Nursing in Sri Lanka: Situating a Study of Nurses' Intent to Leave or Stay in an Organization within the Contexts of Professional Issues and Nurse Migration

by

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ABSTRACT

Retention of nursing staff is a worldwide concern. Inadequate workforce planning, resource constrained undersupply of new nurses, underdeveloped recruitment, retention and return policies, poor incentive and career support structures and complex quality of work-life environments compete with forces supporting nurse out-migration to influence on nurses' intentions to leave or stay in their profession, organization and/or country. Nurse retention influences current and future delivery of healthcare. It also affects the quality and quantity of the nursing workforce. Importantly, nurse out-migration contributes to strengthening the domestic economy through remittances. In Sri Lanka, leadership decisions based on assumptions about nurses' decisions to stay or leave their positions (including out-migrate) are based on little or no evidence-based knowledge of the associated negatives (costs) or positives (benefits) of nurses staying, leaving or migrating. In this country, there is little research on nurse migration at either the macro or micro levels of analysis. Thus, the aim of this research was to begin addressing gaps in research, policy development and knowledge regarding nurse turnover and nurse migration. Multiple methods were used to develop knowledge in this area.

The context for this exploration was set through first-hand knowledge of healthcare and nursing in Sri Lanka and a scholarly analysis of published and unpublished literature (including analysis of academic publications, reports and other grey literature) about the nursing profession and issues and challenges faced by nurses in Sri Lanka (Chapter 1). This critical analysis also informed the overarching study as it set the stage for an empirical study of nurses' turnover intentions. Then an integration of turnover research and commitment theory, published between 1958 and 2016 and contextualized to the Sri Lankan context, was utilized to develop a Contextual Work-Life Experiences model. This model is intended to guide research into micro

level concepts shaping nurses' intentions and decisions to stay or leave, while holding attention to the macro context ambiance (Chapter 2). An initial testing of the model was conducted using a cross sectional survey with 679 nurses at an urban hospital in Sri Lanka to examine nurses' work-life contexts, commitments and turnover intentions (Chapter 3). This limited scope study showed that nurses' decisions are complex, influenced by their immediate work contexts, personal contexts and commitments to the profession, organization, family and country. Drawing on the findings from the initial literature exploration, the limited scope study, and an exploration of the migration literature an analysis of the macro context of nurse migration in Sri Lanka is presented (Chapter 4). This contributed to developing a research agenda and policy framework to situate nurse migration within a nurse workforce-planning framework.

This dissertation makes significant contributions as it identifies some of the gaps in research, policy development and knowledge. It highlighted the need for internal strengthening of the nursing profession through stricter regulation and standardization of competencies, research consciousness, policy and action to promote systematic processes for evidence-based practice, and to address nurse turnover and migration, education, professionalization, research, leadership, and information systems. It emphasized the importance of analyzing factors most proximal to the nurses (factors in nurses' work contexts and personal contexts, including professionalism and transformational leadership skills, opportunities for education and professional development and support for nurses to fulfill their commitments to family, profession and organization) that influence their core motivations. These factors are vital for researchers, policy makers, educators and clinicians in the development of evidence-based strategies to maximize organizational efficiency and effectiveness. It also highlighted the need for researchers and policy makers to take into consideration multiple contexts at multiple levels

involving multiple stakeholders and discourse for meaningful research agendas and policy planning. Finally, the dissertation highlighted that a collaborative evidence and policy-based approach to increase professionalism in nursing enhance nurses' work-life experiences, manage nurse turnover and migration driven by an evidence based policy framework is imperative to the sustainability of Sri Lanka's health care system.

PREFACE

This thesis is an original work by Dilmi Aluwihare-Samaranayake. The dissertation research received research ethics approval from the University of Alberta Research Ethics Board, "An exploration of influences on nurse migration in Sri Lanka", no. Pro00048286; the Sri Lanka Medical Council, ERC/14-027 (with letters of support for data collection from supervisors based in Sri Lanka), and the urban hospital, AAJ/ETH/COM/2014. Permission was obtained from the Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka and consent was implied by completion of the questionnaire.

Chapter 1: "The nursing profession in Sri Lanka: time for policy changes", is accepted for publication International Nursing Review, 24th May 2017. Authorship: D.S. Aluwihare-Samarayanake, L. Ogilvie, G.G. Cummings, and I.R. Gellatly, I was solely responsible for data collection and the manuscript composition. L. Ogilvie, G.G. Cummings and I.R. Gellatly contributed to multiple revisions of this paper, including development and re-structuring of concepts and edits.

DEDICATION

This thesis is dedicated to my mother, the best nurse I know, and other nurses in Sri Lanka. May the knowledge discovered within help empower nurses in Sri Lanka, enhance their work-life experiences and facilitate the delivery of a high standard of nursing care

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PROLOGUE

There are many reasons why nurses change jobs, leave the profession, or migrate internationally. Retention of nursing staff is a worldwide concern. Increasing healthcare demands and changes in the nursing workforce are considered antecedents to the worldwide shortage of nurses with nurse turnover in middle and low-income countries seriously threatening availability, supply and quality of nurses (Garner, Conroy, & Bader, 2016). Nurse migration refers to the processes and patterns of internal and external movement of nurses. Nurses are influenced by "push" factors, including income and cost of living on the one hand and "pull" factors, such as quality of life, working conditions, respect, safety, security, and dignity of the profession. They are also influenced by global and national forces such as trade agreements, national policies and strategies, and economic considerations, as well as variables within the lives of individual workers (Kingma, 2006; Prescott & Nichter, 2014; Shaffer, Bkhshi, Dutka, & Phillips, 2016). While temporary migration can have positive consequences, particularly through increasing nurses' knowledge and skills (Castro-Palanganas, et al., 2017; Garner et al., 2016), the negative effects in middle, low-middle and low-income countries may be significant. Individual nurses make migration decisions based on opportunity and a wide range of intrinsic and extrinsic motivations.

In lower-middle income countries like Sri Lanka, regional nurse workforce inequities, allied with forces favouring international migration, are a reality. For example, migration of skilled workers is moving up the political agenda in Sri Lanka and the nursing workforce is one group of skilled workers that is under scrutiny and bilateral agreements are drawn up for nurses to migrate (SLBFE, 2017). Economic, institutional, professional, and socio-political factors drive an unknown percentage of nurses to leave Sri Lanka to work in other countries, compounded by

the underproduction in 'recipient' countries that creates demand. Because of the multiple entry routes to other countries and practical difficulties of collecting and recording data on employment both inside and outside of Sri Lanka, monitoring and evaluation of nurse migration remains poor and the actual status of out-migration of nurses in Sri Lanka is not known, and probably underreported (Institute of Policy Studies (IPS), 2013). If few migrating nurses return or re-circulate, existing nurse shortages in the healthcare system are exacerbated. A shortage of nurses within the healthcare system and serious mal-distribution of nurses across the country compromise the quality of care and create stressful work conditions for remaining nurses.

Nurse migration is a global phenomenon and macro level concept. Most prior research (internationally) has been analyzed at a macro-level with little attention given to the individual (personal) and organizational (turnover) level of analysis and the historical, political, economic and sociocultural context in which migration happens. This is based on the fact that there is limited research that informs theory or research that results from theory on nurse migration addressing the causes of migration. In contrast to macro-level analysis, micro-level analysis focuses on nurses' intentions to turnover, described as nurses' perceptions of the possibility they will leave their position at some unspecified time in the future. In Sri Lanka, there is little research on nurse migration at the macro or nurse turnover at micro levels of analysis. Therefore we know little about the factors that influence nurses' decision-making in relation to turnover and migration.

This thesis emerges from a belief that nurse workforce planning in Sri Lanka could proceed in a way that captures the complexity of micro and macro level factors that influence nurses' workplace decisions at individual, professional, national and international levels, and that this would enhance nursing professionalism within the country and most importantly, contribute

to the sustainability and quality of health care for the citizens of the country. Addressing this concern entails a research program that goes beyond the boundaries of one project. I had to decide where to start.

Purpose and Objectives of the Thesis

The purpose of this dissertation, therefore, was to begin by addressing some of the gaps in knowledge regarding local turnover of Sri Lankan nurses and, in particular, to identify factors that positively, negatively, directly, or indirectly affect nurses' international migration decisions. The objectives of this thesis were to (a) examine internal and external factors that may directly or indirectly affect nurses' international migration and patterns of movement in Sri Lanka (Chapter 1, Chapter 2); (b) conduct a micro (individual nurse) level of analysis of Sri Lankan nurses' turnover intentions (Chapter 3); and, (c) integrate the above knowledge with the turnover and migration literature and knowledge of the Sri Lankan context, to guide research agendas and policy development of the nursing professional workforce in Sri Lanka (Chapter 4). Derived from a consideration of the purpose, objectives and critical review of relevant literature the following research questions emerged.

- To what extent are Sri Lankan nurses' intentions to leave or stay in their current employment related to their immediate work context or personal context?
- To what extent are nurses' intentions to leave/stay in their current employment mediated by their commitments to the organization, family, profession, and country?
- What can we learn from the perceived work context of nurses at one large urban hospital about work-life issues in nursing in Sri Lanka?
- How does the information shared by the Sri Lankan nurses in this study inform what is known about the issues discussed in relation to the international migration of nurses?

Summary of Theoretical Approach

Derived from a scholarly review of the literature, the empirical part of this thesis is structured using the limited Conceptual Work Life Experiences model, which was developed for the thesis (limited in concepts and scope depicted in Figure 2.1, Chapter 2) (Aluwihare-Samaranayake, Gellatly, Cummings, & Ogilvie, 2017). This figure portrays factors that may affect nurses' intentions to leave or stay and incorporates a broad range or perceptual, experiential and contextual factors, normally studied within the commitment and turnover literature, adapted for the nursing profession (Aluwihare-Samaranayake et al., 2017).

In Chapter 1 (see objective a), drawing on my knowledge of healthcare and nursing in Sri Lanka and existing literature, I began with a scholarly review of issues and challenges faced by nurses in Sri Lanka with the aim of identifying where and how policy changes need to be made. The International Nursing Review (24 May 2017) has accepted this work (manuscript 1) for publication. I identified that policy and action are required to: (a) establish mandatory nurse licensure in the public and private healthcare sectors; (b) implement realistic policies to further develop nursing education; (c) develop a professionalization process to support nursing autonomy and voice, and (d) promote systematic processes for educational accreditation, curriculum revision, continuing professional development, evidence-based practice, research, leadership, and information management systems. This critical review showed that there is limited knowledge on nurse turnover and migration in Sri Lanka, a topic that requires careful examination, analysis and strategic planning by formal nurse leaders.

In Chapter 2 (see objective a), I present a new model, the Contextual Work-Life Experiences Model (CWLEXP), depicting contextual factors hypothesized to influence commitment and turnover intentions of nurses in Sri Lanka. This model is based on an

integration of personal experiences and knowledge of nursing in Sri Lanka and a synthesis of turnover research and commitment theory published between the years of 1958 and 2016, contextualized to reflect the reality faced by Sri Lanka nurses. The model presents a high level view of intrinsic, extrinsic, personal and professional antecedents to nurse turnover where relevance can be used by researchers, policy makers, clinicians and educators to initially establish focus and limited scope models to derive hypotheses and rationale for testing and then expand to examine comprehensive contexts. Understanding of contextual work-life influences on nurses' intent to stay should lead to evidence based strategies that result in a higher number of nurses wanting to remain in the nursing profession and work in the health sector in Sri Lanka. The untested model (presented in Chapter 2) emphasizes the role nurses' work-life experiences play to fortify or weaken their motivations to remain committed to their organization, profession, family and country. Then the model was tested and revised (see Chapter 3) and these study results may provide guidance to leaders to develop evidence based strategies that can result in higher numbers of nurses wanting to remain in the nursing profession and work in the health sector in Sri Lanka. It may also generate additional hypotheses for future knowledge generation.

In Chapter 3 (see objective b), I present the cross-sectional study derived from the CWEXP model with 679 nurses at an urban hospital in Sri Lanka, used to test the model presented in Chapter 2. Ethics approval was obtained to test all the relationships in the CWLEXP model (see Chapter 3) and data were collected to test all the variables in the model. However, for manageability and in the process of learning and to fit within the constraints of a PhD program, I only did an initial test of selected micro context variables that I felt were the most proximal to the nurse (see Chapter 3). The results of the regression analysis indicated that nurses' work context and personal context were linked with nurses' organizational commitment and staying

intentions, and that leadership, position, nurses' commitment to family and profession played critical roles in shaping nurses' commitment to the organization and staying intentions. The results point toward the importance of an empowering leadership style amongst nurse managers, particularly the development of mechanisms that strengthen the support nurses receive in regard to their family commitments. This is vital as the research clearly showed that leadership approach and support for nurses' family commitments was positively related to organizational commitment and staying intentions. In Chapter 3, I also include a detailed description of the research process that illustrates the process of data collection and analysis. The methodological information included in Chapter 3 is beyond a typical paper for publication. However, it is included here because it will be useful for others who wish to learn about the process of accessing participants in bureaucratic and structured organizations and to obtain gatekeeper support and a high number of participants.

In Chapter 4 (see objective c), I offer a critical discussion of Sri Lanka's contexts in relation to nurse turnover and migration and present a research agenda and policy framework situating nurse migration within an overall nurse workforce framework that focuses on five priorities: (a) Developing an evidence base for policy and research planning; (b) Investigating shortages, recruitment and retention; (c) Improving quality and standards for nursing practice; (d) enhancing resources and capacity building; and (e) working toward win-win nurse out-migration and policy. My work points towards recommendations for future research that captures the multi-layered, multi-stakeholder, complex and intersecting nature of nurse turnover and migration to exists within historical, socio-cultural, political and economic contexts and policy. Policy will require formulation, implementation, review and moderation to facilitate evidence based approaches to make nurse migration a positive in Sri Lanka in relation to healthcare

systems needs and value of potential remittances (money sent to families in the country of origin).

Contributions this Thesis makes to Knowledge, Theory, Nursing Practice, Education and Policy

The government in Sri Lanka has adopted an economic model with incentives (remittances) that are intended to promote nurse migration. While these incentives may be driven by a desire for remittance income, nurses choose whether or not to migrate. The study in Chapter 3 explores how Sri Lankan nurses' intentions to migrate are shaped by factors beyond economic considerations. It provides empirical data to assist decision-makers in forming appropriate health system and management policies and interventions, fills a gap in the literature, and facilitates more efficient use of public monies through empirically driven research agendas and policy frameworks and improved nurse migration policies. Moreover, the study has the potential to influence the planning of academic programs and contribute to the functioning of professional associations, regulatory bodies, and unions in proposing work force strategies that could have impact on nurses' motivations to stay, leave or migrate. A more nuanced appreciation of the meaning of nurse migration in Sri Lanka will also make a contribution to the growing international body of literature on health professional migration.

This research makes significant contributions to knowledge, theory practice, education and policy in Sri Lanka. Contributions include (a) the introduction of a contextual work life experiences model and the emphasis that nurse turnover and migration cannot be studied shy of psychological processes and devoid of contexts; (b) an indication of the importance of transformational leadership in influencing nurses staying intentions and the need to develop nurses' transformational leadership skills; (c) a sign of the need to support nurses in meeting

their family commitments; (d) an indication of the importance of supporting nurses professional development and career progression; (e) further development and refinement of the CWLEXP model to support limited scope models to delineate hypothesis for further research at micro-level of analysis; and (f) the development of a research agenda and policy framework to situate nurse migration within a nurse workforce policy framework.

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CHAPTER 1

Title: The Nursing Profession in Sri Lanka: Time for Policy Changes

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Abstract: We address issues and challenges in nursing in Sri Lanka with the aim of identifying where and how policy changes need to be made. Increased global interconnectivity calls for professional leadership, research, education, and policy reform in nursing as these are identified as enhancing health workforce performance and professionalization, thereby improving health systems. We draw on first-hand knowledge of healthcare and nursing in Sri Lanka and a recent survey of nurses at a large urban government hospital in Sri Lanka, followed by discussion and proposed action on themes identified through analysis of published and unpublished literature about the nursing profession. Policy and action are needed to: (a) establish mandatory nurse licensure in the public and private healthcare sectors; (b) implement realistic policies to further develop nursing education; (c) develop a professionalization process to support nursing autonomy and voice; and, (d) promote systematic processes for educational accreditation, curriculum revision, continuing professional development, evidence-based practice, research, leadership, and information systems. There is a policy vacuum that requires careful analysis and strategic planning by formal nurse leaders. Implementing change will require political and professional power and strategic, innovative, and evolutionary policy initiatives as well as organizational infrastructure modifications best achieved through committed multidisciplinary collaboration, augmented research capacity, bolstered nursing leadership, and promotion of partnerships with policy makers.

CHAPTER 1

The Nursing Profession in Sri Lanka: Time for Policy Changes

Globally, professional leadership, research, education, and policy reform in nursing are identified as enhancing health workforce performance and thereby improving the functioning of health systems (Wilson, et al., 2016). Without a strong professional presence, nurses are unable to engage effectively in policy and decision-making processes. In Sri Lanka, socio-cultural perceptions (related to class, gender, and status) of nursing intersecting with other contextual issues pose challenges to achieving the professional power required to influence health system change. There are indications, however, that change is possible. With information gleaned from documents published between the years 2007 and 2017 and data from our 2015 survey of 679 Sri Lankan nurses related to nurse turnover at a large urban government hospital, we describe the current context of nursing in Sri Lanka and suggest strategies to increase the nursing voice in policies relating to health and development of the nursing profession. The issues raised and strategies advocated are likely to resonate with challenges faced in nursing contexts in other countries.

Following a brief presentation of global challenges, we provide an overview of health care and nursing in Sri Lanka before commenting on sociopolitical and historical forces shaping the discipline of nursing and discussing the state of nursing as a profession. We conclude with analysis of the current political and practical positioning of nurses in the health care system and propose changes, research priorities, and policy directions to advance the professionalization of nursing in Sri Lanka.

Global Challenges

Increased global interconnectivity intensifies the need to confront health challenges both locally and worldwide (Gimbel, Kohler, Mitchell, & Emami, 2017), better understand how underdevelopment of professionalism and policy places nurses and patients at risk, and comprehend how resource disparities among nations affect nurses and their families in less developed countries. Addressing inequities and the resulting challenges requires expanded global health research, enhanced educational opportunities, and movement toward achievement of agreed upon global health competencies through strategic and sustainable international partnerships. There is a need for advancements in nursing education, practice, leadership, research, policy, and real work application, both locally and overseas (Gimbel et al., 2017). Globally, current reforms promote greater professionalization, university-based education, optimal leadership and policy development, interdependence and interdisciplinary collaboration for health system and health care implementation and administration, local private/public partnerships, and international partnerships. Progress in nursing is often criticized as slow. This is attributed to weak governance by nursing councils and departments of health, limited planning for implementation, and inappropriate proposals. Thus strengthening of policy capacity in institutions responsible for the leadership and governance of nursing is required if nursing's potential contributions are to be recognized and realized (Blaauw, Ditlopo, & Rispel, 2014).

Nursing in Sri Lanka

With a population of about 21 million people, Sri Lanka is an island located south of India. Comprised of both Western and Ayurvedic health systems, health services are both state-sponsored and free via health centers, hospitals, and dispensaries or provided by the fee-levying private sector. (Aluwihare-Samaranayake & Paul, 2013). The Sinhala population is dominant

with a substantial Tamil minority. Civil war with resultant ethnic tension was the consequence for several years.

Sri Lanka has a low density of nurses (16.4 per 10,000 population) in comparison with more economically advantaged countries but is comparable to other countries in the region: Maldives 50.4, Indonesia 13.8, India 17.1, Myanmar 10.0, Pakistan 5.7, United Kingdom 88.0, and Canada 92.9 (World Health Organization (WHO), 2015). Nurse shortages are greatest in the Northern and Eastern Provinces, where lack of nurses results in limited capacity to meet health needs (Ministry of Health, (MOH), 2016). Sinhala-speaking nurses from other provinces appointed to northern hospitals in efforts to address human resource inequities are often unable to communicate with patients who speak Tamil (primary language of the North). In urban areas health professionals within the healthcare system use English for professional communication both orally and in health records but Sinhala and Tamil may also be used. In our survey nurses reported that their Sinhala speaking, reading, and writing abilities were stronger than their abilities to communicate in either English or Tamil; however, they were all able to communicate in English with varying degrees of competence. In the following paragraphs, we examine nursing in Sri Lanka in relation to its evolutionary, status, educational, regulatory, and employment challenges.

Shaping the Discipline of Nursing

Nursing in Sri Lanka has a long history with archeological evidence of the profession in ancient hospitals. Organized nursing commenced in 1878 with the arrival of the British colonialists (Aluwihare-Samaranayake & Paul, 2013). Initially, there were cultural, caste, class, and gender taboos to recruitment of Sri Lankan women into nursing (Aluwihare-Samaranayake & Paul, 2013). This changed in 1956 with the initiation of a closed economy as it resulted in

more working-class rural women entering the workforce, thus transforming power relations within the profession and a shift in attitudes within nursing and in the larger society from a public service to a paid vocation (Biyanwila, 2008). Although both males and females join the nursing profession, male recruitment is restricted to 5% (14% in our urban sample), although the *Nursing Minute of The Gazette of the Democratic Socialist Republic of Sri Lanka* (SLNSM, 2013) stipulates that the percentage of males recruited can be changed based on exigency of service.

Classified into upper, upper middle, middle, lower middle classes (commonly nurses are from middle and lower middle classes), and poor, social class in Sri Lanka is determined by urban/rural location, history, ethnicity, parental education and occupational status, educational achievement, gender, age, labour market conditions, and economic growth characteristics (Aluwihare-Samaranayake & Paul, 2013). This means that differently classed individuals are coming into nursing with a possibility of upward social mobility through participation in the nursing profession (Bryan, McQuaid, & Munro, 2015).

The State of Nursing as a Profession in Sri Lanka

Nursing in Sri Lanka lacks some markers of a profession. For example, registration as a nurse is available to nurses educated in government facilities but such licensure is not mandatory for employment. To work in the government health sector, nurses must graduate from a government school of nursing or a Bachelor of Science in Nursing program at an institute/university recognized by the University Grants Commission (UGC), complete a six-month orientation and co-ordination course conducted by the MOH, and obtain appointment letters from the MOH (SLNSM, 2013). Many private health facilities have their own schools of nursing, mostly unrecognized by the government and Sri Lanka Nurses Council (SLNC)

(Jayasekera & Amarasekera, 2015), but graduates of these programs are not eligible for registration or for employment in the government sector. To further understand the state of nursing as a profession in Sri Lanka, we discuss key issues related to nursing education, nursing administration, nursing registration, the nurses' association, and nursing unions.

Nursing Education

Influenced by the British nursing tradition, formal nursing education commenced in 1939 and is now in transition to have more nurses qualified with a Bachelor Degree (Jayasekera & Amarasekera, 2015). Three-year Diploma programs in the public sector are managed by the MOH and offered in either Sinhala or Tamil depending on location, with limited access to the vast body of knowledge/evidence available in English. These programs are located island-wide and are affiliated for practical experience with the Teaching Hospital, General Hospital or Base Hospital in the respective district (MOH, 2016). Limited post-registration specialized diplomas in management, teaching and supervision, nursing education, and public health, as well as courses in midwifery and clinical specialties such as psychiatric nursing are offered by the MOH. Despite the rapidly aging population, a shift in disease burden towards non-communicable diseases, and Sri Lanka's need for disaster management preparedness for environmental disasters such as landslides, floods, and tsunamis, limited opportunities exist for relevant field programs for nurses (Jayawardene, Youssefagha, Lajoie, & Torabi, 2013). Nursing education (diploma level) for nurses in the public sector is free, and students receive a stipend. Thus, government makes a significant investment in education of nurses (MOH, 2016). Few policies address training infrastructure, accreditation mechanisms, curriculum development and revision, or faculty shortages (MOH, 2016). There are plans to upgrade the institution providing post-registration specialized programs to a degree awarding body (Jayasekera & Amarasekera, 2015).

Managed by the UGC and Ministry of Higher Education, nursing degree programs are offered in English on site and via distance (University Grants Commission (UGC, 2017). They often operate with insufficient physical resources, funding, and appropriately qualified faculty. Few Sri Lankan nurses (about 1% in our large urban center sample) have education beyond the baccalaureate level (De Silva & Rolls, 2010). Most nurses with graduate degrees are employed by universities or have emigrated. Graduate-level nursing education is not available and there is limited funding from government, donor agencies, or private (personal) sources to pursue advanced education outside of Sri Lanka (Jayasekera & Amarasekera, 2015).

Nurse Employment in the Healthcare Hierarchy

Nursing has limited voice within the MOH as there are few influential positions for nurses. The few nurses in leadership positions struggle to be heard. Doctors hold all senior management positions within the central administrative structure of the MOH (De Silva & Rolls, 2010), based on claims that no nurse is qualified in policy, planning, and strategic development (Jayasekara, 2009; MOH, 2016), as well as all senior administrative positions within hospitals. De Silva and Rolls suggest that physician dominance has contributed to nurses' experiences of oppression and lack of support in their professional roles. Within the MOH, including government hospitals, there are limited opportunities for professional development and advancement of nurses (Jayasekera, 2009). The SLNSM has been amended several times to rectify anomalies in the health system (Jayasekera, 2009) but strategies for advancement of the nursing profession have not been included. Nurses in formal leadership positions and nurses at the grassroots level, mostly through unions, often challenge the MOH's administrative decisions (Jayasekera, 2009).

Nurses have little choice in the location of their work. According to a merit scheme

(based on their examination results), nurses graduating from government hospital-affiliated diploma schools are appointed to positions throughout the country. They are not allowed to request a transfer or obtain leave for four years. Seniority is a factor when transfer requests are considered (MOH, 2016). Thus nurses have little control over where they work, and many are separated from family and friends. Nurses' lack of power in shaping their work lives is illustrated by the complex process required if they wish to change positions (De Silva & Rolls, 2010). Following a chain of command, a nurse's request to transfer is sent via the ward Sister, the Matron, and the Chief Nursing Officer to the Director of the Hospital, then forwarded to the Director General of Health Services (DGHS) at the MOH, who gives it to the administrative officer within the office of Director, Planning and Administration. A meeting of the Transfer Board follows. In attendance are the DGHS, Nursing Directors, and representatives from the Trade Unions. The decision is based on calculations of the number of nurses in hospitals nationwide and analysis of shortages. It is only at such a meeting that the MOH Directors of Nursing hear of a nurse requesting transfer or leave. Otherwise, the Directors of Nursing have minimal input into nursing workforce monitoring or planning.

Working conditions are another challenge. Large numbers of patients are cared for in overcrowded wards with limited resources and facilities (Aluwihare-Samaranayake & Paul, 2013). Nurses' daily tasks include non-nursing tasks such as conducting linen and drug inventories, clerical work, reception, and serving meals to patients (De Silva & Rolls, 2010) and, as revealed in our study, they often work over-time and long shifts with limited opportunity for refusal. Despite official safety guidelines, nurses face risks arising from shortages of soap, masks, and gloves in most government hospitals. Many hospitals lack basic facilities for nurses (such as rest rooms/changing rooms), child-care facilities, adequate beds for patients, and adequate basic

facilities and amenities for relatives and visitors (Aluwihare-Samaranayake & Paul, 2013). Moreover, in contrast to the private sector, the government sector does not offer part-time employment for nurses (MOH, 2016).

Regulation of Nursing in Sri Lanka

The regulation of nursing practice is in transition. The SLNC, The Sri Lanka Nurses' Association (SLNA), and Nursing Unions all have roles in achieving regulatory autonomy for nursing as a profession. Ideally, the Nursing Council will work on issues related to patient safety, while the professional association will focus on standards of care and the unions will focus on working conditions. A brief overview of what is happening is provided.

Sri Lanka Nursing Council (SLNC). In 2012 the SLNC was formed. Nurses who registered with the Sri Lanka Medical Council (SLMC) prior to 2012 are liable to transfer their registration to the SLNC. The appointment of a nurse to President of the Nursing Council is pending but to date nurses do not have power to vote and appoint a nurse to this position. A doctor is currently acting president and nurse's hold remaining positions.

According to the SLNC Act No. 19 of 1988 (SLNC Act, 1988), all nurses are required to register with the Nursing Council but, as the act has not been enacted, failure to register is not penalized. Consequently most nurses do not register and, importantly, not all schools of nursing meet registration standards. The SLNC offers programs targeting unregistered nurses to raise awareness of the importance of obtaining licensure. Nurses are given appointment letters to commence work even if they have not obtained registration – possibly because of the shortage of nurses in the work place - thus placing onus on the nurse to obtain registration. Our data reveal that not all nurses in government hospitals are registered despite a belief that registration is mandatory for such employment. Private sector nurses continue to battle to obtain recognition

and standardization and be allowed to register. Nurses with licensure in countries such as the United States of America, the United Kingdom, Canada, or Australia, subject to review of their nursing qualifications and transcripts, are granted registration. Limited attempts have been made to standardize nurse education across the country to enable nurses educated in the private sector to obtain registration with the SLNC.

Sri Lanka Nurses Association (SLNA). Activities and structures exist to advocate for professional nursing practice and better working conditions for nurses. SLNA was established in 1943, is linked to the International Council of Nurses and the Commonwealth Nurses Federation (SLNA, 2013), and has engaged in various activities towards enhancing professionalism and standards of nursing practice.

Nursing unions. Competing unions focus on collective bargaining (Biyanwilla, 2008). Unions exert significant influence in negotiation of working conditions, development of private nursing schools and degree programs, and development of the profession. Although somewhat successful in their demands for nurses, unions' actions tend to undermine nurses' professional progression. For example, if unions are unable to negotiate or are dissatisfied with the outcomes of collective bargaining, they encourage nurses' participation in work stoppages, walkouts, and sit-in-strikes, even to the detriment of patients and despite threats of punishment such as imposed transfers for engaging in protest actions (Sunil, 2010).

Unions reinforce gender-biased social structures. While nursing is a female dominated profession in Sri Lanka, male nurses tend to hold leadership and administrative posts in nursing unions (Biyanwila, 2008). This may reflect a power differential between male and female nurses (Biyanwila, 2008) or a greater social impetus by male nurses to advance remuneration and status.

