APPROVAL FORM

I, the undersigned, confirm that I have read and endorse the project titled " **AN EVALUATION OF THE EFFECT OF LABOUR OUT-MIGRATION ON PUBLIC HEALTH SERVICE DELIVERY. A FOCUS ON DOCTORS AND NURSES AT PARIRENYATWA GROUP OF HOSPITALS IN ZIMBABWE.**" submitted by **Muposha Edward** to the Great Zimbabwe University, as part of the requirements for the Master of Science Degree in Human Resource Management. I recommend its acceptance.

20/08/23

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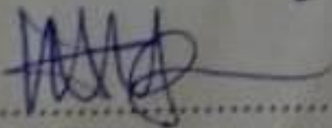
SUPERVISOR DATE



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JULIUS NYERERE SCHOOL OF SOCIAL SCIENCE
DEPARTMENT OF HUMAN RESOURCES MANAGEMENT

A RESEARCH SUBMITTED BY

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ON

AN EVALUATION OF THE EFFECT OF LABOUR OUT-MIGRATION ON PUBLIC HEALTH SERVICE DELIVERY. A FOCUS ON DOCTORS AND NURSES AT PARIRENYATWA GROUP OF HOSPITALS IN ZIMBABWE.

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TABLE OF CONTENTS

Table of Contents

CHAPTER ONE 9
1.1 Introduction 9
1.2 Background to the Study 9
1.3 Statement of the Problem 12
1.4 Specific Objectives 12
1.5 Main Research Question 13
1.6 Specific Research Questions 13
1.7 Significance of the Study 13
1.8 Assumptions of the Study 14
1.9 Scope of the Study 14
1.10 Limitations of the Study 15
1.11 Dissertation Organization 15
1.12 Chapter Summary 16
2 CHAPTER TWO 17
2.1 Introduction 17
2.2 Definition of Terms 18
2.2.1 Migration 18
2.2.2 Labour Migration 18
2.2.3 Brain Drain 18
2.2.4 Push and Pull Factors 18
2.2.5 Globalisation 19
2.3 CAUSES OF MIGRATION 19
2.4 Migration Theories/Models 24
2.5 Conceptual Framework 27
2.6 CASE STUDY ON HEALTH WORKFORCE MIGRATION 28
2.7 Gaps in Literature 32
2.8 Chapter Summary 33
3 CHAPTER THREE 34
3.1 Introduction 34
3.2 Research Philosophy 34
3.3 Research Design 35
3.4 Research Approach 35
3.5 Research Strategy 36
3.5.1 Survey 36

3.5.2 Experimental Studies 36
3.5.3 Longitudinal Studies 37
3.5.4 Action Research 37
3.5.5 Grounded Theory 37
3.5.6 Case Study 37
3.6 Population and Sampling 38
3.7 Data Collection Methods 40
3.8 Research Procedure 42
3.9 Chapter Summary 47
4 CHAPTER FOUR 48
4.1 Introduction 48
4.3 Socio-demographic Profile of Respondents 48
4.4 Request for attestation of good standing from regulatory bodies as a proxy of intention to migrate: 52
4.5 Intention to migrate 52
4.6 Chapter Summary 54
5 CHAPTER 5 55
5.1 Nature and magnitude of Migration of Skilled Health Personnel 55
5.2 Migration Intentions and Causes of Migration 55
5.3 Negative Effects of Migration of doctors and nurses 57
5.4 Positive Effects of Migration 59
5.5 Impact of Health Worker Migration on Health Service Delivery 60
5.6 Return migration 61
5.7 Policy Response 62
5.7 Chapter Summary 63
6 CHAPTER SIX 64
6.0 Introduction 64
6.1 Research Summary 64
6.2. CONCLUSION 66
6.3 RECOMMENDATIONS 66
6.4 Recommended Areas for Further Research 67
6.5 Chapter Summary 67
7 REFERENCES 68
8 APPENDIX 1: INTERVIEW QUESTIONS (HSC & MOHCC) 75
9 APPENDIX 2: INTERVIEW QUESTIONS (PGH) 82
10 APPENDIX 3: APPROVAL TO CARRY OUT STUDY 88

DECLARATION

I, Mr E. Muposha, declare that **AN EVALUATION OF THE EFFECT OF LABOUR OUT-MIGRATION ON PUBLIC HEALTH SERVICE DELIVERY. A FOCUS ON DOCTORS AND NURSES AT PARIRENYATWA GROUP OF HOSPITALS IN ZIMBABWE** is my own original work, and that I have properly cited all sources that I have utilized or taken information from.

……………………………………

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ABBREVIATIONS

EU	European Union
HLMA	Health Labour Market Analysis
HRH	Human Resource for Health
HSC	Health Service Commission
ICT	Information Communication Technology
IOM	International Organisation of Migration
MOHCC	Ministry of Health and Child Care
OECD	Organisation for Economic and Cooperation Development
PGH	Parirenyatwa Group of Hospitals
SADC	Southern Africa Development Community
SAP	Structural Adjustment Programme
STERP	Short-Term Emergency Recovery Programme
UHC	Universal Health Coverage
UK	United Kingdom
WHO	World Health Organisation

ABSTRACT

Due mostly to their exodus to other countries, Zimbabwe is experiencing a severe shortage of nurses and doctors with specialized training. Studies that have mostly concentrated on the migration of Zimbabwe's general population have paid little attention to the movement of doctors and nurses from Zimbabwe. This study aims to identify the driving forces behind the departure of doctors and nurses from Zimbabwe, assess the effects on the provision of healthcare services, and provide an explanation of how these forces operate within a grounded theory framework for health workforce migration. To do this, a review of the literature and an empirical investigation of a small sample of key informants, primarily drawn from senior management and specialized doctors and nurses at the national hierarchy and up to management level, were conducted. A sample group of thirty-two individuals who had worked in the health industry for at least five years was created using a purposive sampling technique. Individual interviews were used to produce and collect data in order to elaborate on the topics brought up. To analyse the data, initial, intermediate, and advanced coding stages were used. As a result, a grounded theory on the migration of the health workforce was developed. According to the grounded theory, doctors and nurses in Zimbabwe believe that moving abroad is the greatest way to achieve their ideal status. The ideal balance between the working environment, lifestyle, and social standing that health professionals believe is appropriate for those in their field is what is referred to as an ideal status. Health professionals only use migration as a drastic and difficult means of improving one's situation when all other options have failed. By creatively utilizing the numerous interventions adopted by the government, the grounded theory contributes to understanding health workforce migration and retention when compared to previous theories of migration. The study found a link between outmigration and the provision of health services. The quality of healthcare suffered as a result of Zimbabwe's exodus of medical professionals. In order to reduce emigration, the report advises that the government establish and expand retention strategies. It is additionally advised that future researchers take into account broadening the scope of migration, as this study only concentrated on particular staff types.

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Introduction

While in the past the global movement of labour was highly restricted, globalisation has contributed to the integration of labour markets and ease of movement of labour thereof (Morgan, et al. 2005). Kristoff (1999:35) states that labour is less mobile today than it was in the 19th century when 60 million Europeans moved to the Americas, Australia and elsewhere. However, Kock (2006:30) and Appleton, Sives and Appleton (2006:227) argue that rapid globalisation in the last few decades has resulted in increased volumes and complexity of movement between countries and regions. Health professionals are among the highly trained workers whose movement has grown as a result of globalization (Morgan et al. 2005:227). Globalization provides a crucial context for understanding migration in modern society, particularly labour migration (Suarez-Orozco and Suarez-Orozco, 2005:96).

Due to the current high level of globalization, a labour shortage in one region of the world can now be felt in the opposite region nearly quickly. Zimbabwe is not an exception to the increased level of labour migration and the effects thereof on human resources for health policies related to HRH Planning and Financing, HRH Deployment and Utilisation, HRH production, Training and Development, HRH Retention Management and HRH Information, Research Monitoring and Evaluation.

This research aims to provide information on labour out migration and its effects on effective and efficient health service delivery. Parirenyatwa Group of Hospitals (PGH) is used as the case study in understanding the labour migration framework and its effects in the Zimbabwean healthcare sector.

1.2 Background to the Study

Health professionals are essential to the health system and play a significant role in enhancing access to high-quality healthcare and services. A health delivery system's human resources for health (HRH) are perhaps its most important component (Madzorera, 2009). Zimbabweans will therefore have a harder time accessing high-quality primary care if they are scarce and not dispersed fairly. Medical personnel leaving Zimbabwe is one of the biggest problems facing

the country's healthcare sector. Based on data from the Ministry of Health and Child Care and the Health Service Commission, the outward migration trend shows that the numbers of health professionals migrating outside the country has been steadily increasing from around 2002. However, out migration of medical professionals sharply increased, to the extent that between 50 and 60 percent of annual terminations from 2020 to 2022 consisted of medical health professionals migrating abroad.

According to Chikanda (2006), the brain drain phenomenon became topical in Zimbabwe where deteriorating economic, social and political conditions aggravated the emigration tide. The country's health delivery sector is arguably the worst affected by the phenomenon wherein health workers are emigrating in search of greener pastures in southern Africa, Europe, North America and Australia. Poor working conditions and low remuneration are cited as the main push factors.

Although labour migration has a long history in Zimbabwe, the country's external movement skyrocketed at the turn of the millennium. The five phases of Zimbabwean health professionals' outward migration are as follows:

Phase one (1982–1987): Internal workforce migration.
Phase two (1990–1998): Migration of skilled professionals by the International Monetary Fund/World Bank Economic Structural Adjustment Program.
Phase three (1999–2008): High out migration levels following the economic recession.
Phase four (2009–2018): Moderate outward migration of health professionals.
Phase five (2019– to date): Mass exodus of health professionals.

The sharp increase may be related to the prevailing economic situation and that during the same year (2020), Zimbabwe was delisted from the WHO safeguard list (Health Service Commission, Cabinet Briefing, 2021). The WHO support and safeguard list is aimed at protecting vulnerable member countries from unsafe international recruitment methods of health professionals by receiving member countries. The same data also showed that nurses, among all the health cadres in the country, have the highest demand abroad due to the advent of the Covid 19 pandemic and the elderly population in most receiving countries is growing but there is little production of health workers.

Zimbabwe's current economic predicament has given rise to several intricate migration challenges marked by a significant brain drain. A increasing migration of medical professionals

leaving the nation has been caused by the economic downturn during the previous five years. The majority of Zimbabweans emigrate to nations like Botswana, South Africa, and the United Kingdom. Namibia, the United States, Canada, Australia, and New Zealand are also popular destinations for migrants from Zimbabwe (Zimbabwe Partial Health Labour Market Analysis, 2021). Due to the migration of professionals and semi-skilled workers, the health industry has been the most severely impacted. The sending, transiting, and receiving of labour migrants has a long history in Zimbabwe. Most people migrating in have been from other countries, such as Cuba and Democratic Republic of Congo.

In March 2009, the Government of Zimbabwe published a document entitled The Short-Term Emergency Recovery Programme (STERP). It acknowledged the many problems bedevilling the health sector including increasing attrition levels due to out migration of health professionals in critical shortage areas leading to high vacancy levels and loss of experienced health professionals and drastic decline in the quality of public health services. Even though the aforementioned highlights the scope of Zimbabwe's migration challenges, the government of Zimbabwe has been limited in its ability to manage the complex migration issues in order to address the negative effects of the brain drain and maximize its positive effects due to a lack of accurate information and a comprehensive and coherent policy framework for putting migration practices into practice in an integrated manner. It has been difficult to include migration issues in national planning or human resource planning for the health sector and other sectors due to a lack of information on migration. The researcher is concentrating on health professionals in the diaspora given this backdrop.

Low pay and unfavorable working conditions in Africa as a result of the failure to undertake structural adjustment programmes (SAPs) have fueled brain drain. According to recent studies (Bloom and Standing 2001; Bundred and Levitt 2000; Ndlovu et al. 2001; WHO 1997), Africa is losing trained medical professionals at an alarming rate. As a result, the delivery of health services has suffered, particularly in distant areas.

There is general agreement in the debate on economic development that skilled health worker migration represents a drain on the human resources of the sending country since it invests in the development of human capital that will be used by the recipient country. Despite the fact that such movements mostly benefit the individuals involved, they have detrimental socioeconomic effects on the sending nation.
In assessing the impact of out migration of medical professionals, the researcher also considered possible benefits to the country which may include remittances over the years. For

instance, according to Ministry of Finance data, between 2009 and June 2015, diaspora and international remittances have scored second after exports in terms of foreign currency earnings, accounting for 27 per cent between January and June 2015. This analysis therefore recommended evidence-based interventions to mitigate the prevailing situation.

The brain drain from developing countries has become a subject of key policy discussion and academic enquiry in recent years. However, knowledge on the magnitude of the phenomenon is limited because of lack of reliable data sources (see, for example, Adepoju 1995; Gaidzanwa 1999; Meyer and Brown 1999; Russell 1993). Where statistical data are available, they tend to be of poor quality, have numerous gaps and cannot be used as reliable data sources. Hence the need to undertake this study to ascertain knowledge in this subject and fill the knowledge gaps.

1.3 Statement of the Problem

Zimbabwe's health delivery system has over the past few years been hampered by a massive internal and external brain and skills drain (Chetsanga, 2004). By 2016 Zimbabwe had 237 medical doctors working in the Organisation for Economic and Cooperation Development (OECD) countries (Jong-Wook, 2017). This has resulted in the loss of experienced and qualified health professionals from the public sector. The remaining health professionals are now spread out thinly, to the extent that some institutions are now staffed by untrained cadres, and this has reduced access for the population to treatment by trained and experienced health workers (Madzorera, 2009).

Purpose of the Study

In order to assess the scope and nature of health worker migration, comprehend the effects on health service delivery, and propose potential interventions to guide Zimbabwe HRH Policy, the study's overall goal is to profile the skills of Zimbabwean health workers in the diaspora.

1.4 Specific Objectives

- 1.4.1 Assess the nature and magnitude of health worker migration from Zimbabwe.
- 1.4.2 Establish causes of emigration of medical professionals at public health institutions.
- 1.4.3 Assess the effect of out-migration of medical professionals on HRH management and the resultant impact on health service delivery in Zimbabwe.
- 1.4.4 Provide policy and programmatic recommendations to mitigate out-migration of skilled medical professionals.

1.5 Main Research Question

The impact of labour out-migration on public health service delivery. A focus on medical professionals at Parirenyatwa Group of Hospitals in Zimbabwe.

1.6 Specific Research Questions

1.1.1 What is the nature and magnitude of health worker migration from Zimbabwe?

1.1.2 What are the causes of out migration of medical professionals from public health institutions in Zimbabwe?

1.1.3 What is the effect of out migration of medical professionals on HRH management?

1.1.4 To what extent has the out migration of medical professionals had an impact on health service delivery in Zimbabwe?

1.1.5 What recommendations and possible strategies can be made for adoption by Government based on the research findings?

1.7 Significance of the Study

While other angles have been researched exhaustively in Zimbabwe, the contemporary migration issues in Zimbabwe require a focused approach targeting health professionals with high attrition levels attributed to migration. This study is particular to medical professionals using a case of a central hospital (PGH), results of which may be generalised for central hospitals in Zimbabwe.

