim of this research is to explore the role of HRM practices in doctor migration in developing countries. The study focuses on Tanzania. Your input is highly valued. The issues raised are meant to increase the understanding of the factors that determine doctors' migration decisions to stay or migrate. It is expected that the outcome can usher in policy interventions to ensure attraction and indeed retention of doctors in Tanzania. Furthermore, the study seeks to unearth hospital strategies to cope with doctors' migration. Please note that the hospital identity, views and experiences shared will only be used for academic purposes and will remain anonymous.

B. Informed Consent

The modus operandi is detailed in Appendix 1.

C. Main Questions

1. Would you like to tell me a little bit about yourself?
2. How long have you been at this hospital?
3. What is your previous work experience?
4. Can you please tell me a brief historical background of this hospital?
5. How do you compare your staffing requirements of medical doctors against the current staffing levels?
6. Can you describe the recruitment process in this hospital?
7. How do you train your doctors?
8. Has the hospital experienced doctor migration?
9. Can you describe your reward management process?
10. Has salary reviews boosted the morale of doctors?
11. Improved health infrastructure is one of the major prerequisites for a conducive work environment. How has this hospital fared in this issue?
12. How are human resource policies formulated and implemented in this hospital?
13. Can you describe the decision making process in this hospital?
14. How would you describe the situation before and after the introduction of hospital reforms?
15. What strategies has the hospital instituted to ensure that doctors are motivated and retained?

D. Closing questions

16. Is there anything that you might not have thought about before, that occurred to you during this conversation?

Thank you for your time, commitment and cooperation

Appendix 4: Medical Personnel per 10,000 population

Region	DOCTORS				AMOS				CLINICAL DOCTORS				DOCTORS AND AMOS	
	Number				Number				Number				Number	Density ¹
	Public Sector	Private Sector	Total	Density ¹	Public Sector	Private Sector	Total	Density ¹	Public Sector	Private Sector	Total	Density ¹		
Mainland	843	443	1,286	0.3	1,108	265	1,373	0.4	5,521	1,180	6,701	1.8	2,659	0.72
Arusha	33	5	38	0.3	55	90	145	1.0	207	52	259	1.8	183	1.24
Dsm	430	263	693	2.5	160	59	219	0.8	623	441	1064	2.8	912	2.25
Dodoma	15	6	21	0.1	44	13	57	0.3	122	41	163	0.9	78	0.41
Iringa	16	5	21	0.1	57	3	60	0.4	381	34	415	2.6	81	0.50
Kagera	22	5	27	0.1	35	3	38	0.2	164	15	179	0.8	65	0.29
Kigoma	7	1	8	0.1	40	6	46	0.3	163	17	180	1.2	54	0.35
Kilimanjaro	28	15	43	0.3	52	20	72	0.5	360	93	453	3.0	115	0.75
Lindi	6	0	6	0.1	23	2	25	0.3	151	7	158	1.9	31	0.36
Manyara	10	1	11	0.1	40	1	41	0.3	195	28	223	1.9	51	0.43
Mara	16	5	21	0.1	46	8	54	0.3	186	25	211	1.3	75	0.48
Mbeya	12	6	18	0.1	51	6	57	0.2	469	26	495	2.1	75	0.32
Moarogoro	29	4	33	0.2	58	6	64	0.3	345	61	406	2.1	97	0.50
Mtwara	15	1	16	0.1	31	3	34	0.3	122	5	127	1.0	50	0.41
Mwanza	75	100	174	0.5	121	21	142	0.4	384	43	427	1.3	316	1.00
Pwani	29	3	32	0.3	45	4	49	0.5	267	19	286	3.0	81	0.83
Rukwa	6	0	6	0.0	33	3	36	0.3	175	4	179	1.4	42	0.32
Ruvuma	24	3	27	0.2	44	0	44	0.4	239	13	252	2.0	71	0.57
Shinyanga	10	8	18	0.1	44	6	50	0.2	305	136	441	1.3	68	0.21
Singida	22	2	24	0.2	32	0	32	0.3	147	5	152	1.2	56	0.46
Tabora	17	3	20	0.1	31	1	32	0.2	229	29	258	1.3	52	0.26
Tanga	22	8	30	0.2	66	10	76	0.5	287	86	373	2.3	106	0.64

Source: Extract from the National Bureau of Statistics [Tanzania] and Macro International Inc. (2007, p. 22).