Employment and Power as a Nurse in the Healthcare System

Nurses in Sri Lanka tend to be relatively powerless, perhaps because of social position, knowledge deficits, attitudinal beliefs, and perceived burden of work (De Silva & Rolls, 2010; Hellerawa, & De Alwis, 2015). Poor management, infrastructure, pay, and recognition of the value of nursing; shortages of resources; failure in recruitment and retention; limited facilities for education; medical dominance; and, few opportunities for career progression or involvement in strategic planning for health development perpetuate nurses' experiences of powerlessness and oppression. Nurses, therefore, may consider nursing as a job rather than a profession (De Silva & Rolls, 2010). Attention to power differentials is essential if Sri Lankan nurses are to raise their status, define their areas of expertise, and achieve greater influence and autonomy. Powerlessness leads to job dissatisfaction, burnout, and depersonalization and contributes to poor patient outcomes (Van Bogaert, Kowalski, Mace Weeks, Van heusden, & Clarke, 2013). As a precursor to developing power and enhancing competence, nurses need additional education, recognition of expertise, and empowerment possibilities arising from their immediate work environments (institutional structures) or psychological states (personal self-efficacy). In Sri Lanka, low educational levels and societal status of nurses in relation to other health professionals contribute to real and perceived powerlessness that disadvantages them in organizational politics (De Silva & Rolls, 2010). Gaining control over the regulation of nurses through mandatory licensure and true decision-making voice in the MOH would enhance the power of nurses to advance their profession and thus their value in health care systems, both public and private.

Discussion: A Time for Change

Shortages of nurses are not a new phenomenon and exist in most countries around the

world (Buchan, 2013). Many countries are faced with natural and man-made disasters, changing demographics, advances in technology, and the need to care for an increasing number of elderly people with a workforce that is also aging or suffering from attrition (Walani, 2015). Several factors could contribute to severe regional and national shortages, such as worldwide drop in number of people entering nursing programs; increase in nurses leaving the profession entirely; and, internal and external migration from disadvantaged areas to advantaged areas within countries or from low and middle income countries to high income countries. Our snapshot of nurses comes from a comparatively advantaged part of Sri Lanka. Registration numbers, nursing qualifications, and employment possibilities are likely some of the best in Sri Lanka but still reveal a gap in licensure and low nursing educational attainment of the majority of respondents.

What does this mean in the Sri Lankan context? For change, nurses need to act to enhance professionalization. For change to happen, attention must be directed toward regulation in the form of mandatory licensure, formulation of evidenced-based policies that shape nursing education, support and recognition of professional autonomy in nursing practice, and creation of systematic processes that support nursing as a professional discipline. Each of these processes is complex. Four approaches are recommended.

Regulation and Standardization of a Mandatory Nurse Licensure Process

People accessing healthcare have a right to know that nurses have met predetermined standards. Mandatory licensure illustrates that: (a) essential qualifications and competencies for nurses are identified; (b) an objective and legal forum is provided and recognized for review of issues and concerns about each registered nurse's practice; and, (c) clear legal endorsement for the scope of practice is established (National Council of State Boards of Nursing, 2011).

Formulation of Realistic Policies to Drive Nursing Education Infrastructure Development

The shortage of nurses in Sri Lanka is mirrored by a corresponding shortage of nursing faculty. There are no Masters or Doctoral programs in nursing. Nurses seeking advanced degrees are required to access universities in other countries and may receive limited or no financial support. Therefore, sustainable funding sources (through public/private partnerships) and student scholarships for all levels of nursing education are needed. Public/private partnerships can support additional faculty positions, nursing faculty research and projects, and specific educational programs (with clinical experience and involvement of nurse clinicians in the education process). Grants need to be created to provide fast-track, low personal cost opportunities for nurses seeking graduate nursing degrees internationally until such time that a sufficient pool of graduate-prepared nurses is built to create in-house programs.

Development of a Professionalization Process to Support Nurse Autonomy and Voice.

Nurses in Sri Lanka are poised to assume accountability for regulation of their professional education and practice; an essential change to advance the nursing profession. Nursing needs disciplinary autonomy, including nursing research associations to advance substantive, methodological, and theoretical knowledge development, in order to facilitate relative independence from other disciplines. This will enhance nurses' abilities to use their knowledge and judgment with confidence and provide nursing care within the full scope of practice as defined by existing professional, regulatory, and organizational rules (Weston, 2008).

Professional and organizational support of the application of nursing knowledge and expertise in patient care is associated with enhancing autonomous nursing practice (Van Bogaert et al., 2013). Nurses in Sri Lanka need to act to gain the authority to make professionally mandated autonomous decisions. Ways in which nurses can enhance their autonomy and

empower themselves include communication and organization of their work through research, and dissemination of their thoughts on the art and science of nursing through presentations and publications.

Nurses' personal perceptions of self-efficacy and organizational support are essential for creation of spaces for nursing voices to be heard. Nurse leaders in formal leadership positions can pro-actively participate within the multi-disciplinary team to outline expectations and establish protocols, standards of practice, and behavioral expectations for all members of the health team in orientation and continuous development programs.

Medical dominance in health care is manifested in Sri Lanka through professional autonomy of doctors, their influence in economic decisions related to health services, the lack of nurses in positions of power related to the nursing workforce in the MOH, and perhaps differences in the class origins of each profession. Medicine is also privileged through dominance over allied health groups, administrative control of health institutions, and the collective influence and status of the medical association. Nurses need strategies through which medical dominance can be challenged. Advanced nursing education and establishment of collaborative nurse-physician partnerships are starting points for creation of powerful multi-disciplinary teams encased in mutual respect. This may mean searching for medical colleagues who will champion such initiatives and collaborate in clinical practice and research.

It will take strong nursing leadership to tackle medical dominance in healthcare. Nurse leaders can (a) highlight benefits of having formal nurse leaders in nursing leadership positions with real influence within the MOH and health institutions; (b) create conditions where nurses are prepared for leadership positions; and (c) take steps to initiate collective, cooperative, and integrative approaches to leadership. In a broader discussion with medical leaders, nurse leaders

can negotiate the positioning of the health disciplines and create policy that entrenches autonomy of nursing as a discipline. Moreover, nurses can engage in learning strategies to deal with inter-professional conflict and promote inter-professional cooperation, partnerships, and equity. Engaging in assertiveness training and participating in discussions about clinical practice, whereby standards of patient care are consequently much improved, could be useful approaches.

Promotion of Systematic Processes

Nurse leaders must formulate realistic policies to drive promotion of systematic processes for the development of nursing education infrastructure and promote a systematic process for nursing education accreditation, curriculum revision, continuing professional development, evidence-based practice, research, leadership, and accurate tracking of nursing workforce issues. Programs offered in Sri Lanka by universities outside Sri Lanka require continuous evaluation to ensure: (a) fit with local needs; (b) congruence with accreditation requirements; (c) maintenance of standards; (d) local commitment with sustainable availability of resources; and, (f) shared understanding of nurses' professional roles and scopes of practice.

Implications for Nursing and Health Policy

Nurses in Sri Lanka struggle to have their voices heard and to achieve professional status. Lack of political and professional power, strategic planning, and human resource development and monitoring in the health sector have led to inadequate nurse recruitment and retention, varied educational preparation, and deficiencies in licensure of the nurse workforce. Work is required to develop nurse leaders and increase nurses' presence at all levels of decision making to optimize impact of nurses' contributions and to make better informed health policy locally, nationally, and internationally. Further, a national framework for nurse education requires development collectively and cooperatively across various nursing organizations, colleges, and

universities. This could be used as a tool in negotiating change with the government. Further, it would enable a national task force to identify a potential advocate within the government to work with them to advance the change politically. The time for change in nursing in Sri Lanka is now. Nurses are aware of issues that need to be addressed to enhance nursing status, power, and practice. The first steps have been taken and the path to success is clear.

Conclusion

There are emerging opportunities for nurses in Sri Lanka to challenge current practice, cease ineffective work, and focus efforts to improve nursing education, practice, research, and management, as well as promote evidence-informed policy to have real impact on innovative, cost-effective, efficient health care for patients. Nurses need and deserve professional autonomy, working environments and cultures with clear visions and values, robust structures and systems for sharing and communicating ideas, and recognition of their advocacy role in patient care and policy generation. Nurses need to work credibly and effectively with other health and development stakeholders. Engagement in policy and politics provides opportunities for nurses to partner with others to discover and lead new ways of delivering effective and efficient care.

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CHAPTER 2

Title: "A contextual work-life experiences model to understand nurse commitment and turnover"

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CHAPTER 2

A Contextual Work-Life Experiences Model to Understand Nurse Commitment and Turnover

Improving the retention of nurses is a global concern as it contributes to the provision of quality healthcare, and there is increasing evidence of the negative effects of high turnover on nurses, patients and health care organizations (Hayes, O'Brien-Pallas, Duffield, Shamian, Buchan, Hughes, Spence, & North, 2012). In this paper I discuss personal and situational factors that might be particularly relevant to why Sri Lankan nurses are motivated to stay or leave their employer. The conceptual frame described in this chapter represents a "contextualized integration" of both turnover theory (for a summary, see Hom, Mitchell, Lee & Griffeth, 2012) and commitment theory (Klein, Becker & Meyer, 2009; Meyer, 2016; Meyer & Allen, 1997; Meyer & Herscovitch, 2001) contextualized to reflect the day-to-day reality faced by Sri Lanka nurses. Thus, I label this model the contextualized work-life experiences (CWLEXP) model. This paper begins with a brief overview of the consequences and implications of nurse turnover within Sri Lanka. Next I describe the development of the contextual model, its components, and the relations among the components. The discussion concludes with an examination of how the CWLEXP complements existing generic and nursing models of turnover. It is my hope that the model will inform management practices with respect to fostering conditions that fortify nurses' experiences, commitment to multiple foci, and motivation to stay. My intention is also to provide a conceptual framework from which hypotheses can be derived and empirically tested.

Background

Decisions to remain or leave an employer are not trivial. Leaving the employment relationship creates significant direct and indirect costs that have serious consequences for the nurses themselves, their families, their patients, and their health-care organizations (Yin & Jones, 2013). The consequences of turnover include replacement, work demand, pressure on remaining staff and loss of organizational knowledge and social capital creating challenges for manpower planning within an organization (Hayes, O'Brien-Pallas, Duffield, Shamian, Buchan, Hughes, Laschinger, North, & Stone, 2006; Hom et al., 2012; Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010). This is especially true in Sri Lanka (Ministry of Health & Nutrition, 2016). For individual nurses significant energy is expended on finding a new job as it depends on local (internal and external) and international opportunities, and adjusting to new situations and environments in their professional and personal lives. Giving up known routines and interpersonal connections at one's place of employment (possibly leaving the known community) can be very stressful for the employee and his or her family members (Boswell, Boudreau & Trichy, 2005; Brown, Fraser, Wong, Muise & Cummings, 2013; Cowden & Cummings, 2012). These and other implications for the organizations, individual nurses and families highlight the need to detect the causes, consequences, moderating and mediating factors of turnover.

Data Sources

This discussion paper and model is based on my personal experiences and knowledge of Sri Lanka and, as previously mentioned, represents a contextualized integration of turnover research and commitment theory published between the years of 1958-2016.

Developing a Contextualized Model of Nurse Turnover in Sri Lanka

I recognize that turnover decisions are influenced by one's ability (i.e., the availability of suitable alternatives) and one's motivation to leave. In this particular context, alternative employment opportunities do, in fact, exist for Sri Lankan nurses. Thus, my focus will be on motivational forces; that is, nurses' deliberate personal choice (volition, intention) to stay or leave, as well as the more important work and non-work factors that influence turnover motivaton (see Cotton & Tuttle, 1986; Griffeth, Hom and Gaertner, 2000; Hom et al. 2012; Lee, Allen, Meyer & Rhee, 2004; Mitchell, Holtom, Lee Sablynski & Erez, 2001; Mobley et al., 1979; Steel & Ovalle, 1984; Tett & Meyer, 1993). Both generic (e.g., Mobley, 1977; Sheridan & Abelson, 1983; Price & Mueller, 1981, 1986; Lee & Mitchell, 1994; Mitchell et al, 2001) and nurse-specific models of turnover motivation (Boyle et al., 1999; Cowden & Cummings, 2011; Tourangeau & Cranley, 2006) were adapted for the Sri Lankan context (for more information about this social-cultural context, see Aluwihare-Samaranayake, 2004; Aluwihare-Samaranayake & Paul, 2013; De Silva & Rolls, 2010).

Sri Lanka's basic social organization is authoritarian with high power distance. It is highly structured and familial with the interests of the individual tending to be secondary to those of the family and collectivist decisions (Gamage & Wickramasinghe, 2012). However, influenced by Western culture and technology, some of the younger generation possess less of a hierarchical mindset and have adopted a mix of individualist and collectivist values making them more likely to choose a career that offers work-life balance so they are not necessarily held in one place because they need or are obligated to remain. This has created a shifting social context where nurse turnover is not likely to diminish. I preface the presentation of the proposed contextual work-life experiences model (CWLEXP Model) with a frame of Sri Lanka's basic

social organization, because it is within this frame that Sri Lankan nurses' turnover or staying intentions materialize.

The Proposed Contextual Work-Life Experiences Model (CWLEXP Model)

As mentioned previously, the theoretical model (CWLEXP) developed to measure nurses' intentions to stay (see Figure 2.1) is an integration of research findings found in the generic and nursing literature on turnover, components of Meyer and Allen's three-component model of commitment, and features of nurses' work contexts and personal contexts as identified from previous work carried out in Sri Lanka. It is also constructed taking into account nurses' social contexts and brings more focus to the notion that nurses' work within complex social circumstances, which emphasizes strong family ties and social status and nurses time at work is inter-twined with their commitments to the organization, profession, families, communities and country. It extends investigations into nurses' turnover intentions or staying intentions and moves beyond studies of affective and cognitive determinants of turnover stemming from the workplace to consider outside work influences particularly those related to immediate and extended families, communities and work-family and family-work balance.

The theoretical model proposes that nurses' commitments are directly related to their motivations intentions to stay or leave and their work contexts and personal contexts are indirectly related to their motivations to stay or leave as they are mediated by their commitments. Influenced by macro contexts, the model also indicates that nurses' motivations to stay directly influence their decisions to stay (see Figure 2.1).

Models that Influenced the Development of the CWLEXP

Existing turnover models. Several well-known (generic) models have been used to explain turnover (Griffeth et al., 2000; Hom & Griffeth 1995; Hom et al. 2012). March and

Simon's (1958) focus on turnover was predicted on movement ease and desirability, influenced by inducements and bio-data such as tenure, gender and age as key determinants of perceived ease of movement, with organizational size and job satisfaction driving the desirability of movement (Holtom, Mitchell, Lee & Eberly, 2008). Later, Mobley's (1977) model theorized that a person goes through a cognitive process of quitting influenced by withdrawal intentions related to their values, job and labour market perceptions (Mobley et al, 1979). Recognizing the need to study turnover as an individual choice behavior, Mobley et al. advocated that future research takes into account that job satisfaction is insufficient as a sole explanatory variable for job turnover, and that non-work values and the need for immediate gratification moderate the effects of job satisfaction and expected utilities on turnover. He also advocated that impulsivity moderates the relationship between turnover intentions and actual turnover, and the impact of changes over time may result in employees engaging in alternative withdrawal behaviours. Similarly, Sheridan and Abelson's (1983) model incorporates organizational commitment and job tension, and considers the dynamic withdrawal process that occurs over time and the intermittent change from retention to termination (Sheriden & Abelson, 1983). Price and Mueller (1981, 1986) build on this in their model of turnover, interpreting it as a result of a decision process. They improved their model later by moving the analysis to the causes of turnover, such as the nature of the job, level of routinization, participation, distributive justice, family ties (such as kinship responsibility), social support and search behavior (Holtom et al., 2008; Price, 2001).

While early turnover models focused primarily on cognitive processes, later models attended to factors external to the workplace. Lee and colleagues introduced the impact of life events into a model of turnover decisions (Lee & Mitchell, 1994; Lee, Mitchell, Wise & Fireman, 1996; Mitchell & Lee, 2001). In their work, Lee and Mitchell included the impact of family

responsibilities and unsolicited job opportunities, indicating that traditional models ignored the role of life events. By life events they referred to illness of a family member, change in child-care pattern, transfer or movement of a spouse or pregnancy. They emphasized how certain events are more proximal to actual leaving than is dissatisfaction promulgating the need for pinpointing causes other than attitudes and alternatives to turnover (Hom et al., 2012).

Departing from looking at the cognitive processes of why people leave organizations, Mitchell et al. (2001) developed the concept of job embeddedness to address the psychological underpinnings of why some people stay while others leave. They suggested three distinct forces cause a person to become embedded: fit (how closely a person matches their job or community); links (how closely they have ties with their work, people at work, family or community outside); and sacrifices (on and off the job benefits that will be relinquished on leaving). Felps and colleagues identified that job embeddedness constrains employees from leaving because of loyalty-induced effects of high commitment to the organization and towards colleagues (Felps et al. 2009). This draws attention to the off-the-job components that for some employees are distally related to turnover, for others, are proximal antecedents of quit intentions (Hom et al., 2012).

In addition to the generic models, several nursing turnover models focusing on determinants of nurses' intentions to stay, theory and concept development exist in the literature. Boyle et al.'s (1999) model proposed that nurse turnover is explained by job satisfaction, job stress, manager characteristics (leadership style, influence, power), organizational characteristics (organizational commitment, promotional opportunity, control over practice, distributive justice); unit characteristics (staffing and workload), nurse characteristics (age, education, tenure expectations, years in position, hospital and profession, and marital status) and work

characteristics (routinization, group cohesion, communication, autonomy). They found managers' power and influence over how nurses coordinated their work promotional opportunities and job opportunities elsewhere contribute directly to nurses' intent to stay.

Building on Boyle et al (1999), Tourangeau and Cranley (2006) proposed that job satisfaction, manager ability and support, organizational commitment, work group cohesion, collaboration and nurses' personal characteristics predicted nurses' intents to stay. However, their model did not support all the hypothesized relationships of Boyle and had different study outcomes. In contrast, they found that nurses' intent to stay was influenced by organizational commitment, job satisfaction, work-group cohesion, collaboration and nurses' age. Expanding on Boyle et al and Tourangeau and Cranley by integrating leadership within the model, Cowden & Cummings (2011) introduced a complex, testable model that included both nurses' affective and cognitive responses to work and their effects on nurses' intent to stay (see also Gellatly, Cowden & Cummings, 2014). Their model drew attention to nurses' emotional responses to work environments, adding concepts of desire to stay (such as job satisfaction), joy at work, and moral distress as important considerations.

Three Component Model of Organizational Commitment (TCM). Meyer and Allen's Three-Component Model (TCM) (Meyer & Allen, 1997; Meyer & Herscovitch, 2001) holds that one's overall commitment to an entity or course of action is experienced as one or more of three multi-dimensional mindsets that are fundamentally rooted in emotion, economic considerations, or felt obligation. These three forms of commitment are experienced as an internal force that ties the individual to an entity or course of action (Meyer, 2016). By definition the focal outcome associated with any form of commitment is staying. The contribution of the TCM is to highlight three primary reasons for one's commitment and why these reasons matter. Applied to nurse

commitment, the TCM suggests that the reasons why nurses might stay with an organization are rooted in their desire to stay, need to stay, and/or feelings of obligation to the focus of commitment (e.g., to one's organization itself, to one's profession, to one's family, and/or to one's country).

Direct and Indirect Determinants of the Contextual Work-Life Experiences Model

In the CWLEXP model (see Figure 2.1), I present some of the variables (briefly described below) that are central to the organization and individual nurses' experiences.

Nurses' immediate work context. One of the more important findings of existing empirical work has been the identification of the pivotal role played by work experiences in shaping turnover intentions (Aiken et al., 2011; Meyer et al., 2002). Important work experience variables include concepts that are central to the organization itself and/or those related to the individual's own perceptions of the work place (see Figure 2.1). Many of these work experiences have been shown to be related to nurses' perceptions about organizational roles, organizational support, climate and justice, interrelationships and leadership, human resource strategies and job scope, nature of the work, role ambiguity and conflict, professional development activities, job security and advancement potential (Lake, 2002; Mathieu & Zajac, 1990; Mosadeghrad, Ferlie & Rosenberg, 2011; Slater & McCormack, 2010).

Quality of work. Quality of work is reflected in individual nurses' perceptions of the extent to which their work is meaningful, challenging and flexible (Cowden et al., 2011; Tourangeau, Thompson, Cummings, & Cranley, 2013) as high quality of work life is essential for employers to attract and retain employees (Aiken et al., 2002). High quality work environments are linked with significantly lower odds of nurse burnout, absenteeism, turnover and job dissatisfaction (Asegid, Belachew & Yimam, 2014). Improving nurses' immediate work

environments holds promise to reducing nurses' intentions to leave, promote nurse retention and foster better nursing care and should be one of the most substantial needs of nurses, which result in nurses wanting to stay. In Sri Lanka, low motivation levels, arising from heavy workload, frequent shortages of supplies and lack of equipment, uncongenial work environment, lack of job description, weak communication by staff, lack of involvement in decision making, doing a lot of irrelevant tasks and having irrelevant responsibilities and time pressure are ongoing problems (De Silva & Rolls, 2010).

Perceived organizational (POS). POS is included in the model as it is reflected in the degree to which the organization values nurses' contributions, cares for their well-being and provides constructive psychological, social and clinical support and opportunities for peer cohesion and collaborative decision-making (Rhoades & Eisenberger, 2002; Schalk et al., 2010). Nurses, who believe that the organization supports them (tangibly or intangibly) in their everyday work by providing them with support and assistance should form strong attachments to the organization, fulfill their needs for approval and affiliation (Laschinger, Purdy, Cho & Almost, 2006) and want to remain a member.

Leadership. Leadership includes critical thinking about the past, present and future, relevant leadership styles, power, influence and working together with others to achieve organizational, nursing and patient goals (Cummings, 2012; Tourangeau et al., 2013). Leadership practices are an important consideration for this analysis because leadership has been thought to positively affect the intent of nurses to remain in their current position or the nursing profession as a whole, which can help reduce the impact of the nursing shortage (Lartey, Cummings and Profetto-McGrath, 2013). Typical days are full of tasks that need completion (De Silva & Rolls, 2010), therefore, nurse managers tend to exhibit transactional, dissonant and autocratic behavior

in their efforts to accomplish the lists of tasks that need to be carried out (Cummings et al., 2010). Further, although nurses are held accountable for the way they practice, their work is carried out under the direction of the medical hierarchy, heavily influenced by the unions and politicians with very little autonomy (Biyanwila, 2008; De Silva & Rolls, 2010). Given this environment that nurses mostly seem to work in, in the model I focus on transformational leadership as it is an approach that should lead to all inspiring change in individuals in the healthcare system in Sri Lanka and social systems (Avolio, 2011; Barling, Christie & Hoption, 2011; Bass, 1999; Bass, 2006) and have a greater probability of nurturing nurses' intentions to stay, ensuing retention among staff and commitment to the organization (Cowden et al., 2011; Lartey, Cummings & Profetto-McGrath, 2013).

Professional development. Professional development refers to the systematic improvement and broadening of knowledge, skills, attributes and competencies to enhance execution of professional duties (Lawton & Wimpenny, 2003). These activities are vital for personal and professional development, increase self- confidence and self-esteem, enhanced competencies, improved quality of care and morale of nurses and are often mandated by professional regulatory bodies (Tourangeau et al., 2013). They can take time away from home, family and other social commitments and the work place, but result in tangible personal outcomes, such as recognition from the organization and colleagues for completing a course and receiving a certificate, diploma or degree, promotions and enhanced marketability. Nevertheless, high opportunities for education and skills development have been linked positively to affective and continuance commitment (Meyer & Allen, 1991) and negatively to turnover and this should be the same in Sri Lanka.

Rewards. This construct encompasses forms of compensation including salary, benefits,

allowances, praise, recognition and leave (such as annual and study). Although a good wage was found to be an important characteristic of nurses' work environment, Schalk et al's (2010) review revealed that changes to salaries were not always possible as they were linked to national standards and policies and required multiple negotiations at different levels to change. Losing attractive benefits (such as retirement money, status, job security and the role of provider in one's family) are perceived as costs of leaving a workplace (Meyer & Allen, 1991). Further investments made by an organization in their employees that seem hard to reciprocate tend to enhance normative commitment (Meyer & Allen, 1991). Such an investment maybe an expensive training that the organization agrees to cover. In Sri Lanka recognition and support given to nurses who have invested or are engaged in transferable professional development activities perchance lead to higher affective and normative commitment in comparison to continuous commitment with some nurses and with others may influence their intentions to leave. Further, in Sri Lanka level of salary may be significantly associated with nurses' intentions to leave. Aside from salary, not being able to discuss the salary and related criteria, such as allowances (for knowledge and skills development, uniform, risk allowance, concessions to work in difficult areas), no child-care facilities, support with transport and accommodation could also be contributing factors. Further, nurses may not know why they receive the salary they do and what they can do to improve it. Thus in Sri Lanka rewards should correlate with affective commitment, normative commitment, continuance commitment and turnover intentions.

***Formalization*.** The construct of formalization addresses employment policies, procedures rules, and structure. A review by Schalk et al. (2010) revealed that role and goal clarity was an important aspect of nurses' work environments because it allowed nurses to know the rules and policies explicitly and what to expect in their daily routine. Meyer and Allen (1991)

found that affective commitment is related to decentralization of decision-making and the formalization of policies and procedures, which indicates that formalization should be positively related to ACO and nurses' intentions to stay.

Personal context. A number of personal context variables such as gender and dependent status, age, tenure, position, marital status, religion, level of education and experience, work family and family work balance, financial status and location of family and residence have been linked to the three components of commitment, although the empirical findings have not been impressive and relations have neither been strong nor consistent (Meyer & Allen, 1991).

Gender and dependent status. Griffeth et al. (2000) found that women's quit rate was similar to men's, suggesting that educated women actually resemble men in turnover rate and pattern. Other evidence shows that gender moderates the age-turnover relationships primarily because of women's traditional roles in domestic duties; household chores and child care decrease as they age. For example, roles in primary child-care and as secondary earners may motivate younger women to abandon paid employment. As the children grow up these household duties diminish, women are motivated to re-join the workforce or remain in the workforce, reducing the likelihood of leaving (Grifffeth et al., 2000; Royalty, 1998).

Age. Age has been found to be positively related to nurses' ACO and staying intentions (Deobelle et al., 2011; Engeda, Birhanu & Alene, 2014; Wang, Tao, Ellenbecker & Liu, 2012), with younger nurses more likely to leave than older nurses to obtain new experiences and to access education opportunities. Older nurses may choose to remain in the organization because they enjoy the relative independence in practicing as a nurse, loyalty, fewer opportunities and increased work and personal commitments (Lok & Crawford, 2001; Meyer & Allen, 1984)

Tenure. Tenure and experience refers to the number of years an employee has been in a position. Greater tenure has been linked to commitment, although the relationships have neither been strong nor consistent (Meyer et al., 2002). Meyer and Allen (1991) suggest measuring tenure in organizational cost assessments related to turnover, as investments generally increase over time (Almalki, Fitzgerald & Clark, 2012; Meyer & Allen, 1991). However, they suggest that a positive relationship between tenure and commitment may be due to tenure-related differences in status and quality or to attempts on the part of senior employees to justify their having remained with the hospital for so long.

Position. Position refers to the nurse's actual position in the place of employment; whether they are an entry/junior level, intermediate or senior level. Research studies have reported that ACO and staying intentions increase when an individual's position in the organization goes higher because their motivation to stay and emotion-based commitment increases because of the nature of their work experiences at higher rather than lower levels (Bahrami, Emamrezaei, Sattar, Ranjbar, Dehghani, 2010; Jahangir & Shokrpour, 2009). Thus in Sri Lanka, because nurses in senior positions have become used to their work, duties and general work environment and how the organization functions, they probably have a higher commitment to the organization and intentions to stay.

Marital status. Meta-analyses have revealed that those who were single scored a lower score than those that were married and had kinship responsibilities or had a spouse that was not employed (Griffeth et al., 2000; Hom & Griffeth, 1995). The analyses revealed a higher score if the spouse was employed and having children meant that employees were less likely to quit because of their commitments. However, both reviews presented a positive relationship between intention to quit and education and negative relationships between age and tenure.

Education. Although Meyer et al. (2002) suggest that education has been linked to commitment the relationships have neither been strong nor consistent. A meta-analysis by Hom and Griffeth (1995) found that more intelligent employees are less prone to quit, whereas an updated meta-analysis by Griffeth et al. (2000) revealed that no correlation existed between cognitive ability and turnover. Both reviews revealed that women's quit rate is similar to that of men, suggesting that educated women actually resemble men in turnover rate and pattern and older nurses are more likely to stay in their present jobs than younger ones. However, Glisson and Durick (1988) revealed that employees' level of education is negatively related to organizational commitment, although Meyer et al. (2002) identified that employees who believed their skills could not be transferred to another organization had higher continuance commitment (see section on professional development).

Family and work balance. Work and family balance relates to a self-perceived and satisfactory integration of time, family care responsibilities fulfillment and work related responsibilities fulfillment (Balmforth & Gardner, 2006; Boles, Howard & Donofrio, 2001; Ungerson & Yeandle, 2005). Within this component the following variables were considered: opportunities for part time work, maternity leave, child-care facilities, sick leave, accommodation and location of family. The inability to balance family and work can bring undesirable results on employee turnover (Boles, Howard & Donofrio, 2001), and as such have a negative effect on nurses' commitment to the organization and intentions to stay.

Race. Griffeth et al. (2000) found no relationship between race and turnover, which they reported might not be conclusive. They report that this is because, although there are accounts that minority employees are more likely to quit (Hom & Griffeth, 1995), their propensity to quit might vary depending on type of minority and demographic composition of their work group

particularly if they are underrepresented in work groups (Griffeth et al., 2000).

Financial status. Meyer and Allen (1997) argue that continuance commitment can develop as a result of any action or event that increases the costs of leaving the organization. Investments and alternatives are two variables that have been identified as contributing to continuance commitment (Meyer & Allen, 1997). Investments include factors such as transferability of skills, retirement money, status, job security and the role of provider in one's family. Alternatives include existing employment opportunities and attractiveness of those opportunities. Meyer and Allen (1997) suggest that a sense of continuance commitment develops with the recognition of investments and alternatives. If however, one does not recognize having made or received costly investments or an individual has no alternatives, then continuance commitment may not develop.

***Location of family and residence*:** Location of family and residence interfere with work life balance (Meyer et al., 2002). In Sri Lanka nurses cannot apply to hospitals of their choice although they can make their preferences known. They are given their appointments for a period of 4 years and transfers are done annually, on exigencies of service, on disciplinary grounds or mutual transfers on requests made (Ministry of Health & Nutrition, 2009). Generally, Sri Lanka is a collectivist society and nurses are responsible for their families, parents and relatives; therefore they prefer to work in or close to their communities. Nurses are given the option of working in their hometowns and options to transfer to their hometowns; however, it is not always guaranteed because of the nursing shortages that are geographically dispersed. Nor are nurses always able to move their families to their places of work because of ties in the community. Thus, because nurses may not have the opportunity to work in their living areas, it could result in having low affective and normative commitment to the organization (Lee et al., 2004).