The outcome from this study is a model that will contribute immensely to identify realistic factors influencing the emigration of medical professionals and proffer practical interventions to address the excessive out migration of critical health workers, especially in the Public Health Sector. The study is expected to provide the Health Service Commission, Ministry of Health and Child Care and other Policy makers with evidence-based insights into how the public health sector can adopt the best strategies to mitigate emigration and retain critical health workers for improved health service delivery. The existing literature on Zimbabwe health workforce migration that targets a specific category of health workers is inadequate, rather it is generalised and lacks the in-depth understanding of a particular phenomenon. Therefore, this study intends to add that missing component to the scholarly research and provide future students with a reference document to the subject of labour migration and research in general.

The society could potentially benefit from this study, suppose it is adopted to guide policy on HRH migration, since they are the ultimate beneficiaries of a sound Public Health system through quality health service delivery. The researcher being a Human Resources practitioner within the Public Health Sector, the study will therefore broaden his understanding of the subject under study and the evidence gathered will influence his decision making in related HRH issues.
The timing of this study could therefore be crucial, realising the recent aggravated levels of HRH outmigration and its detriment on health service delivery.

1.8 Assumptions of the Study

During this investigation, the researcher made the following assumption: Participants provided truthful responses. Participants were not required to write their names; instead, they were given identification numbers and asked to submit the remainder of the information truthfully, protecting their anonymity and confidentiality. Since the volunteers voluntarily agreed to take part in the study, they were free to leave at any time without suffering any consequences. It was assumed that the data that had been gathered represented the reality on the ground.

1.9 Scope of the Study

The study shall focus on medical professionals which constitute doctors and nurses offering services at Tertiary level, at Parirenyatwa Group of Hospitals. It excludes other staff categories other than the two mentioned above. The research was extensive by involving doctors and nurses at different levels of care, from various departments at the institution. The study included Mbuya Nehanda Maternity Hospital, Sekuru Kaguvi Eye Hospital, Psychiatric Hospital, as well as a number of specialist and pediatric wards in addition to the general medical and surgical divisions. Within the PGH complex are these research centres.

By design, Parirenyatwa Group of Hospitals is expected to serve the public with specialist healthcare services. Therefore, focusing on Parirenyatwa Group of Hospitals will give a representative scenario on the effects of out migration on service delivery. Nevertheless, various sources of data were used during the study which was triangulated. These sources of data included the survey conducted, reports from several departments at PGH, Health Service Commission and Ministry of Health and Child Care reports, respective professional associations, related Government Ministries, and departments among other data sources.

The study did not involve all doctors and nurses, however a sample of the population was determined through relevant qualitative sampling method as a representative of the population under study at PGH.

Therefore, the scope was adequate and covered the key variables to constitute satisfactory research standards.

1.10 Limitations of the Study

1.1.6 Insufficient Research on the Subject

Any literature review includes citations from earlier works. There appears to be a lack of thorough research on the topic of health workforce migration in Zimbabwe. As a result, the researcher did not have access to a large body of literature on the migration of the health workforce in Zimbabwe. To fill in the gaps in the local literature, the researcher resorted to mostly utilising international literature.

(1.9.2) Self-reported data

The researcher utilized a method based on self-reported data. Self-reported information is rarely verifiable. It is rife with exaggeration, telescoping, attribution, and selective remembering. The researcher had to look through the organizational records to verify any information obtained from questionnaires and in-person interviews to overcome biases of self-reported data.

1.11 Dissertation Organization

There are five chapters in this study;

1.11.1 The first chapter serves as the study's introduction and establishes the context by addressing the study's background, research topic, objectives, and justification as well as the research's scope.

1.11.2 The review of the literature is covered in Chapter 2. The chapter offers an analysis of the research that many academics have done on the subject of labour migration. It defines the theoretical limits of labour migration and highlights the problems that make this field worth studying. The chapter presents a framework for interpreting the study findings in labour migration by identifying the variables that need to be measured.

1.11.3 The third chapter is devoted to research methodology. The research instrument is chosen and identified in this chapter. In conclusion, this chapter covers topics related to research

design, research philosophy, research strategy, population and sample procedures, data collection methods, and research procedure.

1.11.4 Using the key ideas, graphs, and tables discussed in chapter two, the gathered data is presented in chapter four.

1.11.5 The study's results are interpreted and discussed in chapter five.

1.11.6 The conclusions on the main research findings are covered in Chapter 6, which is the last chapter. The chapter also offers suggestions for the areas of the labour migration issue that still require attention.

1.12 Chapter Summary

The major concerns that underpin this study were introduced in this chapter. It examined the historical context of the labour migration research as well as the central research issue. The study's goals and the rationale for why it was necessary to be conducted were also made clear. It was discussed how the study was to be limited and what it could cover.

CHAPTER TWO

LITERATURE REVIEW ON LABOUR OUT MIGRATION

2.1 Introduction

The initial framework for the research was laid up by a literature review. The historical and methodological background of the research study is established through a strong literature evaluation (Wellington, 2010:128). This implies that the researcher can clearly map out the study's boundaries, identify the knowledge gap it wants to fill, and determine the niche it will occupy through a literature study. If done correctly, it also creates a connection between any study's data analysis and research questions (Wagner, 2010:37). The sources consulted for this evaluation of the literature came from the Internet as well as books, journals, and pertinent policy documents and pieces of legislation.

The field of migration studies is sharply divided into rival fields that frequently do not exchange any knowledge, theories, or points of view. There is no overarching paradigm from which the many disciplines can approach the study of migration, which has been bemoaned by several migration experts (Brettell, 2008:114). The gap between social scientists who use a top-down, micro approach and use the individual migrant or the migrant's family as the study's unit and those who adopt a "macro" approach and analyse labour migration through policies, market forces, and other significant socio-economic units is even wider (Brettell and Hollifield, 2008:2). To provide a thorough explanation of the phenomenon of labour migration, a solid framework for comprehending the migration of medical professionals is necessary. As a result, an evaluation of micro, meso, and macro theories is done. More academics now recognize that the migration process is gendered and that migration research, as well as the creation and implementation of migration policies, must take this into account. As a result, this chapter also discusses migration from a gender viewpoint.

This chapter summarizes the research on labour migration that has been done by various academics. According to Hart, who is cited by Bell J (2010), a review of the literature is crucial since it aids the researcher in developing a more comprehensive grasp of the subject under investigation. This chapter examines the literature on the following topics to gain a wider knowledge of labour migration:

i. Definitions of migration and labour migration
ii. Causes of Migration
iii. Theories underpinning labour migration
iv. Case study on health workforce migration
v. Gaps in labour migration literature

2.2 Definition of Terms

2.2.1 Migration

Many authors have made contributions to clarifying the relevance and meaning of labor mobility. In the paragraphs that follow, some of the definitions that have been presented will be given.

Suarez-Orozco and Suarez-Orozco defined migration as the "more or less permanent movement of people across space". Salt (1987) explains that migration is a response to spatial diversity in the means of production, a factor resulting from the spatial and temporary inequalities in the levels of economic development. According to data used by Morgan, Sives, and Appleton (2005:226) to illustrate the extent of global migration, approximately 175 million people were residing outside of their place of birth in 2005.

2.2.2 Labour Migration

It is the movement of health workers from one country to another country for the explicit purpose of seeking employment (Roberts, 2009:150).

According to the International Organisation of Migration (2008), Labour migration is defined as the movement of persons from their home State to another State for the purpose of employment.

2.2.3 Brain Drain

This is the loss of abilities the source nation experiences as a result of professional emigration and the ensuing detrimental socioeconomic effects (De Villiers, 2007:68).

2.2.4 Push and Pull Factors

El-Khawas (2004) defines pull factors as the socioeconomic features of receiving nations that foreign-born professionals find alluring.

El-Khawas (2004) defines push factors as those unfriendly internal conditions that force professionals and skilled workers to leave their native nations in search of employment elsewhere.

2.2.5 Globalisation

Globalization provides a crucial context for understanding migration in modern society, particularly labour migration (Suarez-Orozco and Suarez-Orozco, 2005:96). The "deepening, widening, and speeding up of the worldwide interconnectedness" and interdependence, according to Brown (2008: 285), can be thought of as globalization. This suggests that as a result of globalization, the world is getting smaller, and more connections are being made between nations and areas. Therefore, in globalisation different national economies are incorporated into one system and free movement of resources, including labour, is essential in the making of global business. The high level of globalisation that currently exists has come to mean that a shortage of labour in one part of the globe can be felt in the opposite part almost immediately. With the deepening of globalisation in the past few decades, the migration of labour has intensified and has come to affect every country of the world (Kock, 2006:30).

2.3 CAUSES OF MIGRATION

According to Skeldon (1997:4), asking why individuals migrate assumes that movement is abnormal and that sedentary living is the rule. Skeldon (1997:4) asserts that a more sensible query in this case is, "Why do people not migrate?" These reasons, however, have not stopped academics from looking into the causes of migration due to the volume and influence that migration has.

2.2.1 Globalisation as a cause of migration

2.2.1.1 Globalisation has been accused of being both the trigger for and facilitator of migration and especially labour migration. A useful evaluation of this is provided by Suarez-Orozco and Suarez-Orozco (2005:96) who attempted to establish a clear relation between migration and globalisation. They present the following as ways in which globalisation interacts with migration:

2.2.1.2 Globalisation affects the development of economies differently producing success stories in some, and disasters in others, hence creating conditions for migration by heightening the migration gradient.

2.2.1.3 The new information and communication technology (ICT), at the centre of the present wave of globalization, tends to encourage new cultural expectations and

habits, the fulfilment of which is typically only found elsewhere, which tends to encourage migration.

2.2.1.4 Another aspect of globalization is the accessibility and cost of mass transit. People now have a wide range of migration alternatives because to this.

2.2.1.5 Deeply globalized nations' economies are predicated on the availability of "foreign" workers who are prepared to perform unpleasant, hazardous, and dirty jobs.

2.2.1.6 Labour has a tendency to follow international capital flows, which is a key aspect of globalization and encourages migration.

It has been hinted at above that globalization brings prosperity to some nations while bringing devastation to others (Shivji, 2002:104; Wangwe and Musonda, 2002:61; Ogbu, 2004:37). The effects of globalization, which include the destruction of local industries and livelihoods, a weakened state unable to meet its citizens' social needs, capital flight, loss of skilled manpower, polarization due to a widening income gap in the population, cultural confusion, ecological destruction, and other negative effects, have disproportionately affected countries in the South and particularly those in Africa. The success tales, on the other hand, are primarily from northern countries, where they describe increases in economic growth, human advancement metrics, and public awareness of democracy and human rights (Jansen, Mwapachu, and Semboja 2002:4). Increased living and working conditions between nations lead to a significantly steepened migration gradient and the possibility for extremely large migration flows.

The modern economic system, according to some analysts, is defined by information and communication technology (ICT), which is at the center of globalization (El-Ojeili and Hayden 2006:60). Migrants can now quickly get information on destination countries' entry and residency requirements as well as differences in income and prospects through the same ITCs (Weiner, 1995:25).

In many nations, immigrants are only allowed to work menial, hazardous jobs (Mooney and Evans, 2007). This kind of work is typically monotonous and is carried out under unfavorable circumstances. Since their main goal is to simply enter the labor market, these positions frequently give migrant workers a foot in the door, making them the sole workers willing to perform this work (Harzig et al., 2009:77). According to Suarez-Orozco and Suarez-Orozco (2005:96), migrant employees are frequently regarded as more dependable, adaptable, punctual, and prepared to work overtime, and the recruiting firms find it easier to supply them

to employers. According to Trimikliniotis, Gordon, and Zondo (2008:1329), migrant workers are more prevalent in some fields of employment in South Africa because they are less protected against exploitation than native workers, who belong to a variety of unions and political parties.

The globalized world has a tendency towards fast-moving capital, particularly finance, and the technology exists to enable this. Labour must move with the other kinds of capital as it is a component of that capital. This is only possible, though, under particular conditions. It is well known that labour movement is less free than that of other types of capital (Mooney and Evans, 2007:166).

The only part of labour that is typically permitted to be mobile is the skilled portion. The immigration policies of nations place numerous limitations on the movement of the unskilled labour component, and these policies "only encourage certain types of migrants based on employability, financial means, language means, and cultural capital in general" (Mooney and Evans, 2007:166). Therefore, assuming that all capital is equally free to move around the world is false.

2.2.2 Other causes of migration

Although Weiner (1995:25) concurs with Suarez-Orozco and Suarez-Orozco (2005:96) that globalization has had a greater impact on migration, he adds that state policies that encourage migration directly or indirectly to pursue political, economic, or foreign policy goals can also have an impact.

The push and pull factor theory is advanced by other migration theorists (Dovlo, 2003; El-Khawas, 2004) to explain the movement of workers. Rarely is the migration of labour from one nation or region of the world to another attributable to a single cause. It has been determined that specific socioeconomic factors are to blame for the movement of labour across international borders. The push and pull factors can be classified into two categories. According to Dovlo (2003:4), "push factors" are the unfriendly environments present in the source nations that drive professionals and skilled individuals to leave and look for work abroad. According to El-Khawas (2004), pull factors are the favourable socioeconomic circumstances in recipient countries that entice experts.

The push factors that are commonly listed according to (El-Khawas, 2004:40; Dovlo, 2003:4) are:

2.2.2.1 Low salaries,
2.2.2.2 Job scarcity,
2.2.2.3 Political repression,
2.2.2.4 Crime and conflict,
2.2.2.5 Poor educational systems,
2.2.2.6 Poor conditions of service,
2.2.2.7 Lack of progression within a career,
2.2.2.8 Limited chances for self-advancement and
2.2.2.9 Lack of necessary technology and resources.

Most of these push forces have an economic basis. One of the main drivers of labour migration has been recognized as low pay, which is closely related to working conditions. Employees want to succeed in their careers, therefore any barrier to that advancement is often irksome. Workers also consider how they might improve themselves by gaining new skills.

Employees from sending countries are being drawn to receiving ones by a variety of pull reasons, mostly socio-economic in nature (Dovlo, 2003:5; El-Khawas, 2004:40). Key among these are the following:

2.2.3.1 Less bureaucratic control,
2.2.3.2 Better conditions of service,
2.2.3.3 Greater environmental safety,
2.2.3.4 Higher standards of living,
2.2.3.5 Higher chance of professional and personal improvement,
2.2.3.6 Higher salaries for the similar jobs in the receiving countries, and
2.2.3.7 Advanced technology and availability of resources that make work simpler and safer.

According to migration scholars, workers go to nations with better working and living conditions in order to improve their own conditions by finding employment there. As a result, the workers are sometimes said to be seeking "greener pastures." According to El-Khawas (2004:40), differences in living conditions and employment prospects between sending and receiving nations are a factor in labor migration. Dovlo (2003:5) continues by using different gradients to better characterize the differences between the sending and receiving countries. These include the following gradients: the income gradient, the job satisfaction gradient, the

governance gradient, the protection and risk gradient, and the social security and benefits gradients. Dovlo (2003:5) uses differences in these indices to explain how abilities move from one country or region to another. Rich countries require immigrants to deal with the current economic and demographic pressures, both the highly skilled professionals like engineers, doctors, and nurses who are in short supply locally, and the unskilled to perform the boring, risky job that the locals avoid (Adepoju, 2010:16).

Between refugees fleeing conflict in their home countries and economic refugees trying to escape the negative impacts of economic collapse, there is a fine line. It can be challenging to categorize migrants as refugees or economic migrants because nations that experience significant conflict typically also experience severe economic problems, and migration patterns from these nations frequently stem from both conflict and economic hardship (Sorensen et al., 2002:9). Migration is influenced by factors such as the relative availability of jobs, education, secure access to healthcare, and political stability. People migrate due to the desire to protect their own and their close relatives' survival as well as the pursuit of economic development (GFMD, 2009:2).