Appendix 5: Out Migration Pattern in Hospital A (1999-2009)

Country/ Institution	USA	Botswana	WHO	United Kingdom	South Africa	Canada	Zimbabwe	Ethiopia
Number	7	5	3	3	2	1	1	1

Source: Hospital A Records, (2008).

Appendix 6: African Physicians from census of nine receiving Countries

Sending Country	Domestic*	UK	USA	France	Canada	Australia	Portug al	Spain	Belgium	South Africa	Total Abroad
Algeria	13,639	45	50	10,594	10	0	2	60	99	0	10,860
Angola	881	16	0	5	25	0	2006	14	5	31	2,102
Benin	405	0	4	206	0	0	0	1	13	0	224
Botswana	530	28	10	0	0	3	0	0	1	26	68
Burkina Faso	314	0	0	77	0	0	0	0	1	0	78
Burundi	130	5	0	53	10	3	0	1	55	9	136
Cameroon	1,007	49	170	332	20	0	0	4	267	3	845
Cape Verde	202	0	15	10	0	0	186	0	0	0	211
Cent. African. Republic.	120	0	0	79	0	0	2	1	5	0	87
Chad	248	0	0	69	0	0	0	0	1	0	70
Comoros	50	0	0	20	0	0	0	0	1	3	24
Congo, DR	5,647	37	90	139	35	0	42	4	107	98	552
Congo, Rep	670	11	15	468	0	0	49	4	665	135	747
Cote D'voire	1,763	0	10	262	0	0	0	1	8	3	284
Djibouti	86	0	0	25	0	0	0	0	1	0	26
Egypt	143,555	1,465	3,830	471	750	535	1	17	31	19	7,119
Equatorial. Guinea	47	0	0	4	0	0	1	76	0	0	81
Eritrea	173	18	55	0	20	5	0	0	0	0	98
Ethiopia	1,310	65	420	16	30	9	1	1	2	9	553
Gabon	368	0	0	61	0	0	0	0	4	0	65
Gambia	40	16	30	0	0	0	0	0	0	0	46
Ghana	1,294	590	850	16	95	0	0	4	2	82	1,639
Guinea	898	3	15	69	10	0	0	11	7	0	115
Guinea-Bissau	103	0	15	75	0	0	160	0	1	0	251
Kenya	3,855	2,733	865	0	180	110	1	4	1	81	3,975
Lesotho	114	8	0	0	0	0	0	0	0	49	57
Liberia	73	10	105	5	0	0	0	5	1	0	126
Libya	6,371	349	120	20	75	5	0	9	7	0	585
Madagascar	1,428	6	30	878	0	0	0	0	6	0	920
Malawi	200	191	40	0	0	10	2	1	1	48	293
Mali	529	0	15	138	0	0	0	0	4	0	157
Mozambique	435	16	20	0	10	3	1218	4	2	61	1334
Namibia	466	37	15	0	30	9	0	0	0	291	382
Niger	386	0	10	23	0	0	0	1	3	0	37
Nigeria	30,885	1,997	2,510	29	120	0	1	13	6	180	4,856
Rwanda	155	4	25	8	0	0	1	0	70	10	118
Sao Tome & Principle	63	0	0	0	0	0	96	1	0	0	97
Senegal	640	0	40	603	10	0	1	9	12	3	678
Seychelles	120	29	0	4	10	3	0	0	0	4	50
Sierra Leon	338	118	115	9	0	0	0	0	3	4	249
South Africa	27,551	3,509	1,950	16	1,545	1,111	61	5	0	834	7,363
Sudan	4,973	606	65	17	15	40	0	1	4	10	758
Swaziland	133	4	4	0	0	0	1	0	0	44	53
Tanzania	1,264	743	270	4	240	54	1	1	3	40	1,356
Togo	265	0	10	168	0	0	0	0	2	0	180
Tunisia	6,459	16	30	3,072	10	0	0	4	60	0	3,192
Uganda	2,429	1,136	290	1	165	61	1	1	3	179	1,837
Zambia	570	465	130	0	40	39	3	0	3	203	883
Zimbabwe	1,530	553	235	0	55	97	12	1	6	643	1,602
Africa	280,808	15,258	12,813	23,494	3,715	2,140	3,859	1,096	1,107	1,459	64,941
Sub-Saharan	96,405	13,350	8,558	4199	2,800	1,596	3,847	173	696	1,434	36,653