Commitment: Forms. As mentioned earlier, the first component in the TCM, affective commitment, refers to one's "emotional attachment to, identification with and involvement in the organization" (Meyer & Allen, 1997; p. 67). Personal characteristics, the nature of the work itself, work experiences, and aspects of the situation influence affective commitment. Of these factors, it is the nurse's immediate work experiences – especially those that increase the nurse's feelings of comfort and competence in their role – that should have the most potent impact in shaping emotional attachment (cf. Allen & Meyer, 1990). One's sense of comfort has been associated with organizational dependability, management receptiveness, equity, peer cohesion, role clarity and goal clarity, whereas feelings of competence are enhanced by job challenge, goal difficulty, personal importance, feedback and participation (Meyer & Allen, 1997). The next component is referred to as continuance commitment. In contrast to emotion-based attachment, this form of commitment is rooted in personal sacrifices that would be incurred if one were to leave the organization and in the availability of alternatives (Meyer & Allen, 1997). With continuance commitment individuals weigh the personal costs and risks associated with leaving the organization against the personal benefits of staying. From this perspective, this form of commitment is economically based. The third component, normative commitment, is neither emotionally-based nor economically-based but rather is rooted in one's feeling of obligation or duty. Normative commitment occurs when nurses are guided by a sense of duty, moral obligation or loyalties towards the organization. For example, Meyer and Allen suggest that strong normative commitment may be seen in persons who have received considerable education and training from their employer and consequently believe they have a duty to remain loyal to their employer. When normative commitment is high, nurses' commitment to stay is increased (Meyer, Allen, & Smith, 1993).

Commitment: Focus. In our CWLEXP model we consider four commitment foci, which we believe will be important for Sri Lanka nurses, namely commitment to the organization, profession, family and country. It is noteworthy that in the conceptual model presented in Figure 2.1, the different commitment foci have been organized together. However, it is important to realize that feelings of commitment – regardless of the focus – is essentially a personal attitude that could also be listed along with other personal context factors. That said, given its proximal connection to turnover motivation any of these commitments could be specified as an independent and intermediate link within the decision-making process. For instance, in the next chapter, affective commitment to the organization is featured in a process model of nurse turnover.

The case for recognizing different commitment foci originated in the seminal work of Meyer and Herscovitch (2001). In this paper, the authors shifted the TCM to reflect a broader, more general model of workplace commitment by applying it to various specific (entities) or targets (bases/behaviours/action) other than the organization. This idea was, in part, stimulated by an increase in the number of studies applying the three-component model to explain commitment to other foci, including occupations and professions (Snape & Redman, 2003), supervisors, leaders and teams (Vandenberghe, Stinglhamber, Bentein & Delhaise, 2001), customers and organizational change (Meyer et al., 2002). In addition to the organization, nurses experience-varying degrees of emotional connections to their profession, family and country. It can be commitment to one's chosen career, profession or career goal, the members of their family (including extended) and one's country and viewed as personal attributes that nurses bring to their daily work or personal relationships, influence how they feel about those relationships and the organization in which they work – have a spill over effect.

Meyer and Herscovich (2001) argue that people who experience high affective commitment to their profession interpret their professional role broadly to include both focal and discretionary acts. This means that based on qualifications and licensing requirements, if a nurse is deemed competent, they will likely (a) voluntarily and regularly engage in activities to develop themselves professionally irrespective of whether they obtain recognition for their efforts by the employer, and (b) engage to develop their knowledge because of the potential cost associated with not taking steps to improve their knowledge and skills (Meyer et al., 1993; Meyer & Herscovitch, 2001; Meyer et al., 2002). The potential professional costs of leaving may include loss of seniority and inability to engage in career progression activities, such as applying for supervisory/leadership or specialist positions. On the other hand, nurses who see themselves as professionally accountable for the way they practice may feel morally obligated to engage in activities to develop their knowledge and skills (Meyer et al., 1993). Thus an organization that supports nurses to engage in professional development and career progression activities may have a negative effect on nurses' intentions to leave. Cole (2004) identified that working overtime incurs cost to family life and if work is demanding it results in negative family outcomes and vice versa. Having to uproot family and disrupt personal relationships, however, can be perceived as potential costs of leaving a healthcare organization (Meyer & Allen, 1991).

I describe commitment to the family as an individual's identification with and wanting to engage in a course of action because of attachment to shared family values and/or obligation to family. McNeese-Smith (2001) has reported obligation to meet family needs by having a regular job and security, domestic responsibilities, creating a better life, having a plan to retire and not wanting to turn to their investments or risk unemployment are positive determinants of nurses wanting to stay (Mathieu & Zajac, 1990; Sikorska-Simmons, 2005). It is possible that a nurses'

commitment to the organization is more because of the cost involved in leaving, and family commitment matters for ACO and staying intentions as it offers emotional stability and allows nurses to fulfill their moral obligation to their families. As mentioned previously, nurses' love and attachment to their family may also have a spill over effect to the organization.

Commitment to country and community influences nurses' staying intentions. This is because of a psychological sense of belonging and socializing with dimensions of fulfillment, group membership, influence and emotional connection (McMillan & Chavis, 1986; Peterson, Speer & Jughey, 2006). Also, because a sense of community can differ by various groupings and identities, it is important to account for this diversity when measuring community or country commitment influences on nurses' intentions (Coffman & Belue, 2009; Townley, Kloos, Green & Franco, 2011). For example, Sri Lanka is a collectivist society with a) high power distance where subordinates accept power and hierarchy; b) feminine values such as caring for one another rather than accomplishing individual goals and c) a medium-low uncertainty avoidance culture, which implies that communities value neighborhood connection more than in Western countries and communities (Wilkinson, 2007). Prior studies have shown that high levels of sense of community related positively to social support (Mak, Cheung & Law, 2009; Wilkinson), implying that if nurses' level of social support is high then it is possible that their level of affective commitment is high.

Macro contexts. Macro context refers to the "why" and "when" of change and concerns itself with influence from the outer context (such as the historical, prevailing economic, socio-cultural, political environment) (Pettigrew, Ferlie, & McKee, 1982). Many of the variables in the immediate work context box and some of the variables in the personal context will to some extent be influenced by some of the macro factors. However, in this model I specify the macro

context as ambient background context that affects everything and although empirical analysis of the influence of macro context on the variables in this model is beyond the scope of this thesis, a model of nurses' turnover intentions must reflect these realities (see Chapter 4 for further discussion on these macro contexts). The tension between the collective nature of Sri Lanka's collectivist culture and the individualist features of turnover decisions may moderate the relationship between how nurses feel about staying in their job and their withdrawal behaviours (Arzu Wasti, 2016); the relationship being stronger in an individualistic cultural context compared to the primarily collectivist culture that exists in Sri Lanka. Further, there is evidence that international, social cultural, political, economic and professional contexts influence nurses' turnover intentions (see Figure 2.1) (Squires et al., 2016) with economics (rewards and financial support for the individual), insufficient development and career opportunities and individual's need for a better quality of life and recognition predominant (Tummers, Groeneveld & Lankhaar, 2013).

Fit of CWLEXP Model with Other Frameworks of Turnover and Meyer's TCM

In summary, the generic models tested in different locations and occupations revolve around concepts related to the ease, ability and desirability of leaving (also reflected by the number of available and suitable employment alternatives), cognitive factors external to the workplace (life events such as illness of a family member, change in childcare pattern, transfer or movement of a spouse, pregnancy, family responsibilities, unsolicited job opportunities and psychological processes (motivations and desires) often reflected by intentions to leave and consideration of non-work values and causes of turnover including kinship responsibilities. In contrast, influenced by nurses' personal characteristics, nursing turnover models focused mainly on job-related affective and cognitive determinants of nurses' intentions to stay. Early versions

of Meyer's TCM focused on organizational commitment with latter versions expanding to include additional foci (entities) or targets (bases/behaviours/action) (Meyer & Herscovitch, 2001).

In comparison and in terms of fit (value and goals congruence) the CWLEXP is built on existing generic turnover models, nursing models, and Meyer's TCM. It takes into account key features of Sri Lanka's social organization. The theoretical basis of the model provides the rationale for the testing of a holistic view of nurses' turnover intentions that accounts for the cognitive, psychological and macro contexts in which nurses work and live including nurses' commitment to the organization, profession, family and country.

Implications for Nursing

Analysis of turnover that incorporates personal level factors is vital for researchers, policy makers, educators and clinicians in the development of evidence-based strategies to maximize organizational efficiency and effectiveness; it necessitates scrutiny of factors most proximal to the nurse. Guided by the evolving conceptual model (see Figure 2.1), this paper presents a discussion on some of the more proximal factors (nurses' commitments to the profession, family, community and country, and their immediate work contexts and personal contexts) that influence a nurse's core motivations.

Common to all the conceptualizations of commitment found in the literature is a link with turnover, although the nature of that link differs; employees who are strongly committed are those who are least likely to leave the organization (Allen & Meyer, 1990; Price, 2001). Research on organizational commitment is well-established, and tools to measure organizational commitment are characterized by sound psychometric properties (Allen & Meyer, 1996). Meta-analyses on organizational commitment with evidence based antecedents and consequences of

commitment across occupational groups have been carried out (Cohen, 1993; Mathieu & Zajac, 1990; Meyer et al., 2002). Further, research and structural models have shown that organizational commitment is tied to both direct and indirect predictions and is highly associated with intent to leave and actual turnover (Hinshaw, Gerber, Atwood & Allen, 1983; Larrabee et al., 2003; Wagner, 2007).

Healthcare organizations are social institutions that depend on nurses to provide direct service to patients. Retention of nurses by the healthcare organization that employs them is crucial to future delivery of healthcare. One potential solution is a better understanding of the major factors that are associated with or that modify nurses' commitment to their work. Research on organizational commitment is of importance to healthcare institutions that strive for a competitive advantage. Nurses work long hours and experience frequent shift changes as well as other unique stressors, such as threat to personal safety. Work as a nurse requires autonomous, independent decision making in direct patient care, all for a modest amount of pay. Many nurses, however, persist in hospitals despite such hardships. Why nurses continue or leave may be explained in part by the commitment they feel towards their immediate work environment including their patients, families, profession, community or country. However, only limited studies of these relationships exist in literature outside North America and focus on nurses.

Conclusion

The proposed model can be used to create and cross-validate limited-scope models to guide research that explores gaps in knowledge about nurses' staying intentions. Nurse managers, within limited scope, can also examine alternative explanations to aid accuracy in measuring and modeling independent, dependent, moderating and mediating variables to increase nurses'

commitment to the organization and enhance nurses' intentions to stay and increase the likelihood of making important contributions to theory and practice.

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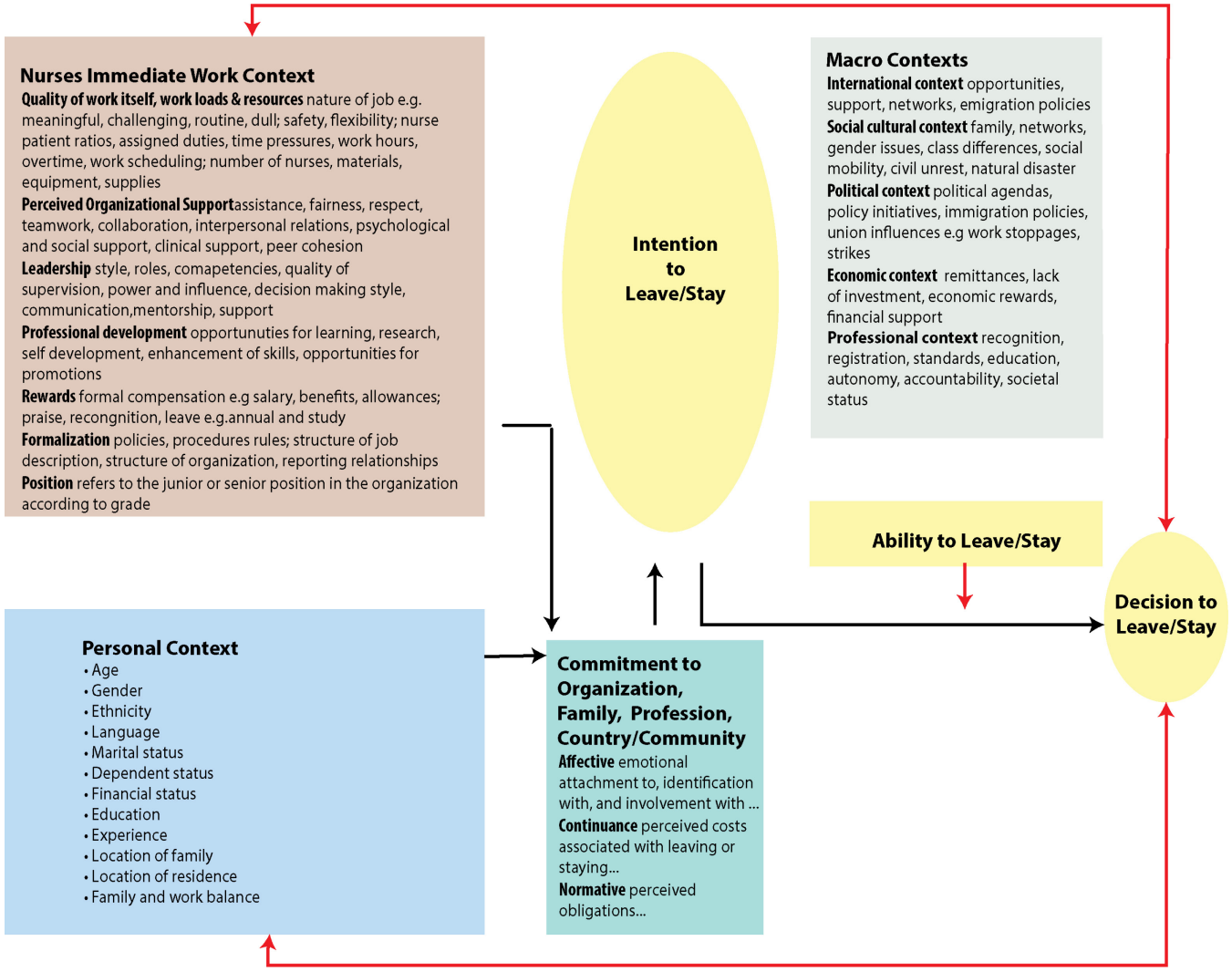
FIGURE

Figure 2.1. Contextual Work-Life Experiences Model (CWLEXP)



CHAPTER 3

An Initial Test of the CWLEXP Model of Nurse Turnover within Sri Lanka

Studies of voluntary turnover decisions are numerous, with many exploring the various personal and situational/contextual factors that influence the psychological processes believed to shape one's motivation to stay or leave (for reviews and commentary, see Griffeth et al., 2000; Holton et al. 2008; Hom et al. 2012; Lee & Mitchell, 1994; Mitchell & Lee, 2001; Steel, 2002). An emerging body of work has focused specifically on nurses, and how their unique work and non-work circumstances directly or indirectly affect their desire to stay (Boyle, Bott, Hansen, Woods & Taunton, 1999; Cowden & Cummings, 2012; Tourangeau & Cranley, 2006). In the previous chapter I outlined the underlying logic and rationale for the CWLEXP Model. In this chapter I offer an initial – albeit limited – empirical test of the micro section of the CWLEXP Model. As mentioned previously, our focus is on how nurses' personal attributes and work/non-work experiences affect their decision to voluntary stay or leave the employer. A central idea explored here concerns the role of affective commitment to the organization (ACO), and whether it mediates the influence of personal and situational factors on turnover intentions (see Figure 3.1).

Background

Existing knowledge about a variety of factors shaping workers' motivations to stay in their current positions informed this project. Drawing on this literature, I begin with an inquiry into the phenomenon of nurse turnover and the role played by individual nurses' intentions to stay or leave. Then the discussion moves to an explanation of a particular form of organizational commitment that is believed to be a potent and proximal determinant of turnover intentions. Finally, the factors (both work and personal) believed to influence both nurse commitment and

turnover intentions are discussed within the context of a process model, which, in turn, forms the basis of the study hypotheses. Hypotheses (H1 to H9) for this study are presented.

Nurse Turnover and Turnover Intentions

Nurse turnover describes the situation where individual nurses decide to terminate employment (Griffeth et al., 2000). A holistic view of nurses' turnover intentions encompasses the affective, cognitive, psychological, and macro contexts in which nurses work and live including their commitment to the organization, profession, families and country (Aluwihare-Samaranayake, et al., 2017). Given that intent to leave has been shown to accurately represent individuals' actual turnover behaviors as both a proxy and predictor, our focus in this study is on individual's turnover intentions rather than actual turnover, which is affected by a range of factors outside the model, such as job opportunities. The argument for the focus on turnover intentions as a proxy is that no data exist in Sri Lanka examining nurses' actual turnover. Moreover, nurses' turnover intentions are either related to organizational level work context factors or individual nurses' personal level factors or both.

Commitment to the Organization: Affective

Affective commitment to the organization (ACO) is defined as nurses' positive emotional attachment to the organization. A nurse who is affectively committed identifies with the goals of the organization and desires to remain in the organization (Lee et al., 2004; Meyer & Allen, 1997). In other words, affective commitment will motivate nurses to continue with the organization because they *want* to because they are viewing their personal needs, expectations and values as congruent to the goals and values of the organization (Meyer & Allen, 1997). Allen and Meyer (1996) have pointed out that the strongest evidence has been provided for work experience antecedents, specifically those experiences that fulfill employees' psychological

needs to feel comfortable in the organization and competent in the work role. Given that antecedents of affective commitment fall into four categories: personal characteristics, job characteristics, work experiences and structural characteristics (Allen & Meyer, 1990), our focus in this study is also on examining factors that influence nurses' affective commitment to the organization and how factors that influence nurses' intentions to stay are affected or not by nurses' affective commitment to the organization.

Work Context

Empirical work has demonstrated the pivotal role of work experiences in determining turnover intentions (e.g., Aiken et al., 2011; Gellatly, Cowden & Cummings, 2014; Meyer, Stanley, Herscovitch, & Topolnytsky, 2002). Work experience variables include those central to the organization itself and/or related to the individual's own experience. Considered within the work-experiences category, for this study, are the quality of work itself, transformational leadership (TFL), perceived organizational support (POS) and the position (Posit) held by the nurse.

Quality of work-life. Quality of work life is a phenomenon that reflects nurses' perceptions of their work environment (i.e., the extent in which their work is meaningful, challenging, flexible and stimulating), and has been measured using various instruments internationally (Cummings, Hayduk & Estabrooks, 2006: Lee, Dai, Park, & McCreary, 2013; Schalk, et al., 2010; Slater & McCormack, 2007; Slater, O'Halleran, Connelly & McCormack, 2010). Nurses' perceptions of their work environment (associated with quality of work life, work load, and resources) has been associated with "organizational characteristics of a work setting that facilitate or constrain professional nursing practice" (Lake, 2002, p. 178) and is considered imperative to attract and retain nurses (Aiken, Clarke & Sloane, 2002). Quality of work life

should account for the strength and weaknesses of nurses' work environment or to be precise in this study it should account for nurses' perceptions and evaluation of work conditions that include their perceptions about career opportunities and advancement (COA), use of the nursing process (NP), staffing resource adequacy (SRA), nurse physician relations (NPR) and nurse manager ability and leadership (NML) (Mosadeghrad, Ferlie & Rosenberg, 2011; Slater & McCormack, 2010). High quality of work has been associated with lower absenteeism, lower turnover and improved job satisfaction, and organizations' ability to recruit nurses and enhance competitiveness (Asegid, Belachew & Yimam, 2014). Thus, high quality of work life should be one of the most important needs of nurses, an antecedent of organizational commitment, and result in nurses with the perception 'I want to stay' (Rhoades & Eisenberger, 2002).

H1a: Quality of work life is positively related with nurses' staying intentions

H1b: Quality of work life is positively related with nurses' with ACO

Transformational leadership (TFL). Transformational leadership is defined as a leadership approach that causes inspiring change in individuals and social systems creating valuable and positive change in followers with the driving goal achievement of empowering followers and developing followers into leaders (Avolio, 2011; Barling, Christie & Hoption, 2011; Bass, 1999; Bass, 2006). Transformational leaders offer support and encourage followers to use novel approaches to think critically, involve followers in decision making processes, invite autonomous decision-making, inspire loyalty, recognize different needs of each follower to develop his or her personal potential and offer praise and recognition (Cummings et al., 2010). They invest time and energy to nurture better work environments and take time to build relationships and meet individual needs of their staff, and have a greater likelihood of fostering nurses' intentions to stay rather than intentions to leave, leading to retention among staff and

affective commitment to the organization (Cowden et al., 2011; Lartey, Cummings & Profetto-McGrath, 2013). Transformational leadership practices are an important consideration for this analysis because leadership can affect the intent of nurses to remain in their current position or organization, or to stay in the nursing profession as a whole. Nurses who are exposed to transformational leaders want to stay and have higher affective commitment to the organization because they experience their leaders caring about their health and well-being, supporting their professional development activities, empowering and encouraging them to make decisions and taking action to enhance their performances as nurses (Lin, MacLennan, Hunt & Cox, 2015). There is considerable research available to suggest that transformational leadership should relate positively with organizational commitment in a variety of settings and cultures (Avolio, Zhu, Koh & Bhatia, 2004) and is associated with increased intentions by nurses to stay in the workplace (Cowden, Cummings & Profetto-McGrath, 2011; Brown et al., 2013).

H2a: TFL is positively related to turnover intentions and positive to staying intentions

H2b: TFL is positively related to ACO

Perceived organizational support (POS). Perceived organizational support (POS) refers to the global beliefs employees form about the level to which an organization values their contributions and cares about their well-being (Rhoades & Eisenberger, 2002). Nurses who believe that the organization supports them tangibly or intangibly in their everyday contributions and attends to their well-being by providing necessary assistance to do their job effectively will form strong ACO and develop strong staying intentions (Laschinger, Purdy, Cho & Almost, 2006). This happens because when nurses feel supported they feel an obligation to reciprocate and settle their indebtedness (through their attitudes and deeds) by helping the organization reach

its objectives (Eisenberger, Rexwinkle, Lynch & Rhoades, 2001). Remaining loyal (i.e., showing support for the organization and commitment by being attentive to organizational goals and objectives, working well with positive attitudes, behaviours and actions) might be a way of returning good will. Generated through favourable work conditions, nurses' POS is believed to generate thoughts of trust and strong feelings of classification with the organization and increase ACO and staying intentions by fulfilling nurses' needs for esteem, approval and affiliation (Rhoades & Eisenberger, Armeli, 2001). Thus, according to theory and prior work in other, non-nursing contexts, it seems reasonable to expect that nurses who experience POS should experience strong affective commitment (i.e., emotional ties) to the organization and want to remain a member.

H3a: Perceived organizational support is positively related to staying intentions

H3b: Perceived organizational support is positively related to ACO

Position. Position refers to the nurse's actual position in the place of employment; whether they are at entry/junior, intermediate or senior level. At junior level a nurse may know fundamental concepts and procedures but will work under supervision, follow routine and instructions and will not have had the time to grow an attachment to the organization. In contrast, studies have reported that when position increases with seniority and tenure, ACO and staying intentions increase (Bahrami, Emamrezaei, Sattar, Ranjbar, Dehghani, 2010; Jahangir & Shokrpour, 2009). Nurses' motivation to stay and emotion-based commitment should increase because of the nature of their work experiences at higher rather than lower levels (less routine at higher levels and more autonomy, feelings of control over work and independence of decision making). A study conducted in Saudi Arabia found that nurses who have senior positions may have become used to their work, duties, co-workers, general work environment and the

functioning of the organization, which led them to develop a high level of commitment to their work, position and organization and low intentions of leaving (Almalki, FitzGerald & Clark, 2012).

H4a: Position is positively related to nurses' staying intentions.

H4b: Position is positively related to nurses' ACO.

Personal Context

The variables encompassed within personal or individual nurse's context are: commitment to the profession, commitment to the family, family work balance and age. Commitment to the profession and commitment to the family are included in the personal context category because of its proximal link to the individual nurse. A nurse's profession is a journey of formal and informal learning, working and re-learning in nursing that he or she has done and a nurse's family are people that nurses hold in proximate, have traditional or non-traditional relationships with, are immediate or extended and they have an obligation to.

Commitment to the profession. A profession is defined by a unique body of knowledge; autonomy in the application of that knowledge; commitment to a specialized line of work; identification with, involvement in and emotional attachment to the profession; and, responsibility to society for ethical use of that knowledge and maintenance of standards (Meyer, Allen & Smith, 1993). In addition to social entities like an actual work department or organization, commitment theory asserts that people can form emotional connections to courses of action – in this case, commitment to one's chosen career-path, career-goal or profession (cf. Meyer & Herscovitch, 2001). Implied in Figure 3.1 is the notion that attachment to one's profession be viewed as a more primary personal attribute that nurses bring to their day-to-day relationships, and impact how they feel about those relationships – including commitment to

one's immediate organization. In essence I am proposing a type of spill-over effect whereby one's general feeling about the profession extends to those entities and interactions that facilitate the nurse's ability to practice what he or she loves to do – and by extension, remain with the organization.

H5a: Commitment to the profession is positively related to staying intentions

H5b: Commitment to the profession is positively related to ACO

Commitment to the family. I describe commitment to the family as an individual's identification with and wanting to engage in a course of action because of attachment to, identification with or shared family values or obligation to their family. For example, family needs, creating a better life for self and family, and having a plan to retire from the organization, all have been reported as positive determinants of nurses wanting to stay (McNeese-Smith, 2001). Studies examining the relationship between organizational commitment and marital status have found that married employees show more commitment to the organization compared to single employees because of their domestic responsibilities, and feelings of obligation to respond to the needs of their families by having a regular job and security, not wanting to turn to their investments or risk unemployment (Mathieu & Zajac, 1990; Sikorska-Simmons, 2005). It is arguable that a nurses' commitment to the organization may be more because of the cost involved in leaving, but I posit that family commitment matters for ACO and staying intentions as it offers emotional stability and allows nurses to fulfill their moral obligation laden commitments to their families. In addition, following the logic used to advance H5b, the strong emotional bonds that nurses have with their families may transfer to their activities and associations that are consistent (and facilitate) family commitment.

H6a: Commitment to family is positively related to nurses' staying intentions.

H6b: Commitment to family is positively related to nurses' ACO.

Family and work balance. Family and work balance relates to a self-perceived and satisfactory integration of time, and fulfillment of family care and work related responsibilities (Netemeyer, Boles & McMurrian, 1996; Ungerson & Yeandle, 2005). Family and work requirements can interfere with each other making it difficult for an individual to maintain a balance between family and work responsibilities like fulfilling family commitments and meeting the criteria of the work place (Balmforth & Gardner, 2006). The inability to balance family and work can negatively affect nurses' intentions to stay (Boles, Howard & Donofrio, 2001). Meyer et al. (2002) suggest that affective commitment to the organization correlates negatively to work family conflict (p = -.20). Research has also shown employee perceptions regarding family are related to intentions to leave the organization (Allen, 2001). For example, Akintayo, Rehman and Waheed (2012) have shown a negative relationship between work family interference and organizational commitment and Benligiray and Sonmez (2013) in a study of work family conflict with doctors and nurses identified that an increase in commitment to the organization increased work-family conflict and vice-versa. In Sri Lanka, limited opportunities for work-family balance possibly result in low affective commitment and staying intentions**.**

H7: Family and work balance is negatively related to nurses staying intentions.

H7: Family and work balance is negatively related to ACO.

Age. Research has found that age is positively related to nurses ACO and staying intentions (Deobelle et al., 2011; Engeda, Birhanu & Alene, 2014; Wang, Tao, Ellenbecker & Liu, 2012). Younger people have an experimental stage at the beginning of their professional life where they are more likely to leave for different experiences or obtain further education. In contrast, I expect in Sri Lanka older nurses will have stronger bonds to the organization because

they are governed by generational attitudes, values, goals and expectations (Tourangeau, et al., 2010). In addition, older nurses may chose to remain in the organization for reasons of loyalty, relative autonomy and independence in practicing as a nurse and because they thought there are fewer job opportunities chose to remain employed. Age is an important consideration with turnover intentions because nurse leaders need to prepare and manage knowledge transfer strategies in preparation for the exit of experienced nurses from the workforce. Literature also shows that there is a linear relationship between organizational commitment and age, and the older the nurse, the higher the level of organizational commitment and motivations to stay (Lok & Crawford, 2001; Meyer & Allen, 1984)

H8: Age is positively related to staying intentions.

H8: Age is positively related to ACO.

Affective Commitment to the Organization as a Mediator

As alluded to earlier, prior research suggests that emotion-based (affective) commitment is a consistent predictor of intended and actual turnover across people and situations (for a review, see Gellatly & Hedberg, 2016) not to mention a variety of other behavioral outcomes such as job performance and citizenship behavior (e.g., Klein et al., 2009; Meyer & Herscovitch, 2001; Meyer et al., 2002; Meyer, 2016). Further, ACO has long been viewed as a proximal predictor of turnover intentions (Gellatly & Hedberg, 2016). To the extent that the personal and contextual concepts investigated in this study influence the strength of ACO, then it is reasonable to expect that the effect of these external variables on nurses' intentions might be indirect through ACO.

H9: The relationship between both the personal context and work context factors and staying intentions will be mediated by ACO.

Method

Sample and Procedure

Survey data were collected during 2014-2015 from 679 nurses employed in an urban non-fee paying hospital in Sri Lanka. This particular organization was chosen because it is the hospital that is the most likely to contain a large number of nurses, where working conditions are one of the best and better resourced and staffed than anywhere else in the country, where there is variation in terms of departments and where there are nurses with better opportunities to influence their turnover intention. Since our purpose was simply to obtain a large-enough sample to test our study hypotheses, it was appropriate to use a convenience sample (i.e., a sample where the population is not clearly defined; Highhouse & Gillespie, 2009). One of the challenges of conducting a study in Sri Lanka is that no computerized list of nurses employed in the hospital existed and to create one would have resulted in a time, money and effort costing exercise of copying names by hand. Thus, participants were not randomly sampled. Rather, survey packages were simply left in the various units with cover letters that invited participation. Because I cannot be sure that every eligible nurse received a package the sample population cannot be determined; thus, a response rate cannot be computed. However, with an N of 679 I had a sufficient power to test my hypotheses (Tabachnick & Fidell, 2007; Faul, Erdfelder, Lang, & Buchneret, 2009;).