Political Causes: In the case of Zimbabwe, the country's political and economic environment served as the primary driving force for unauthorized migration to other countries in quest of jobs, higher pay, and better working conditions (Chikanda and Tawodzera, 2017). The Zimbabwean government's lack of political will to regularize migration encouraged irregular movement to neighboring nations like South Africa, Botswana, Namibia, Lesotho, and Mozambique (Munhende, 2019). Unauthorized labor movement from Zimbabwe imposed a significant strain on the SADC region as a whole, particularly South Africa.

Economic Causes: People who have lost their jobs or who are having trouble finding work possibilities as a result of industries closing are linked to reasons for irregular migration (Raftopolous, 2011). Most unauthorized immigrants hail from neighborhoods or homes where daily per capita consumption is less than $1.90 (Elver, 2019). According to a survey done in South Africa by Maphosa and Ntau (2018), 80% of respondents transferred money to their families in Zimbabwe. Remittances from the diaspora, which are frequently sent through both formal and informal means, are helping to alleviate poverty in Zimbabwe (Ratha, 2018).The economic difficulties in Zimbabwe continue to drive the flight of professional health care workers to countries in the region and the global world in pursuit of jobs (Zanamwe and Devillard, 2018).

Social Causes: Most healthcare professionals have migrated to the diaspora in search of higher living standards in nations like South Africa, Botswana, the United Kingdom, the United States, and Canada due to the relative collapse of basic infrastructure such as the health and education systems in Zimbabwe (de Jager and Musuva, 2016). When many professionals leave the country due to lucrative salary and work possibilities abroad, the brain-drain phenomenon is negatively impacted, making Zimbabwe a training ground for most regional nations like South Africa (Potts, 2010). Social networks play a significant role in encouraging unauthorized migration. According to the social capital theory, migration will not occur in a social vacuum; as a result, networks and relationships will influence the destination nations (Muyambo and Ranga, 2020). Family ties and friendships, as well as social networking systems, hasten the process of irregular migration (Tawodzera et al., 2015).

Environmental Causes: The economic and social services that support people's livelihoods, like the health and education sectors, are significantly deteriorating as a result of poverty. Given that migrants expect to send money back to their families after settling abroad, labor migration is a solution to food insecurity. The Covid 19 pandemic triggers have intensified recent trends of labor outmigration. In contrast, the exporting nations have witnessed a brain drain, notably of the critical and experienced cadres. The pandemic has increased work prospects in the diaspora, particularly for the nursing cadre. As a result, the pandemic has increased misery in the sending nations, which are now serving as training grounds for the higher-paying nations like the United Kingdom, Australia, and Canada. The destination country's immigration laws' relaxation and exemptions are related to the aforementioned. These nations now find it simpler to recruit workers from developing and undeveloped nations because to their strategic strategy.

2.4 Migration Theories/Models

Scholars have sought to understand the causes, effects and dynamics of migration for a long time and in the process generated a wide spectrum of theories. However, these theories are unfortunately compartmentalised into several disciplines that enjoy little interaction (Brettell, 2008:114). The disciplines that study migration are amongst others anthropology, history, demography, economics, geography, law, political science and sociology. Some of the more salient of the theories from the different disciplines are reviewed in this section.

Before presenting a migration model, it is helpful to quickly differentiate between the several categories of explanations that are frequently cited. Three major categories of theories about international migration are recognized by academics; these categories are not mutually exclusive (Brettell, 2008). Macro theories place a strong emphasis on the structural, measurable

causes that "push" and "pull" people to migrate. Economic difficulties like unemployment, low pay, or a low per capita income in comparison to the country of destination are frequently push factors in economic migration. Legislation governing immigration and the state of the labor market in recipient nations would be pull factors. Macro circumstances are essential for explaining voluntary migration, according to the majority of theorists. Similar push factors exist in many sending areas, but while in some cases they generate mass emigration, in others there is almost less mobility.

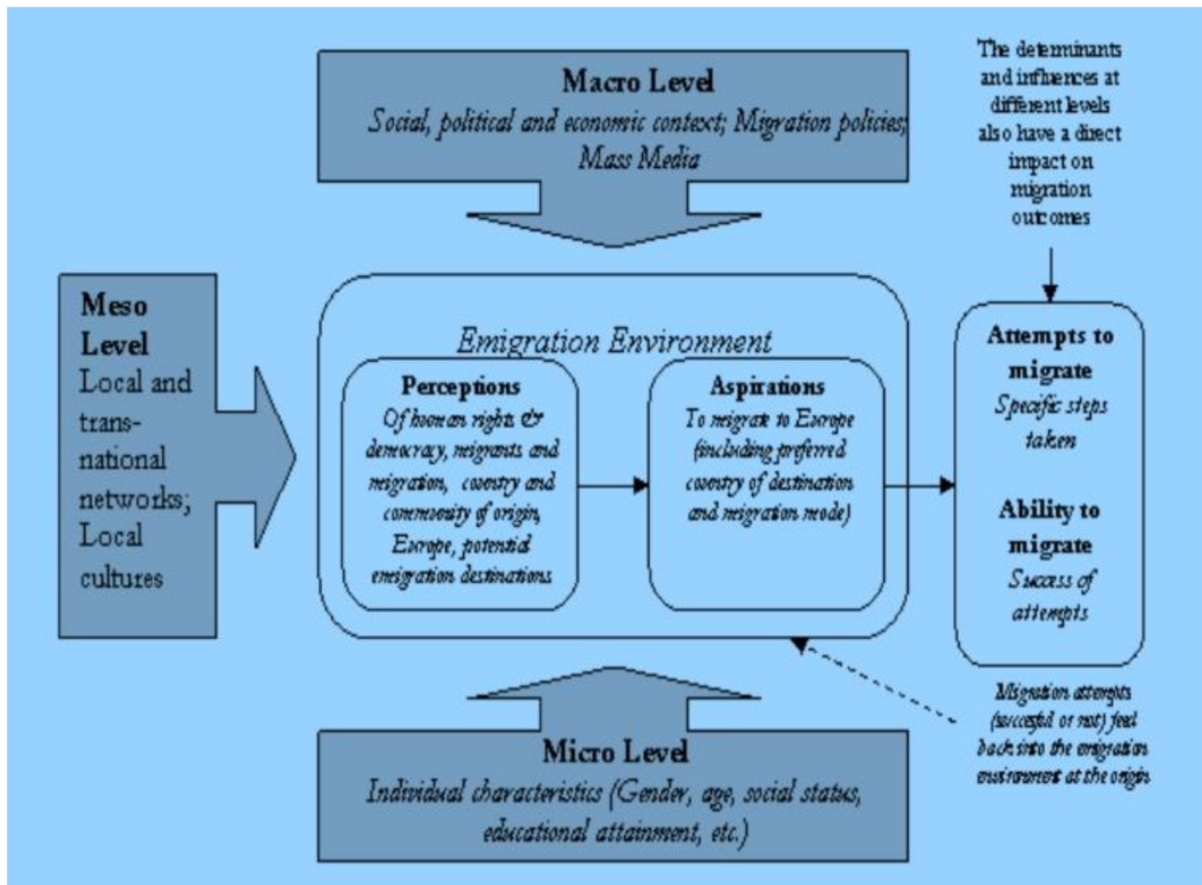
These differences can be explained in part by meso hypotheses. They reject the macro emphasis on push and pull causes and place migration patterns inside a complicated network of interstate connections. Systems and networks are two ideas that are very crucial for meso theories. It is considered that migration takes place within a migration system, which is a collection of nations bound together by migratory flows as well as economic, political, and cultural ties. As a result, rather than a set of objective indicators, the conditions creating movement are regarded as the dynamics or interactions between two areas. According to El-Khawas (2004), networks are made up of a variety of individual and group players, including actual and potential labor migrants, their families, businesses, religious or social organizations, and so on. Once established, networks can have a significant impact on the direction and scale of labor migration patterns by offering resources that facilitate movement, such as knowledge, contacts, and financial and social support. The resources that flow through networks make moving a more appealing and practical option for other network members, and this phenomenon has been referred to as "chain migration" (Faist, 2001; Bilsborrow and Zlotnik, 1994; Faist, 2001). Chain migration is the phenomenon of serial, large-scale migration from one area to another defined area. Although it can help to explain the choice of destination nations for labour migrants, this meso level is less pertinent for explaining involuntary migration. Systems and networks may make locations more accessible, safer, or desirable as vacation spots.

Micro theories analyse how potential migrants compare the many costs and benefits of migrating, focusing on the factors influencing individual decisions to move (Martell, 2010). Benefits could include a higher wage or physical safety, while costs could include the financial and psychological resources necessary to move to and integrate in the destination country. The rational choice theory, which makes a number of debatable assumptions about how and why people make decisions, is a common source of inspiration for micro theories. However, the micro viewpoint is a crucial level of research for illuminating how people interpret and evaluate the numerous factors driving labour movement internally. As a result, it acts as a check or a

type of control for macro and meso theories by defining how people base their judgments on relational or objective criteria.

One could get the conclusion that macro theories provide the best insight into the causes initially driving voluntary labour movement by summarizing the respective merits of these three methods. The persistence of voluntary migration and the reasons why it originates in some regions but not others are best explained by meso theories. They can also aid in illuminating the choice of location made by labour migrants. Finally, micro theories can demonstrate how the translation of macro and meso influences into individual migration decisions. This categorization of hypotheses offers a helpful context for understanding cross-border labour migration and serves as a solid foundation for developing a general theory of the causes of labour migration.

Figure 1



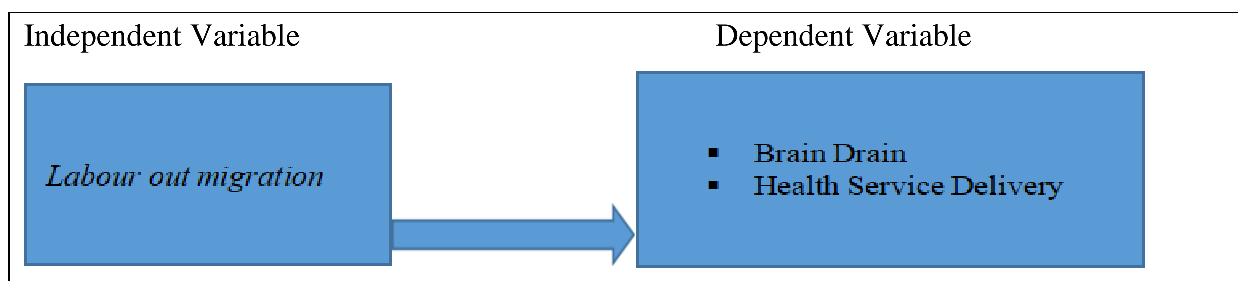
Source: Adapted from Timmerman, et al (2020) "Project Paper 1 Conceptual and Theoretical Framework EUMAGINE Research Project.

However, it is useful to distinguish between four different types of causal factors: root causes, proximate causes, enabling conditions, and sustaining factors. Root causes refer to the underlying structural or systemic conditions which provide the pre-conditions for labour migration. In terms of the theories discussed above, they combine a combination of macro and meso factors, such as economic underdevelopment, a weak state, severe social fragmentation, as well as migration systems shaping interactions between sending and receiving countries. Proximate causes refer to the immediate conditions that trigger movement, which again can be macro or meso, such as deteriorating working conditions or new opportunities abroad. The enabling conditions render the actual labour movement, entry and stay in countries of destination possible. They will include factors such as resources, legislation, and travel restrictions. Finally, sustaining factors encourage persistent or chain labour migration from places or countries of origin. These are almost exclusively a function of migration networks. All the four categories of causes imply different types of policy response.

2.5 Conceptual Framework

Attempts to migrate are preceded by the development of perceptions on human rights and democracy in developed countries, and aspirations to migrate based on several causes of migration broadly grouped as pull and push factors. These goals may take the shape of very general desires to immigrate to the majority of industrialized nations or more precise choices for certain locations and migration routes (such as through family reunion, family formation, temporary employment programs, asylum, or illegal entry). The emigration environment has been referred to as the distinct cultural, political-legal and economic context in which migration-related beliefs and ambitions arise (Carling, 2002). The project's design was influenced by a particular analytical framework on which it is built outlining an independent variable (labour out migration) against dependent variable (brain drain and health service delivery). (See Figure 2).

Figure 2



Conceptual Model Influence of labour out migration on Brain Drain among Health Practitioners and ultimately Health Service Delivery

The processes are influenced by factors at three levels. The macro level includes the factors that are common to all potential migrants, such as national policies on emigration and immigration, the overall economic and political situation in the country, the mass media, and the human rights and democracy level. The meso level encompasses the factors in between the individual and the society at large (Goss & Lindquist, 1995). Most important are the local and transnational networks through which people collect information and exchange ideas. Finally, the micro level concerns characteristics of individuals.

2.6 CASE STUDY ON HEALTH WORKFORCE MIGRATION

2.5.1 The case of Philippine – Adopted from the Human Resource for Health (HRH) 2030 Policy Brief (2020).

Health professionals are essential to the health system and have a big impact on expanding access to high-quality healthcare. Therefore, access to high-quality primary care would be limited if they are scarce and not dispersed fairly. International migration of healthcare professionals is one of the biggest difficulties facing the Philippine health care system. The migration of health professionals has steadily increased between 1990 and 2017, according to data from the Commission on Filipinos Overseas (CFO) and the Philippine Overseas Employment Administration (POEA). The same research revealed that nurses, out of all the health care professionals in the nation, are most in demand abroad, where the old population is rising but there is limited health worker production. Between 1990 and 2017, 350,361 medical professionals—including physicians, nurses, and midwives—left the country to work abroad, according to both the CFO and the POEA. The remaining 16% of migrants have relocated permanently abroad, compared to approximately 84% who work abroad temporarily. 95% of this group are nurses, 3% are doctors, and 2% are midwives. Domestic migration, on the other hand, contributes to unequal distribution. A recent finding is that due to pay disparities, health professionals from the private sector have transferred to the public sector.

2.5.2 Policy issue and magnitude of the problem

Over time, the Philippines' subliminal support for labour exportation—which prompted the establishment of government organizations devoted to easing migration—has contributed to

the nation's reputation as an ethical provider of health professionals. Since 1990 till 2017, the overall number of HRH migrants has been continuously rising at an average rate of 19 percent annually. Temporary migrants make up the majority of migrants between 1990 and 2017, making up 84 percent of the total. While there have been more temporary migrants overall than permanent migrants throughout the same time period, the growth rate has been the opposite. In comparison to temporary migrants, who experienced an average annual growth rate of 6% from 1990 to 2017, permanent migrants experienced an average annual growth rate of 10%. 60,000 HRH, predominantly nurses between the ages of 25 and 34, were lost to permanent migration between 1990 and 2017, according to CFO data. The movement of HRH was affected by push and pull influences. Push factors are the circumstances in the Philippines that prompted HRH to go. Poor working conditions in the Philippines, such as low pay, unstable employment without tenured positions, unsafe and subpar working conditions, antiquated medical technology, and a lack of employment and career possibilities, were among these. Inconsistencies in practice, obsolete or incorrect curricula, institutional politics, and a lack of possibilities for specialized training also had an impact on migration decisions.