Source: (Clemens & Pettersson Gelande, 2006a)

Appendix 7: Migration Flows from 31 Countries to the US and UK

Country	US	UK	Total
Angola	2	1	3
Benin	6	0	6
Burundi	8	1	9
Cameroon	159	29	188
Congo	3	0	3
Cote D'Ivoire	0	3	3
DRC	37	8	45
Ethiopia	594	52	646
Ghana	927	553	1,480
Guinea	7	0	7
Kenya	512	178	690
Liberia	67	27	94
Madagascar	17	0	17
Malawi	13	33	46
Mali	1	0	1
Mauritius	58	0	58
Mozambique	5	3	8
Niger	3	0	3
Nigeria	3,509	3,533	7,042
Rwanda	6	0	6
Senegal	9	2	11
Seychelles	4	0	4
Sierra Leon	9	2	84
Somalia	53	8	61
South Africa	2,936	15,356	18,292
Sudan	0	1111	1111
Tanzania	213	86	299
Togo	4	0	4
Uganda	237	148	385
Zambia	118	203	321
Zimbabwe	231	369	600

Source: (Okeke, 2009)

Appendix 8: Migrant doctors compared with remaining numbers

ESA Country	Physicians' workforce at home (1)	Emigration level (2)	Emigration rate (%) (2/(1+2))
Angola	881	2,102	70.5
Botswana	530	68	11.4
DRC	5,647	552	9.0
Kenya	3,855	3,975	51.0
Lesotho	114	57	33.3
Madagascar	1,428	920	39.2
Malawi	200	293	59.4
Mauritius	960	822	46.1
Mozambique	435	1,334	75.4
Namibia	466	382	45.0
South Africa	27,551	7,363	21.1
Swaziland	133	53	28.0
Tanzania	1,264	1,356	52.0
Uganda	2,429	1,837	43.1
Zambia	670	883	57.0
Zimbabwe	1,530	1,602	51.0
All of Africa	280,808	64,941	19.0
Sub-Saharan Africa	96,405	36,653	28.0

Source: Adapted from Clemens and Pettersson Gelandér (2006a)