I used the *Tailored Design Method* (TDM) proposed by Dillman, Smyth and Christian (2009) and a foot-in-the-door approach to access and recruit participants, beginning with securing support from the hospital director and Chief Nursing Officer (CNO). As alluded to earlier, I placed flyers advertising the study in Sinhala, Tamil and English in central locations around the hospital (see Appendix B). Questionnaires (see Appendix C) were distributed to

nurses on the selected study units. Each questionnaire package included a cover letter conveying information about the study, potential benefits, the significance of the study, and the estimated time required to complete the questionnaire, as well as contact information should the potential participant have concerns. This package also contained consent information, a paper version of the questionnaire, a note of appreciation for participation, and a stamped, self-addressed envelope for return of the completed questionnaire. The questionnaire was distributed in three languages to allow nurses to complete it in the language of their choice.

Over the three-week estimated period of data collection, staggered visits (1-5 times a week) were executed to meet with nurses to distribute the questionnaires. All participants were given sufficient time from distribution (one week and then the reminder for a further week) for the completion of the questionnaire. Dillman et al. indicated that response rates would be 20 to 40% higher with personal follow-up-contact than those that might be attained otherwise. Therefore, one week following the distribution of the questionnaire, a second flyer (see Appendix D) was distributed, thanking those who completed the questionnaire and asking those who have not, to do so as soon as possible. Participants were informed that they may hand return the completed questionnaire; keep the completed questionnaire, sealed in an envelope in a box in the ward collection; or mail the completed questionnaire (using the stamped, self-addressed envelope) to improve questionnaire completion. An electronic data collection method was not an option, as not all nurses have access to a computer or Internet access.

Ethical Considerations

This study received ethics approval from the Health Research Ethics Board at the University of Alberta, the Sri Lanka Medical Council (with letters of support for data collection from supervisors based in Sri Lanka), and the urban hospital. Permission was obtained from the

Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka and consent was implied by completion of the questionnaire (see Appendix A).

Measures and Instruments

The English questionnaire was translated from English into Sinhala and Tamil using a standard translation-back-translation procedure and repeated checking and reviewing by bilingual nurses and researchers (English and Sinhala or English and Tamil or Sinhala and Tamil speaking individuals). The questionnaires were developed primarily using psychometrically tested measures and were pretested among nurses in a university environment in Sri Lanka to make sure all the items were understood. Below I present the instruments used for measuring the constructs. Note, I empirically measured all subscales associated with multi-dimensional constructs.

Quality of work. Quality of work was directly assessed using a modified 33-item NWI-R measure with a six-factor model. Measures of reliability revealed $\alpha = 0.87$ for career opportunities and advancement, $\alpha = 0.80$ for nursing process, $\alpha = 0.85$ for adequate staff and resources, $\alpha = 0.84$ for nurse physician relations, and $\alpha = 0.80$ for nurse management and leadership ability (Slater & McCormack, 2007). Subscales were used to measure different variables of the limited model in Figure 3.1. To complete the measurement, respondents were asked to indicate the extent to which they exhibit each behavior using the four point Likert scale ranging from 1 = "strongly disagree" to 4 = "strongly agree" for each item. Higher scores indicated a more favorable view of the practice environment. The reliability for career development and advancement was $\alpha = 0.79$, $\alpha = 0.71$ for nursing process, $\alpha = 0.69$ for adequate staff and resources, $\alpha = 0.78$ for nurse physician relations, $\alpha = 0.69$ for nurse management and

leadership ability and α = 0.62 for nurse participation. Because it was not possible to improve the reliability of the component nurse participation, it was removed from the analysis.

Leadership. Leadership was measured using the *TFL Behavior Inventory* developed by Podsakoff, Moorman and Fetter (1990). This 22 item scale assessed the following dimensions of TFL: (1) articulating a vision (five items: α = 0.70 to 0.84); (2) providing an appropriate model (three items: α = 0.66 to 0.87); (3) fostering acceptance of group goals (four items: α = 0.75 to 0.90); (4) high performance expectations (three items: α = 0.80); (5) providing individual support (four items: α = 0.78 to 0.88); and (6) intellectual stimulation (three items: α = 0.75 to 0.78). Previous research (Podsakoff, MacKenzie & Bommer, 1996; Podsakoff et al., 1990) provided strong evidence supporting the hypothesized factor (reliability α = 0.66 to 0.90). In this study nurses were invited to indicate the extent to which their direct superior performs each behavior using a six-point Likert scale ranging from 1 = "strongly disagree" to 6 = "strongly agree" for each item. The items for each participant averaged with a higher scale score indicating that strong TFL behaviors are exhibited. The composite score was used in this study and the reliability in this study for TFL was α = 0.942

Perceived organizational support (POS). I measured POS using an 8-item scale with a mean reliability alpha of 0.93, with item-total correlations ranging from 0.70 to 0.84 and mean and median item-total correlations of 0.75 and 0.73 respectively (Rhoades & Eisenberger, 2002). Respondents were asked to indicate the extent to which they disagree or agree using a six point Likert scale ranging from 1 = "strongly disagree" to 6 = "strongly agree" for each item. The items for each participant were averaged with a total score representing POS. A high score indicated a high POS. Reliability with the 8 items in this study was α = 0.441. Therefore, I carried out a principal component analysis (PCA) and reduced the scale to include 4 of the 8

items: the organization values my contributions to its well-being", the organization really cares for my well-being", "the organization takes pride in my accomplishments at work", and "the organization cares about my general satisfaction at work". In this study the reliability with these four items was $\alpha = 0.686$.

Affective commitment to the profession, organization, and normative commitment to family. Affective commitment to the profession (ACP) was measured using the 7-item scale described by Meyer and Allen (1997) ($\alpha = 0.8$), a scale developed as an adaptation of the scale devised to measure commitment to the organization. They reported an average reliability of $\alpha = 0.85$ in more than 40 studies and Irving, Coleman and Cooper's (1997) analysis evidenced the consistency of applying Meyer et al.'s (1993) measures across various occupations and the value of obtaining the three-component conceptualizations of professional commitment. Respondents were asked to indicate the extent to which they exhibit each behavior using the six point Likert scale ranging from 1 = "strongly disagree" to 7 = "strongly agree" for each item. High scores are interpreted as high affective commitment.

Meyer et al. (1993) reported, "…the wording of the items is such that someone wanting to use the scales to measure commitment to other occupations could do so simply by substituting the appropriate descriptors" (p. 539). Therefore, using the existing normative commitment to the organization as a guide, 3 questions were used to measure normative commitment to family. These items were, "I would feel guilty if I leave my family now", "I would not leave my family now because I have a sense of obligation to the people in it", and "I owe a great deal to my family". The items were designed to be answered on a 7-point Likert type scale with 1 = "strongly disagree", 7 = "strongly agree". The reliability for affective commitment to the

profession was α = 0.72, affective commitment to the organization (ACO) was α = 0.90 and normative commitment to the family (NCF) was α = 0.75

Position. In this study, position was measured as follows: "1=Grade 111, 2 = Grade 11, 3 = Grade 1, 4 = Supra Grade, 5 = Special Grade, 6 = Executive Grade".

Work family balance (WFB) and family and work balance (FWB). Netemeyer et al.'s (1996) scales were used because (a) they measure the interrelated concepts separately preserving the conceptual distinction between the two; and (b) existing research suggests that intention to leave an organization is positively related to both concepts (Lee, Zvokkovi, & Crawford, 2013); (c) the scales have 5-items each, (which means that they are less cumbersome for a respondent to answer than more extensive scales), and they attend to dimensionality, which augments study power. Netemeyer, et al. (1996) assessed the scales across three study samples and the WFB scale had an average alpha of α = 0.88, coefficient average of 0.88 and average variance of 0.60 and the FWB had an average alpha of α = 0.87, average coefficient of 0.86 and average variance of 0.58. Nurses were invited to respond on a 7 point Likert scale, ranging from 1 = "strongly disagree" to 7 = "strongly agree". Items were summed to reflect individual scores of both measures. A high score represented a high level of work-family conflict or family-work conflict and low level of balance and vice versa. The scores from the WFC and FWC were averaged separately to maintain their dimensionality. A high score indicated a high level of perceived conflict between WFB and FWB, while a low score reflected a low level of perceived conflict between WFB and FWB. The reliability for WFB was α = 0.835 and for FWB was α = 0.811.

Age. In this study age was measured using, *"1=20-24, 2 = 25-29, 3 = 30-34, 4 = 35-39, 5 = 40-44, 6 = 45-49, 7 = 50-54, 8 = 55-59, 9 = 60-64, 10 = 65-69".*

Staying intentions (SI). Bozeman and Perrewe's (2001) 5-item scale was used to measure nurses staying intentions. The items of this scale included: "I will probably look for a new job in the near future", "At the present time, I am actively searching for another job in a different organization", "I do not intend to quit my job (RS[1])", "It is unlikely that I will actively look for a different organization to work for in the next year (RS)", "I am not thinking about quitting my job at the present time". In this study, the reliability with five items on the scale was $\alpha = 0.597$. The items were designed to be answered on a 5-point Likert type scale with 1 = "strongly disagree", 2 = "disagree" 3 = "neutral", 4 = "agree", 5 = "strongly agree". Therefore, I carried out a principal component analysis (PCA) to determine the items that account for most of the variance and most closely represent nurses' intent to leave and recalculated the reliability. The loadings were higher on items 3, 4 and 5 and showed a reliability score of $\alpha = 0.712$.

Analytic Strategy

The data from 679 participants were used in the following analysis using SPSS (version 24). Little's (1988) MCAR test was carried out to test the hypotheses in order to ascertain if values are missing in a random way or non-random way and data were screened to ensure that assumptions needed for the analysis were met. Next, I computed coefficient alpha to ascertain the reliability for each of the composite scales. Then, principal component analyses were carried out with study measures that had a low reliability and items that had a higher loading were retained and items with a low loading removed. This allowed me to retain the best overall summary of the study measures without changing the meaning or interpretation of the scale as well as improve its alpha coefficient (Tabachnick & Fidell, 2007).

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[1] RS refers to reverse scored.

Descriptive statistics and correlations among the variables used in the study were also computed, which help identify basic bivariate relationships of the predictor variables with affective commitment to the organization and nurses' staying intentions. Then to examine which variables best explain staying intentions and affective commitment to the organization I used hierarchical regression (see Tables 3.1, 3.2, 3.3). In the final phase of the analysis, I followed the procedures described by Baron and Kenny (1986) to test the study H9 using multiple hierarchical regression analysis. Baron and Kenny (1986) advocate that a variable operates as a mediator when the following conditions are met: the independent variable accounts for variations in the mediator (path a), the mediator accounts for variations in the dependent variable (path b), and when the variations in path a and path b are controlled, a previously significant relationship between the independent and dependent variables is no longer significant, and mediation is demonstrated when the relationship between the independent variable and dependent variable is zero (path c is zero). If it is not zero but less than the relationship between the independent variable and the mediator variable he suggests that the mediator variable partially mediates the relationship between the independent variable and the dependent variable.

Baron and Kenny (1986) also suggested that to test for mediation the mediator should be regressed on the dependent variable, the dependent variable should be regressed on the independent variable and the dependent variable should be regressed on both the independent variable and the mediator. Using the regression equations above to establish the mediation relationship, he suggests the independent variable must be related to the mediator; the independent variable must be related to the dependent variable; and the mediator must be related to the dependent variable (Baron & Kenny, 1986). These recommended procedures were followed.

Results

Missing Data Analysis

Little's (1988) MCAR (Missing Completely at Random) test showed a Chi-square of 69, DF 68 and Sig. = 0.63, which is not statistically significant. This indicated that the data were probably missing completely at random and I was able to use means imputation or means substitution technique to impute missing values in order to have a complete data set (see Appendix E for tables of variables used in this thesis).

Respondents Profile

Respondents were Sinhala (85%), Tamil (6%), and a few Burger, Muslim or Malay. Sixty percent of nurses were married, 86% were female and 74% reported caregiving responsibilities for dependent children or adults. In terms of educational attainment, 74% had a diploma in nursing, 2% had a post-basic diploma in a nursing specialty, 13% had a baccalaureate degree in nursing, 1% had a master's degree in nursing and other .1%. Seventy-three percent of respondents reported holding nursing registration and 80% reported being on permanent status working between 1 and 200 hours per month of paid overtime suggesting a nursing shortage. Of these nurses, 44.6% were designated as Grade III (refers to nursing position), 38.7% as Grade II, 10.4% as Grade 1, 5.2% as Supra Grade, and 1% as Special Grade.

Descriptive Statistics and Relationships between Core Variables

Means, standard deviations, reliability and correlations among the study contextual variables are presented in Table 3.1. Correlation coefficients between career opportunities and advancement (r = .26), nursing process (r = .14), staff resource adequacy (r = .14), nurse physician relations (r = .33), nurse manager ability and leadership (r = .37), TFL (r = .42), perceived organizational support (r = .26), position (r = .21) from work context variables and

ACP (0.28), NCF (0.17) and age (r = .24) from personal context factors were positively related to ACO with work family balance ((r = -0.12) negatively correlated with ACO. These results reveal that TFL had the strongest relationship with ACO, followed by nurse manager ability and leadership, nurse physician relationship and ACP. In contrast, affective commitment to the organization had the strongest link with staying intentions ((r = .38), followed by commitment to the profession (r = .29), use of TFL (r = .25), nurse manager ability and leadership (r = .19), commitment to family (r = .16), age (r = .15), position (r = .14), nurse physician relation (r = .13) and career opportunities and advancement (r = .10) (Table 3.1). Interestingly, nursing process, staff resource adequacy, POS, work family balance and family work balance showed no relationship to staying intentions possibly relating to the fact that nurses work in an environment with shortages of human and material resources, do not feel the support they receive from the organization makes them want to stay, and the level of support received from the organization does not influence nurses' intentions to stay.

Test of Hypotheses

As mentioned previously, hierarchical multiple regression was used to test the study hypotheses. First, staying intentions of nurses were regressed on career opportunities and advancement, nurse-physician relations, nurse management and leadership ability, TFL, position from work context variables and commitment to the profession, normative (moral) commitment to the family, and age from personal context. The results of this analysis are presented in Table 3.2. My selection of variables to use in the regression analysis was based on my theoretical knowledge and the statistical significance reflected in the correlations table.

Overall, when regressing staying intentions on the above-mentioned work context and personal context factors the results indicate that both of these predictors explain unique criterion

and account for 25% of variance in staying intentions, with nurses' work context offering 9% (R^2 = 0.09, F = 12.77, p <.01) and personal context explaining 16% (R^2 = 0.16, F = 19.94, p <.01) of variance in nurses' staying intentions. The results indicated that personal context factors explain more variance in staying intentions than work context factors. An examination of the regression coefficients that pertain to each of the relevant study hypothesis now follows.

H1a: Quality of work life is positively related with nurses' staying intentions. When testing this hypothesis, I regressed staying intentions on career opportunities and advancement, nurse-physician relations, nurse management and leadership ability, the unstandardized regression coefficients indicated that only nurse physician relations (B = 0.02) and nurse management and leadership ability (B = 0.08) were significant predictors of nurses' staying intentions. Thus, I conclude that H1a is partially supported.

H2a: Transformational leadership is positively related to staying intentions. The results of the regression analysis revealed that TFL (B = 0.20) from work context factors was a significant predictor of nurses staying intentions. Thus, I conclude that H2a is accepted.

H3a: Perceived organizational support is positively related to staying intentions. In the results of the correlation analysis, POS showed no relationship to nurses' staying intentions (see Table 3.1). Therefore, I did not include it in the regression analysis.

H4a: Position is positively related to nurses' staying intentions. When staying intentions was regressed on the work context factor position (B = 0.09), the unstandardized regression coefficients indicated position was a significant predictor of nurses' staying intentions. Thus, I conclude that H4a is accepted.

H5a: Commitment to the profession is positively related to staying intentions. Analysis of this hypothesis revealed that ACP (B = 0.19) was a significant predictor of nurses' staying intentions. Thus, I conclude that H5a is supported.

H6a: Commitment to family is positively related to nurses' staying intentions. When staying intentions was regressed on commitment to family, the unstandardized regression coefficient (B = 0.09) indicated that commitment to family was a significant predictor of staying intentions. Thus, I conclude that H6a is accepted.

H7a: Family and work balance is negatively related to nurses staying intentions. In contrast to the previous hypothesis, I found that because family and work balance showed no relationship to staying intentions (see Table 3.1). I did not enter it into a regression analysis.

H8a: Age is positively related to staying intentions. Bivariate correlation analysis revealed that age was positively related to staying intentions (see Table 3.1). However, when I regressed staying intentions on age (see Table 3.2), the unstandardized regression coefficient was not significant. Thus, I conclude that H8a is rejected.

In a second regression analysis, I regressed ACO on career opportunities and advancement, nurse-physician relations, nurse management and leadership ability, TFL, position from work context variables and commitment to the profession, normative (moral) commitment to the family, and age from personal context (see Table 3.3). Overall, these results indicate that situational and personal context predictors explain unique criterion and account for 58% of variance in ACO, with personal context offering 32% ($R^2 = 0.32$, $F = 19.94$, $p < .01$) in variance in comparison to 26% ($R^2 = 0.26$), $F = 47.97$, $p < .01$) of variance in nurses' work context. In comparison to when staying intentions were regressed on work context factors and personal factors, when ACO was regressed on work context factors and personal context factors, I found

that work context factors showed more variance with ACO than with staying intentions. Again, I now review the regression coefficients that pertain to the hypotheses involving ACO.

H1b: Quality of work life is positively related to nurses' ACO. Analysis of results after regressing ACO on quality of work life factors showed that only nurse-physician relations (B = 0.33) and nurse management and leadership ability (B = 0.25) from quality of work life factors were significant predictors of ACO. Thus, I conclude that H1b is partially accepted.

H2b: TFL is positively related to ACO. Regressing ACO on TFL (B = 0.39), TFL was the strongest predictor of nurses' ACO. Thus, I conclude that H2b is accepted.

H3b: Perceived organizational support is positively related to ACO. Although POS was linked with ACO, it was not linked to staying intentions.

H4b: Position is positively related to nurses' ACO. When I regressed ACO on position, position (B = 0.17) was a significant predictor of ACO. Thus I conclude that H4b is accepted.

H5b: Commitment to the profession is positively related to ACO. Testing this hypothesis, the unstandardized regression coefficient of ACP (B = 0.21) was a significant predictor of nurses ACO. Thus, I conclude that H5b is accepted.

H6b: Commitment to family is positively related to nurses' ACO. In relation to this hypothesis, commitment to family (B = 0.12) was a significant predictor of ACO. Thus I conclude that H6b is accepted.

H7b: Family and work balance is negatively related to ACO. When I analyzed family work balance and work family balance and relationship with ACO, work family balance was negatively linked to ACO and family work balance was not linked to ACO.

H8b: Age is positively related to ACO: In relation to age, the unstandardized regression coefficient was not significant. Thus, I concluded that age is not significant predictor of nurses' staying intentions.

Finally, in the third regression analysis, I examined the mediating role of ACO on the relationships between work context and personal context factors and nurses' staying intentions (see Figure 3.1 and Table 3.4)[2]. Following the analytic procedures mentioned earlier (e.g., Kenny & Baron, 1986), I first regressed staying intentions on ACO, and then in the second step, I regressed staying intentions on career opportunities and advancement, nurse-physician relations, nurse management and leadership ability, TFL and position. On the final step, I regressed staying intentions on affective commitment to the profession, normative commitment to family and age. The regression analysis revealed that only TFL, ACP, NCF and ACO met Baron & Kenny's criteria as discussed earlier to test for mediation. For mediation I checked to ascertain if TFL, ACP and NCF were significantly associated with ACO, if ACO was significantly associated with staying intentions and if the direct relationship between TFL, ACP, NCF and staying intentions

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[2] Using confirmatory factor analysis, the construct validity of six distinct, yet related concepts were examined: transformational leadership (the 23 items were organized into 6 item parcels), perceived organizational support (4 items), staying intentions (3 items), affective commitment to the profession (6 items), affective commitment to the organization (6 items), and normative commitment to the family (3 items). In total, the fit of three nested measurement models were assessed and compared: a one-factor model where all 28 items were specified to load on a single latent factor [$\chi^2 = 3761.93$, $df = 350$; *comparative fit index (CFI)* = .45; *root mean square error of approximation (RMSEA)* = .12; *standardized root mean square residual (SRMR)* = .11]; a model where the items (indicator variables) loaded on their respective latent factors and where the six factors were specified to be uncorrelated ($\chi^2 = 1227.49$, $df = 350$; *CFI*= .86; *RMSEA* = .06; *SRMR* = .14); and, finally, a model where the indicator variables loaded on their respective latent factors and the six factors were allowed to correlate ($\chi^2 = 823.21$, $df = 335$; *CFI*= .92; *RMSEA* = .05; *SRMR* = .04). Values of *RMSEA* less than .06, *SRMR* values less than .08, and *CFI* values close to .95 are generally indicators of a good fit (Hu & Bentler, 1999), thus, of the three models tested, the six oblique-factor measurement model provided the best fit to the data.

was reduced to zero to establish full mediation, lessened to establish partial mediation or relations were not mediated at all and ACO simply belongs in the box of personal context factors. It appears that only for TFL and ACP that the mediation hypothesis seems to partially hold up with NCF mediated by ACO.

In Figure 3.2, I depict the relationship of TFL, ACP, NCF, ACO and staying intentions with unstandardized coefficients. Each arrow in this diagram represents a relationship between two variables to which an unstandardized regression coefficient is given to show the direction and magnitude of the effect of one variable on the other (see also Table 3.4). First, the diagram shows a significant association between X and M with TFL (B = 0.39), ACP (B = 0.21) and NCF (B = 0.12) significantly associated with ACO (*M*) to test for path a, to confirm the significance of the relationship between the initial TFL, ACP, NCF (*X*) and ACO (*M*). Next, the analysis shows ACO (B = 0.18) (*M*) predicting staying intentions (*Y*) to test the significance of path b alone, to confirm the significance of relationship between the ACO and staying intentions in the presence of the TFL, ACP, NCF. Then the diagram shows X predicting Y to test for path C alone to confirm the significance of the relationship between TFL (B = 0.13), ACP (B = 0.15), NCF (B = 0.07) and staying intentions, to confirm the insignificance of the meaningful reduction effect of the relationship between the initial TFL, ACP, NCF and staying intentions in the presence of the affective commitment to the organization. Following the analysis, I looked at steps 1-3 to establish whether zero-order relationships between TFL, ACP, NCF and staying intentions existed as mediation exists only when the first and third equations are shown to be significant (Baron and Kenny, 1986). I found that ACO significantly predicted staying intentions and the direct relationship between TFL, ACP, NCF and the staying intentions was reduced in absolute

size but was different from zero. Therefore, I tentatively conclude that mediation was present only for NCF and partial mediation for TFL and ACP.

The block of variables presented in Table 3.4 explains unique criterion variance. Overall, these predictors account for about 52% of the variance in staying intentions with ACO explaining 15% variance, work context predictors explaining 16% and personal context explaining 21% of variance. Except for the effects of NCF, TFL and ACP do not significantly diminish (see Figure 3.2, and compare results in Table 3.2 with Table 3.4). These effects of TFL and ACP are above and beyond ACO and suggest partial mediation between TFL and staying intentions, partial mediation between ACP and staying intentions and mediation between NCF and staying intentions partially supporting (H9). Further, the results indicated that 48% of the variance in staying intentions was not explained.

In summary, nurse-physician relations, nurse manager and leadership ability (H1a,b partially accepted), transformational leadership (H2a,b accepted), position (H4a,b confirmed), ACP (H5a,b is accepted) and NCF (H6a,b is confirmed) are significant predictors of nurses' staying intentions and ACO. However, only NCF operates through ACO and affects nurses' staying intentions with TFL and ACP partially passing through ACO. The other factors have more of a direct affect with nurses' staying intentions. In this study H3a,b, H7a,b and H8a,b were rejected.

Discussions and Implications

In this study, I sought to explore factors that influence nurses staying intentions. My study revealed that nurse physician relations, nurse management and leadership ability, transformational leadership and position from work context and affective commitment to profession and normative commitment to family were significant predictors of nurses' staying

intentions and affective commitment to the organization. However, whereas TFL and ACP were partially mediated by ACO, NCF was the only factor that was mediated by ACO (note the unstandardized regression coefficient for c pathway for NCF is 0.07, a negligible rise from zero, see Figure 3.2). My analysis revealed, however, that findings would be more fruitful if I were to allow for direct relationships between the predictor variables and nurse's staying intentions. Therefore, based on these results I modified the model accordingly (see Figure 3.3). This revised model hypothesizes a direct relationship between organizational commitment and nurses' staying intentions, between the work context variables and ACO and intentions to stay, and personal context variable and affective commitment and intentions to stay.

This study provides important insights into factors shaping nurses' staying intentions in an urban hospital in Sri Lanka, particularly key aspects of their work contexts (TFL and position) and personal contexts (affective commitment to the profession and normative commitment to the family). These insights may inform leaders' efforts to target interventions that improve nurses' staying intentions. Although the analyses reported here are informative, they would be supported by additional wider and comprehensive research fully evaluating the direct impact of work-life contexts on nurses' staying intentions. I discuss theoretical and practical implications of the findings for nursing management and workplace interventions.

Theoretical Implications

This study provides empirical support for the assertion that work-life factors are linked with nurses' staying intentions. Similar to other studies, work-life factors including career opportunities and advancement, nursing process, staff resource adequacy, nurse physician relations and nurse management ability and leadership, were positively related to ACO; and except for nursing process and staff resource adequacy, the other factors were also positively

related to staying intentions (Eren & Hisar, 2016; Damayanthi, Wickaikhum & Chontawan, 2014; Tourangeau et al, 2010; Gellatly, et al., 2014). A possible explanation for these findings (nursing process and staff resource adequacy not being related to staying intentions) is that nurses in Sri Lanka experience severe nursing shortages translating into delays in treatments of patients, resulting in neglect of the nursing process, task oriented work, and nurses working in inflexible, centralized and bureaucratic environments where participation in decision making is relatively low (Damayanthi et al., 2014; Hellerawa & De Alwis, 2015). Nevertheless, although the circumstances of Sri Lankan nurses differ in some ways, the link between quality of work-life and staying intentions (as found by other researchers) holds (Gellatly, et al., 2014; Slater & McCormack, 2010; Tourangeau et al.,,2010).

Counter to what was predicted, the effects of work-life factors were found to influence turnover motivations directly rather than through ACO. The findings suggest that TFL and ACP were major predictors of nurses staying intentions, albeit partially mediated by ACO. In contrast, NCF was mediated by ACO in predicting nurses' staying intentions. Interesting results – these results probably reflect that transformational leadership comes from within the nurse leadership in the organization, which is positive and supports the need for providing training programs for nurses to build their transformational leadership skills and for leaders to create an environment that is supportive of encouraging and empowering nurses. In contrast, ACP partially mediated by ACO reflects the limited opportunities within the organization for educational and professional development and that nurses seek opportunities outside. A recommendation is that hospitals build public/private partnerships with educational institutions, nationally and internationally and nurses be offered scholarships (in terms of finance and study leave) to further their education and professional development. I envisage that increased opportunities for educational and

professional development through the organization will be an incentive for nurses to continue within their organization and increase their wanting to stay. NCF being mediated by ACO reflects the influence that organizations have on nurses' family life and nurses wanting to stay. It reflects nurses wanting to stay in the organization for stability (whether related to the location of their residence, children's schooling), pension or retirement options and/or career progression that comes with seniority. It also reflects, however, that nurses may choose to leave if other opportunities arise that will contribute to improving their life chances and will take precedence over their wanting to stay in the organization.

Supported by other studies, our findings indicated that TFL has the potential to retain nurses by creating a positive, supportive and empowering work environment, leading to increasing ACO (Brewer et al., 2016; Cummings et al., 2010) and the probability of nurses' intent to stay (Cowden et al, 2011) implying that managers must recognize the leadership behavior that will motivate nurses level of commitment to the organization and reduce nurse turnover. On another note, I observed that POS was positively related to ACO (Gupta, Agarwal & Khatri, 2016), but showed no relationship to staying intentions. These findings contradict findings by Masters and Liu (2016) who identified that POS was strongly associated with nurses' intentions to stay and career success. Nevertheless, congruent with other studies, our study results signify that if nurses are given career progression support and steps are taken to increase nurses' motivations (nurses' contributions are recognized and nurses are given positions of added responsibility) or self-esteem then nurses' intentions to stay can increase (Gellatly et al., 2014; Gellatly & Hedberg, 2016).

I found that nurses' commitment to the profession was positively related to ACO but had a more direct relationship to staying intentions rather than being mediated by ACO (it was

partially mediated). Similarly, Nogueras (2006) found a strong positive relationship between nurses' professional commitment and intent to stay and Meyer et al. (1993) reported a moderate correlation between nurses' intent to stay and professional commitment. Nurses in Sri Lanka face limited opportunities for professional development, to subscribe to professional journals and participate in their professional association. However, our study findings suggest that nurses were committed to their nursing profession as they are dedicated and automatically motivated (Gellatly & Hedberg, 2016) because they work diligently even in the face of shortages of resources, staff and opportunities. In relation to age, the literature indicates that younger nurses are motivated to stay by opportunities for promotion, educational and professional development whereas nurses with seniority are more established and have more confidence, patience and prestige in the workplace than younger nurses (Larrabee et al., 2003; Tourangeau & Cranley, 2006; Tourangeau et al., 2010).

Findings of this study revealed a positive relationship between normative commitment to family, ACO and staying intentions, indicating that ACO and staying intentions were influenced by nurses': (a) moral commitment to family; (b) need to keep a good job; (c) being the primary source of income to care for their families; (d) having children and/or parents under their care and (e) preference for stability rather than change. These findings reflect the traditional instilled sense of obligation nurses in Sri Lanka feel towards their families and to their organization.

In contrast, I found that although work family balance was negatively related to ACO, it showed no relationship to staying intentions, and family work balance showed no relationship to ACO or staying intentions, which may reflect that nurses found it difficult to balance work and family and received little support from the organization to achieve a balance. These results are similar to the literature (Hatam, Jalali, Askarian, & Kharazmi, 2016; Tao, Ellenbecker, Wang, &

Tang, 2015; Yamaguchi, Inoue, Harada, & Oike, 2016) and indicate that mechanisms need to be in place to support nurses to fulfill family responsibilities and reduce work-family conflict in order to increase their commitment to the organization and staying intentions.