The pull of foreign migration was one of the main reasons HRH left the nation. The possibility of better social, economic, and professional prospects overseas as well as the presence of family in the desired location were pull factors. Higher wages, better working conditions and technologies, and employment openings with open positions because of local shortages all served as draws to destination nations. Finally, the HRH's migration was made easier by the institutional and policy assistance that was in place.

For instance, in order to assist family reunion, the visa policies of the destination nations permitted family members to travel with the migrant health professional. The fact that policies from various government departments were not consistent and occasionally at odds with one another did not help. For instance, the Department of Labour, POEA, and CFO produced policies that allowed and safeguarded HRH migration in order to lower unemployment in the nation, whereas the Department of Health promulgated laws that encouraged the retention of health professionals in the nation. The international income disparity offered typically seals the draw factor. Philippine midwives, nurses, and doctors make less money than professionals in other nations, such Saudi Arabia.

Survey participants in a study on the causes, effects, and policy responses of health personnel migration from the Philippines identified the following effects: a shortage of workers (42%), a reduction in services offered (20%), an increase in errors and poorer care delivery (8%), and

longer wait times for critical services (7%). Health professionals with expertise and skills were typically recruited and sent abroad to work.
The unchecked growth of health professions, particularly nursing education, has been the most noticeable effect. The economic contribution made by migrant workers' remittances has been a major factor in why governments have favoured formalized labour export on a national level. The total social gain of HRH migration as a whole, however, was less than the social disadvantages.

2.5.3 Need for policy support to manage HRH migration

Although it is a human right for people to migrate and move about, the Philippines' predominately outward-directed flow of health professionals has had a negative effect on the provision of healthcare services and, consequently, the achievement of health outcomes. Poor health outcomes for Filipinos were partly attributed to the collapse of local health care systems due to the emigration of medical personnel. Therefore, it is essential that global HRH migration be controlled to lessen its negative consequences on the health care system. If at all possible, there is an urgent need to focus on the creation and implementation of efficient policies to encourage beneficial migration. Measures to safeguard and advance the welfare of migrant workers and their families are provided under the original Migrant Workers and OFW Act of 1995. The Act aims to reintegrate returning Filipino migrant workers in the health and non-health sectors into Philippine society in order to promote and facilitate local employment and to utilize (and enhance) their talents and potential for the advancement of the country. The Act states that, despite the fact that Filipino migrant workers make a sizable contribution to the national economy through their remittances of foreign currency, the State does not encourage abroad employment as a way of sustaining economic growth and achieving national development.

Therefore, the State's objectives are to consistently foster the equitable distribution of income and the advantages of development. However, there is tremendous room for improvement in how these policies are implemented. Along with the aforementioned, the Philippine government has since 2003 entered into bilateral and regional agreements regarding the hiring of medical staff abroad. There were agreements in place enabling doctors, nurses, and midwives to be recognized by other ASEAN members. In accordance with bilateral agreements with Japan, Germany, Canada, Spain, and Norway, training, the twinning of medical institutions, the development of circular migration, and educational initiatives have all received funding (Philippine National Reporting Instrument, 2015). It is unclear if the policies in place

are effective at managing migration because the impacts of these agreements have not yet been felt. As a result, it is necessary to develop policy support to manage HRH migration in order to lessen its negative consequences and maximize its positive ones.

2.5.4 Policy Alternatives for Philippine

2.5.4.1 Option 1. Allow market forces to operate (status quo)

The job conditions and locations that health workers choose are influenced by current labor laws. By allowing people to be hired by the government and the local business sector or to seek employment overseas when the opportunity arises, this strategy supports the status quo. Health professionals can also find employment in nearby non-health sectors.

2.5.4.2 Option 2. Create and implement competitive compensation (salary and benefits) packages

The goal should be to equalize the appeal of working abroad and here in the Philippines. Working in the Philippines has the advantage of HRH being in the home country closer to their families and communities, even though salaries, perks, and possibilities may not be at the same level as working in destination nations in Europe, North America, or the Middle East. To motivate HRH to work in the Philippine health sector, this and other previously recognized "stick" considerations (such as staying with their family, assisting their countrymen, and feeling fulfilled by serving the country) should be used.

2.5.4.3 Option 3. Install regulatory migration policies

The Philippine health sector will have time to implement production and retention policies that will encourage health workers to remain and work locally while also limiting the amount of HRH that destination nations can recruit. It may be time for government to take active action given that the shortage of available health workers and the unequal distribution of HRH have persisted for decades and have a direct influence on the delivery of health services and health outcomes. However, this choice places restrictions on the freedom of health professionals to practice where they want.

Conclusion – case study

It appears that option 2, which will develop and implement competitive compensation and benefits, is the best in terms of accomplishing the policy objectives, according to the results of the examination of the policy options. Low pay and subpar working conditions are two major push factors that are directly addressed by this alternative. Additionally, by offering improved working circumstances, the public and private sector employers can step up their efforts to keep health professionals on staff. These actions would call for long-term dedication, sound governance, and possibly even the backing of the international community. Additionally, it appears that the third option, which establishes a linked policy regime from production to placement, is a good substitute for achieving the primary policy objectives of equity and liberty. Technical and political viability, however, are limited due to the amount of policy coordination and alignment that this alternative demands from numerous national government agencies. The proper execution of the UHC law's provisions, which make it easier to link up various sectors and national authorities, may help to ensure financial viability.

The first option, which would allow market forces to function as they do at the moment, will not contribute to the development and implementation of significant reforms in the domestic health labour market. This alternative is the least preferable because it won't help address problems that still afflict the HRH industry, particularly the shortage of HRH in the health sector and the unequal distribution of HRH.

As a result, this choice would result in status quo health results, which is unacceptable. The government should keep negotiating mutually advantageous arrangements with other nations to control the migration of the health workforce because it will be impossible to stop migration. In a world with a globalized economy, migration is inevitable. However, managing migration strategically requires an understanding of "why" migration occurs. It is important to address the problems of production misalignment with evolving domestic and global demand patterns as well as factors contributing to domestic retention.

2.7 Gaps in Literature

The research review mentioned above brought to light a number of problems with health labour migration. It has been observed throughout the review that labour migration currently faces theoretical issues. There is no consensus definition of labour migration, claim Lewis and Heckerman (2006), McDonnell (2009), and McDonnell et al (2010). Differences in cadre and national characteristics can account for this. The literature is also quiet on how nations develop

a common view of what labour migration means. Without addressing cultural, economic, social, or political distinctions among specific nations, the literature merely exposes how countries conceptualize and operationalize labour migration.. Collings and Mellahi (2009), McDonnell et al (2010) and Tarique and Schuler have intimated that the existing researches are based on anecdotal information and portray several theoretical deficiencies.

The brain drain from poor nations has recently been the focus of important policy debates and scholarly investigation. The paucity of trustworthy data sources, however, has hampered our understanding of the phenomenon's scope (see, for instance, Adepoju 1995; Gaidzanwa 1999; Meyer and Brown 1999; Russell 1993). When statistical data are accessible, they frequently contain many gaps and are of poor quality, making them unreliable as sources for data.

2.8 Chapter Summary

This chapter reviewed the literature on health labour migration. The areas of focus in the literature review included the definitions of labour migration, causes of labour migration, and labour migration theories. The chapter also looked at a case study on labour migration. The case depicted how other countries are managing labour out migration, designing and implementing successful labour migration policies and systems.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

An overview of the research approach that was employed is given in this chapter. The qualitative research methodology used for this project is covered in the chapter. The chapter offers a glimpse into the research's methodology framework, which includes the research design, research approach, research strategy, research instrument, and data analysis procedure. In this chapter, these techniques are explained and supported. Discussions also include the research's ethical issues and the reliability of its findings.

3.2 Research Philosophy

Research philosophy discusses the development and nature of knowledge (Saunders, Lewis, and Thornhill, 2007). Philosophical perspectives on ontology and epistemology both describe the nature of knowledge. The term "ontological" refers to the controversy over whether social entities should be viewed as objective things with a reality apart from social actors or as social constructions dependent on the perceptions and actions of social actors. According to Bryman and Bell (2007), these ideas are known as objectivism and constructionism, respectively. What epistemologists regard as knowledge, in contrast to beliefs, are accepted and established standards (Blaike, 2001). The two most prevalent epistemologies are positive and interpretivist. Positivism links knowledge to observable truths that exist apart from the intellect, whereas interpretivism maintains that people and their institutions are fundamentally distinct from those in the scientific sciences.

The interpretivism approach makes an effort to understand a concept within its context. For the following reasons, the interpretivism approach to epistemic philosophy was utilized in this study:

3.2.1 Due to the ambiguity surrounding the concept of labour migration, a research strategy requiring a detailed analysis of the phenomena under study's subjective aspects is required.

3.2.2 Since interpretivism makes it simpler to investigate people's experiences, it gives the researcher the ability to understand what happens in labour outmigration and its effects on the healthcare sector.

3.2.3 The interpretivism approach allows the researcher the possibility to critique the strategies employed in managing human resources during labour migration.

3.2.4 Allows the investigation of topics that the researcher may not have directly seen, such as labour migration, using semi-structured interviews and secondary sources of data such company reports and websites.

3.3 Research Design

Several study designs set the qualitative research approach apart. According to Trochim (2006), the research is held together by its design. According to Birks and Mills (2011:24), a research design serves as a roadmap for the study and must specify the philosophical and methodological stances that will be used to accomplish the predetermined goals. The approach, methods, and processes for data collecting and analysis are outlined in the research design. This study used an exploratory approach because it was an unstructured investigation into how labour outmigration affected the provision of healthcare services. Using this type of methodology, a closer examination of PGH yielded data that let the researcher respond to the study questions.

3.4 Research Approach

Strong arguments have been made against the polarization of the two techniques, leading researchers to place the qualitative and quantitative approaches on a continuum (Bamberger, 2000; Glaser-Zikuda and Jarvela, 2008). Both research strategies are currently regarded as useful since they conduct an organized analysis of a certain phenomena. The researchers and participants may bring subjectivity into a study, whether it is qualitative or quantitative in character, hence both are also regarded as subjective (Fischer, 2006). The qualitative research approach is now seen on an equal footing with the quantitative approach and is no longer seen as a "soft" approach that is only effective in speculative research (Goulding, 2004:295). Qualitative research usually focuses on the in-depth understanding of a natural phenomenon whilst the quantitative approach focuses mostly on theory testing.

Therefore, it was decided that the qualitative method was the better choice. The qualitative technique also provides for a range of viewpoints on the study's issue since it gives participants a more flexible means of expressing their perspectives and illuminating their behavior (Henning et al., 2004:3). This method was determined to be the most suitable for this study since it gave participants the freedom to voice their opinions without being constrained by the researcher's predefined categories. In this way, individuals were able to openly address the different forces that ultimately influenced their decision to relocate as well as, to a certain

extent, their perceptions of how such migration might affect the provision of health services. Majority of the empirical investigation was qualitative.

3.5 Research Strategy

There are an abundance of methods available for conducting research. These tactics can be categorized under the positivistic/objectivist and phenomenological/subjective philosophies, according to Collins and Hussey (2003), Table 3.1.

Table 3.1: Research Strategies

Objectivist	**Subjectivist**
i. Surveys	Case Studies
ii. Experimental studies	Action Research
iii. Longitudinal studies	Participative Enquiry
iv. Cross-sectional studies	Grounded Theory

Source: Collins and Hussey (2003)

The paragraphs that follow will briefly explore each technique listed in Table 3.1 in an effort to provide justification for the researcher's decision.

3.5.1 Survey

A survey is a methodical way to gather information from a population of interest. It tries to gather data from a sample of the population so that the results are representative of the population within a specific margin of error and is frequently quantitative in nature (Glasow, 2005). A survey's objective is to gather quantitative data, typically through the use of a structured and standardized questionnaire. However, this approach is typically criticized since processing and interpreting the findings requires some statistical expertise, sampling, and other specialized abilities.

3.5.2 Experimental Studies

To establish cause-and-effect linkages is the main objective of experimental research (Belli 2008). Experimental research involves the random assignment of subjects to various treatment conditions, the manipulation or control of at least one independent variable, and the measurement of some dependent variable after the application of the treatments. The variations in the treatment conditions that were used can thus be blamed for any changes that emerge in

the dependent variable across the treatment groups. Since most real-life events and socio-cultural phenomena are simply too complex to be condensed into a small number of treatment and outcome variables, this study technique is frequently criticized for lacking efficacy or accuracy.

3.5.3 Longitudinal Studies

It is an ongoing investigation into a factor or subject group. The goal is to investigate the same circumstance or individuals repeatedly or continuously throughout the problem's duration in order to better understand its dynamics. This approach's chain of investigations is one of its distinguishing characteristics. Each link in the chain examines or re-examines a related group, social process, or a component of a larger group, social process, or both.

3.5.4 Action Research

It is a methodology that works under the premise that both the researcher and the social world are dynamically evolving. A sort of applied study known as "action research" aims to discover the most efficient means of enacting a deliberate change in a situation that is only partially under control. Entering a situation, attempting to effect change, and then tracking results are the core goals of action research.

3.5.5 Grounded Theory

Although Glaser and Strauss (1976) established this approach for use in the medical area, it is now applicable across a wide range of fields. The theory places a strong focus on the value of empirical fieldwork and the necessity of closely relating any explanations to what actually occurs in real-world scenarios. An effective illustration of an inductive strategy is grounded theory.

3.5.6 Case Study

The researcher used the case study approach in this investigation. A case study is an in-depth examination of one or a few units (Laws and McLeod 2006). A person or an organization are examples of an entity that can be described using this technique. For a case study, thorough research must be done on the analytical unit. In fields with little hypotheses or bodies of knowledge, case studies are frequently referred to as exploratory research. The researcher chose case study as the best technique in light of the research problem stated in chapter 1 and the gaps in the body of literature around HRH out migration. Yin (2009) defined a case study as an empirical inquiry that investigates a contemporary phenomenon within its real-life

context. In conducting this research, the researcher was guided by Myers (1997) who postulated that case study involves four stages namely;

i. Establishing the current situation: this was done by looking through employee files and conducting structured and semi-structured interviews.
ii. Examining personnel files and conducting structured and semi-structured interviews helped gather knowledge on the circumstances leading up to the current predicament.
iii. Collecting additional detailed information through consulting organizational documentation, surveys, in-person interviews, and organizational work process observation,
iv. The creation of the final study report enabled the presentation of an analysis of the results and suggestions for further research.

Yin (2009) hinted that when one adopts a case study as a research strategy it is imperative that the case meets one of the following or all the conditions:

i. The case should be critical in confirming, challenging or extending a theory, because it is the only one that meets all the conditions.
ii. The case is rare or extreme and finding other cases is highly unlikely.
iii. The revelatory case provides unusual access for academic research.

The study met criteria i and iii because it provided access for academic research and its findings could be generalized to challenge or advance our understanding of labor migration as a modern theory that can be used to increase employee retention in the Zimbabwean health sector. Relevance, practicality, accessibility, and application are factors taken into account when choosing the case study.

3.6 Population and Sampling

3.6.1 Population

The entire set of people which the researcher wants to determine some characteristics is called the population or universe (Bless and Higson-Smith, 1995). In social science research populations include individuals, groups, social organizations and social artifacts. According to Saunders (2009) a population is the full set of cases from which a sample will be drawn. It consists of all the possible observations of the random variable under study (Wegner, 1993). In this study the population comprised of 1,338 qualified doctors and nurses (90 doctors and 1,248 nurses).