Appendix 9:Public/Civil Service Pay Trends in Tanzania

Month & Year	Nature of Decision	Authority	Remarks
1980s	Skilled professionals with more than three years of training whose specialties were in scarce supply and highly demanded in the economic development of the country were categorized as Rare profession	Cabinet	Demonstrated government value of the highly skilled professions in the Tanzania labour market elevated their status.. Although there was no significant difference on salary scales, clustering them as Rare professionals connoted high recognition. The system was however abused by political influences through which even non rare professionals who did not meet the stated criteria were classified as rare. It was later abandoned
July 1986 - 1990	Annual salary increments were frozen	Cabinet	The mid 1980s and 1990s were characterized by the Economic Recovery Programme (ERP) in which reduction of public expenditure played a critical role. Indeed, annual salary increases in the public service were frozen for four years, from July 1986 to July 1990. Since there was no pay rises, there was proliferation of tax-free allowances which benefited senior civil servants only
July 1989	Annual salary increments remained frozen for the year	Cabinet	Before the new salary structure with four scales, there was basically a salary structure with one scale to which all employees belonged.
July 1990	Salaries were increased by 20% on average	Cabinet	The impact of salary increments for four years was that salaries did not reflect staff seniority. Annual pay increments were halted in July 1986.
	Annual salary increments were allowed again		The rates were so low that employees felt no positive impact.
	House maintenance allowance of 40 % of salary for entitled officers was introduced	Permanent Secretary Establishment	This benefited only a few senior medical doctors
July 1991	Salaries were increased by 40 % at the minimum and 15 % for top grades	Cabinet	Since the adoption of Civil Service Reforms (CSR) in 1991, the Tanzania government has been supportive of pay reforms
September 1991	Fuel , Car maintenance and Mileage allowances were redefined and introduced	Permanent Secretary Establishments	This package benefitted the top officials who could afford to own a car.
	Fare allowance of Tsh. 1000/= and Tsh. 1000/= was introduced for Cities and Towns respectively	Permanent Secretary Establishments	The fares were below the market rates hence ineffective

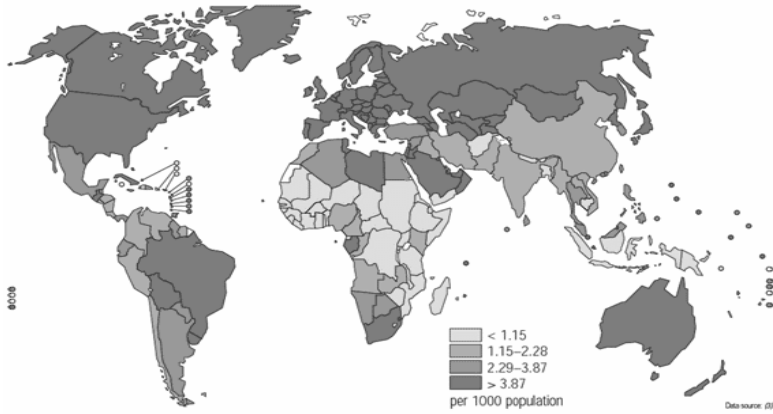
Month & Year	Nature of Decision	Authority	Remarks
	Allowances for purchases of the domestic appliances (e.g. Refrigerators, Cookers, Air Conditioners, Sewing Machines were re-introduced.	Permanent Secretary Establishments	The advances were halted in 1975 due to financial constraints.
July 1992	Salaries were increased by 42.8 % at the minimum and 15 % for the higher grades	Nsekela Salary Review Commission.	The increases on hitherto low rates had no significant impact on the standard of living of the employees.
November 1992	Housing Revolving Fund for Civil Servants was re-introduced to enable public service personnel to acquire soft loans for home construction.	Cabinet through the recommendation of the Civil Service Department	The fund was abolished in 1972 after the formation of the Tanzania Housing Bank (THB). However few civil servants have been able to benefit so far because the size of the fund is very small (how much) compared to the demand.
July 1993	Cost of living allowance (COLA) of between Tsh. 1500/= and Tsh. 2000/= per month was introduced for all Civil servants	The President through the recommendation of Trade Unions	The Trade Union had proposed to raise the minimum salary to Tsh. 94,000/= from TSh. 3,500/=
July 1994	The civil service average nominal wage was raised by a phenomenal 74%. The pay raise ranged from 100% for the minimum wage to 48.3% for the top salary. The Cost of living allowance (COLA) was abolished.	Cabinet through the recommendation of the Civil service Department	In spite of the differential pay increase between high (i.e. 48.3 percent) and low pay (i.e. 100 percent) levels, the later benefited more because of the higher salary scales.
July 1995	Salaries were increased by 75 % for the minimum pay and 71 % for the top pay.	Cabinet through the recommendation of the Civil service Department	While the government intention was to improve the Pension package upon retirement, this was negatively perceived by the employees on the grounds that the gains were eroded by high taxes on the income
	The government decided to consolidate some allowances into the basic pay. These were Domestic, Servant, Water and Sewerage, Special Skills, Teaching, Medical, Topping Up Judicial and Drivers allowances.. Consolidation of the allowances paved way for introduction of 16 different scales based on professional categories		
July 1997	Salaries were increased by 17 % for the minimum pay and 9.3 % for the top pay.	Cabinet through recommendation s from the Head of Public Service	Periodic abandonment of incentives is one of the factors which created low morale in the public sector. Consolidated items were subjected to tax and hence minimal positive impact on the employees.
	Additional allowances were consolidated into the basic pay. These include Non practice, Fuel and Vehicle maintenance, Mileage, Fare assistance and Environmental.		