Finally, the findings shed light on the vital intervening role of affective commitment to the organization in TFL and staying intentions. In Sri Lanka, nurses work mostly within a hierarchy-oriented culture (Gamage & Wickramasinghe, 2012). Thus, in this study, it is intriguing that TFL is significantly related to nurses' staying intentions partially mediated by ACO. However, these results are consistent with previous research, which have shown that TFL was positively linked to organizational commitment and nurses' staying intentions (AbuAlrub & Alghamdi, 2012; AbuAlRub, El-Jardali, Jamal, & Al-Rub, 2016; Gellatly, et al., 2014). In Sri Lanka nurses struggle to have their voices heard and face many upheavals. Yet the results indicate that nurses' professional advancement and commitment to the profession strengthens nurses' staying intentions. These results are in line with past studies (Tourangeau & Cranley, 2006; Tourangeau et al., 2010), which have shown that nurses' commitment to the profession is positively related to several indicators including intentions to stay. This study also demonstrates that nurses' commitment to their family strengthens nurses' staying intentions. Finally, these findings contribute to theory development as they emphasize the need to consider leadership approaches and nurses' family commitments in, research agendas, and organizational policy development, work-life improvement interventions, and professional development programs including career advancement opportunities.

Practical Implications

Implications for managers and hospital administration. The predictors ACO, TFL, position, commitment to the profession and commitment to family all inform efforts to target

operational intervention strategies that may strengthen nurses' staying intentions. Interventions such as adopting a transformational, empowering and relational style of leadership and attending to varying perspectives of all key stakeholders in decisional processes, ensuring needs are adequately represented and nurses' sense of motivation and empowerment are supported will assist leaders to improve nurses' staying intentions. The results encourage nursing leaders to promote policies and practices that: a) improve nurses' work-life environments so that work is meaningful, b) support knowledge development and implementation of scopes of practice that acknowledge nurses' knowledge, skills and abilities; c) enhance professionalism in the work place through the implementation of standards and regulation; and, d) recognize and value nurses' contributions to nursing, patient care and organizational success. Finally, the findings indicate that nurses' commitment to family has a significant effect on their ACO and staying intentions, and it is imperative that practical mechanisms (such as provision of child care/crèche facilities within the hospital, parental leave, part time or nonstandard flexible work arrangements, access via banks to apply for educational/housing/car loans) are in place to support nurses' family commitments.

Implications for understanding nurses' decisions to stay or leave. These results highlight areas that require focus on targeted interventions to improve nurses' work-life environments and enhance staying intentions. A key finding in this study is that TFL and ACP may work through ACO. Therefore, more research is necessary to unpack and further clarify within the Sri Lankan context how transformational leadership and ACP shape nurses' commitment to the organization and turnover intentions and ultimately their decisions to stay or leave. This will enable leaders to fully appreciate the appropriate methodology that effectively enhances performance in public sector health care organizations. In addition, I recommend that a

similar study be carried out in the private sector (or in public and private) to determine whether the relationship between TFL and ACO varies in the different sectors. Comparative research across regions, for example, may be particularly useful for national workforce planning and policy.

Additionally, the study lends support to: (a) examine direct relationships among work-life factors, personal context factors and staying intentions (see Figure 3.3,) because not all the work context and personal factors operate through nurses' affective commitment to the organization and they have a more direct relationship with nurses' intentions to stay; (b) investigate complex work-life factors that shape nurses' intentions to stay in their current work place; (c) craft hypotheses for further research and develop research based workplace interventions to enhance nurses' intentions to stay; and, (e) foreground the critical need to strengthen research consciousness, capability and divergence of attention to nurse turnover at individual, organizational and country level.

Limitations

This study is limited by its reliance on cross-sectional questionnaire data and the fact that data were correlational in nature and therefore, conclusions about causality are unwarranted. Only associations can be inferred. Thus, data were collected at one-point without considering the dynamic nature that can be captured through the study of longitudinal relationships. In addition, the use of self-report measures for almost all the variables may have resulted in bias attributable to social desirability, mood states and affectivity of the participants and resulted in inflated or deflated relationships among the study variables, depending on the direction of the bias (Schwarz, Schwarz & Rizzuto, 2008). To minimize social desirability, participants were informed several times that their responses would be kept confidential and nurses were aware that I was neutral in

allegiance to the hospital in which data were collected (Druckman, 2005). Thus, I advocate caution when interpreting these study results. Moreover, this study examined selected variables that influence on nurses' staying intentions, but as reflected in the unexplained variance in our regression analysis, other organizational variables can also affect nurses staying intentions and organizational commitment. Lastly, since the current study focused on nurses working in one urban hospital, this research is not generalizable to nurses working in other urban areas or rural settings (Bratt, Baerholdt, & Pruszynski, 2014). For example, there may be less ethnic diversity in the nursing workforce in rural and other urban settings and ethnicity is likely to be tied to location of hospital. However, differences in age and work values would be present in the various settings where nurses work. Further, the nature of the relationships tested in the current study should be the same and could be applicable to nurses in other practice settings. Despite its limitations, this study contributes to Sri Lanka's knowledge as it is the first time a study of this nature has been conducted in Sri Lanka and underscores an imperative for further quantitative and qualitative research to examine needs and interests of nurses and factors that affect nurses' turnover intentions. Although the findings of this study cannot be generalized, it provides important information for future research.

Conclusions

Our study provides empirical evidence describing how work-life factors affecting nurses' staying intentions in an urban hospital in Sri Lanka. These findings support claims that factors that affect nurses' work-life must be integrated into policy if strengthening nurse recruitment and retention are goals. Establishing the leadership approaches of nurse managers and examining nurses' family commitments and influence on nursing work-life are two key areas that require attention to improve nurses staying intentions. This study is comprised of nurses in

one urban setting, and it foregrounds the usefulness of replicating the study in other urban and rural settings across the island. Finally, replication of this study in different national contexts would ascertain if my model holds across cultures and other societal differences that influence nurses and nursing.

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TABLES

Table 3.1 Descriptive statistics, reliability and zero-order correlations

	PV	*M*	*SD*	α	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	COA	2.37	0.56	0.79														
2	NP	2.93	0.44	0.71	**0.40**													
3	SRA	2.21	0.55	0.69	**0.42**	**0.32**												
4	NPR	2.63	0.5	0.79	**0.40**	**0.40**	**0.44**											
5	NML	2.62	0.55	0.69	**0.40**	**0.39**	**0.38**	**0.51**										
6	TFL	3.76	0.9	0.94	**0.37**	**0.34**	**0.29**	**0.36**	**0.60**									
7	POS	3.45	0.97	0.68	**0.33**	**0.16**	**0.24**	**0.29**	**0.28**	**0.37**								
8	Posit	1.78	0.89	*n/a*	0.07	0.00	0.02	0.07	0.03	-0.04	0.00							
9	ACP	4.96	1.12	0.72	0.08	**0.11**	0.08	*0.10*	*0.09*	**0.11**	0.06	*0.08*						
10	NCF	5.76	1.17	0.75	0.02	**0.12**	-0.03	0.08	0.04	*0.08*	-0.02	0.03	**0.10**					
11	WFB	4.76	1.25	0.83	**-0.16**	0.04	**-0.16**	**-0.14**	**-0.15**	*-0.08*	**-0.17**	*-0.09*	-0.03	**0.11**				
12	FWB	3.18	1.22	0.81	0.02	-0.11	0.05	-0.07	-0.01	-0.01	**0.12**	0.05	**-0.11**	-0.06	**0.18**			
13	Age	3.09	1.8	*n/a*	0.08	0.02	0.06	0.07	0.01	0.03	0.02	**0.62**	**0.17**	0.00	*-0.08*	-0.01		
14	ACO	4.58	1.31	0.9	**0.26**	**0.14**	**0.14**	**0.33**	**0.37**	**0.42**	**0.26**	**0.21**	**0.28**	**0.17**	**-0.12**	0.01	**0.24**	
15	SI	3.49	1.22	0.81	**0.10**	0.07	0.07	**0.13**	**0.19**	**0.25**	*0.10*	**0.14**	**0.29**	**0.16**	-0.06	-0.04	**0.15**	**0.38**

Note. $N = 679$. Correlations significant at $p < .01$ are in bold, and $p < .05$ are in italic.
PV-Predictor variable, α = Cronbach's Alpha, *M* = Mean, *SD* = Standard Deviation, COA -Career opportunities and advancement, NP-Nursing process, SRA-Staffing resource adequacy, NPR-Nurse physician relations, NML-Nurse manager ability and leadership, TFL-Transformational leadership, POS-Perceived organizational support, Posit-Position, ACP-Affective commitment to the profession, NCF-Normative commitment to the family, WFB-Work family balance, FWB-Family work balance, Age-What is your age group? ACO-Affective commitment to the organization, SI-Staying intentions.

Table 3.2 Hierarchical Multiple Regression against Staying Intentions)

	Predictor Variables	ΔR^2	$F\,\Delta$	p of Δ	B	p
Step 1	Career opportunities and advancement				-0.04	*ns*
	Nurse physician relations				0.02	0.01
	Nurse management and leadership ability				0.08	0.01
	Transformational leadership				0.20	0.01
	Position	0.09	12.77	0.01	0.09	0.01
Step 2	Affective commitment to the profession				0.19	0.01
	Normative commitment to the family				0.09	0.01
	Age	0.16	19.94	0.01	0.02	*ns*

Note: Position is measured as follows: "Grade 111, 2 = Grade 11, 3 Grade 1, 4 = Supra Grade, 5 = Special Grade, 6 = Executive Grade with executive grade being the most senior. Unstandardized regression coefficients = (B). Significant levels = *p*. *ns* = non significant.

Table 3.3. Hierarchical Multiple Regression against Affective Commitment to the Organization)

	Predictor Variables	ΔR^2	$F\,\Delta$	p of Δ	B	p
Step 1	Career opportunities and advancement				0.08	*ns*
	Nurse physician relations				0.33	0.01
	Nurse management and leadership ability				0.25	0.05
	Transformational leadership				0.39	0.01
	Position	0.26	47.97	0.01	0.17	0.01
Step 2	Affective commitment to the profession				0.21	0.01
	Normative commitment to the family				0.12	0.01
	Age	0.32	19.94	0.01	0.09	*ns*

Note: Position is measured as follows: "Grade 111, 2 = Grade 11, 3 Grade 1, 4 = Supra Grade, 5 = Special Grade, 6 = Executive Grade with executive grade being the most senior. Unstandardized regression coefficients = (B). Significant levels = *p*. *ns* = non significant.

Table 3.4. Hierarchical Multiple Regression against Staying Intentions

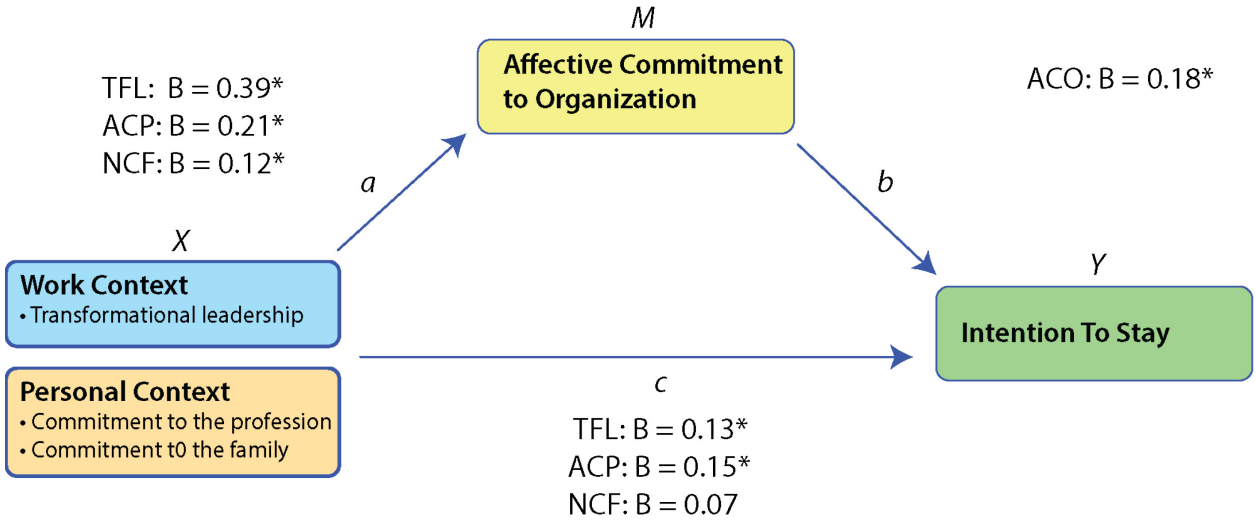
Predictor Variables		ΔR^2	$F\,\Delta$	p of Δ	B	p
Step 1	Affective commitment to the organization	0.15	116.25	0.01	0.18	0.01
Step 2	Career opportunities and advancement				-0.06	*ns*
	Nurse physician relations				-0.04	*ns*
	Nurse management and leadership ability				0.04	*ns*
	Transformational leadership				0.13	0.01
	Position	0.16	2.70	0.01	0.06	*ns*
Step 3	Affective commitment to the profession				0.15	0.01
	Normative commitment to the family				0.07	0.01
	Age	0.21	11.93	0.01	0.01	*ns*

Note: Position is measured as follows: "Grade 111, 2 = Grade 11, 3 Grade 1, 4 = Supra Grade, 5 = Special Grade, 6 = Executive Grade with executive grade being the most senior. Unstandardized regression coefficients = (B). Significant levels = *p*. *ns* = non significant.

FIGURES

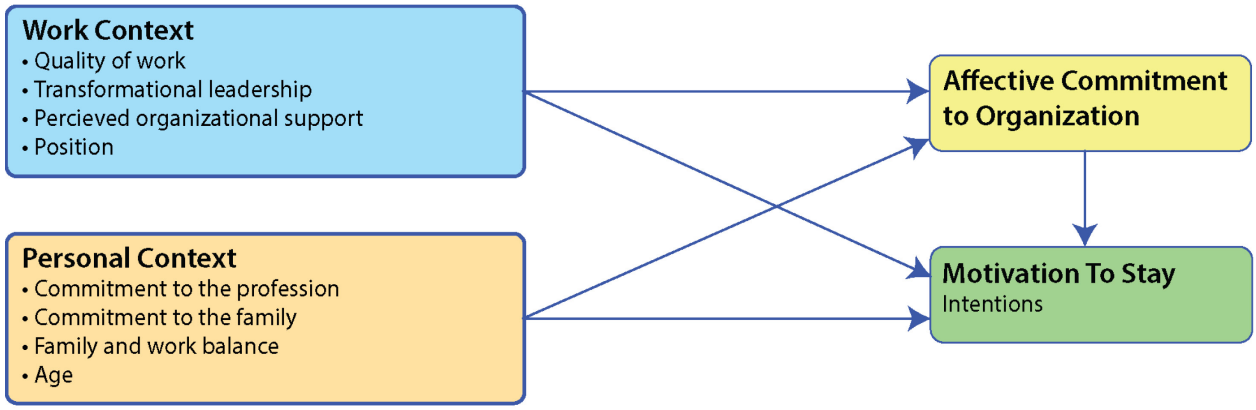
Figure 3.1. Original Limited Scope CWEXP model

Figure 3.2. Conceptual illustration of mediation analysis



Note:
* = $p < .05$
X = Predictor variable
M = Mediator variable
Y = Outcome variable

Figure 3.3. Revised Limited Scope CWEXP model



CHAPTER 4

Shaping Policy and Research Agendas in Relation to Nurse Migration from Sri Lanka: Balancing Opportunities with Societal Needs

As a global phenomenon and macro level concept, *nurse migration* refers to patterns of nurse movement internal and external to a country (Kingma, 2006). These patterns are influenced by historical, political, global, and national forces such as trade agreements, national policies and strategies, and economic conditions, as well as complex social variables within the lives of individual nurses (Bargraim, 2013). Most international migration occurs from low or middle-income countries (LMICs) to high-income countries (HICs) and has significant effects on individual migrants and source nations (Castro-Palaganas et al., 2017; Li, Nie, & Li, 2014;). While there is substantial relevant nursing literature, country-specific research is limited and none of it emerges from Sri Lanka.

Sri Lanka provides an interesting case study in relation to nurse migration. Nursing shortages are acknowledged (Hellerawa & Adambarage, 2015), while migration policies and agreements (not all specific to nursing) are in place that seem to encourage nurses (as skilled labour) to migrate (Ministry of Foreign Employment, Promotion and Welfare [MEFPW], 2008; Sri Lanka Bureau for Foreign Employment [SLBFE], 2015). Historical, cultural, political, and economic relationships cause nurse shortages, spur nurse production, and pattern nurse migration. Putting it simply, nurse migration is broader than a single individual's decision to move in search of better life-chances including social mobility and social equality. It is a combination of familial, professional (see Chapter 1), economic, social, and political factors. The International Centre on Nurse Migration reports evidence that remittances, money sent to families in the country of origin, may more than adequately make up for the loss of health professionals from health

systems, particularly as nurses appear to return higher remittances than other migrants (International Centre of Nurse Migration, 2013). International migration, when permanent however, is generally linked with a country's loss of intellectual capacity, wasted investment in human capital, and sub-optimal delivery of healthcare, as well as social costs affecting households and communities. Materialism and dependency on overseas remittances increase and can adversely affect national development plans (Castro-Palaganas et al., 2017). Brain drain and the effects of dislocation, such as the suffering related to mother-child and family separation when families do not migrate as a unit, are among the detrimental effects attributed to international migration (Prescott & Nichter, 2014). Brain circulation, a newer term, places a more positive spin on consequences, particularly when reverse migration back to the source country occurs (Garner et al., 2015; Timmons, Evans, & Nair, 2015), as new knowledge is shared and technology transfer increases.

This discussion emerges from an examination of issues and challenges in nursing in Sri Lanka with the aim of identifying where and how policy changes need to be made (see Chapter 1) and preliminary testing of a framework (see Chapter 2) developed to guide quantitative empirical research on micro-level theoretically posited influences on nurse turnover intentions (see Chapter 3) that are then nested within macro-level influences on international nurse migration identified in the literature and explored through a few brief qualitative questions in my research. Immediate work context and personal context contribute to strengthening commitment to the organization, family, the nursing profession, and a specific community/country and, therefore, stated intentions to leave a job or community. Selected relationships were explored in research at a large urban hospital in Sri Lanka (Chapter 3) and can be contextualized in relation to analysis of the current status of professional nursing in Sri Lanka (Chapter 1). These micro-level contexts, influenced

by opportunities or dangers at the macro-level, need to be validated empirically in Sri Lanka through exploration of relationships to international policies, agreements, or codes. Our empirical work in relation to nurse turnover (organizational level) and theoretical extrapolation to international nurse migration (macro level) sheds light on complex factors that shape nurses' decisions to remain in a nursing position in Sri Lanka or to leave, and identifies a need to craft work-life interventions and policies that enhance retention of nurses or mitigate the effects of decisions to leave (emigrate). I explore the paradox of nurse shortages aligned with policies that promote nurse migration from theory, practice, and policy perspectives and propose a research agenda for increasing the evidence base for moving forward on nurse workforce planning and policy. Before focusing on the Sri Lankan context, however, I present the international context of nurse migration.

The International Context

It is within the worldwide context of migration that the specifics of Sri Lankan nurse migration are located. Motivators for international nurse migration are linked to economic, professional, educational, political, social, and personal factors, as well as migration opportunities (Kingma, 2006; Walani, 2015). Push factors (disincentives to stay), such as emotional exhaustion, problems in work design, lack of training opportunities, poor remuneration (e.g., low salary, poor health insurance coverage), stressful working environments (e.g., work overload or slow promotion), ineffective healthcare management systems, limited opportunities for employment of choice, inadequate health budget, and lack of socio-political and economic stability, result in temporary or permanent loss of nurses from the work place (El-Jardali, Dumit, Jamal, & Mouro, 2008; Garner et al., 2015; Habermann & Stagg, 2010). Pull factors (incentives to migrate) include higher income, good benefits and compensation packages,

better working conditions, and opportunities to gain knowledge and skills (Garner et al., 2015). Other pull factors may include opportunities to include family in the migration, prospects of travel and exposure to new cultures, influence from peers and relatives who have migrated, and hope for socio-political and economic stability (Castro-Palaganas et al., 2017; Walani, 2015). Permanent immigrants often mention the opportunity of a better future for their children as a prime factor in decision-making (Pickering, Tazreiter, Powell, & Barry, 2015). Migration is a family decision and nurses may leave as spouses of primary emigrants, with their nurse designation irrelevant in decision-making.

International standardization of professional training, economic policies promoting trade, emergence of labor markets relatively free of national controls, and hassle-free residency access permits for people possessing 'nursing' qualifications also contribute to international nurse migration (Prescott & Nichter, 2014). Governments – bilaterally, regionally, or through the World Trade Organization (WTO), with 147 member nations – operate on a global level to liberalize trade among nations, negotiate trade agreements, and settle trade disputes (WTO, 2004). Although a country's economy and access to healthcare services may improve through liberalized trade, the benefits of trade in international health services and professionals often come at the expense of equitable health care, generally through diminished quality of care in the source countries of emigrating health professionals (Valiani, 2012). Returning nurses with international clinical experience or advanced education, however, can improve health systems and the money sent home to family left behind in the form of remittances can make substantial contributions to family social mobility and the national economy (Garner et al., 2015; Li, Nie, & Li, 2014; Walton-Roberts et al., 2017). The responsibility of governments in both source and destination countries is to regulate migration to foster growth and development in both countries

while simultaneously protecting the rights of migrant workers (International Labour Organization [ILO], 2010: Ogilvie, Mill, Astle, Fanning, & Opare, 2007). National policies and organizational statements such as those of the Royal College of Nursing (RCN) and International Council of Nurses (ICN) recommend limits on international recruitment of health professionals in order to guard against depletion of poorer nations of their nurses (Castro-Palanganas, et al., 2017; Garner et al., 2015; Prescott & Nichter, 2014).

At the 63rd World Health Assembly in May 2010, the World Health Organization (WHO) presented a Code of Practice on international recruitment of health personnel (WHO, 2010a). The code presents voluntary ethical principles and practices and receiving countries are encouraged to use health migration policy research to adapt their international health personnel recruitment processes. It asks recruiting countries to take into account the rights, obligations, and expectations of countries of origin and destination and of migrant health personnel (Ogilvie et al., 2007; WHO, 2010a; WHO, 2010b). The International Council of Nurses (ICN) has denounced the unethical recruitment practices in which some countries are engaged (ICNM, 2013). The ICN recognizes, however, that nurses in all countries have the right to choose to migrate irrespective of the motivation for migration.

Governments and Private Recruiters have Varying Standards and Practices

No worldwide external regulation of international nurse migration practices exists. Some private recruiters require migrating nurses to pay commissions after obtaining employment (Kingma, 2006) and some nurses incur debt to migrate and/or are not compensated for visa or work permit expenses (Castro-Palaganas, et al., 2017). Other recruitment agencies offer free travel tickets, subsidized accommodation, and tax-free salaries (Beaton & Walsh, 2010; Garner et al., 2015). Further, there are reports of nurses experiencing problems when wishing to

terminate their employment to return to their home country or confronting language and cultural differences as they seek to integrate into new healthcare systems (Dastjerdi, Olson, & Ogilvie, 2012; Troy, Wyness, & McAuliffe, 2007; Walani, 2014). Less formal recruitment through grassroots activities and other pathways and social networks stimulate further migration (Prescott & Nichter, 2014). Social networks among communities, family members, and friends, as well as destination country nursing associations composed of nurses from the same source country, strengthen such connections and build a sense of professional and personal community (Prescott & Nichter, 2014). Point systems for immigration in countries like Canada reward post-secondary school education and raise expectations that nursing qualifications will be recognized, even when licensure may not be easy or possible (Ogilvie, Higginbottom, Burgess-Pinto, & Murray, 2013).

As the actual and anticipated demand for qualified nurses increases in HICs, overseas recruitment continues to gain momentum (Prescott & Nichter, 2014). Recruitment practices have become an entrenched government strategy in some HICs even though reliance on overseas professional nurses to fill gaps is not a long-term solution for sustainability of the nurse workforce in any country (Kalipeni, Semu, & Mbilizi, 2012). In the process of recruiting nurses from other countries, insufficient consideration may be given to the effects of the outflow of nurses and how nurse migration affects healthcare within departure countries (Adhikari & Grigulis, 2013; Timmons et al., 2015; Young et al., 2010), including the long-term consequences for the migrating nurses, remaining nurses, and their families. The effects of outflow of nurses may be difficult to assess however, because most source countries are not equipped technically to assess the magnitude and characteristics of the outflow of nurses nor have the stakeholders developed contextualized ethical codes of practice or policies relating to nurse migration to complement the WHO Global Code of Practice or the Commonwealth Code of Practice.

Empirical examination of nurse turnover and migration is lacking in most countries. Nevertheless, some countries (e.g., the US and UK) have implemented policies in attempts to foster ethical recruitment of nurses internationally. For example, the Commission on Graduates of Foreign Nursing Schools (CGFNS) Alliance was created in the United States to bring multiple stakeholders to work together to promote ethical recruitment practices (Shaffer et al., 2016). Whereas the Alliance Code provides detailed guidelines to individuals and companies operating in the healthcare recruitment sector, the WHO Code articulates global principles and a framework for international cooperation (Shaffer et al, 2016). Similarly, in the UK the NHS adheres to the UK Code of Practice for international recruitment, although there are reports of nurses migrating through the back door and recruitment practices fluctuate in response to economic and political changes with little consideration of how irregular recruitment practices affect nurses from overseas (Adhikari & Grigulis, 2013). Further, Young et al. (2010) argue that such codes have limited effectiveness in preventing unethical recruitment, as the codes are voluntary and not legally binding; thus recruitment from countries with nurse shortages continues. Nevertheless, national ethical codes complement the WHO Global Code of Practice and are necessary to maximize the impact of these global standards in local settings (Edge & Hoffman, 2013).

Nurse Production for National Needs vis-a-vis Nurse Production for Migration

In countries such as India, Kenya, South Africa, Thailand, and Sri Lanka new healthcare system policies and needs affect the demand for nurses. Examples include new health financing or insurance systems, introduction of healthcare coverage, expansion of private provision of healthcare, promotion of medical tourism, realignment of healthcare systems towards a focus on primary health care and achievement of millennium development goals, and wider

epidemiological, demographic, and socio-economic factors (Reynolds et al., 2013; Timmons et al., 2016). Some countries have deliberate policies to over produce nurses with nurse migration explicitly viewed as an export (revenue generating) opportunity. In the Philippines nurse migration has improved quality of life for households and generated substantial remittances for the nation, but the over production of nurses has resulted in financial benefits at the cost of worsening skill mix in hospitals within the country, experienced nurses leaving to work overseas, and a shortage of skilled senior nurses to mentor new entrants. New nurses are both unable to gain the experience to meet the requirements for overseas work and under-qualified to fill local vacancies. Nursing has become a profession with high status and better remunerated nurses who migrate and low status nurses who stay and endure low wages and poor working conditions. As nursing is a common pathway to international migration from the Philippines, there has been massive retraining of physicians to become nurses, thus generating severe problems for the health system including the closure of wards and hospitals (Castro-Palaganas et al., 2017; Lorenzo, Galvez-Tan, Icamina, & Javier, 2007).

Policy coherence must exist between production of nurses for export and assurance of a sufficient supply of high quality nursing graduates to meet domestic needs (Lorenzo et al., 2007). New ways must be discovered to mitigate costs to health systems of nurse emigration, including realistic operational bilateral agreements to ethically manage migration that includes a tripartite benefit – to the individual (household), the source country, and the receiving country. The Philippine experience illuminates the need to improve socio-economic conditions and work-life experiences of domestic nurses in order to make staying an attractive and viable option (Castro-Palaganas, et al., 2017).

Sri Lanka: An Overview

Geography, Demography and History

Sri Lanka has a population of about 20 million people; 18.2% live in the urban sector, 77.4 % in the rural sector, and 4.4 % in the estate (plantation) sector. There are Sinhalese (74.9%), Sri Lankan Tamils (11.2%), Indian Tamils (4.1%), Moors (9.3%), and others (0.5%). Buddhism is the major religion (70.1%), followed by Hinduism (12.6%), Islam (9.7%), and Christianity (7.6%) (Central Bank of Sri Lanka [CBSL], 2016). There has been a gradual improvement in the three dimensions of standard of living (life expectancy, access to knowledge, and a decent standard of living as measured by GDP) (UNDP, 2016). The Human Development Index (HDI) for Sri Lanka was 0.766 in 2015 (UNDP, 2016), positioning Sri Lanka at 73 out of 188 countries and territories. Sri Lanka ranked the highest among countries in the South Asian region, in contrast to India at 131, Bhutan at 132, Maldives at 105 and Bangladesh at 139. Nevertheless, poverty and the aftermath of natural (floods, tsunami, landslides) and man- made (civil war) disasters remain issues and are important influences on people's migration patterns. The Central Bank of Sri Lanka reports that the 2012/2013 all island mean per household monthly income was SLR 45,878 (US$ 302.00) and mean per person monthly income was SLR 11.819 (USD$ 77.50) (CBSL, 2016). Nurses earn from US$196 to US$327 per month (MOH, 2017).

Although there have been noticeable economic growth and structural changes in the economy with the movement from agriculture to manufacturing and service sectors, a considerable portion of the population still lives in poverty (Department of Census & Statistics (DC&S), 2013). The rising cost of living has affected low-income Sri Lankans and there is a widening gap between high and low-income groups. Population data show an inverse relationship between family size and income. The average size of households existing 50%

below the poverty line is about seven persons while it is about 4.5 persons for the non-poor, and 3.6 for households living at four times above the reference poverty line (DC&S, 2013). Nurses in our study reported average household sizes of 5 and 74% had children and/or dependent adults in the home.

A Healthcare System under Strain

Healthcare in Sri Lanka is provided through both public and private services, with public health services delivered via a network of health centers, hospitals, and dispensaries. Providing care to 60% of the population, the public healthcare system (funded by the government) is comprised of Allopathic (Western) and Ayurvedic curative, preventative, and rehabilitative services (DC&S, 2013). Western, Unani, Homeopathic, and Siddha health services and practices are available in the private sector (privately funded), enabling people to access the care of their choice (MOH, 2016).