3.6.2 Sampling

A sample is a portion of the overall population that is the subject of the researcher's study, and its characteristics will be applied to the entire population as a whole. It is challenging for social scientists to get information from every member of the population under study. Therefore, through a technique known as sampling, researchers rely on gathering data from a percentage of the entire population. Both probability (random) and non-probability sampling are types of sampling techniques. According to Bless and Higson-Smith (1995), probability sampling takes place when it is possible to calculate the probability of including each member of the population in the sample, whereas non-random sampling takes place when this probability is unknown. Table 3.2 highlights the sampling procedures which belong to each sampling method.

Table 3.2: Sampling procedures

Probability Sampling	Non-probability Sampling
Simple random	Accidental or availability
Interval or systematic	Purposive or judgemental
Stratified	Quota
Cluster or multi-stage	

Source: Bless and Higson-Smith (1995)

Purposive or Judgemental Sampling

This sampling technique is based on a researcher's assessment of the qualities of a representative sample. The method used for this technique is to pick out units that are thought to be representative of the population being studied.

In this study, the non-probability approach of sampling was employed. This was mostly due to the qualitative nature of the current investigation. In cases of non-probability, the researcher employed a judgmental or purposeful approach. The Health Service Commission managers, MoHCC managers, medical and nurse managers, specialist physicians and nurses, non-specialist doctors and nurses, and nurse tutors were the six groups of respondents the researcher selected to locate for this study. Therefore, the selection of these respondents was deemed appropriate since it gave the researcher access to staff categories at various levels, which provided broader insights into the scope of labour outmigration and its impact on the provision of health services. The research sample is described in Table 3.3.

Table 3.3: Research sample

Category	Population	Sample	Percentage of sample to population
Health Service Commission Managers	5	1	20%
MoHCC Managers	8	1	12.5%
Medical and nurse managers	102	4	3.9%
Specialist doctors and nurses	377	8	2.1%
Non-specialist doctors and nurses	829	16	1.9%
Nurse tutors	30	2	6.6%
Total	**1,351**	**32**	**2.3%**

Out of the research population, 32 were sampled. This accounted for 2.3% of the study's participants. It was impossible to predict how many people would participate in the study at the outset because the sampling strategy used was theoretical sampling, which is a theory-driven and purposeful way of sampling. When sampling and data creation should end is determined by the theoretical concept of data saturation (Creswell, 2008:442). In the end, 32 people participated in the study.

3.7 Data Collection Methods

White (2006) argues that in research, how data is collected is as important as the data itself. There are numerous tools available for data gathering in qualitative research. These tools include conducting interviews, making observations, and compiling documentation. The researcher employed organizational documents, a questionnaire, and an interview schedule as research tools in this study.

3.7.1 Questionnaire

According to Bless and Higson (1995), a questionnaire is a set of questions with fixed wording and sequence of presentation as well as how to answer each question. For some cadres in this study, a questionnaire was used. This approach was adopted in part to minimize the researcher's contribution to the questions' resolution. This made it possible for the researcher to compare the findings in an impartial manner.

3.7.2 Interview schedule

Utilizing interview subjects that have in-depth and thorough expertise of the area of interest is essential (Holme & Solvang 1997). In order to strengthen the dependability of a study, interviews with standard questions are considered ideal for qualitative research (Silverman, 2006). Unstructured interviewing, on the other hand, which is frequently characterized by open-ended questions, is typically more adaptable and dynamic and enables the interviewer and respondent to engage in an honest dialogue. The respondent can supply their own responses in open-ended interviews (Babbie, 2007). Respondents are free to share their ideas and opinions about the study topic and their knowledge of it in the questions. They also allow for more investigation. The researcher was given the chance to gain a deeper grasp of the respondents' underlying assumptions and experiences through this method.

The researcher decided to utilize fewer structured questions and more open-ended, unstructured questions for this investigation. This was done to enable a more adaptable and lively interview process. The complexity of the topic and the sensitivity of the study challenge were two key reasons for utilizing open-ended questions.

3.7.3 Document analysis

Additionally, the researcher gathered and examined PGH's current human resources documentation and health service delivery indicators. These secondary data were useful in providing context for the study. Exit interviews, job termination reports, performance evaluations, leave and attendance records, retention and recruitment rules, and other documentation were gathered. Employee burnout rate, incident reports, fatality rates, and bed utilization rates were all included in the records that provided health service performance metrics.

3.7.4 Pretesting of the Instrument

Degu and Yigsaw (2006) state that the instrument must be tested and a number of practical preparations must be made before data collection can begin. Pre-test research enables the researcher to spot any issues with the created instrument. Pre-testing is the process of conducting a preliminary study and running the complete research process on a small sample of participants. A pre-test sample, according to Morrel and Connor 57 (2007), must be modest and is not required to constitute a representative sample of the population. As a result,

pretesting is advised as a crucial stage in the creation of the research since it helps to assess the applicability, validity, reliability, and practicability of the strategy, technique, and research instrument (Degu & Yigsaw, 2006).

The interview guide and questionnaire's structure and order are improved thanks to the pre-test respondents' suggestions. It's also critical to understand how long the interview will last. Pretesting was conducted utilizing 16 employees of Harare Central Hospital, a company with comparable working and environmental conditions to PGH. This was primarily due to the researcher's desire to focus on PGH when doing the final investigation. The 16 employees were chosen using the practical sampling technique. The final interview guide had modifications following the pilot study. The questions had to be understandable, use acceptable language, and be clear.

3.8 Research Procedure

3.8.1 Data Collection

There are various techniques to conduct an interview. Face-to-face interviews, in which the interviewer and the respondent meet, are the most common technique. This kind of interview gives the researcher the chance to read body language and better understand when a question has been misconstrued. The respondent may also be given the opportunity to pre-answer some of the more challenging questions by receiving the researcher's questions in advance (Fontana and Trey, 1994). The researcher made sure the interviewees were at ease and at ease when conducting a face-to-face interview. To help the respondents unwind and feel comfortable, the interviews began with small conversation. According to Krag (1993), the interviews included a brief presentation about the subject of the study and how the responses would be handled.

To make the interview process simpler and the respondents better prepared, the research questions for this study were provided to the participants in advance. The questions that were submitted to the respondents were laid out clearly. Before the interviews began, the study topic was presented and there was a brief discussion.
The interviews also began with open-ended questions regarding the organization or each candidate's personal career goals.

3.8.2 Data Analysis

Data analysis is required because, in the words of Robson (2002, p. 387), "the data do not speak for themselves, the messages stay hidden and need careful elicitation." Therefore, analysis was done with Creswell's (2007) data analysis spiral.

The following topics are examined in the spiral:

i. Data collection, interview transcription; field notes and documents
ii. General review of the information collected
iii. Creating summaries of field notes; file units; organizing data
iv. Reading, reflecting and writing notes
v. Data managing (organizing field notes in files)
vi. Reading and coding data; reducing data; paying attention to words and phrases; using metaphors
vii. Context; categories; comparisons
viii. Describing, classifying and interpreting
ix. Matrices, Trees, propositions
x. Representing, visualising

i. Interview transcription and field notes

The primary sources of data were the various categories of nurses and doctors, national management, and organizational documentation. As a result of taking note of these massive amounts of data, field notes and interview transcripts combined to produce a sizable database. The following step was to look through the data, as doing so is a crucial exercise in attaining the study's goals.

ii. Review of information collected

The data was read and filed in order to develop a thorough comprehension. To validate data and fill up any gaps, the researcher asked respondents for explanation.

ii. Creating summaries of the field notes

In qualitative research, data analysis consists of preparing and organizing the data (Carswell, 2007). Field notes were summarized for this investigation. Later, the researcher discovered problems related to the research questions.

iii. Reading, reflecting and writing notes

We reread the field notes to look for any hidden implications. The researcher examined the notes in an effort to learn more about the thoughts and experiences the respondents had on the topic under investigation. Writing down relevant details from the tales the respondents told that emerged during the process of rereading and pondering on the field notes was necessary and became essential in identifying significant difficulties. This stage helped to identify other emerging ideas and corroborate a number of motifs that were present in the literature.

vi. Data management

Coding is viewed as a data analysis process that has the capacity to influence continuous data collecting, according to Huberman and Miles (1994). As a result, data coding started during the literature review phase. The researcher is helped by guiding principles when analyzing data (Creswell 2007). The researcher was able to handle a lot of material by filing and categorizing field notes.

vii. Reducing and coding data

Large amounts of data that fit into various themes were accumulated as a result of the use of semi-structured interviews. According to Creswell (2007), after the data have been organized, researchers continue their investigation by gaining an understanding of the entire data set. At this point, it was crucial to pay closer attention to metaphors, words, and important phrases in order to clarify the foreign concepts surrounding labor migration. The qualitative method the researcher employed made the data analysis time-consuming. According to Robson (2002, p389), this was mostly because "in qualitative analysis the technical help is more limited and the researcher often spends a considerable amount of time breaking down the information."

viii. Context, categories, comparisons

In order to include them in the analysis, synthesis, and interpretation, more insightful stories or remarks were collected during this step. People create their own realities and give them significance, which is largely to blame for this (Ramenyi et al., 1998). The parallels and contrasts between the comparisons were emphasized. This step was essential, particularly in the area of labour migration where there is a lack of widespread comprehension of the idea.

ix. Describing, classifying, interpreting

Creswell (2007) asserts that the core of qualitative research is coding and categorization. The results were not standardised because this research is qualitative. However, as Saunders (2007) argued, the outcomes of this need to be categorized. The researcher had to describe, classify,

and interpret the data in light of the literature study and the advanced theories after classification and contextualization.

x. Matrices, trees and propositions

Data can be expressed in a variety of ways once it has been categorized. The various definitions and notions of HRH migration were presented in tables.

xi. Representing, visualising

After gathering the data, researchers can display it in tabular, text, or figure form, according to Creswell (2007). Different figures were utilized in this investigation. The data was also represented using narratives.

3.8.3 Validity and Reliability

Reproducible research findings are a sign of reliability, according to Bryan and Bell's 2007 analysis. If a respondent provided the same response when asked the same question by several interviewers on different occasions, that would be a sign of high reliability in a qualitative study. Reliability for a qualitative study largely concentrates on how well the study's design aspects represent the research investigation. The necessity for an exploratory study, which called for a thorough analysis of the HRH migration and the PGH human resources systems, arose from the commissioning of this study. The case study, which produced an in-depth examination of the issue under study, added to this. Each sub-group of responders was given the same set of created questions to increase reliability. For instance, specialized and non-specialist doctors and nurses each had their own standard questions, whereas medical and nurse supervisors had their own. Each relevant sub-group was regularly posed with these questions.

By posing the questions one at a time, respondent bias was reduced, further boosting reliability. Every research project, according to Bryan and Bell (2007), should make an effort to produce findings that ensure the validity of the study. Validity in qualitative research refers to the application of appropriate conceptual inquiries (Kabwe 2012).

Applying the construct validity notion could improve validity. According to Yin (2009), research must have passed the following two tests in order to pass the construct validity test:

i. Definitions of the primary phenomena should be given in terms of the concepts, and they should be connected to the goals.

ii. It is important to identify the operational measurements that correspond to the notions in academic literature and related publications.

3.8.4 Ethics and Values

i. Autonomy

By making sure that any permission to engage in the study is legitimate or informed, autonomy is safeguarded in research (Degu and Yigsaw, 2006). This means that explaining a specific respondent about your study is insufficient; knowledge and the respondent's ability to choose whether or not to participate are what matter most. The study's researcher ensured that there was no kind of coercion used to compel respondents to participate.

ii. Non-Maleficence

Degu and Yigsaw (2006) assert that a researcher shouldn't hurt or expose people to undue dangers for the sake of the study. If the subjects would not be competent in some way, such as the capacity to provide informed consent, this is very crucial. As a result, the researcher requested permission from the organization's administration to speak with the respondents.

iii. Veracity

Any study should always tell the truth to all participants. In order for the research to be considered an authentic academic study, the researcher made sure that the research topic was accepted by the HR department of the Great Zimbabwe University's School of Social Science.

iv. Privacy

Respondents offer themselves access when they sign up for a research study, but this access shouldn't be unrestricted. According to Degu and Yigsaw (2006), the phrase "access" is broad and typically refers to the ability to see, touch, or have knowledge about the respondents. Despite having been given authorization to conduct the research at PGH, the researcher made sure to limit his access to only papers pertaining to labour migration and to only ask questions related to the topic at hand.

v. Confidentiality

Despite allowing a researcher only limited access to themselves, respondents are not required to give up control of the data they provide (Degu and Yigsaw, 2006). No respondent's permission-acquired information may be shared with a third party without that respondent's permission. The researcher made sure that all the data was used strictly for scholarly purposes. This information must not be made public to the press.

3.9 Chapter Summary

The research approach guiding this study was the main topic of this chapter. The chapter offered information on the methodological framework of the study, the research design, the research methodology, the research strategy, the analytical unit, the research instrument, the pilot study, the data analysis procedure, the validity and reliability of the data, as well as the ethics and values of the study. What's more, the chapter made clear that the research in question is primarily qualitative; as a result, the chapter's discussion of data presentation and analysis is grounded in this kind of study.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

The presentation, analysis, and interpretation of data are covered in this chapter. Data was presented and analysed using thematic data analysis. Data was presented in themes and sub themes. Biographic data was presented in tables, charts, and graphs.

The response rate was very high since almost all the members of the targeted sample participated in the study. Interviews were held at the participants' workstations. The high response rate is attributed the flexibility in terms of time of interviewing participants. Participants were interviewed as and when it became convenient for them.

4.3 Socio-demographic Profile of Respondents

It is important in any inquiry to have an understanding of the background variables such as age sex, among other things are obtained. These variables are important in providing a full understanding of the situation at hand. As alluded to in section 3.4.3 the managers at PGH formed the major unit of analysis. To have a clearer picture of the results, the demographic profile was analysed. In explaining variations in responses relating to respondents' perceptions on migration of doctors and nurses at PGH, the following variables were deemed appropriate for analysis; gender profile, age profile and each employee's length of employment.

4.3.1 Gender Profile

Below is a table which depicts the gender profile of the respondents.

Table 1: Gender profile

Gender	Respondents
Female	67%
Male	33%

The gender profile, as shown in figure 4.3.1 above, highlights that the majority (67%), of the respondents were female while 33% are male. The results indicate that PGH is predominantly being managed by female managers. As a health institution where most of the professions are health professionals, the common myth that nursing is predominantly a female environment has found sense at this organisation.

4.3.2 Respondents' Age Profile

The table below highlights the age groups of the respondents.

Table 2: Age profile

Age group	Frequency	Percentage
18-30	4	13.33
31-40	12	40
41-50	8	26.66
51 and above	6	20

According to the data in table 4.2 above, the age group from 31 to 40 has the highest percentage of respondents (40%), out of all the age groups. The middle management is made up of this team. The age ranges of 31 to 40 and 41 to 50 together make about 60% of the population. Since experience is a major factor taken into account for promotion in the health sector, these individuals are typically at various management positions. 20% of responders were in the 51 and older age bracket. These individuals are the top management at HSC, MoHCC, and PGH and have been employed for a considerable amount of time.