Month & Year	Nature of Decision	Authority	Remarks
	Lunch, Over time and Sitting allowances were abolished		
	Allowances which were retained for the year were House rent assistance and House maintenance.		
March 1998	Job evaluation and job grading was conducted by the Bench Mark Study for the Civil service	Permanent Secretary Establishment	This was in the wake of the Civil Service Reform Programme
January 1999	The Public Service Medium Term Pay Policy was approved. The policy envisaged raising public service pay by between 15 – 17 percent on average per annum over a five year period to 2003/04.	Cabinet through recommendation s by the Civil service Department.	The increases were targeting higher increases for professional, middle level technical and managerial staff. However, The salary increases were well above the rates in the medium term pay projections
July 1999	In 1990, senior officers entitled to either free or rental housing and who lived in their own houses, became eligible for house maintenance allowances to a maximum value of 40% of their salaries. In the same year, fuel, car maintenance and kilometre allowances were redefined and re-introduced. The annual salary increments that were frozen in 1986 were brought back in July 1990. The top salary was raised by a hefty 55% while the bottom salary was increased by 17%.		These initiatives benefitted the top cadres leaving the low and medium cadres highly demotivated. In the case of the health sector this system benefitted senior doctors and not junior doctors. The increments were so low that they had no significant impact. The annual salary increments triggered rise of consumer goods.
1999	A medium term Pay Reform Strategy was introduced . Pay rises ranged from 13-17% for the lower grades, 36-45% t for middle to senior grades and 34-55% for the top senior civil servants.		The fund was launched following the enactment by Parliament of Act No. 2 of 1999, the Public Service Retirement Benefits Act. Positive move. The scheme has a five-year “building up” period and becomes fully operational in July 2004. The new scheme replaced CAP. 371, of 1932; as amended in 1954. An Ordinance for regulating Pensions Gratuities and Allowances to cater for permanent employees working in the Central Government. It was a non-contributory scheme paid out of the Consolidated fund.
July 2000	The government sought to specially reward the core of “highly qualified and highly tasked” senior officers when it adopted, in February 2000, a Selective Accelerated Salary Enhancement (SASE) scheme, which targeted salary enhancement for key professional, technical and managerial personnel “whose		SASE is designed to target salary enhancement for key professional, technical and managerial personnel whose efforts are critical to the improvement of service delivery, management of reform efforts and the production of strategic government outputs. Through the scheme, donor funding complements the MTPRS to systematically accelerate the pace of salary enhancement for key managerial, professional and technical staff in line with the Government medium term pay targets.

Month & Year	Nature of Decision	Authority	Remarks
	efforts are critical for the improvement of service delivery, management of the reform efforts and the production of strategic government outputs.”		
2001-2007	Over the period of 2000/01 – 2007/08, the average salary increased by 215.73 percent from shillings 74,183 in 2000/01 to shillings 234,224 in 2007/08		The salary increases were below the projected increases in the policy which envisaged average increases of between 15 – 17% per Annum.

Source: Extracts from Kiragu and Mukandala (2003, pp. 142 - 149).

Appendix 10: Health Worker Distribution Worldwide



Source: (WHO, 2006)

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