One of the major strengths of the Sri Lankan healthcare system is free access to public healthcare services that provide both preventive and curative care with qualified nurses. In addition to the public system, the expanding private system focuses on provision of curative care, mainly in urban areas where disposable incomes are highest. It is convenient and easily accessible although it has only a fraction of the capacity of the free public healthcare system. It is expensive with minimum coverage by health insurance and as a system lacks transparency (Govindaraj, Nawaratne, Cavagnera, & Rao, 2014). Generally, in the public system, personal financial status does not bar access to any preventative services, few curative health services, or education. There are relatively low infant and maternal mortality rates, high immunization rates, and good community medicine and primary health care. Life expectancy in Sri Lanka is: Male 72, female 78 and total life expectancy is 75 giving Sri Lanka a World Life Expectancy ranking of

67 (WHO, 2015). Health outcomes in Sri Lanka are better than expected for the comparative wealth of the country with approximately 4.2% of GDP spent on health (World Bank, 2011). High literacy rates and educational attainment in Sri Lanka contribute to the relatively good health indicators.

Sri Lankan healthcare is under strain from multiple challenges that affect nurses' work. Its capacity is reduced by factors such as frequent labour disputes and strikes related to wages and working conditions as well the country's experiences of civil war and natural disasters. This inadequate capacity is manifest in limited access to specialist treatment with long waiting lists, inconsistent service standards with disparities between urban and rural areas, and poor healthcare structures, particularly in the north and east. Key issues that undermine the potential effectiveness of the health system leading to inadequate recruitment and retention of nurses include lack of strategic planning; inadequate financial and human resource development, monitoring, and evaluation; underdeveloped recruitment and retention plans; little inter-sectoral co-ordination in program planning; poor management skills and leadership; limited resources and facilities to educate nurses; and, low healthcare system capacity with a lack of government and public investment. In addition, Sri Lanka has a growing elderly population, increase in non-communicable diseases, high suicide rate, and a history of protracted conflict resulting in fractured disease control programs and significant impact on the mental health of the country's population (Siriwardhana & Wickramage, 2014). Other challenges include politicization, unionization, infighting amongst nurses and doctors, and constraints faced as a result of shortage of experienced staff (Hellerawa & Adambarage, 2015). My recent study focusing on nurses' turnover intentions revealed that 28% of responding nurses work 100 hours paid overtime per month.

Historical Context

Colonial relationships continue to have a tremendous impact on present day labour migration. Migration from Sri Lanka dates from the colonial period beginning with the arrival of the Portuguese in 1505, followed by the Dutch era in 1963, and British rule from 1817 until independence in 1948. Migration of nurses was entwined with Sri Lanka's position as a British colony (Jones, 2004). Developments in organized nursing were connected to and influenced by British policy and institutions during and after independence, with missionaries and social conditioning generating the supply of labour for mobilization into nursing (Aluwihare-Samaranayake & Paul, 2013).

Following independence in 1948 and opening of a contract labour market in the Middle East, Singapore and East Asia, migration of nurses commenced in the post-colonial era to the Middle East, the Gulf and developing Southeast and East Asian economies in order to support families in Sri Lanka with remittances (Reeves, 2014). Later nurses migrated to countries such as Canada, Australia, the United Kingdom, New Zealand, and the United States of America stimulated by the demand for qualified labour (including nurses) in these HICs coupled with the slow growth of the Sri Lankan economy (low salaries and extensive un-employment) (Reeves, 2014).

Socio-cultural Context

Beginning in the 1970's largely temporary new migration flows to the Middle East and Southeast Asia emerged related to employment opportunities driven by formal/informal mechanisms, labour shortages, or pay differentials (Dias & Jayasundere, 2004). Migrants may be semi-skilled or unskilled, are generally poor, and migrate as individuals on a contract basis (SLBFE, 2015). Many are domestic workers who are not permitted to take their families and are

required to return to Sri Lanka at the end of their contract (Dias & Jayasundere). The poor regulation of recruitment agencies, the effects of the gender imbalance among migrants (currently, most migrants are women), the lack of insurance and protection against illness, and lack of fair work contracts create significant challenges for those who leave, as well as for their families who remain in Sri Lanka. The gendered migration pattern shifted to women during the 1980's when an economic slowdown within Middle Eastern oil producing countries reduced the demand for male workers. The demand for female domestic workers continued. Employment of domestic workers from countries like Sri Lanka was affordable, improved the freedom of women in destination countries, and provided a marker of social status among affluent families in host countries (Ukwatte, 2005; Timmons, Evans, & Nair, 2015), Current migration from Sri Lanka, therefore, is both a temporary and a permanent phenomenon, occurs for both economic and political reasons, and has the potential to create skilled labour shortages (Institute of Policy Studies, IPS, 2013).

Intermittent civil war has been a feature of Sri Lankan life for the past four decades with the most recent conflict ending on the 18th of May 2009 and fostered migration particularly among members of the Tamil community as they sought asylum in India, Europe, and Canada (Arunathilake, Jayawardena, & Weerakoon, 2011). The war had a tremendous cost on both sides; not only in terms of the dead, displaced, disposed, maimed, traumatized, and made bereft, but through the depletion of much of the country's health infrastructure and resources (De Alwis, 2010). During times of war, nurses (amongst others) endured many hardships (physically and emotionally). These included difficult working conditions such as practicing with limited or no resources, working long hours, and caring for staggering numbers of military and civilian victims (Nagai, Abraham, Okamoto, Kita, & Aoyama, 2007). Nurses were deeply affected physically

and emotionally when caring for patients. They faced many challenges and often continued to care for patients while they themselves were at risk (Jayawardene, Youssefagha, Lajoie, & Toraby, 2011). Many of these nurses lived with constant fear, sadness, and a sense of helplessness (Jayawardene et al., 2011). Although the end of the war saw the Sri Lankan government embrace the development of war-torn regions, the deeper and more enduring psychic wounds of a war-torn Sri Lanka sadly remain unaddressed (De Alwis, 2010).

Persistence of war has effected nurses' job satisfaction in Sri Lanka. A study of job satisfaction among nurses caring for war victims in Sri Lanka portrayed the multiple, compounding expectations placed on these nurses (Jayawardene et al., 2011). They cared for large numbers of military and civilian victims, most of whom arrived by air due to unsafe ground transport. One hospital (with a capacity of 1328 beds and considered the third largest in the country) managed 4697 victims of war (men, women and children). Nurses depicted how the intensity of simultaneously caring for war-victims in combination with other factors including being married, having more than two children and other family responsibilities, experiencing greater than one to five years of nursing in the same hospital, wanting a change, being unable to find a colleague to discuss what could be confidential work-related issues, perceiving a low level of self-rated performance as a nursing professional, having poor relationships with supervisors, and working in poor overall conditions influenced decisions to seek a transfer.

In addition to the impact of war, natural disasters (including droughts, floods, severe cyclones, landslides, and tsunamis - latest floods and landslides in 2017) have negatively affected the infrastructure of Sri Lanka in many ways. In 2004 a tsunami had significant consequences for the healthcare sector as a result of the death of large numbers of healthcare workers and the destruction of physical resources (Carballa, Dalta, & Hernandex, 2005).

Estimates suggest that more than 17% of curative care institutions in the coastal belt were severely damaged, economic costs to the country exceeded $60 million, and the cost of reconstruction mounted to around $84 million (Perera, 2005). The demands on health services were high for many reasons including the large number of injured people, the challenge of identifying and handling many dead bodies, hospitals running out of refrigerated mortuary space, the psychological burden on remaining healthcare providers, the hospitals running out of equipment and experiencing losses and shortage of human resources, and the periodic and short-lived increases in diseases such as viral fevers and diarrheal infection (Carballa et al., 2005).

Economic Context

Severe economic hardships, inadequate salary, indebtedness, limited career prospects, few educational opportunities, increasing cost of living, and the compelling desire for a better standard of living and social status are the main motivations leading to out migration of Sri Lankan men and women, including nurses (SLBFE, 2015). Remittances provided from Sri Lankans working abroad bring economic benefits to the families of migrant workers, are vital to the Sri Lankan economy, and remain a primary influence on nurse out-migration (Dias & Jayasundere, 2004; Shaw, 2008; Murphy et al., 2016). The impacts of remittances on the wellbeing of families depend on pre-departure costs; duration, nature and conditions of work abroad; salary and money management skills of migrants and their family members; and, the maintenance of a local income source while the migrant is away (Shaw, 2008; IPS, 2013). Unlike countries such as Nepal and Bangladesh, the Sri Lanka government does not impose restrictions on people leaving the country because their remittances are a major component of household income and foreign earnings (Raghruram, 2005). The impact of *high-skilled* out-migrations on the Sri Lankan economy is difficult to ascertain due to data limitations (Arunathilake, et al.,

2011). Monitoring occurs within the SLBFE but only if the migrant goes through it or a recognized recruitment agency based in Sri Lanka. This tension between the dependence on remittances from migrants and the associated loss of skilled labor and complex personal and social problems for children and families of migrants creates a dilemma for the Sri Lankan government. Yet, the Sri Lankan government's commitment to out-migration continues.

Study Findings of Relevance to International Migration of Nurses

While my study of 679 nurses employed in a large urban government hospital (Chapter 3) focused primarily on conditions that influence nurses' turnover decisions, I did include questions related to interest in migrating internationally. While 3.4% of responding nurses had already worked outside of Sri Lanka, 40% would consider leaving the country because of poor recognition by peers, poor appreciation by superiors, poor social status, limited attention from government, poor economic situation, and insufficient praise from patients. Thirty three percent of respondents would consider leaving because of pay dissatisfaction, heavy workload, shortage of staff, having to work over time, and lengthy travel time to work. These findings are consistent with studies in other countries where nurses were not satisfied with their work-life (Almalki, Fitzgerald, & Clark, 2012; Garner et al., 2015) and with commonly identified push factors for nurse migration. Fourteen percent of nurses commented that poor access to professional development in terms of educational opportunities and desire for career progression and better facilities and resources would drive them to leave. Another 5% commented they would consider leaving because of work place politics. Examples provided included interference from or disputes with other health categories/professionals, frustrations with nursing and disputes within the profession, and concerns about political interference. A further 8% remarked they would consider leaving in the hope of a better quality of work and home life, including better access to

opportunities for their children. The findings of this study validate in a quantitative way the importance of personal factors in migration decision-making. Interestingly, in the overall study personal factors seemed to be slightly more important than organizational factors in fostering nurses' turnover intentions (Chapter 3). Thus workplace initiatives to increase job and professional satisfaction may not affect nurse migration as much as anticipated. Family and other personal factors may be more salient. A surprising finding of the study was that only 73% of respondents held Sri Lanka professional nursing licenses. While nurse licensure is not a requirement for employment in private health institutions, and nurses who graduate from private schools of nursing are not always eligible for licensure, it is a requirement in public ones. Lack of nurse licensure nationally makes it difficult to track the nurse workforce, particularly in the private health sector as no central database of nurse employment exists.

The Sri Lankan Policy Context in Relation to International Migration.

Sri Lanka has joined global initiatives for promoting out-migration and development linkages (Ministry of Foreign Employment Promotion and Welfare, MFEPW, 2008). The cumulative results of these policies have resulted in the MFEPW with the support of the International Labour Office (ILO) in Colombo launching the national policy for labour out-migration in 2009. This policy enables men and women to out-migrate in conditions of: (a) good governance of the migration process; (b) provisions for protection and empowerment of migrant workers and their families; and, (c) linkage of migration and development processes. All recruitment agencies are required to register with the government and potential migrants are encouraged to participate in training prior to leaving. Additionally, the Sri Lanka National Migration Health Policy (2012) was developed by the Ministry of Health for the protection of rights of all migrant populations including migrant workers and their families. The SLBFE

(2010) receives complaints from migrants about the non-payment of agreed upon wages, difficulties in communication and adaptation to a different culture, sickness, harassment (physical and sexual), death (natural, accidental, homicide, suicide), lack of reception on arrival, being stranded without employment, problems at home (Sri Lanka), breach of employment contract, premature termination, and illegal money transactions (Gamage, 2013). Most of these complaints are received from unskilled labour migrants, although a few have been received from middle level migrants (which include nurses). Sri Lanka's political goal of encouraging out-migration, particularly of skilled healthcare workers, makes these negative consequences of particular importance to various levels of government.

The SLBFE brokers the temporary migration of workers through licensure of employment agencies, data on migrant workers, setting of standards, and negotiation of employment contracts and welfare measures (SLBFE, 2017). In addition, the Association of the Licensed Foreign Employment Agencies was incorporated in 1985 to resolve disputes between licensed employment agencies and to offer recommendations to the SLBFE about the promotion and regulation of employment outside Sri Lanka (Arunathilake et al., 2011). The data at the SLBFE, however, does not reflect the actual figures of migrant nurses (IPS, 2013). This is because limited information is captured during pre-departure immigration formalities and there is disparity with how nurses are identified within the SLBFE. For example, although nurses are recognized as being in the middle level manpower category, within this category they are identified as *nurses – general, nurses – midwife, nurses – professional, nurses – staff*. There is no rationale provided to show how these categories were developed and it is not known if these differences are clear to those filling out the forms. Further, registration with the SLBFE prior to departure is not mandatory. Nurses usually seek job opportunities directly and, therefore, leave

under the general emigration laws of the country. This bypassing of the SLBFE affects the reporting and recording of accurate temporary nurse migration statistics (IPS, 2013) and does not capture nurses who plan permanent migration, particularly if nurses are migrating facilitated by social networks of expatriates in the destination country rather than through bilateral agreements. Records indicate that in 2007 Sri Lanka had the 3rd highest expatriation rate of nurses (2,032 left) in the Organization for Economic Cooperation and Development (OECD) countries (Dumont & Zurn, 2007). No more recent data could be found.

The MOH in Sri Lanka has a history of involvement in bilateral agreements (some of the countries are in the Middle East and the West) where nurses are given the option of taking two to five years of unpaid leave to be involved in circular migration. To be qualified to take two to five years of leave nurses must have worked in the healthcare system for at least four years and be currently employed within a public healthcare institution. The nurse may initiate the migration and the choice may be influenced by opportunities created through a bilateral agreement with another country. To keep their positions in Sri Lanka nurses are required to return to Sri Lanka within two years to obtain an extension for another two years, and then to return again to obtain a final extension for the remaining year (unless a bilateral agreement is drawn up for a period of greater than two years). The need for returning to renew leave is positive as these visits help nurses reconnect with colleagues, family, and community and there are opportunities for stakeholders to impart new knowledge and skills. In 2009 there were international requests for 821 nurses but only 32 departed and in 2010 there were requests for 1001 nurses with the data revealing that 51 departed (SLBFE, 2015). In 2011, 31 nurses were selected by the Ministry of Health, Kuwait as the first ever recruitment of nurses from Sri Lanka to Kuwait (Ministry of External Affairs, Sri Lanka, 2011). More recently, a 5-year agreement was signed between the

Sri Lanka Foreign Employment Bureau and Kama Services, a global recruitment provider recognized by the United States (US) to provide job opportunities for over 3000 nurses in private and government US hospitals, which has resulted in nurses undergoing training with all expenses met including travel for successful candidates who are qualified to work in the US health sector (The Official Government News Portal of Sri Lanka, 2017).

What is clear from this discussion of the Sri Lankan context of international nurse migration is that emigration of nurses is happening, agreements are in place to foster temporary and permanent migration, and that reasons for migration are congruent with the *push-pull* theory of migration (Kingma, 2006). What is not clear is that there is an overall migration policy framework for the country as a whole but it is certain that a specific one for nursing is lacking. What would it take to get such a framework in place? My discussion of research and policy agendas will be situated within discussion of needs to track what exists currently and to undertake research to provide an evidence base for workforce planning and policies that take advantage of the potential benefits of international migration but also meet domestic needs for professional nurses.

Research and Policy Agendas to Situate Nurse Migration within an Overall Nurse Workforce Framework

Multi-stakeholder national dialogues are required to examine what needs to be done to make nurse migration a positive in Sri Lanka in relation to healthcare system needs and the benefits of potential remittances (San Jose, 2015). At the outset, any policy and research agenda (see Table 1) in Sri Lanka must be created with attention to: (a) an in-depth understanding of the interaction between Sri Lanka's historical, socio-cultural, economic, and political contexts, its global migration patterns, and existing policies and international agreements; (b) knowledge of

factors that influence decision making at individual, household, community/organizational, and country levels; (c) inquiry into nurses' journeys and experiences to understand how and why nurses move, and how international mobility affects identities, relationships, and the societies through which they pass; (d) policies and practices that address nursing shortages, recruitment, and retention; and, (e) ethical management of nurse migration for revenue generation that respects nurses' right to migrate (Ogilvie et al., 2007). In keeping with these imperatives, these ideas are refined and consolidated into research priorities and needs for policy development.

Priority 1: Developing an Evidence Base for Policy and Research Planning

The first priority is to address the limitation in available data on the nurse work force in Sri Lanka. There is a need for researchers and policy makers in Sri Lanka to determine what currently exists in terms of health workforce information system facilities and data management skills to record nurse data such as number of nurses available in relation to existing and future needs, tracking of both internal and external migration, registration/licensure details, qualifications in relation to current and projected positions, adequacy of current number and categories of nursing positions given expected contributions of nurses within the health system, and regional inequities. It will be easier to get accurate statistics within the government system as compared to the private health sector. Thus collaboration and coordination between the two sectors is needed.

Priority 2: Investigating Shortages, Recruitment, and Retention

Researchers and policy makers need to focus on ascertaining nurse shortages and work towards producing and retaining nurses for Sri Lanka's healthcare system development (Buchan, et al., 2013; Buykx, Humphreys, Wakerman, & Pashen, 2010). Research is required in the fee paying and non-fee paying sectors in urban and rural areas as work-life conditions vary between

the two and more information will help planning toward national healthcare equity including access to nursing services. As stated previously, my research on nurses' turnover intentions (see Chapter 2 and 3) carried out with 679 nurses revealed that nurses' personal context factors explain more variance in nurses staying intentions than work context factors. In addition, the study revealed that nurse physician relations and nurse management and leadership ability had significant effects on nurses staying intentions. Further research is required, however, to inform policies that will enhance nurses' quality of work-life experiences, job satisfaction, retention, and out of work context factors. Moreover, interventional studies are required to test programs in work environments that are implemented to improve work life conditions for nurses as failed programs have economic and social consequences (Yagi, Mackey, Liang, & Gerlt, 2014). Other research could focus on examining nurse qualifications in the public and private sectors to examine transferability of skills across sectors with a view to having equal access to opportunities to work in either sector or to emigrate. Research must also include an examination of nurses' reasons for staying or leaving the profession, the organization, or the country. These recommendations are situated in turnover theory and research and are justified by the notion that individual reasons for leaving or staying with an organization may be translated into solutions that can be implemented to help recruit and retain nurses for that organization.

Priority 3: Improving Quality and Standards for Nursing Practice

Nurses' decisions to leave are fueled by lack of rewards (economic and emotional) and increasing workloads and expectations, which could harm quality and standards of practice. Lack of rewards and increasing workload can affect work stress, reduce emotional commitment to the organization and increase turnover intension. To maintain standards and motivation of nurses to stay, supportive work-life contexts with evidence based multifaceted resource strategies are

required. My research study revealed that it is important to expend energy developing nurses' transformational leadership skills, as this will have an impact on nurses' staying intentions. In addition, the research reveals that strategies to improve quality of care and standards for nursing practice must include innovative workforce planning, staffing, and skill-mix; communication and team building; empowering leadership approaches; and, career and professional development opportunities. This will require facilitation by: (a) multi-level, multi-stakeholder collaborative efforts and public private partnerships and (b) local and international partnerships with academic and professional institutions. This is to create enabling environments for nurses to develop skills and competencies to participate in addressing inequities in health and healthcare delivery and develop competencies to enhance political leadership, teamwork, influence, and professional credibility; leadership in organizations or the profession; critical reasoning and data management skills; self-awareness; and, social astuteness. In addition, professional organizations will require strong nursing leadership to ensure nursing presence and voice in policy decision-making, preservation of a united nursing front, and guidance for nurses to become effective in lobbying government and stakeholders to address social determinants of health, which influence health and access to healthcare. Nurses need to become credible collaborators in inter-professional and inter-disciplinary teams and networks. Achievement of such goals will require attention to nursing curricula, opportunities for advanced education, and nursing input and accountability in the strategic planning and management of institutions and other settings in which they practice.

Priority 4: Enhancing Resources and Capacity Building

Increased complexity and pace of change within healthcare environments makes it also imperative in this post-bureaucratic, increasingly networked, and mobile and information rich age for organizations to realize human potential by investing purposefully in people. There is a

need for enhancing and ensuring high quality nursing education (one standard and not two, not one for export and one for home) even with increasing students and limited faculty (see Chapter 1). As Sri Lanka is operating with limited access to resources, options to improve include: (a) implementation of a *train-the-trainers* program – to increase opportunities for graduate study as there is limited access in Sri Lanka; (b) development of home grown quality sustainable undergraduate, graduate, and post-graduate programs via public/private partnerships; (c) enforcement of strict regulations to prevent mushrooming of private schools of 'nursing' of varying quality; (d) creation of minimum standards to ensure that school and university programs in nursing have sufficient qualified faculty to teach and conduct research effectively; and, (e) facilitation of sustainable mutually beneficial partnerships and programs through international partnerships and collaborative action research. Within this context it is also important for nurses to develop their transformational leadership (TFL) capability as in Sri Lanka TFL has the potential to slow attrition and retain nurses by creating positive work-life environments and increasing job satisfaction and organizational commitment (Brewer et al., 2016; Fischer, 2016). Specifically TFL in Sri Lanka would: (a) manage pressures for efficiency (including decreasing cost) and implement reform; (b) craft compelling nurse-led visions; (c) navigate complex sociocultural, economic, and political scenarios to drive visions to fruition; (b) exhibit through leadership the authority of evidence-based reasoning and creativity free of convention or coercion; (c) inspire and mobilize change through personal influence and creation of work-life environments for the best contribution of nurses; (e) demonstrate the value of nursing contributions without union-led strike actions that are detrimental to patient care; and, (f) practice responsible and relational leadership (Cummings, et al., 2010). Although such measures are easy to promote, they may be difficult to operationalize in the presence of entrenched class,

inter-professional, and gender hierarchies. Nursing leadership, unity, commitment, and perseverance will be critical. In the process, nurses will be in competition with other vested interests for allocation of scarce resources.

Priority 5: Working toward Win-Win Nurse Out-Migration Research and Policy

Steps must be taken to synthesize descriptive and empirical evidence on lessons learned from other source countries and regions, such as the Philippines, Caribbean, Africa, China, and India, about the production and migration of nurses to illustrate ways in which knowledge can be shared and analysis can be deepened, refined, and rendered more critical. Resources could focus on examining how source countries: (a) manage nurse migration – what was successful, what failed; (b) manage or fail to manage their local nursing workforce to ensure quality and equitable care; (c) input incentives (if any) to promote win-win situations for return migrants; and, (d) ensure welfare and security of nurse migrants (including welfare of families left behind and creation of ethical policies, codes of practice, bilateral and multilateral agreements) (San Jose, 2015). These reviews are critical, as they will potentially prevent duplication of empirical work or failure to apply international comparative analysis leading to naïve and uninformed policy, nurse migration frameworks that are not implementable or sustainable, and misuse of scarce resources. Added to this, an examination of existing multi-lateral agreements is necessary to identify gaps and limitations; document, publish and replicate research of positive migration experiences across contexts; ensure adequate compensation between Sri Lanka and destination countries so that agreements promote reciprocal benefits; and, in the case of temporary migration, ensure re-integration arrangements are made for returning nurses. My research confirms that at least some of the macro-level factors identified in the model (see Chapter 2) are salient to nurse migration from Sri Lanka. More research, however, is needed to establish the pathways and

strengths of links through which such factors manifest and thus contribute to theoretical understanding of both temporary and permanent nurse migration in the Sri Lankan context.

Conclusion

Nurse migration in Sri Lanka matters because it is viewed at a macro level as a mechanism for export of skilled labour for remittance generation and a mechanism, when return migration occurs to obtain knowledge, skills, and attributes. Analysis of what is happening in Sri Lanka reveals that nurse migration is both a temporary and a permanent phenomenon and linked to an intricate web of political, economic, socio-cultural, and historical contexts. What is happening in Sri Lanka is not unique and there are similar forces elsewhere. Civil conflict and natural disasters have created challenges for health professionals and nurses' decisions to migrate are entangled in professional and individual contextual features that they encounter in their work and personal lives. Nurse migration is not a simple individual decision or action in which a nurse decides to move in search of better life-chances. Rather, nurses' motivations and decisions to migrate are embedded in multi-pronged processes and contexts involving many stakeholders that include themselves, as well as networks that are private, public, and social including family, community, national, and international. These all have relevance to any inquiry about patterns of nurse migration within and from Sri Lanka. A research agenda that focuses on knowledge for development of a nurse workforce framework for Sri Lanka, with supportive policy development that also incorporates the phenomenon of international nurse migration would demonstrate a vision of nursing's potential contributions to the twin needs of national health development and access to foreign currency for national economic development. A *win-win* strategy that meets health sector needs, as well as contributes to overall national development would strengthen nurses' status within Sri Lanka and balance opportunities for nurses with societal needs.

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TABLE

Table 4.1: Research Agenda and Policy Framework

Research Agenda & Policy Framework

Situating Nurse Migration within a Nurse Work Force Planning Framework for Sri Lanka

Multi-level multi- stakeholder dialogs

Base for research & policy	Recruitment & retention	Quality & Standards	Resources & capacity building	Win-win nurse migration
Historical, socio-cultural, economic, political transformations				
• Nursing information system mangement facilities. • Data management skills to: • Map number of nurses, shortages, tracking internal and external migration, registration, licensure details, qualifications, need in terms of position, eligibility, location of work.	• Determine recruitement & retention strategies. • Research in fee-paying, non-fee paying, rural and urban sectors towards equitable access. • Research to determine work-life experiences and what needs to be done to improve job satisfaction and retention. • Qualitative and quantitative research at individual, organizational, and country levels.	• Research and development for quality and standards. • Innovative workforce planning, staffing and skill-mix, communication and team building, empowering leadership approaches, and career and professional development opportunities. • Local, international, public, private, multi-stakeholder partnerships to develop nurse competencies.	• Ensure one standard of nurse education to meet domestic and export needs. • Sustaible development with built in 'train the trainers' concept - a multi-stakeholder effort. • Investigations into how best to integrate regulatory mechanisms to ensure standards. • Research on how best to inculcate transformational leadership to drive nurses' visions to fruition.	• Critical reviews of migration codes and policies. • Review and learn from other source country experiences. • Quantitative and qualitiative research to study the influence of nurses' personal contexts on influences to stay or leave. • Research into migration processes (privately, government), transitions and journeys, and re-integration processes.

EPILOGUE

This thesis has provided insights into the complex micro and macro influences on nurse migration, particularly nurses' decisions to leave their current profession, organizations, and/or country. In doing so the findings provide some guidance into how these contexts can be shaped to situate nurse migration within an overall nurse workforce framework that should inform policy and leadership practice to meet Sri Lanka's healthcare system planning. Here, I critically reflect on some aspects of the research process including the overall strengths and limitations of this work. I describe challenges faced with carrying it out and delineate a way forward.

Retrospective Reflections

One of the issues I faced at the outset was with drawing up the proposal for the study. I live in Sri Lanka and wanted to focus on an area where limited knowledge was available and an area that would contribute to developing nursing in Sri Lanka. I also wanted to share with others within and outside Sri Lanka issues and challenges faced by nurses in this country. In particular, I wanted to use an empirical approach so that different stakeholders, such as nurses, nurse leaders at different levels, researchers and policy can benefit and drive further research and policy development for the enhancement of nursing in Sri Lanka.

As mentioned in Chapters 1, 2, 3 and 4 at a macro level, similar to other countries the development of nursing in Sri Lanka is shrouded in historical, socio-cultural, political and economic contexts (see Chapter 1 and 4). And at a micro level, again similar to other countries, nursing in Sri Lanka faces a gamut of issues, such as, shortages, retention, recruitment, need for more professional development opportunities, need to improve nurses work environments, regulation, standards and competencies, develop leadership skills and support for nurses to meet family commitments (see Chapter 3) – all of which will contribute to nurses' commitment to the

organization and intentions to stay, leave or migrate. Sri Lanka has experienced recently severe floods and landslides, and currently a dengue epidemic and a garbage crisis resulting in many deaths, and quite different but relevant, a politically driven needs to steer nurse migration up the political agenda. To cope better with these ever changing environments, Sri Lanka needs to have more better prepared nurses with improved knowledge, skills, including leadership skills, and attributes to meet the needs of Sri Lanka's healthcare system, people and improve the quality of nursing care. Similar to the rest of the world, however, Sri Lanka would benefit from addressing the shortage of nurses and improving recruitment and retention of nurses, while at the same time situating nurse migration within a nurse workforce-planning framework (see Chapter 4).

Study Limitations and Strengths

Identifying and describing issues and challenges faced by nurses was difficult as there was and continues to be limited research on nursing and nurses in Sri Lanka – a current study of issues and challenges faced by nurses was accomplished in this dissertation (see Chapter 1). Reviewing literature on turnover theory and commitment and contextualizing to fit the Sri Lankan context, I presented a model and discussion on contextual factors that influence nurses' commitment and turnover intentions to be used by researchers, policy makers, clinicians and educators (see Chapter 2). The model highlighted (a) several lists of factors that affect multiple aspects of nurses' work-life experiences and the relationships among them; (b) a broader range of perceptual, experiential and contextual factors than have normally been studied within the commitment and turnover literature adapted for the nursing occupation - all are unknown in Sri Lanka; and (c) the need for an evidence based, multi-stage, multi-level, multi-stakeholder approach to addressing issues and challenges confronting nurses. In hindsight however, because there is a lot of unknown in Sri Lanka, it would have been prudent to work with a smaller model

that included fewer factors. The model was very large, unwieldy, with many unknowns and multiple factors that can be tested at different times (see Chapter 3 for testing of a limited set of factors from the study). However, the large nature of the model has ultimately added more new knowledge than I anticipated.

A limitation of the questionnaire was its length; especially given nurses' heavy work schedules and time commitments. Six hundred and seventy-nine nurses completed the questionnaire. However, at the outset, rather than collecting data for all the variables in the model in one go, it may have been prudent to devise a shorter questionnaire to test selected variables from the model. If a similar study is carried out at another urban government hospital, or government rural hospital, I would edit the questionnaire to include only those variables under study.