Attrition level: Migration of health professionals has long been a problem, and it has now increased attrition from the public sector. According to the evidence gathered, the average annual attrition rate for health professionals was 5.2% as of December 2022. This rate was higher for nurses (6.6%) and dieticians (14.3%) but slightly lower for non-specialist doctors (4.7%). As a result of increased emigration, the overall number of health employees on the government payroll fell by 9.2%, from 50,100 in 2019 to 45,500 in 2021. Particularly among nurses, the desire to move had maintained over time, with 3.6% (or 1,079) of them actively requesting letters of good standing each year. The pattern had changed over time, closely mirroring times of economic difficulty and more recently amplified by pandemic triggers.

Table 3: MoHCC Staff Attrition selected Doctors and Nursing staff categories 2022

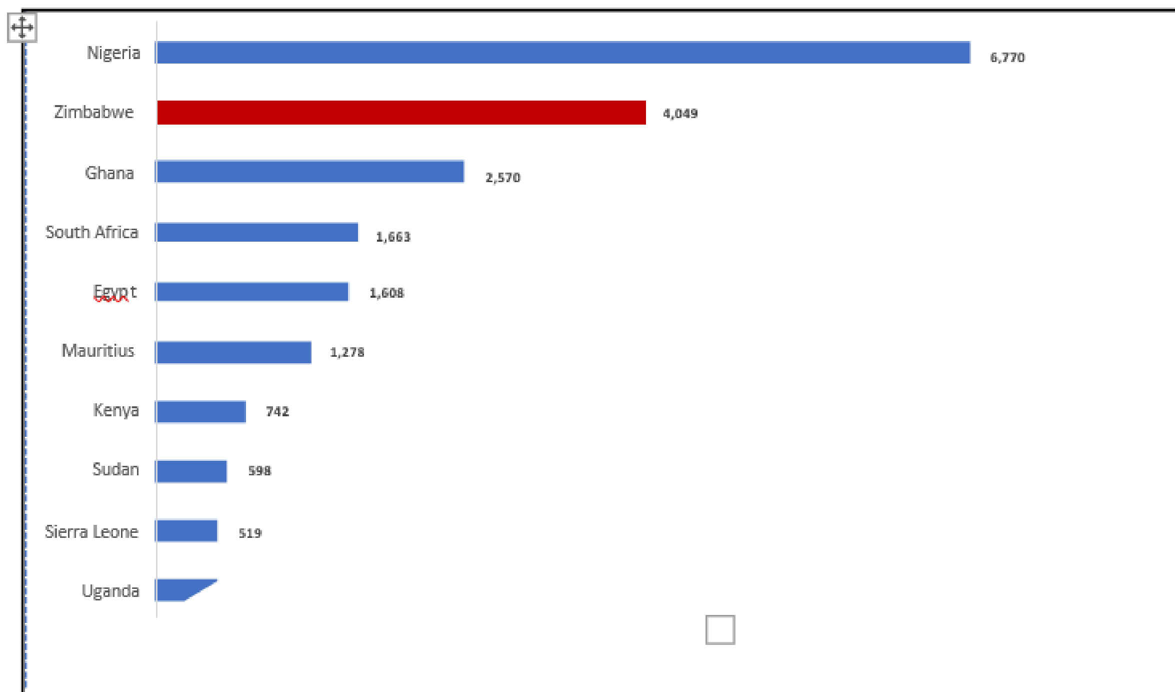
Staff Category	In post Jan 2022	In post December 2022	Appointments	Terminations	Vacancy
Nurse Anaesthetist	121	111	10	20	86
Intensive Care Nurse	68	60	9	17	226
Midwife	3040	2979	187	248	505
Opthalmalmic Nurse	144	142	12	14	74
Oncology Nurse	57	56	2	3	136

Renal Nurse	46	42	4	8	89
Paediatric Nurse	122	108	32	46	456
Theatre Nurse	243	243	7	7	174
Orthopaedic Nurse	52	50	12	14	102
Mental Health Nurse	374	343	14	45	187
Principal Tutor School of Nursing	11	10	1	2	1
Nurse Tutor/Senior/Principal	175	173	2	4	83
Government Medical Officer	319	312	28	35	90
Specialist Doctor	60	57	9	12	18
Grand Total	**4,832**	**4,686**	**329**	**475**	**2,227**

The above scenario resonates with the prevailing situation at PGH, wherein one respondent in charge of one training school indicated that from January 2018 to March 2023 in her respective department alone,10 Tutors and 4 Clinical Instructors left the hospital. This is the trend with most clinical departments at the hospital. It was reported that the institution is losing more staff members than it can replace. The overall replenishment rate is exceptionally low.

The research that is now available indicates that beginning in 2021, the outmigration of health professionals accelerated, with Ireland, the United States of America, Australia, and the United Kingdom being the most preferred destinations. As illustrated in figure 34, the English NHS had 4,049 Zimbabwean physicians, nurses, and clinical support workers in 2019 compared to 21,372 physicians and nurses in Zimbabwe's public health sector in 2020, the second-highest number from Africa. 20% of the doctors and nurses who received their training in Zimbabwe are employed by the English NHS. The pattern has been this for a long time.
According to figure 1 and Table 4, the findings corroborate the briefing given to the UK parliament.

Figure 1: Number of health workers in the English NHS from Africa, 2019



Source: UK Parliamentary Briefing Number 7783; https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7783

Table 4: Ranking of source countries for all health workers in UK NHS

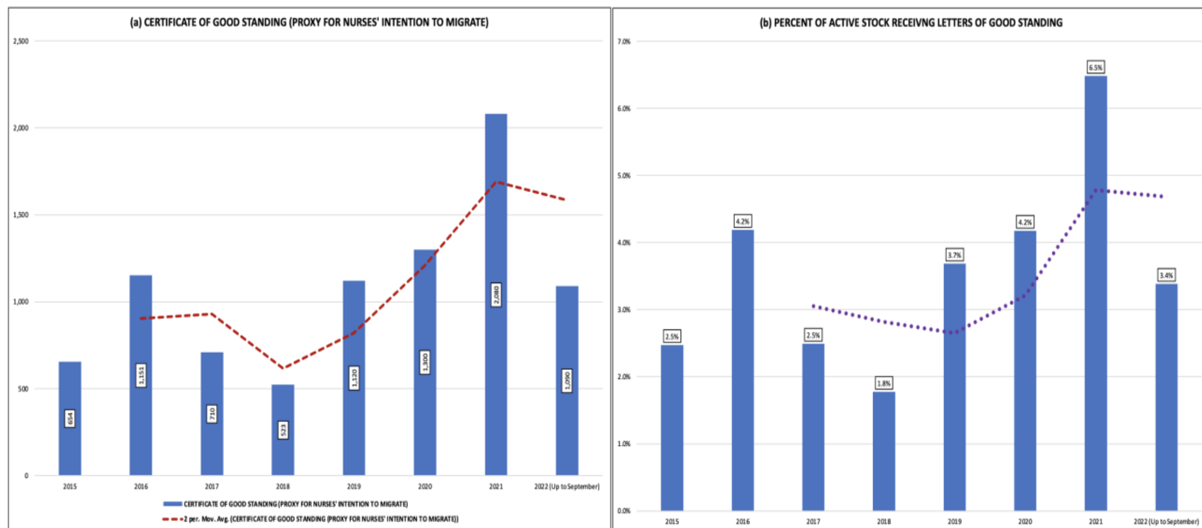
Rank	Country	All Health Workers in NHS	Position on the Global Contribution -All health workers
1	Nigeria	6770	6
2	Zimbabwe	4049	10
3	Ghana	2570	12
4	South Africa	1663	19
5	Egypt	1608	21
6	Mauritius	1278	26
7	Kenya	742	31
8	Sudan	598	37
9	Sierra Leone	519	39
10	Uganda	516	40

Data from the Health Service Commission revealed that 2,235 healthcare professionals, mostly nurses (1647) and doctors (188), could have left the country in 2021. By the middle of 2021, the attrition rate was higher than it had been for the entire period from 2017 to 2020.

4.4 Request for attestation of good standing from regulatory bodies as a proxy of intention to migrate:

The desire to relocate has remained constant over time, with 1079 (or 3.6%) of nurses actively obtaining letters of good standing each year. The pattern has followed economic downturns in the past, and it has recently intensified in response to pandemic triggers. However, as shown in figure 35, this had decreased from 6.5% in 2021 to 3.4% as of September 2022. This fall might be attributable to the administrative procedures that the government had put in place.

Figure 2: MoHCC trends in issuances of letters of good standing to nurses as a proxy for intention to migrate



MOHCC, Health Labour Market Analysis for Specialists Health Professionals in Zimbabwe (Harare: Ministry of Health and Child Care, Zimbabwe, 2021).

4.5 Intention to migrate

In order to determine the possibility that health professionals would leave the country soon, it was also sought after whether they intended to immigrate. According to the survey's findings, 68% of respondents are thinking about leaving the nation to find employment elsewhere. For the majority of these experts, the United Kingdom (29%) represents their most likely destination. However, a sizable portion of them like locations in Africa, primarily South Africa and Botswana. The respondents also mentioned Australia (5.6%), the United States (4.8%), New Zealand (2.2%), and Canada (2.2%) as other well-liked travel locations.

4.5.1 Push Factors

The survey's findings indicate that a push-pull combination of socioeconomic and political forces has been primarily responsible for the exodus of medical professionals from Zimbabwe. Low salaries in Zimbabwe (92% agreed), the country's general economic situation (90%

agreed), and unfavourable working conditions (84% agreed) were the main driving forces behind the majority of respondents leaving the country. Other push factors, listed in order of importance by the percentage of respondents who agreed, included political issues in Zimbabwe (68%), subpar working conditions that led to layoffs (84%), poor management, a lack of resources and tools for the job, work overload, role ambiguity, and inadequate workplace safety.

4.5.2 Pull Factors

Better pay abroad (92% agreed), better benefits (82%), better working conditions (75%) and better promotion chances for dependents (76%) were mirrored in the push factors for leaving. greater prospects for future growth (76%), as well as greater study opportunities for responders (61.5%), were other pull factors mentioned. Joining friends (20%) or family (25%) was a significantly less significant motivation for emigrating. The respondents listed the availability of academic possibilities for dependents as a key reason in their decision to depart, which is perhaps understandable given Zimbabwe's recent decline in educational standards. Good business governance and possibilities for career advancement are other draw factors.

Table 5: Pull and push factors for migrating among Zimbabwean health professionals

Push/Pull Factor	Agree	Indifferent	Disagree	Not applicable
general state of the economy	90%	5.5%	1.5%	3%
Availability of social services	65%	15%	10%	10%
Professional specialization is available.	70%	12%	10%	8%
Zimbabwean salaries are low	92%	2.5%	3.5	2%
Zimbabwe has poor working conditions.	84%	6%	6%	4%
Political motives	68%	13.5%	9.5%	9%
to pursue a degree	61.5%	17.5%	12.5%	8.5%
Self-advancement	75%	10%	6.5%	8.5%
Adopting a family	25%	15%	24.5%	35.5%
going to join friends abroad	20%	15%	30%	35%
better pay overseas	92%	4%	2.5%	1.5%
superior advantages abroad	82%	7.5%	6.5%	4%

better circumstances for work	75%	10%	10%	5%
Study possibilities	76%	6%	6.5%	11.5%

4.6 Chapter Summary

The information gathered through interviews, questionnaires, and document analysis was presented and examined in this chapter. This was done in light of the chapter two literature review, as well as the research objectives and questions. The questionnaire response rate, sociodemographic information about the respondents, and data presentation based on the themes being studied were all specifically handled in this chapter. It also covered the difficulties management at PGH faced in trying to control HRH metrics and keep key HRH to keep delivering high-quality services at PGH.

CHAPTER 5

DISCUSSION OF FINDINGS

5.1 Nature and magnitude of Migration of Skilled Health Personnel

All four staff categories—medical and nursing supervisors, specialized physicians and nurses, non-specialist physicians and nurses, and nursing tutors—that were surveyed for this study are still leaving Zimbabwe. Nevertheless, since mid-2022, there has been a general decline in out-migration. The number of nurses and doctors leaving Zimbabwe between 2018 and 2022 increased significantly, largely going to the UK. The results are in line with Doylo's observation from 2022 that the health industry in the global south is migrating to the global north due to a number of variables. Health professionals with more than five years of work experience are thought to emigrate at a rate of 67%. For nurses and doctors, information about staffing patterns was acquired at the national level, however some information was lacking or incomplete. This was caused by the recent introduction of computerization at the majority of the nation's healthcare facilities. Despite these flaws, the respective councils (the Medical and Dental Practitioners Council of Zimbabwe and the Nurses Council of Zimbabwe) were able to provide substantial information on the registered medical and dental professionals in the nation.

Some of the experienced medical staff members mentioned above are leaving the hospital for better opportunities. Although other staff categories are also somewhat impacted, this is primarily the case for employees with specialized abilities in the nursing and medical staff categories. The above scenario confirms the literature presented in chapter 2 that Zimbabwe is losing the critical and experienced nurses and doctors especially in the public health sector at the detriment of health service delivery in Zimbabwean public institutions, including PGH as confirmed by (Adepoju, 2010:16).

5.2 Migration Intentions and Causes of Migration

The literature has well-documented and debated the factors that influence skilled health worker migration in general, frequently employing the oversimplified but descriptively intuitive "push"/"pull" dichotomy. Push factors for the Zimbabwean health workforce include low pay, unfavourable living and working circumstances, a lack of opportunity for professional advancement, a high prevalence of HIV and MDR-TB, a high cost of living, and economic and employment insecurity. Pull factors, which encourage inward migration to nations with greater incomes, often include the availability of jobs, higher pay, better living and working

circumstances, chances for career advancement, and the assurance of safety and security for the family. Both "push" and "pull" factors can function in conjunction with active recruitment by destination countries.

Although the extent of this intention contrasts sharply with the remarks made by several of the key informants on the substantial decline in health workforce migration, a declared intention to move does not guarantee that a health worker will ultimately leave. Concerns about the workplace are gradually giving way to bigger political and economic ones. Less than 5% of respondents said they were content with their family's or personal safety or the future of their children. Almost no respondents were satisfied with the nation's high levels of poverty and inequality.

The low levels of satisfaction with important government action measures were startling, even when taking into account the fact that it is simpler to criticize government policies than to commend them. Across all professions, there is a common concern about economic policies and corruption, which may be a factor in migration. Additionally, there was a clear evidence of workplace pressure points for nurse migration. The majority of respondents voiced complaints about their working conditions, including their accommodations, tools, resources, and management. Of course, money is a factor, but it shouldn't be the top priority for members; if they don't enjoy what they do, why would they get out of bed in the morning?

The study found that economic factors dominated the main causes of migrant intentions. Most professionals would like to emigrate in order to earn better salary in their new country of residence, or they would like to save money rapidly in order to purchase a car or pay off a mortgage. Still others want to leave Zimbabwe for better living conditions because the country's healthcare system is underfunded and lacking in facilities, they don't see a future there, or the quality of the healthcare there is deteriorating. Health professionals claimed that the public sector didn't pay them competitive wages and that it was difficult for them to make ends meet. The medical professionals agreed that they had to work two or more jobs to make ends meet even though their salaries were paid on time. According to the data acquired, the majority of respondents would prefer to remain in the public sector if they were given better pay; nonetheless, a sizeable percentage were considering leaving for the private sector, which pays more. In addition to the aforementioned benefits, the private sector provides superior fringe benefits to the public sector.

The majority of highly trained health professionals have immigrated in quest of better pay and living conditions, according to interviews with the respondents. Others, however, were escaping the nation's political and social climate, believed their children had no future, and were dissatisfied with the lack of resources and facilities there. Others, like Dovlo and El-Khawas, had noticed a general degradation in the nation's health care services, and some people had left the country as a result (Dovlo, 2003; El-Khawas, 2004).

The study also showed that there are a number of push and pull variables related to the exodus of medical professionals from Zimbabwe. Poor pay, unpleasant working circumstances, a lack of necessary equipment of the profession, and the availability of opportunities to advance their talents and deepen their specialization are just a few of the push and pull issues. Medical "brain drain" from Zimbabwe is unlikely to decline significantly in the short- or medium-term as uncertainty grows regarding new policies, the economic and political situation in the country, and its potential impact on health service delivery, even though the "pull" factors may have moderated somewhat due to fiscal austerity in "destination" countries. The findings are in sync with preceding studies (Philippines Briefing case study, 2020) which showed that despite efforts by the government to retain health professionals, out migration of HRH continues though at varying levels.

Nurse migration from Zimbabwe is also said to be on the decline, which is partly attributable to a halt in hiring from the UK since new immigration regulations only permitted foreign nurses to work permits if companies could show that staffing from Britain and other EU nations was unavailable. Further still, the top management at the national level confirmed the reduction and linked it to two potential causes, including Zimbabwe's inclusion on the updated WHO Safeguard List and the amended health-specific allowances, which are fixed in US dollars but payable in ZW RTGS.

5.3 Negative Effects of Migration of doctors and nurses

According to the report, there are a number of consequences of doctors and nurses moving to Zimbabwe to work in the country's expanding health facilities. The quality of healthcare provided in the medical institutions has been negatively impacted by the country's exodus of trained medical professionals. Senior physicians and nurses who answered to the poll noted deteriorating care standards, including "uncaring and abusive" behaviors toward patients. Low morale brought on by an excessive workload and the stress of caring for so many terminal patients was largely to blame for this. However, claims that some patient groups were being turned away from hospitals because they lacked particular medical services raised serious

concerns. This clearly affects how equally the poorest people have access to care, thus further research is required before corrective action can be taken. The results are in line with a 2010 paper by the International Organization of Migration on migration, which emphasized the detrimental consequences of important HRH leaving Zimbabwe on the standard of healthcare provided by public health institutions.

The quality of care given has significantly changed as a result of the fall in the number of qualified health professionals working in the public sector. For instance, the respondents claimed that it has resulted in understaffing in crucial departments at PGH, which causes patients to wait longer for medical attention. Some patients pass away from a disease that is otherwise treatable. The loss of experienced staff has caused a decline in care quality and a virtual collapse of the nation's health system, with PGH suffering the most as a result of the nature of its services, which call for critical care and tertiary care. The lack of skilled labour has had the greatest impact on the population's marginalized and underprivileged segments. Additionally, the nurse-to-patient ratio has fallen even lower, necessitating the use of cadres with less professional training to care for patients. As a result, the standard of care provided has been impaired. The situation at PGH has worsened to the point that there are no mentors to assist the new cadres joining the hospital. This results in the promotion of apprentices into senior positions even though they are ill-prepared to serve as managers. Poor nursing and medical care are the outcome.

According to HSC and MoHCC senior officials, the excessive brain drain influenced HRH Planning and other related HR metrics which included recruitment and selection, training and development, discipline and grievance matters, performance management, retention, and migration policies. For example, it was highlighted that the organisation has incurred high recruitment costs due to repeated efforts to replace certain cadres. The country has become a training ground and those that graduate with health-related programmes especially nurses and doctors who are supported by the Ministry to undertake various programmes are leaving the system, PGH in particular. As a result, the health system is failing to gain return on training investment. There has been a noticeable surge in disciplinary issues and grievances at PGH attributed mainly to significant attrition levels which have resulted in disgruntlements amongst the remaining health workforce.

Further to the above, the respondents derived from the hospital cited that, despite local efforts to retain the cadres, it was deemed not sufficient to retain the critical cadres especially specialist nurses and doctors. Evidence gathered through the termination register at the institution

indicated that the hospital is processing terminations on regular basis thereby hindering effective HRH decision making and wasting time that could have been invested in more productive functions.

5.4 Positive Effects of Migration

The new skills that the emigrants bring back when they return are one of the benefits that the respondents at the national level cited for the movement of the health workforce out of Zimbabwe generally. One benefit of individuals that travel is that they continue to study cutting-edge trends and methods, making them more adept when they return than they were before they left. Another part of exposure is learning new, possibly superior ways of doing things and perhaps being exposed to various forms of technology.

The other main benefit, remittances, is asserted by some HRH managers at the national level to counteract any negative effects of health workforce relocation. Zimbabwe is anticipated to be the fifth-largest recipient in Sub-Saharan Africa in 2022, receiving about US$2 billion in remittances from the diaspora. However, remittances only help individuals, families, and households; they have no direct impact on the public health or the educational system (apart from any taxes that may be imposed on them). Instead, they are frequently used to purchase needs. The lack of a concrete benefit to the hospital from the remittances received was bemoaned by the respondents. They suggested that there should be systems in place so that investments would directly benefit training institutions and the hospital as a whole.

"Yah you know, somebody would say for instance 'I've started improving my home' so she is remaining there (outside of Zimbabwe) so she can finish the project," one key informant said. The scope and purpose of the migration of the Zimbabwean health workforce to Remit are essentially conjectural. The respondents disclosed their intention to remit after immigrating as well as the expected percentage of their foreign earnings that they would send back home. Although many respondents were undecided whether they would move or whether they would remit, the results show that significantly more of those with a more certain purpose to migrate were planned to remit. However, it seems that there isn't much evidence to back up the claim that remittances make up for lost knowledge, expertise, or training expenditures. According to the Zimbabwe Health Labour Market examination (2021), the suggested cost of emigrating nurses alone to Zimbabwe has been assessed at $1.41 billion based on an examination of lost return on investment.

5.5 Impact of Health Worker Migration on Health Service Delivery

The impact of HRH migration is viewed as generally detrimental, notwithstanding some good impacts. Lack of personnel is a major concern. As a result of bad management of a public health system with inadequate funding, shortages of specialized doctors increased from 30% in 2018 to 55% in 2022, while those of nurses were 35% and 45%, respectively. The majority of medical graduates specialize, go into the private sector, or leave the country, notwithstanding a slight increase in the number of health professionals trained in the nation who choose to work in the public sector. This is taking place despite predictions that the doctor-to-patient ratio will fall between 2018 and 2021.

Insufficient workforce to meet demand for care results in "burnout" and significant employee turnover. According to the study, 80% of respondents agreed that many doctors and nurses were considering quitting the hospital due to the intense workload. According to the existing literature, dealing with crisis circumstances, making important judgments on the spot, and working overtime produced more job stress among Zimbabwean doctors than physicians in Europe or the USA. Although conditions for doctors and nurses at PGH have improved in several ways, personnel shortages and burnout still exist: I'm an intensive care nurse myself, and I've had to work a 48-hour shift before due to shortages, one reply joked.

Among the sampled responses, a representative of a nursing group noted that those who persisted worked even harder and with more patients. "And you have to consider whether locals would consider me unqualified to travel abroad? That sort of stuff that affected the nurses' interest and morale. Some nurses, I know, were unable to travel and quit their jobs altogether. That was the severity back then. Migration abroad makes these internal problems worse. Some professions are particularly affected, as the head of a midwifery school lamented: "It's a loss for us. We probably wouldn't have the scarcity if we had all the pharmacists who had left the nation. At one point, we lost 1200 people annually.

Even while there is evidence of return migration, there are far fewer health professionals than are required and this is at least in part due to the effects of migration. There are shortages in the private sector as well. Another sign that active recruitment is still occurring is the HSC executive's complaint that "it is unacceptable, but still they poach our paediatricians and take them abroad."

Institutions of higher education at MoHCC are also impacted by the migration of the health workforce. One reply emphasized that the implications are horrendous because, for instance,

there are currently only three of us in our department who are certified tutors, and we must manage a sizable number of post-basic pupils. Key informants were now more concerned with the domestic management of health professionals than with out-migration per se, which they have almost given up, despite ongoing pushes and pulls for HRH migration. As a result of the health professionals' observations that the number of emigrants is dropping and that migration cannot be completely stopped, migration is no longer considered as the main issue facing the nation's health system.

While there is little evidence that this viewpoint is deterring specific professionals from leaving the country, over 90% of doctors, nurses, and all management at HSC and MoHCC in the survey sample believed that out-migration would have a somewhat or extremely negative impact on the country's health system. The hospital is losing experienced staff that was taught at a low cost, with the majority of the training costs being covered by the government, as a result of migration, which cannot be translated into any substantial benefits. resulting in a lack of vital human resources for health in the nation. The system that trained and supported the cadres is not getting its money's worth.

5.6 Return migration

The survey raised questions about return migration. A handful of the respondents who have been named were practicing abroad but have since come home. Some survey participants disclosed interactions with return migrants, indicating that the exodus of health workers from PGH was starting to mirror the "circular migration" that has been extensively explored in the literature. The professional categories varied greatly, with specialists and generalist doctors being more likely to be returnees. The majority of doctors and nurses, according to the replies, were coming home from their jobs in the UK.

Family ties, lifestyle, culture, and social life were regarded as the top motivators for return migration, whilst the expense of living and harsh weather were the main "pushes" away from their target nations. Doctors are using the opportunity to go abroad for a few years to make some money, as one head of medicine observed, not with the intention of relocating permanently but rather to get experience, make some money, and then return to establish a practice here. However, nurses who have relocated from abroad are now working in the public sector, specifically in search of re-employment at PGH.

Even though the size of return migration does seem to be a fresh discovery of this study, the evidence for its durability is more deceptive.

5.7 Policy Response

To lessen the detrimental effects of health workforce migration, a number of international, bilateral, and domestic solutions have been attempted. The most promising attempts to lessen health worker migration and the resulting shortages of health professionals are those carried out within Zimbabwe itself by enhancing the living and working conditions of health workers and the human resources for the health system. Increased recruitment of nurses and doctors is just one example of attempts to boost training of the health workforce. Great Zimbabwe University created new medical schools, and University of Zimbabwe, National University of Science and Technology, and Midlands State University all boosted their enrolments.

To help with staffing shortages, the government has hired foreign medical personnel, particularly specialized doctors. There are bilateral agreements between the governments of Zimbabwe and the DRC and Cuba, and as of 2010, 117 Cuban physicians were licensed to practice in Zimbabwe. While some key informants noted that the presence of such foreign healthcare professionals reduced staffing shortages and raised the standard of treatment, others observed that teamwork was hampered by language difficulties and that the respite was only temporary because the employees were on short-term contracts. During the survey, this contention was supported.

In order to guarantee the retention of qualified health professionals in the public sector, the Zimbabwean government also implemented a number of policies and programs. These policies, according to the key informants, include of giving out housing and a transportation allowance, having a performance management system, salary evaluations, fellowship programs, advanced training programs, and bonding newly graduated employees. After realizing that the exodus of health professionals was jeopardizing the delivery of services, several efforts were taken to retain trained health workers. Fellowship programs and advanced training programs are intended to increase the ability of health professionals to provide their services and to lessen the movement of health professionals for the purpose of pursuing higher education.

To keep up with the cost of living in a hyperinflationary climate, salary reviews were implemented. Due to a staffing crisis, call allowances were implemented to enable professionals to work beyond hours. Rural areas currently have better call allowances than urban locations. Members of the health team, whose extra hours go beyond their regular

working hours, are hostile toward the government's stance that call allowances should not exceed the pay of the health professionals.

The aforementioned actions produced a range of outcomes. For instance, bonding has been beneficial in keeping employees on board, and wage restructuring has helped to stem the exodus of personnel from the public health sector. Call allowances have also aided in staff retention, but recently there have been many complaints about them, leading to a strike by healthcare workers. Therefore, it might be argued that if the fundamental issue of low pay continues unaddressed, strategies aimed at retaining staff may not produce the desired effects. Zimbabwe has recently been included to the WHO Health Workforce help and Safeguards List 2023, which suggests that countries with the greatest need for health workforce resources in relation to universal health coverage should be recognized and given help and safety measures. This is yet another strategy to reduce excessive migration.

To lessen the growing outmigration, training for less-skilled workers—such as community health workers—was also being tested. The hospital also commended the government for bringing back primary care nurse training as a stopgap solution to lessen the effects of nurses leaving the country.

However, the management-level responders claimed that they had not taken any deliberate steps to try and keep medical workers at the institutional level. They think that the only entity that can effectively work to retain qualified medical personnel is the government. They bemoaned the lack of communication between them and the government, which prevented them from participating actively in the institution's development and execution of HRH retention initiatives.

5.7 Chapter Summary

The results of this investigation were covered in this chapter. During the discussion, it was discovered that the research is consistent with extant literature. This research has been able to contribute to debates about how some of the factors interact in the literature by taking a viewpoint on HRH migration as it pertains to the Zimbabwean Public Health sector. Despite these differences, the investigation found that its conclusions and a few chosen theories about the subject under study often agreed.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

With a focus on the Parirenyatwa Group of Hospitals, the objective of this research study was to identify and assess the effects of the health workforce in the nursing and medical staff categories on the provision of healthcare services. The researcher discussed the study's findings in the previous chapter, and that discussion supported the theoretical viewpoint that, even though labor outmigration might not be stopped, it must be reduced to manageable levels because the consequences of excessive outmigration are disastrous for the provision of high-quality health services. Therefore, the research indicated a favorable correlation between the provision of health services and labor outmigration. The researcher draws a conclusion about the research findings in this chapter and makes some suggestions and tactical maneuvers based on the intended use and major discoveries of the study.

6.1 Research Summary

An empirical study that was driven by a grounded theory and a qualitative approach was done in order to accomplish the goal of this research. In keeping with this objective, the researcher summarizes the research investigation and the research findings in this final chapter. By outlining research objectives and providing background information on the research subject, chapter one established the general direction of the entire study. In Chapter 2, a study of the literature revealed that while general studies were carried out in Zimbabwe at the national level, non-in-depth research was conducted at the institutional level that targeted certain cadres in this wide research issue. But these connected studies served as a baseline for the research's conclusions and served as a source of information for creating contemporary literature. The study technique was laid out in Chapter 3 to direct the collection of data. Following that, Chapter 4 revealed the research study's findings, and Chapter 5 provided a discussion and interpretation of those findings.

The research study's conclusions are summarized, as well as its debates. Due to the nature and extent of outmigration, cadres with specialized skills—primarily those with experience and essential roles in the health workforce—migrate most frequently. The Covid 19 outbreak, which has increased job prospects for health workers, particularly in wealthy nations, but at the expense of underdeveloped countries that are losing such essential services, has worsened the outmigration. The aforementioned circumstance supports the research that was done on the Philippines health system case study, which was compared to the situation in Zimbabwe.

According to the study, the majority of medical professionals moved primarily for socioeconomic and political reasons, for personal progress, to improve their education, and to find better employment possibilities and educational opportunities for dependents. Additionally, a sizable percentage of health professionals have succeeded in their goal of emigrating because they are now better paid, have taken on more senior roles, and have received specialized training after leaving Zimbabwe. Although pull forces also draw a portion of the health workforce, particularly doctors, whose primary motivation is to learn and save money for investments back home, push factors are still largely to blame for migration.