The second limitation related to the questionnaire was cultural appropriateness of the measurement tools was a potential source of bias as the tools were developed and tested in the west. The measurement tools were back translated into Sinhala and Tamil, but it was challenging to determine if the questions were precisely interpreted such as the meaning remained consistent with the intent of the questions. Before questionnaire items are used again in Sri Lanka, the findings will be validated through a presentation and solicitation of the extent to which findings fit with what participants expected me to find. Sri Lankan nurses will review questionnaire items in order to better assess construct validity within the Sri Lankan context.

The framework that drove this study has provided many questions that will drive my ongoing research program and a huge data set that can be used to test various relationships to determine nurses' turnover and commitment intentions, including affective, continuance and normative commitment to organization, profession, family and country. From this model, I

derived a simpler model to explain the relationships between nurses' work context, personal context, affective organizational commitment and factors that influence nurses' intentions to stay. This model development and testing is relevant to the overall body of research on nurses' staying intentions.

This study revealed that nurse managers together with nurse researchers must identify factors that influence nurses' turnover intentions at local, provincial and national levels, at an organizational level and country level so that features of supportive work-life environments can be put in place to enhance nurses' staying intentions. It was an ambitious project and encompasses that of setting up a research program with a long-term goal, but deciding to test the model piece by piece. Breaking the project into more manageable tasks enabled me to complete the work as well as strengthen the end result. It also (rather than a weakness) generated a huge data set in which to carry out further analyses. This is the first time that a study of this nature on turnover, commitment and migration has taken place in Sri Lanka. It is also the first time that some of the tools to measure the identified variables have been tested or used in Sri Lanka.

Situating nurse migration within a nurse work force framework in Sri Lanka as depicted in this thesis requires multi-stage, multi-level, multi-stakeholder efforts and carried out within historical, socio-cultural, political and economic context, as well as sustainable human and financial resources. That being the case it also requires a helicopter view to organize areas of priority and shape research and policy agendas. In this Chapter, I consolidated what I learned at micro (organization) level and macro (emigrate) level (see Chapter's 1, 2, 3, 4) to shape a research and policy agenda to balance nurses' opportunities to migrate with Sri Lanka's healthcare and quality nursing care needs.

Challenges

I faced a myriad of challenges on this journey, some of which reached were beyond those I would have encountered had I been in Canada and some of which I faced as an international transient migrant student from a source country studying in a recipient country. Aside from the challenges I faced studying from a distance as I was based in Sri Lanka, additional challenges to this thesis were the lack of available information on nurses in Sri Lanka, and limited access to some gatekeepers and the research site as well as the immense amount of time required to obtain information and access key informants and stakeholders. I also had to be tolerant on occasion of strikes and work stoppages that prevented my meeting with people. Gaining access required months of planning ahead, setting the scene and getting to know key persons within the MOH, local universities and the study hospital. Eventually, for the study to be carried out ethics approval was obtained as mentioned previously from the ethics review committees of the University of Alberta, Sri Lanka Medical Council (who requested the support of two local supervisors to supervise the data collection), the study hospital and the MOH. This is in line with recommendations by Mill and Ogilvie (2002) who advocated research must meet ethical standards of the institutional setting and cultural environment in which the research is taking place. Once gate-keepers were accessed the study also required numerous visits to the hospital to build rapport and show commitment to the project. I believe the time and effort spent walking around and meeting different people paved the way to the 679 nurses showing support and participating in the study.

Implications for Future Practice, Policy and Research

Practice considerations for nurse leaders. Concerns raised by nurses in this study may echo the concerns of nurses in other settings, and I believe are most useful to nurse leaders.

Nurses unanimously reported the challenges of their workplace, particularly the overtime hours they worked and the limited resources available to them. They also reported the limited power they experienced within the health care system and how hard it was to access opportunities for professional development. Most nurses also reported difficulties they experienced in obtaining study leave to attend educational programs. Initiatives to improve the work environment and the delivery of high quality care are important to nurses in Sri Lanka. Analysis of the results revealed a need for nurses to have opportunities to develop their leadership skills as an empowering leadership approach is essential to ensuring that nursing staff remains committed to their profession and to the overall objectives of the organization. Nurse leaders have opportunities for action on these fronts.

Policy considerations. The findings of this study may inform policy makers as they develop policies enhancing the retention of nurses and encourage the return of migrating nurses. The CWEXP model may support analysis of problems related to turnover and increase awareness of additional research needed for evidence based policy decision-making.

Research considerations. This CWEXP model (Figure 2.1) has implications for researchers to develop a more complex understanding of critical day-to-day decisions that affect nurses' decisions to stay or leave. Further, the proposed model can be used as a guide by researchers to guide the development of limited scope models (with different variables) for in-depth study in different social contexts and for the development of evidence based nurse retention strategies. Managing the impact of turnover or migration of nurses requires long-term policy and human resource development and management initiatives to sustain the supply of nurses.

I learned from this dissertation that it was important to carry out studies at a micro level and then examine how and where the new knowledge links with or can be translated to drive further research and/or theory development, enrich how what is learnt fits in with the study of macro context factors and/or drive policy. I also learned that the study of the influence of macro factors on, for example nurses' abilities to leave has to be done separately to avoid muddling the micro examinations and allow for transparency.

I recommend a step-by-step process to studying various aspects of the model, including the direct relationships between the work context, personal context and turnover intentions and organizational commitment. For example, as a follow up study as a secondary analysis I can examine the direct relationships between rewards on nurses' affective commitment to the organization and turnover intentions. Rewards because work rewards are shown to have an effect on nurses staying intentions (Torangeau, Cummings, Cranley, Ferron & Harvey, 2010), it may be prudent to hypothesize that,

H1a Rewards are positively related to nurses' staying intentions

H1b Rewards are positively related to nurses' affective commitment to the organization.

I think however, this study would also benefit from a qualitative component searching answers to the question, 'what is my reward for the amount and type of work I do in the place where I do it'. I feel that the way in which the model has been drawn up invites the study of multiple direct relationships between variables.

Another virtue of this project is that it introduces psychological and sociological theories to the complex topics of nurse turnover and nurse migration. This begins to pave the way to align national and hospital policies with micro-level factors that influence decisions. There is much more work to be done in this area.

Another area for future research relates to conducting a secondary analysis between nurses' commitment to country and intentions to stay or leave. Little research has been done in this area and it will be useful to compare these results with the results obtained from an analysis of the relationship between nurses' commitment to the organization and turnover intentions. Given that migration is a macro concept and turnover is a micro concept, it would be interesting to see how nurses' responses are the similar or different.

Academic considerations. There is an urgent need for nurses to gain control of their discipline, including the education process. The study detailed in Chapter 3 was carried out with a sample from an urban hospital in Sri Lanka, and given Sri Lanka's healthcare context (see Chapter 4) the differences in rural and urban Sri Lanka and variation of resource availability and educational opportunities between the government and private sector, I recommend that similar research be carried out with nurses working in the rural sector followed by the private sector. As identified in Chapter 1, there are varying standards in education and preparation between nurses operating in the private sector and government sector.

Dissemination and Way Forward

My way forward is to begin work towards operationalizing the research agenda and policy framework highlighted in Chapter 4. As a first step, dissemination of the findings of research project will be ongoing and include presentations at conferences (nationally and internationally) and with key stakeholders, as well as publications in peer review journals. The first paper has been accepted for publication in the International Nursing Review and my hope is that it will stimulate conversations about issues and challenges in nursing faced by nurses in Sri Lanka. The second paper is under review the Journal of Advanced Nursing, and I hope to derive papers from Chapter 3 and Chapter 4 for publication in peer review journals. The findings of this

work will be suitably packaged to the target audience to enable appropriate uptake of recommendations. I will give copies of the papers derived from this thesis to key persons in the MOH and the urban hospital with letters of appreciation for their support. I will also share my work with the Sri Lanka Medical Council, Nursing Council and the local supervisors, one who is the Deputy Director General Education, Training and Research with the MOH and the other who is the Director, Medical Education Development and Research Centre of the University of Colombo. I envisage that sharing my work will facilitate building partnerships with key stakeholders, help with obtaining funding for crucial project components and increase opportunities for expansion of the study to other similar settings.

Conclusion

The thesis was a first step in addressing some of the knowledge gaps, issues and challenges that impede progress in our understanding of influences on nursing migration in Sri Lanka. The issues in relation to nursing can be historical, gendered, economic, political socio-cultural, organizational or personal, local, provincial, national or global. In order address these issues and challenges, as they might exist in any given time, we must use a rational, proactive and empirical approach in identifying policy problems, formulating policy proposals, and legitimizing, implementing and evaluating policy in a timely manner. This is necessary because if we do not address problems as they arise, they fester, and become more difficult to resolve. There is a policy vacuum in nursing in Sri Lanka that requires careful analysis and strategic planning by formal nurse leaders – it is a step that requires empirical research and incremental change to lead to evidence based strategies that can enhance the nursing profession in Sri Lanka and meet Sri Lanka's healthcare needs for high quality nursing care.

This study journey has been professionally and personally challenging, but ultimately

enlightening. My work in relation to nurse turnover (organizational level) and nurse migration is the first to shed light on what is really happening in Sri Lanka. It points towards the embedded forces that serve to keep nurses in powerless positions; the need for a strong independent voice for nurses in Sri Lanka, along with the need for policy that emphasizes the vital professional role of nurses in the health care system; attention to the complex factors that shape nurses decisions to stay or leave their work places, and the need for formulating, implementing, reviewing and moderating work-life improvement interventions to mitigate nurses leaving or migrating or ethically mange nurse turnover and/or migration. My research also calls for a research consciousness to ensure evidence based policy and practices are developed and adopted (see Chapter 5), with built in mechanisms for 3-5 yearly reviews and empirically based modifications.

We come across people and places in our lives for a purpose. We are reminded of where we have been, what we want to do and where we want to go. On our journeys some people are with us for a short time, and others come with us to remind us that there is more we can give, we can surpass obstacles, there is no such word as 'can't' and it is a question of finding a way. I began this journey with naivety and wanting to make a meaningful difference. I travelled through and over heavy and seemingly unchallengeable terrain. I arrived and accomplished something that I knew I could, but at the time I started, I did not know I could or how I could. I have unearthed a path to continue my journey and to respectfully help nurses and nursing in Sri Lanka.

> Having made a discovery, I shall never see the world again
> as before. My eyes have become different; I have made
> myself into a person seeing and thinking differently. I
> have crossed a gap, the heuristic gap, which lies between
> problem and discovery (Polyani, 1962, p. 151).

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APPENDIX A

Ethics Approvals and Supervisor Commitment for Data Collection Period

Ethics Approval from the Research Ethics Office University of Alberta

UNIVERSITY OF ALBERTA

RESEARCH ETHICS OFFICE

308 Campus Tower
Edmonton, AB, Canada T6G 1K8
Tel: 780.492.0459
Fax: 780.492.9429
www.reo.ualberta.ca

Notification of Approval

Date:	July 09, 2014
Study ID:	Pro00048286
Principal Investigator:	Dilmi Aluwihare Samaranayake
Study Supervisor:	Greta Cummings
Study Title:	Nurse Migration in Sri Lanka: An Examination of Micro-Level Factors in Context
Approval Expiry Date:	July 8, 2015

Thank you for submitting the above study to the Research Ethics Board 2. Your application has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

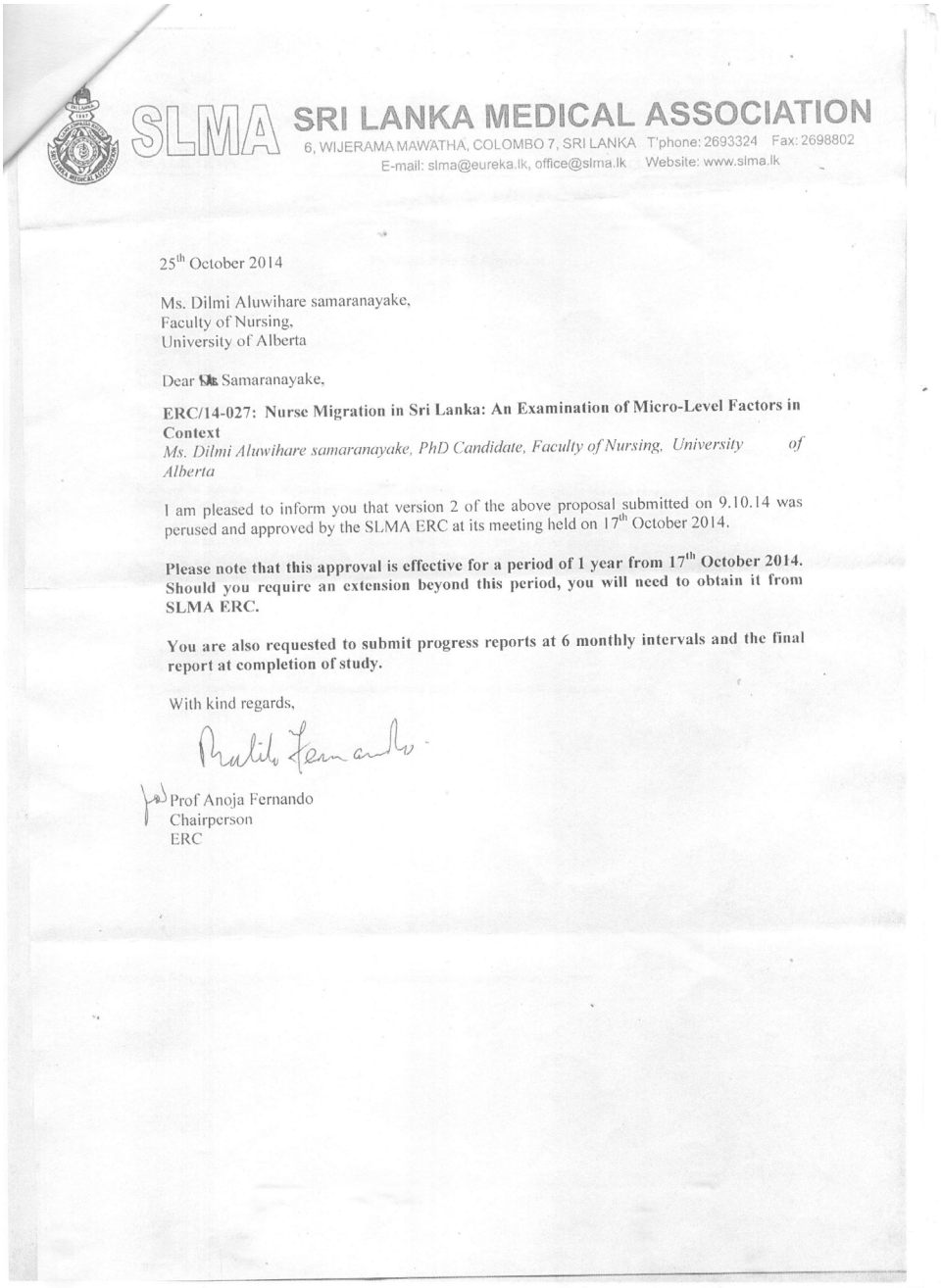
Approval by the Research Ethics Board does not encompass authorization to access the staff, students, facilities or resources of local institutions for the purposes of the research.

Sincerely,

Stanley Varnhagen, PhD
Chair, Research Ethics Board 2

Note: This correspondence includes an electronic signature (validation and approval via an online system).

Ethics Approval from the Sri Lanka Medical Association



SLMA SRI LANKA MEDICAL ASSOCIATION

6, WIJERAMA MAWATHA, COLOMBO 7, SRI LANKA T'phone: 2693324 Fax: 2698802
E-mail: slma@eureka.lk, office@slma.lk Website: www.slma.lk

25th October 2014

Ms. Dilmi Aluwihare samaranayake,
Faculty of Nursing,
University of Alberta

Dear Ms. Samaranayake,

ERC/14-027: Nurse Migration in Sri Lanka: An Examination of Micro-Level Factors in Context
Ms. Dilmi Aluwihare samaranayake, PhD Candidate, Faculty of Nursing, University of Alberta

I am pleased to inform you that version 2 of the above proposal submitted on 9.10.14 was perused and approved by the SLMA ERC at its meeting held on 17th October 2014.

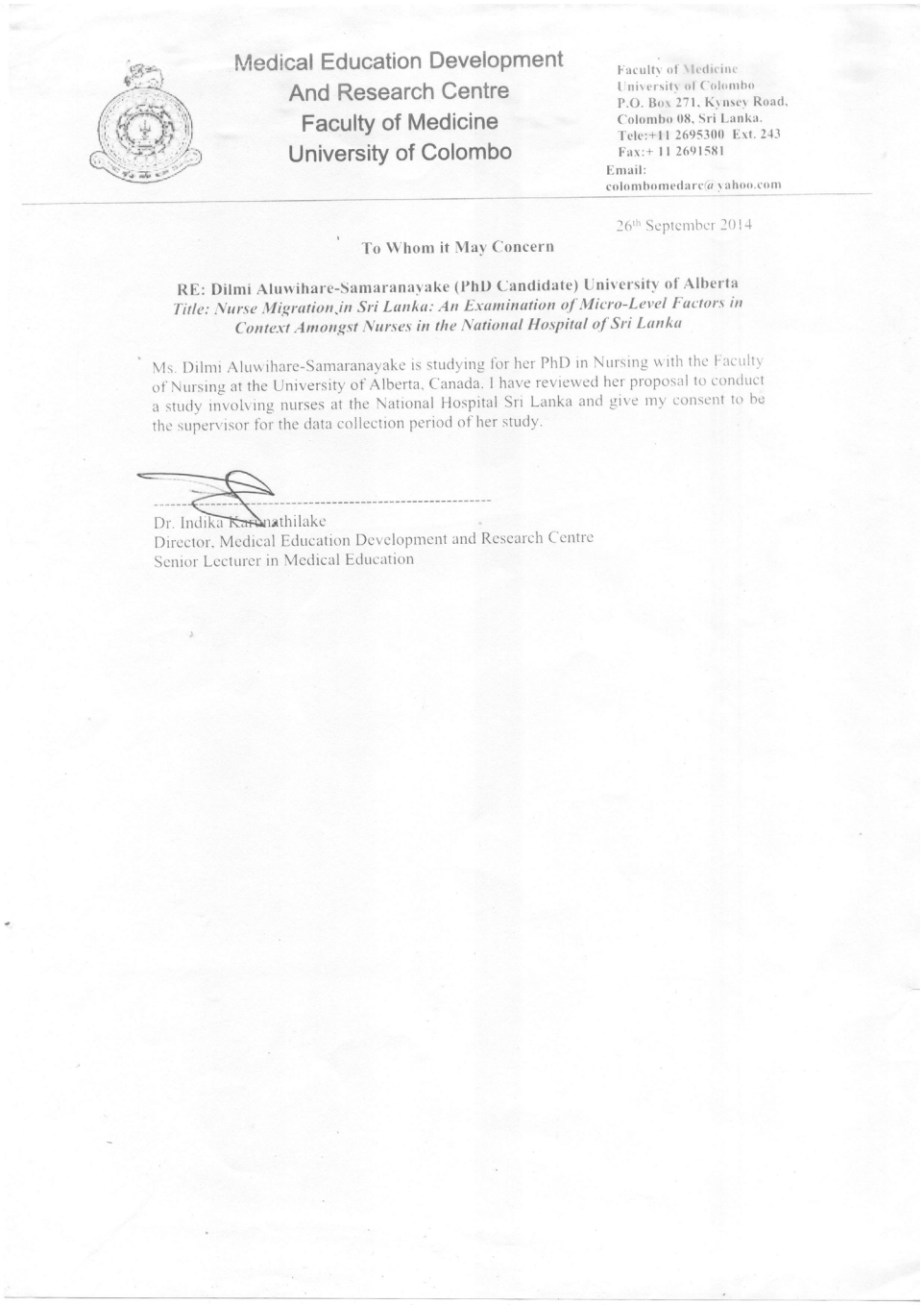
Please note that this approval is effective for a period of 1 year from 17th October 2014. Should you require an extension beyond this period, you will need to obtain it from SLMA ERC.

You are also requested to submit progress reports at 6 monthly intervals and the final report at completion of study.

With kind regards,

Prof Anoja Fernando
Chairperson
ERC

Letters of Support for Data Collection Period from Two Local Supervisors



Medical Education Development
And Research Centre
Faculty of Medicine
University of Colombo

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26th September 2014

To Whom it May Concern

RE: Dilmi Aluwihare-Samaranayake (PhD Candidate) University of Alberta
Title: Nurse Migration in Sri Lanka: An Examination of Micro-Level Factors in Context Amongst Nurses in the National Hospital of Sri Lanka

Ms. Dilmi Aluwihare-Samaranayake is studying for her PhD in Nursing with the Faculty of Nursing at the University of Alberta, Canada. I have reviewed her proposal to conduct a study involving nurses at the National Hospital Sri Lanka and give my consent to be the supervisor for the data collection period of her study.

Dr. Indika Karunathilake
Director, Medical Education Development and Research Centre
Senior Lecturer in Medical Education

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சுகாதார அமைச்சு
Ministry of Health

To Whom It May Concern

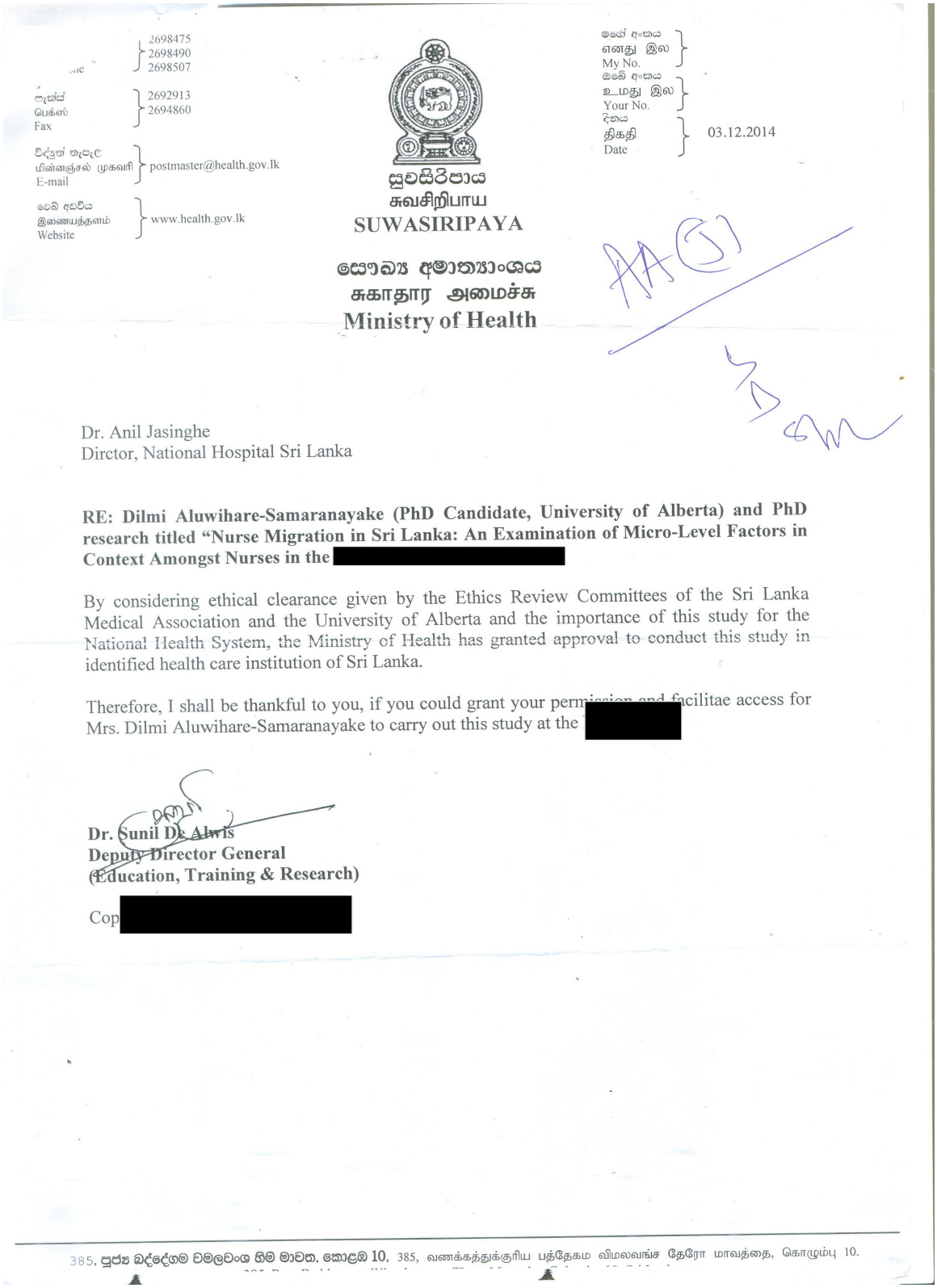
Re: Dilmi Aluwiare-Samaranayake (PhD Candidate) University of Alberta
Title: Nurse Migration in Sri Lanka: An Examination of Micro-Level Factors in Context Amongst Nurses in th [redacted]

Ms. Dilmi Aluwihare-Samaranayake is studying for her PhD in Nursing at the University of Alberta, Canada. I am expressing my consent to be the supervisor for the data collection period of her study at the [redacted]

Dr. Sunil De Alwis
Deputy Director General
(Education Training & Research)

385, පූජ්‍ය බද්දේගම විමලවංශ හිමි මාවත, කොළඹ 10. 385, வணக்கத்துக்குரிய பத்தேகம விமலவங்ச தேரோ மாவத்தை, கொழும்பு 10.
385, Rev. Baddegama Wimalawansa Thero Mawatha, Colombo 10, Sri Lanka.

Letter of Approval from the Ministry of Health, Sri Lanka



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Ministry of Health

මගේ අංකය
எனது இல
My No.

මගේ අංකය
உமது இல
Your No.

දිනය
திகதி
Date
03.12.2014

Dr. Anil Jasinghe
Dirctor, National Hospital Sri Lanka

RE: Dilmi Aluwihare-Samaranayake (PhD Candidate, University of Alberta) and PhD research titled "Nurse Migration in Sri Lanka: An Examination of Micro-Level Factors in Context Amongst Nurses in the [redacted]

By considering ethical clearance given by the Ethics Review Committees of the Sri Lanka Medical Association and the University of Alberta and the importance of this study for the National Health System, the Ministry of Health has granted approval to conduct this study in identified health care institution of Sri Lanka.

Therefore, I shall be thankful to you, if you could grant your permission and facilitae access for Mrs. Dilmi Aluwihare-Samaranayake to carry out this study at the [redacted]

Dr. Sunil De Alwis
Deputy Director General
(Education, Training & Research)

Cop[redacted]

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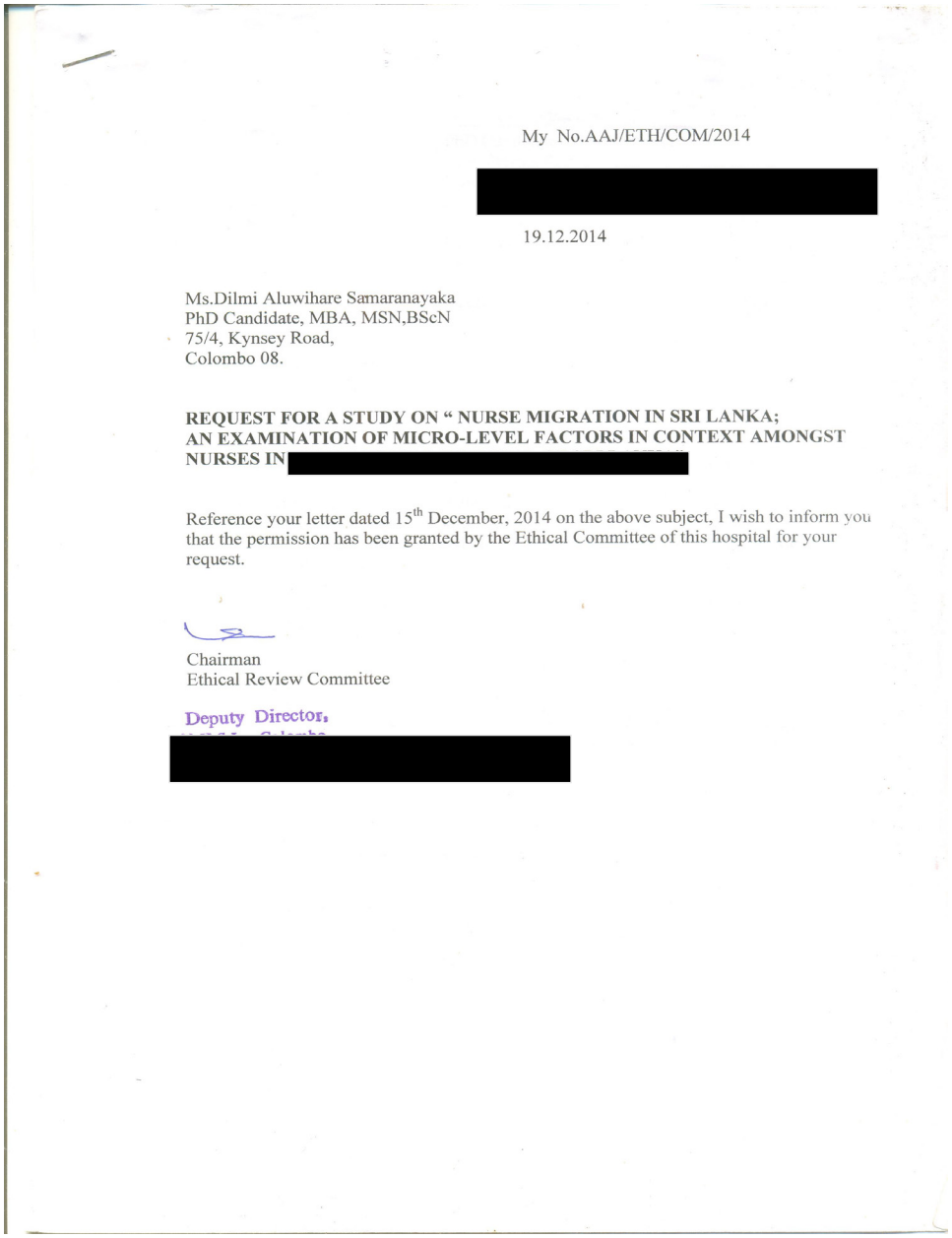
Ethics Approval from the Urban Hospital in Sri Lanka



My No.AAJ/ETH/COM/2014

[redacted]

19.12.2014

Ms.Dilmi Aluwihare Samaranayaka
PhD Candidate, MBA, MSN,BScN
75/4, Kynsey Road,
Colombo 08.