The research established that, in line with the existing literature, outmigration of health workforce negatively affects the country's ability to offer quality health service rendering the health system dysfunctional. This further confirms the assertion that human resources are the most important resource to any organisation, especially critical HRH such as doctors and nurses with direct contact with patients. The volatile movement of HRH also affects the management of HRH metrics which include recruitment and selection and training and development.

The research findings largely reinforce the known global evidence that investing in the health workforce provides a significant return on investment. The argument is that though there is positive impact derived from organised labour migration gained through remittances and skill transfer, such benefits are far below the cost of investing in human capital and losing such critical cadres without return on investment. The major impact is on poor health service delivery experienced by the sending countries at the benefit of the receiving countries.

Return migration also became a brand-new phenomena. Although the size of return migration does seem to be a novel discovery of this study, the evidence for its durability is more deceptive. This is especially obvious with doctors who move overseas not with the intention of residing there permanently but rather to learn about contemporary practices, get experience, and save money in order to open a private practice at home. Other staff types, on the other hand, return primarily for personal reasons and join the public health industry.
The research could help government to understand that addressing labour outmigration requires evidence-based decision making. Policy responses must address the identified cause of migration. It is clear from the study that low remuneration was the major cause of outmigration and when the government introduced USD indexed health specific allowances, the attrition levels declined. It can therefore be concluded that there is a positive relationship between the cause and policy response on migration.

6.2. CONCLUSION

It is urgent to address the exodus of qualified health professionals from the nation since the situation has become grave. To address the complaints of health professionals, there must be political will. One of the government's top priorities should be to stop the exodus of talent from public health institutions now taking place. Because it guarantees the availability of a healthy workforce, it is important to recognize that a strong health sector is a necessity for economic growth and sustainable development. The study demonstrates the necessity of adopting and putting into practice an integrated retention policy that will keep qualified health professionals in the nation for the benefit of the Zimbabwean people.

6.3 RECOMMENDATIONS

In this section, the researcher summarises recommendations and incorporates further thoughts based on the findings of the empirical study.

In order to mitigate outmigration and retain doctors and nurses within Zimbabwe, the researcher recommends the following:

6.3.1 The government of Zimbabwe should think about establishing bilateral agreements with the leaders of the nations that employ the majority of Zimbabwean health professionals, particularly the governments of the UK and Australia, which employ specialized Zimbabwean health specialists. The agreements might enable planned tax transfers, bilateral funding to Zimbabwe, support for training from the hosting nations, and perhaps even the temporary repatriation of medical personnel to provide essential healthcare.

6.3.2 Gradually review salaries to transfer identified wage levels.
6.3.3 Targeting Health Workers with High Attrition Rates and Expanding HRH Retention Plan to Prioritize Such Cadres and Include Them on Special Category Under HRH Retention Plan to Reduce Outmigration of Critical Health Workforce. The compensation should be commensurate with how important these cadres are.

6.3.4 The Ministry should think about revising the framework for bonding agreements in order to build ethical, evidence-based policies on the migration of health personnel. It may be expanded to include these cadres because it was tested with a small number of them and was successful in reducing the issue of outmigration.

6.3.5 Establish and strengthen a cross-ministerial committee on labor migration to address issues of policy coherence between the relevant government departments, agencies, and ministries.

6.3.6 Offering scholarships and offering an incentive once credentials have been attained to help nurses and doctors who want to increase their educational credentials and professional skills.

6.4 Recommended Areas for Further Research

The researcher suggests topics that might require additional research based on both the literature review and the empirical research.

6.4.1 In order to determine whether the models and theories developed in this study are transferable and can be extended to cover other migrant professionals, it is necessary to replicate this research with other migrant Zimbabwean health professionals, for instance other clinical health professionals migrating abroad.

6.4.2 A study of the best service conditions for retaining health professionals in Zimbabwe. In this study, it became clear that the low pay and unfavourable working circumstances were the main reasons why migrant doctors and nurses were leaving their countries.

6.4.3 An empirical investigation of how regional nations might work together and effectively use the health staff they have at their disposal to alleviate shortages in their own countries.
6.4.4 a survey of foreign-based Zimbabwean nurses and medical professionals. If cooperation could be created between the migrant health workers, the MoHCC, and the HSC, this may provide an audit of the skills that are already available.

6.5 Chapter Summary

In this closing chapter, the researcher considered the conclusions of this study largely in relation to the objectives of this research. Recommendations were also proffered in this chapter, and these related to the need to mitigate health workforce outmigration and suggested areas of further research based on the available literature and the research findings.

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APPENDIX 1: INTERVIEW QUESTIONS (HSC & MOHCC)

Interview guide for professional informants in the health system – HSC & MOHCC

TOPIC: An evaluation of the effect of labour out-migration on public health service delivery. A focus on Doctors and Nurses at Parirenyatwa Group of Hospitals in Zimbabwe.

<u>INTERVIEW QUESTIONS FOR ACADEMIC RESEARCH</u>

Target Group: Management at Health Service Commission and Ministry of Health and Child Care

The interview guide below is part of the Master of Science in Human Resources Management at Great Zimbabwe University. A study that seeks to evaluate the effect of labour out-migration on public health service delivery.

<u>Contact Details</u>

Edward Muposha

263781 602 726/ 263776 627 444

<u>IMPORTANT DEFINITION</u>

Labour migration: is the movement of persons with the aim of employment or income-generating activities (e.g. entrepreneurship) (Sensenig-Dabbous, 2011)

INVITATION TO PARTICIPATE IN AN ACADEMIC RESEARCH STUDY

Dear Respondent

You are invited to take part in a research study that forms part of research conducted for a Master of Science in Human Resources Management at Great Zimbabwe University. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or the supervisor any questions about any part of this study that you do not fully understand. It is particularly important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is entirely voluntary, and you are free to say no to participate. You are also free to withdraw from the study at any point, even if you do agree to take part now.

The purpose of this study is to establish, understand and evaluate the effect of labour out migration on health workforce management and ultimately health service delivery. Please take note that the risks to you in this study are minimal and is mostly concerned with the inconvenience of time, but this will be limited by giving you the choice of the day that you would like to take part in the study. The information from all respondents will always be treated as confidential and will not be made available to any entity or third party. Neither your name nor that of your organisation will be linked to any responses as the responses will be captured anonymously.

The information obtained from the interview guide will be used for academic research purposes only. Only the researcher and the supervisor will be able to look at your findings. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data, it will be password protected. Although you will not receive any compensation for participating, the information collected in this study may benefit your sector by providing a framework that would minimise employee attrition and improve retention of HRH for improved health service delivery.

If you have any questions or concerns about being participants in this study, please use contact details provided above. Thank you for taking time to assist me in my educational endeavours.

Declaration by participant

By signing below, I ……………… agree to take part in the research and declare that:

- I have read the above information/ it was explained to me in a language with which I am fluent and comfortable.
- The research was clearly explained to me
- I understand that taking part in this study is voluntary and I have not been pressured to take part
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.

Signed at (place)………………………………..on (date)……………………20…………

Signature of participant…………………………………………

Declaration by the researcher

I, Edward Muposha declare that:

- I fully explained the purpose of the study and I am satisfied that the participant will adequately understand all aspects of the research, as described above.

Signature of researcher………………………………………………..

Thank you for your cooperation and your time.

INTERVIEW QUESTIONS FOR ACADEMIC RESEARCH

Target Group: Management at Health Service Commission and Ministry of Health and Child Care

TOPIC:

An evaluation of the effect of labour out-migration on public health service delivery. A focus on Doctors and Nurses at Parirenyatwa Group of Hospitals in Zimbabwe.

SECTION 1: ORGANISATIONAL INFORMATION

Name of Organisation: ______________________________________

Sector ____

Contact Details: ____

SECTION 2: INTERWIEW QUESTIONS

2.1 Nature and magnitude of health workforce migration in Zimbabwe

What is the vision and direction of health system policies and governance in relation to out migration of health workforce?

What are the scale and characteristics of health professional mobility in Zimbabwe?

As a government, have you commissioned a research/study on labour migration in Zimbabwe, directly or through third parties?

What were the major highlights from the studies, and to what extent were the findings incorporated into Ministry policies and practices?

2.2 Causes of out migration of medical professionals from public health institutions

What are the motivations of health workforce migration?

2.3 Effect of medical professionals out migration on HRH management

What are the effects of labour outmigration on related policy decision, e.g. on salaries and wage expectations?

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What can be done to retain skilled health personnel, or to mitigate the effects of migration?

What policies or strategies have been successfully, or not successfully applied?

What are the reasons and determinants of successful application of policies and strategies?

What would be the consequence of restrictions if employment of Zimbabwean migrants were suddenly constrained, e.g. the inclusion of Zimbabwe on the WHO Safeguard List?

2.4 Impact of out migration on health service delivery in health institutions

What are the resulting impacts of HRH migration on health system performance?

What is the policy relevance of those impacts?

What are some of the economic consequences of migration?

2.5 Recommendations and possible strategies for adoption by Government

What are the policy options to address health professional out migration?

What are the roles of governments, donors, partners and the communities in addressing the situation?

What mechanisms are being implemented to monitor labour migration and to what extent are they effective?

APPENDIX 2: INTERVIEW QUESTIONS (PGH)

Interview guide for professional informants at Parirenyatwa Group of Hospitals

TOPIC: An evaluation of the effect of labour out-migration on public health service delivery. A focus on Doctors and Nurses at Parirenyatwa Group of Hospitals in Zimbabwe.

INTERVIEW QUESTIONS FOR ACADEMIC RESEARCH

Target Group: Doctors and Nurses including Management at Parirenyatwa Group of Hospitals

The interview guide below is part of the Master of Science in Human Resources Management at Great Zimbabwe University. A study that seeks to evaluate the effect of labour out-migration on public health service delivery.

Contact Details

Edward Muposha

263781 602 726/ 263776 627 444

IMPORTANT DEFINITION

Labour migration: is the movement of persons with the aim of employment or income-generating activities (e.g. entrepreneurship) (Sensenig-Dabbous, 2011)

INVITATION TO PARTICIPATE IN AN ACADEMIC RESEARCH STUDY

Dear Respondent

You are invited to take part in a research study that forms part of research conducted for a Master of Science in Human Resources Management at Great Zimbabwe University. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or the supervisor any questions about any part of this study that you do not fully understand. It is particularly important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is entirely voluntary, and you are free to say no to participate. You are also free to withdraw from the study at any point, even if you do agree to take part now.

The purpose of this study is to establish, understand and evaluate the effect of labour out migration on health workforce management and ultimately health service delivery. Please take note that the risks to you in this study are minimal and is mostly concerned with the inconvenience of time, but this will be limited by giving you the choice of the day that you would like to take part in the study. The information from all respondents will always be treated as confidential and will not be made available to any entity or third party. Neither your name nor that of your organisation will be linked to any responses as the responses will be captured anonymously.

The information obtained from the interview guide will be used for academic research purposes only. Only the researcher and the supervisor will be able to look at your findings. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data, it will be password protected. Although you will not receive any compensation for participating, the information collected in this study may benefit your sector by providing a framework that would minimise employee attrition and improve retention of HRH for improved health service delivery.

If you have any questions or concerns about being participants in this study, please use contact details provided above. Thank you for taking time to assist me in my educational endeavours.

Declaration by participant

By signing below, I ……………… agree to take part in the research and declare that:

- I have read the above information/ it was explained to me in a language with which I am fluent and comfortable.
- The research was clearly explained to me
- I understand that taking part in this study is voluntary and I have not been pressured to take part
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.

Signed at (place)………………………………..on (date)……………………20…………

Signature of participant…………………………………………

Declaration by the researcher

I, Edward Muposha declare that:

- I fully explained the purpose of the study and I am satisfied that the participant will adequately understand all aspects of the research, as described above.

Signature of researcher………………………………………………..

Thank you for your cooperation and your time.

INTERVIEW QUESTIONS FOR ACADEMIC RESEARCH

Target Group: Doctors and Nurses including Management at Parirenyatwa Group of Hospitals

TOPIC:

An evaluation of the effect of labour out-migration on public health service delivery. A focus on Doctors and Nurses at Parirenyatwa Group of Hospitals in Zimbabwe.

SECTION 1: ORGANISATIONAL INFORMATION

Name of Organisation: ______________________________________

Sector ____

Contact Details: _____________________________________

SECTION 2: INTERWIEW QUESTIONS

2.1 Nature and magnitude of health workforce migration in Zimbabwe

What is the present picture of and recent historical trends in the migration of highly skilled health personnel from the institution?

Which staff categories are leaving the hospital?

How do you confirm that workers who have left the institution are migrating or not?

How many doctors and nurses have left the institution from January 2018 to March 2023?

2.2 Causes of out migration of medical professionals from public health institutions

What reasons do they give as pull or push factors for leaving?

2.3 Effect of medical professionals out migration on HRH management

What are the effects on other health professionals and on newcomers into the professions when their colleagues migrate?

What immediate measures are implemented to offset the effects of attrition?

What is the role of the institution in mitigating out migration and what internal mechanisms have you implemented as a hospital to retain your critical health workforce?

How effective were such interventions in addressing brain drain at institutional level?

2.4 Impact of out migration on health service delivery in health institutions

What are the most critical consequences of the emigration of highly skilled health workers that should be examined?

How could these consequences be measured to optimize the potential for comparative policy analyses?

Are there any positive impact or contribution from the migration of Zimbabwean medical professionals to other countries?

Can you give your factual position on the cost/benefit analysis of labour outmigration?

What can you suggest as possible strategies to help the country to derive benefit from HRH outmigration?

2.5 Recommendations and possible strategies for adoption by Government

What is the range of responses that have been considered, proposed, and implemented to address these critical causes and consequences of out migration of doctors and nurses?

What have been some of the outcomes of these responses?

Do we have return migrants who have re-joined the hospital and which staff categories?

What were their reasons for returning and re-joining the Ministry?

What is the status of the current data generation methods on labour outflows and how do you propose to improve?

Can you propose policy recommendations to mitigate HRH outmigration and enhance the positive impact of migration of health professionals in the country?

APPENDIX 3: APPROVAL TO CARRY OUT STUDY

HSB Offices,
Parirenyatwa Hospital Complex
Harare
Telephone: +263 4 759970-4
E-mail:infor1@hsb.co.zw,

Ref:
Health Service Board,
Private Bag A6104,
Avondale,
Harare,

ALL CORRESPONDENCE SHOULD BE ADDRESSED TO THE SECRETARY

03 April 2023

The A/Chief Medical Officer
Parirenyatwa Group of Hospitals

APPLICATION TO UNDERTAKE RESEARCH PROJECT: MUPOSHA EDWARD: HEALTH SERVICE COMMISSION

It is noted that Mr Muposha is seeking the Health Service Commission's approval to undertake a research project titled **"An evaluation of the effect of labour out-migration on public health service delivery. A focus on Doctors and Nurses at Parirenyatwa Group of Hospitals in Zimbabwe."**. This is in partial fulfilment of the requirements for an Msc in Human Resource Management degree studies.

Please be advised that the Health Service Commission granted Mr Muposha approval to undertake the proposed research on the condition that he will uphold high levels of confidentiality and ethical standards in conducting the research.

Be guided accordingly.

A. Mbengwa (Mr)
A/Secretary
Health Service Commission
Cc: Mr E. Muposha