REQUEST FOR A STUDY ON " NURSE MIGRATION IN SRI LANKA; AN EXAMINATION OF MICRO-LEVEL FACTORS IN CONTEXT AMONGST NURSES IN [redacted]

Reference your letter dated 15th December, 2014 on the above subject, I wish to inform you that the permission has been granted by the Ethical Committee of this hospital for your request.

Chairman
Ethical Review Committee

Deputy Director,
[redacted]

APPENDIX B

Flyer 1 – Survey Invitation

AN INVITATION: NURSES PARTICIPATION IN RESEARCH

I need your help and would like to invite you to participate in the **"Work-Life Survey: Nurses".** This work is part of my PhD dissertation research at the University of Alberta. I want to study whether job and work-group experiences are related to work and life behave

Significance and benefits of participation:

- Opportunity to describe your work environment and work-life related attitudes and attachments.
- Your contributions will help with planning for policy, education and research.
- Your contributions will be acknowledged.

Who can participate?

- Qualified nurses who have one year or more experience at the hospital can participate.

How you can participate:

- You can participate by completing a questionnaire.
- Participation is voluntary and your name is not required.

Thank you in advance for your support
For more information:
Dilmi Aluwihare-Samaranayake
PhD Student (University of Alberta, Canada)
MBA, MSN, BSc (HONS) Nursing

Tel No: _____

APPENDIX C

Information Letter and Questionnaire

"WORK-LIFE SURVEY: NURSES"

Researcher
Dilmi Aluwihare-Samaranayake
PhD (Candidate), MBA,MSN,BScN,RN
Faculty of Nursing
University of Alberta

Work-Life Survey 2014

University of Alberta
INFORMATION LETTER

Dear Nurse,

You are invited to participate in the "Work-Life Survey: Nurses". This work is part of my PhD dissertation research at the University of Alberta. I want to study whether job and work-group experiences are related to work and life behaviours. Ethics approval for the study has been obtained from the Ethics Boards of the University of Alberta and the Sri Lanka Medical Association. The Ministry of Health Sri Lanka has granted permission for the study and the Director of the National Hospital of Sri Lanka has reviewed the survey. We have procedures in place to ensure that your answers remain private. Here are some answers to common questions.

Why should I participate? We need to hear from as many nurses as possible. Many of the questions ask whether you agree or disagree with a number of work-related and life-related statements. The National Hospital is a large and complex organization. The results will be more accurate if more people participate.

Do I have to complete this survey? No. Participation is completely voluntary. You should feel no pressure to fill out this survey. You have the right to refuse to answer any question. The questionnaire has 5 parts. Please complete only one version of the survey (English, Sinhala or Tamil) and return it in the enclosed envelope. You can hand it to me during one of my visits, leave it on your unit in an assigned place or post it. The survey should take about 30-40 minutes for you to complete.

Who will see my responses? No one from National Hospital will ever see your personal responses. I am the only person who will see your responses. The University requires that the surveys be kept for five years accessible by only the research team. After that all of the surveys will be shredded. To keep your responses private and confidential, I have arranged for completed surveys to be sent directly to the University of Alberta, where they will be kept in a locked filing cabinet. The information gathered for this study may be used in future research after receiving appropriate ethics approval.

What are some of the benefits of the study? We believe that the findings of this study will increase knowledge of the link between work and life behaviours. Showing how work affects our life decisions and how occurrences in our life affect work will help managers and policy makers to make a healthy workplace for nurses. This will also promote patient health. Research reports will be placed with the Director of the Hospital and the Chief Nursing Officer. If you would like your own copy of the study, you may reach me by e-mail or at the phone number given below.

What are some of the possible risks of participation in the study? We are unaware of any possible risks for you as a result of participation in this study.

What if I need help? If you would like to participate, but are having trouble understanding some of the questions, please contact me at _____. If you would like to discuss this project with someone at the University of Alberta, please contact Prof. Greta Cummings at _____ or Prof. Linda Ogilvie at _____.

*** Deadline for survey completion is** …….

*** If you have responded to this survey previously, thank you for your interest and please do not respond to this survey again.**

Sincerely, ----------

Dilmi Aluwihare-Samaranayake

PART 1
This section will help you describe where you work and your position at work.

YOUR WORK AND POSITION AND UNIT INFORMATION

1. What is your nursing position?
❑ Grade III ❑ Grade I ❑ Nursing Sister
❑ Grade II ❑ Supra Grade ❑ Other (Please specify) _____

2. What is your employment status?
❑ Permanent ❑ Temporary
Is this what you like ❑ Yes ❑ No
If 'no' what status would you like ❑ Permanent ❑ Temporary

3. How many years have your worked as a nurse?_____

4. How many years have you worked in this hospital?_____

5. Where do you primarily do your work? Please mark one response only.
❑ Accident Service
❑ Anesthesia and Intensive Care
❑ Burns
❑ Cardio Electro Physiology
❑ Cardio-thoracic Surgery
❑ Cardiology
❑ Dermatology
❑ Diabetes and Endocrinology
❑ ENT
❑ General Medicine
❑ General Surgery
❑ Gerontology
❑ Nephrology
❑ Neurology
❑ Neuro-Surgery
❑ Orthopedic Surgery
❑ Outpatients Department
❑ Plastic and Reconstructive Surgery
❑ Psychiatric Unit
❑ Radiology
❑ Rheumatology and Rehabilitation
❑ Urology
❑ Vascular/Transplant Surgery
❑ Other (Please Specify)

6. Some of the units listed above have a number of wards. How many years have you worked on your present ward in this unit?
_____

7. What hours do you currently work on this ward?
❑ Full time ❑ Part time ❑ Casual ❑ Overtime
Is this what you like? ❑ Yes ❑ No
If 'no' what do you like?
❑ Full time ❑ Part time ❑ Casual ❑ Overtime

8. How many *paid* overtime hours do you work a month? (Please specify)_____

9. How many *unpaid* overtime hours do you work a month? (Please specify) _____

10. Do you work on other units in addition to your position on this ward where you are based?
❑ Yes ❑ No

11. Have you worked elsewhere in Sri Lanka?
❑ Yes ❑ No

12. Where else in Sri Lanka have you worked as a nurse? (Please specify)_____

13. How many years have you worked in another hospital in Sri Lanka? (Please specify) _____

14. Have you worked as a nurse outside Sri Lanka?
❑ Yes ❑ No

15. How many years have you worked as a nurse outside Sri Lanka (Please specify) _____

16. Are you registered as a nurse with the Sri Lanka Medical Council (SLMC) or Sri Lanka Nursing Council (SLNC)?_____

17. In what year did you register as a nurse in Sri Lanka?_____

PART 2.0
To help you describe aspects of your work environment, in this section, you are presented with a series of statements. Please indicate if you agree or disagree by drawing a circle around the number of the 4-point scale.

See example: If you strongly agree with the statement "I enjoy my work", you will circle the number 4 for "strongly agree"

	Strongly Disagree	Disagree	Agree	Strongly Agree
I enjoy my work	1	2	3	4

DESCRIPTION OF YOUR WORK ENVIRONMENT

1.	Active in-service continuing education programs for nurses	1	2	3	4
2.	Career development/clinical ladder opportunities	1	2	3	4
3.	Opportunity for staff nurses to participate in policy decisions	1	2	3	4
4.	Support for new and innovative ideas about practice	1	2	3	4
5.	Opportunities for advancement	1	2	3	4
6.	Nurse staff supported in pursuit of degrees in nursing	1	2	3	4
7.	A clear philosophy of nursing pervades the patient care environment	1	2	3	4
8.	High standards of nursing care are expected by the administration	1	2	3	4
9.	Nurses actively participate in efforts to control costs	1	2	3	4
10.	Working with nurses who are clinically competent	1	2	3	4
11.	Written, up-to-date nursing care plans for all patients	1	2	3	4
12.	Patient assignment fosters continuity of care	1	2	3	4
13.	Standardized policies, procedures, and ways of doing things	1	2	3	4
14.	Working with experienced nurses who know the hospital	1	2	3	4
15.	Nursing care plans are verbally transmitted from nurse to nurse	1	2	3	4
16.	Adequate support services allow me to spend time with my patients	1	2	3	4
17.	Enough time and opportunity for me to spend time with my patients	1	2	3	4
18.	Enough registered nurses on staff to provide quality patient care	1	2	3	4
19.	Enough staff to get the work done	1	2	3	4
20.	Praise and recognition for a job well done	1	2	3	4
21.	Doctors and nurses have good working relationships	1	2	3	4

	Strongly Disagree	Disagree	Agree	Strongly Agree
	1	2	3	4

22.	Good relationships with other members of staff	1	2	3	4
23.	Much teamwork between doctors and nurses	1	2	3	4
24.	Doctors give high-quality medical care	1	2	3	4
25.	Collaboration (joint practice) between doctors and nurses	1	2	3	4
26.	Managerial staff that is supportive of nurses	1	2	3	4
27.	A ward leader who is a good manager and leader	1	2	3	4
28.	A nurse manager who backs up the nursing staff in decision-making even if it conflicts with a doctor	1	2	3	4
29.	Nurse managers consult with staff on daily problems and procedures	1	2	3	4
30.	The nursing staff participates in selecting new equipment	1	2	3	4
31	Staff nurses are involved in the internal governance of the hospital (e.g. policy and practice committees).	1	2	3	4
32.	Staff nurses have the opportunity to serve on hospital committees	1	2	3	4
33.	The contributions that nurses make to patients are publicly acknowledged	1	2	3	4

Part 2.1 For the next set of items the scale changes slightly and I would like you to indicate the extent to which rules, procedures, instructions and communication are written by circling the number on the 5-point scale.

	Very Inaccurate	Inaccurate	Neutral	Accurate	Very Accurate
	1	2	3	4	5

1.	Clear, written goals and objectives exist for my job	1	2	3	4	5
2.	My job responsibilities are clearly specified in writing	1	2	3	4	5
3.	In this organization, performance appraisals are based on written standards	1	2	3	4	5
4.	Written schedules, programs and work specifications are available to guide me on my job	1	2	3	4	5
5.	My duties, authority, and accountability are documented in policies, procedures and job descriptions	1	2	3	4	5

	Very Inaccurate	Inaccurate	Neutral	Accurate	Very Accurate
	1	2	3	4	5

6.	Written rules and guidelines exist to direct work efforts	1	2	3	4	5
7.	Written documents (such as budgets, schedules, and plans) are used as an essential part of my job	1	2	3	4	5
8.	There are contradictions and inconsistencies among the written statements of goals and objectives	1	2	3	4	5
9.	There are contradictions and inconsistencies among the written guidelines and ground rules	1	2	3	4	5

PART 3.0

In this section, you will be asked to describe how you perceive your leader or supervisor and how that person influences your values and aspirations and motivates you to perform to the best of your ability, satisfaction and to improve your performance. Please circle your response on the 6-point scale. He/she....

	Strongly Disagree	Disagree	Moderately Disagree	Moderately Agree	Agree	Strongly Agree
	1	2	3	4	5	6

1.	Is always seeking new opportunities	1	2	3	4	5	6
2.	Describes an interesting picture of the future for our group	1	2	3	4	5	6
3.	Is able to get others committed to his/her dream of the future	1	2	3	4	5	6
4.	Inspires others with his/her plans for the future	1	2	3	4	5	6
5.	Has a clear understanding of where we are going	1	2	3	4	5	6
6.	Leads by "doing" rather than simply by "telling"	1	2	3	4	5	6
7.	Is a good role model for me to follow	1	2	3	4	5	6
8.	Leads by example	1	2	3	4	5	6
9.	Encourages employees to be "team players"	1	2	3	4	5	6
10.	Helps collaboration among work groups	1	2	3	4	5	6
11.	Develops a team attitude and spirit among his/her employees	1	2	3	4	5	6

Strongly Disagree	Disagree	Moderately Disagree	Moderately Agree	Agree	Strongly Agree
1	2	3	4	5	6

12.	Gets the group to work together for the same goal	1	2	3	4	5	6
13.	Insists on only the best performance	1	2	3	4	5	6
14.	Will not settle for second best	1	2	3	4	5	6
15.	Shows that he/she expects a lot from us	1	2	3	4	5	6
16.	Treats me without considering my personal feelings	1	2	3	4	5	6
17.	Acts without considering my feelings	1	2	3	4	5	6
18.	Shows respect for my personal feelings	1	2	3	4	5	6
19.	Behaves in a manner that is thoughtful of my personal needs	1	2	3	4	5	6
20.	Has stimulated me to think about old problems in new ways	1	2	3	4	5	6
21.	Asks questions that make me think	1	2	3	4	5	6
22.	Has provided me with new ways of looking at things that used to be a puzzle	1	2	3	4	5	6
23.	Has ideas that have stimulated me to re-examine my assumptions about my work	1	2	3	4	5	6

PART 4.0
This section starts with a series of statements to help you examine the extent to which you feel the unit where you work values your contributions and cares about how you are physically, mentally, socially and economically. Please indicate your agreement or disagreement with a circle on the number of the 6-point scale.

WORK-LIFE RELATED ATTITUDES AND ATTACHMENTS

Strongly Disagree	Disagree	Moderately Disagree	Moderately Agree	Agree	Strongly Agree
1	2	3	4	5	6

1.	The organization values my contributions to its well-being	1	2	3	4	5	6
2.	The organization fails to appreciate any extra effort from me	1	2	3	4	5	6
3.	The organization disregards my best interest (what is best for me) when it makes decisions that affect me	1	2	3	4	5	6

Strongly Disagree	Disagree	Moderately Disagree	Moderately Agree	Agree	Strongly Agree
1	2	3	4	5	6

4.	The organization really cares for my well-being	1	2	3	4	5	6
5.	Even if I did the job well, the organization would fail to notice	1	2	3	4	5	6
6.	The organization cares about my general satisfaction at work	1	2	3	4	5	6
7.	The organization shows very little concern for me	1	2	3	4	5	6
8.	The organization takes pride in my accomplishments at work	1	2	3	4	5	6

Part 4.1 Now the section changes to include a list of items that you may value. Please identify your level of satisfaction with the following items by drawing a circle round the relevant number of the 5-item scale.

Very Dissatisfied	Moderately Dissatisfied	Neither Dissatisfied nor Satisfied	Moderately Satisfied	Very Satisfied
1	2	3	4	5

1.	My take home pay	1	2	3	4	5
2.	My current salary	1	2	3	4	5
3.	My overall level of pay	1	2	3	4	5
4.	Size of my current salary	1	2	3	4	5
5.	Hours that you work	1	2	3	4	5
6.	Flexibility in scheduling your hours	1	2	3	4	5
7.	Opportunity to work days continuously	1	2	3	4	5
8.	Opportunity for part time work	1	2	3	4	5
9.	Weekends off per month	1	2	3	4	5
10.	Flexibility in scheduling your weekends	1	2	3	4	5
11.	Compensation (extra pay or days off) – for working weekends	1	2	3	4	5
12.	Praise and recognition from your supervisor	1	2	3	4	5
13.	Recognition of work from your peer	1	2	3	4	5
14.	Amount of encouragement and positive feedback	1	2	3	4	5

Part 4.2 The following section turns to questions related to how you balance your personal or family life with work. Please indicate your agreement or disagreement with a circle on the relevant number on the 7-point scale.

	Strongly Disagree	**Disagree**	**Moderately Disagree**	**Neutral**	**Moderately Agree**	**Agree**	**Strongly Agree**
	1	2	3	4	5	6	7

1.	The demands of my work interfere with my home and work life	1	2	3	4	5	6	7
2.	The amount of time my job takes up makes it difficult to fulfill family responsibilities	1	2	3	4	5	6	7
3.	Things I want to do at home do not get done because of the job demands my job puts on me	1	2	3	4	5	6	7
4.	My job produces strain that makes it difficult to fulfill (do properly) family duties	1	2	3	4	5	6	7
5.	Due to work-related duties, I have to make changes to my plans for family activities	1	2	3	4	5	6	7
6.	The demands of my family or spouse/partner interfere with work-related activities	1	2	3	4	5	6	7
7.	I have to put off doing things at work because of demands on my time at home	1	2	3	4	5	6	7
8.	Things I want to do at work don't get done because of the demands of my family or spouse/partner	1	2	3	4	5	6	7
9.	My home life interferes with my responsibilities at work such as getting to work on time, accomplishing daily tasks, and working overtime	1	2	3	4	5	6	7
10.	Family- related strain interferes with my ability to perform my job-related duties	1	2	3	4	5	6	7

Part 4.3 This section now changes to give you an opportunity to express your motivations to stay.

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
	1	2	3	4	5

1.	I rarely think of leaving where I am presently working	1	2	3	4	5
2.	I am not voluntarily searching for a new job in another organization	1	2	3	4	5
3.	I do not intend to quit my job	1	2	3	4	5
4.	I still will be working in this organization one year from now	1	2	3	4	5
5.	I am not thinking about quitting my job	1	2	3	4	5
6.	I am not thinking about migrating in the future	1	2	3	4	5

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
	1	2	3	4	5

7.	I would only migrate if my family can come with me	1	2	3	4	5
8.	Who did you consider as your family when you answered question number 7					

Part 4.4 This section gives you an opportunity to express your personal feelings of attachment to nursing and your organization.

	Strongly Disagree	**Disagree**	**Moderately Disagree**	**Neither Disagree nor Agree**	**Moderately Agree**	**Agree**	**Strongly Agree**
	1	2	3	4	5	6	7

1.	Nursing is important to my self-image	1	2	3	4	5	6	7
2.	I regret having entered the nursing profession	1	2	3	4	5	6	7
3.	I am proud to be in the nursing profession	1	2	3	4	5	6	7
4.	I dislike being a nurse	1	2	3	4	5	6	7
5.	I do not identify with the nursing profession	1	2	3	4	5	6	7
6.	I am enthusiastic about nursing	1	2	3	4	5	6	7
7.	I have put too much into the nursing profession to consider changing now	1	2	3	4	5	6	7
8.	Changing profession now would be difficult for me to do	1	2	3	4	5	6	7
9.	Too much of my life would be disrupted if I were to change my profession	1	2	3	4	5	6	7
10.	It would be costly for me to change my profession now	1	2	3	4	5	6	7
11.	There are no pressures to keep me from changing professions	1	2	3	4	5	6	7
12.	Changing professions now would require considerable personal sacrifice	1	2	3	4	5	6	7
13.	I believe people who have been trained in a profession have a responsibility to stay in that profession for a reasonable period of time	1	2	3	4	5	6	7
14.	I do not feel any obligation to remain in the nursing profession	1	2	3	4	5	6	7
15.	I feel a responsibility to the nursing profession to continue in it	1	2	3	4	5	6	7

16.	Even if it were to my advantage, I do not feel that it would be right to leave nursing now……..	1	2	3	4	5	6	7
17.	I would feel guilty if I left nursing……	1	2	3	4	5	6	7
18.	I am in nursing because of a sense of loyalty to it……	1	2	3	4	5	6	7
19.	I would be very happy to spend the rest of my career with this organization……..	1	2	3	4	5	6	7
20.	I really feel as if this organization's problems are my own……	1	2	3	4	5	6	7
21.	I feel a strong sense of belonging to my organization……	1	2	3	4	5	6	7
22.	I feel emotionally attached to this organization……..	1	2	3	4	5	6	7
23.	I feel like part of the family at my organization……	1	2	3	4	5	6	7
24.	This organization has a great deal of personal meaning for me……	1	2	3	4	5	6	7
25.	Right now, staying with my organization is a matter of necessity as much as desire……..	1	2	3	4	5	6	7
26.	It would be very hard for me to leave my organization right now, even if I wanted to……	1	2	3	4	5	6	7
27.	Too much of my life would be disrupted if I decided I wanted to leave my organization now...	1	2	3	4	5	6	7
28.	I feel that I have too few options to consider leaving this organization……	1	2	3	4	5	6	7
29.	If I had not already put so much of myself into this organization, I might consider working elsewhere……	1	2	3	4	5	6	7
30.	One of the negative consequences of leaving this organization would be the scarcity of available alternatives……	1	2	3	4	5	6	7
31.	I do not feel any obligation to remain with my current employer……	1	2	3	4	5	6	7
32.	Even if it were to my advantage, I do not feel it would be right to leave my organization now.	1	2	3	4	5	6	7
33.	I would feel guilty if I left my organization now……..	1	2	3	4	5	6	7
34.	This organization deserves my loyalty……..	1	2	3	4	5	6	7
35.	I would not leave my organization right now because I have a sense of obligation to the people in it……	1	2	3	4	5	6	7
36.	I owe a great deal to my organization……	1	2	3	4	5	6	7

Part 4.5 This section now changes to give you an opportunity to express your attachment to your country and family.

Strongly Disagree	**Disagree**	**Moderately Disagree**	**Neither Disagree nor Agree**	**Moderately Agree**	**Agree**	**Strongly Agree**
1	2	3	4	5	6	7

1.	I would be very happy to spend the rest of my life in this country……..	1	2	3	4	5	6	7
2.	I feel as this country's problems are my own……	1	2	3	4	5	6	7
3.	I feel a strong sense of belonging to my country……..	1	2	3	4	5	6	7
4.	I feel emotionally attached to this country……..	1	2	3	4	5	6	7
5.	I feel like part of the family in my country ……	1	2	3	4	5	6	7
6.	This country has a great deal of personal meaning for me……	1	2	3	4	5	6	7
7.	Right now, staying in my country is a matter of necessity as much as desire……	1	2	3	4	5	6	7
8.	It would be very hard for me to leave my country right now, even if I wanted to……..	1	2	3	4	5	6	7
9.	Too much of my life would be disrupted if I decided I wanted to leave my country now……..	1	2	3	4	5	6	7
10.	I feel that I have too few options to consider leaving this country……..	1	2	3	4	5	6	7
11.	If I had not already put so much of myself into this country, I might consider living in another country……	1	2	3	4	5	6	7
12.	One of the negative consequences of leaving this country would be the scarcity of available alternatives……	1	2	3	4	5	6	7
13.	Even if it were to my advantage, I do not feel it would be right to leave my country now……..	1	2	3	4	5	6	7
14.	I would feel guilty if I left my country now……	1	2	3	4	5	6	7
15.	This country deserves my loyalty……	1	2	3	4	5	6	7
16.	I would not leave my country now because I have a sense of obligation to the people in it……	1	2	3	4	5	6	7
17.	I owe a great deal to my country……	1	2	3	4	5	6	7
18.	I do not feel any obligation to remain in my current country……	1	2	3	4	5	6	7
19.	I would be very happy to spend the rest of my life with my family……..	1	2	3	4	5	6	7
20.	I feel as this family's problems are my own……	1	2	3	4	5	6	7
21.	I feel a strong sense of belonging to my family……	1	2	3	4	5	6	7
22.	I feel emotionally attached to my family……..	1	2	3	4	5	6	7

		Strongly Disagree	Disagree	Moderately Disagree	Neither Disagree nor Agree	Moderately Agree	Agree	Strongly Agree
		1	2	3	4	5	6	7
23.	The other members of my family treat me with respect and consideration, and include me in important family decisions	1	2	3	4	5	6	7
24.	This family has a great deal of personal meaning for me	1	2	3	4	5	6	7
25.	Right now, staying with my family is a matter of necessity as much as desire	1	2	3	4	5	6	7
26.	It would be very hard for me to leave my family right now, even if I wanted to	1	2	3	4	5	6	7
27.	Too much of my life would be disrupted if I decided to leave my family now	1	2	3	4	5	6	7
28.	I feel that I have too few options to consider leaving my family	1	2	3	4	5	6	7
29.	If I had not invested so much of my personal time and resources with my family, I might consider leaving	1	2	3	4	5	6	7
30.	Leaving my family would take an enormous personal sacrifice on my part	1	2	3	4	5	6	7
31.	One of the negative consequences of leaving my family would be the scarcity of available alternatives (e.g., jobs, housing, emotional and financial stability)	1	2	3	4	5	6	7
32.	Even if it were to my advantage, I do not feel it would be right to leave my family now	1	2	3	4	5	6	7
33.	I would feel guilty if I left my family now	1	2	3	4	5	6	7
34.	This family deserves my loyalty	1	2	3	4	5	6	7
35.	I would not leave my family now because I have a sense of obligation to the people in it	1	2	3	4	5	6	7
36.	I owe a great deal to my family	1	2	3	4	5	6	7
37.	I feel an obligation to remain with my family	1	2	3	4	5	6	7

PART 5

Our individual characteristics affect our attitudes, behaviours and actions in our work and life. The following is a list of characteristics and options that will help describe you. Please select the most appropriate response to the questions listed below to help us understand how you relate to work and life experiences.

DEMOGRAPHIC INFORMATION

1. What is your highest level of education?

❑Certificate in Nursing ❑Diploma in Nursing ❑Post Basic Diploma in Management
❑Doctorate in Nursing ❑Other (Please Specify) ❑MSc in Nursing

2. What is your gender?

❑Female ❑Male

3. What is your age group?

❑20-24 ❑30-34 ❑40-44 ❑50-54 ❑60-64
❑25-29 ❑35-39 ❑45-49 ❑55-59 ❑65-69

4. How would you identify your ethnicity?

❑Sinhala ❑Tamil ❑Burgher ❑Muslim ❑Malay ❑Other (Please Specify)_____

5. How would you identify your language ability?

	Strong	Moderate	Weak
Sinhala	❑	❑	❑
Tamil	❑	❑	❑
English	❑	❑	❑

Other (Please Specify)_____

6. What is your marital status?

❑Single ❑Married ❑Living with partner
❑Separated ❑Divorced ❑Widowed
❑Single parent

7. Do you have caregiving responsibilities for dependents?

❑Parents ❑Children
❑Siblings ❑Other (Please specify)

8. How many people are in your household (Please specify number)

Adults _____ Children_____

9. What is your monthly income from your nursing position in Sri Lankan rupees?

❑15,620	❑18,100	❑21,660	❑25,620
❑26,130	Allowances (please specify amount in rupees)_____	Overtime (please specify amount in rupees)_____	

10. What is your family income in total (Please specify) _____
(You may include the total of your income from your nursing profession, income of other person/s in your household, and other additional sources of income).

11. Why do you think nurses may consider leaving Sri Lanka?_____
_____
_____
_____
_____
_____
_____

12. Are there any other comments you would like to make? _____
_____
_____
_____
_____
_____
_____

Thank-you for completing this survey
Dilmi Aluwihare-Samaranayake, Doctoral Candidate, MBA, MSN, BScN, RN

Please return this survey in the stamped and addressed return envelope

APPENDIX D

Flyer 2 - Appreciation and Reminder

REMINDER
&
THANK YOU

A few weeks ago you received a survey titled "Work-Life Survey: Nurses". . I sincerely thank you for participating by completing the questionnaire. If you have not had a chance, please take a few minutes and complete the survey and send it back in the addressed, stamped envelope by ……. .

Thank you again in advance for your help

For more information:
Dilmi Aluwihare-Samaranayake
PhD Student (University of Alberta, Canada) MBA, MSN, BSc (HONS) Nursing, RN
Tel No: _____

APPENDIX E

Table of Variables

Table of variables from scales used in the initial test of the CWLEXP model[3]

	N	*M*	*SD*	*MC*		Range	
					Percent	Low	High
COA-Active in-service continuing education programs for nurses	707	2.6	0.92	3	0.4	0	0
COA-Career development/clinical ladder opportunities	698	2.2	0.86	12	1.7	0	55
COA-Opportunity for staff nurses to participate in policy decisions	698	1.96	0.84	12	1.7	0	33
COA-Support for new and innovative ideas about practice	693	2.16	0.81	17	2.4	0	36
COA-Opportunities for advancement	699	2.14	0.82	11	1.5	0	31
COA-Nurse staff supported in pursuit of degrees in nursing	706	2.57	0.83	4	0.6	0	0
COA-A clear philosophy of nursing pervades the patient care environment	699	2.97	0.77	11	1.5	37	0
NP-High standards of nursing care in pursuit of degrees in nursing	701	3.22	0.74	9	1.3	22	0
NP-Nurses actively participate in efforts to control costs	696	3.05	0.81	14	2	36	0
NP-Working with nurses who are clinically competent	694	2.83	0.76	16	2.3	44	0
NP-Written, up-to-date nursing care for all patients	703	2.58	0.86	7	1	0	0
NP-Patient assignment fosters continuity of care	698	3.01	0.77	12	1.7	32	0
NP-Standardized policies, procedures, and ways of doing things	664	2.71	0.78	46	6.5	50	0
NP-Working with experienced nurses who know the hospital	699	3.05	0.69	11	1.5	21	0
NP-Nursing care plans are verbally transmitted from nurse to nurse	690	3	0.79	20	2.8	35	0
SRA-Adequate support services allows me to spend time with my patients	699	2.4	0.83	11	1.5	0	0
SRA-Enough time and opportunity for me to spend time with my patients	695	2.43	0.85	15	2.1	0	0
SRA-Enough registered nurses on staff to provide quality patient care	703	1.85	0.88	7	1	0	39
SRA-Enough staff to get the work done	696	1.97	0.80	14	2	0	26
SRA-Praise and recognition for a job well done	706	2.4	0.82	4	0.6	0	0
NPR-Doctors and nurses have good working relationships	709	2.69	0.68	1	0.1	39	0
NPR-Good relationships with other members of staff	707	2.76	0.65	3	0.4	28	0
NPR-Much teamwork between doctors and nurses	707	2.62	0.70	3	0.4	56	0

[3] See Chapter 3 and questionnaire in Appendix C

	N	*M*	*SD*	*MC*		*Range*	
					Percent	Low	High
NPR-Doctors give high-quality medical care	702	2.48	0.69	8	1.1	59	22
NPR-Collaboration (joint practice) between doctors and nurses	705	2.61	0.67	5	0.7	44	28
NML-Managerial staff that is supportive of nurses	700	2.52	0.77	10	1.4	0	0
NML-A ward leader who is a good manager and leader	689	2.74	0.75	21	3	45	0
NML-A nurse manager who backs up the nursing staff in decision making even if it conflicts with a doctor	695	2.6	0.79	15	2.1	64	0
NML-Nurse managers consult with staff on daily problems and procedures	700	2.62	0.78	10	1.4	63	0
TFL-Is always seeking new opportunities	705	3.63	1.37	5	0.7	0	0
TFL-Describes an interesting picture of the future for our group	700	3.31	1.45	10	1.4	0	0
TFL-Is able to get others committed to his/her dream of the future	698	3.57	1.4	12	1.7	0	0
TFL-Inspires others with his/her plans for the future	698	3.76	1.38	12	1.7	0	0
TFL-Has a clear understanding of where we are going	703	3.65	1.41	7	1	0	0
TFL-Leads by “doing” rather than simply by “telling”	698	3.63	1.51	12	1.7	0	0
TFL-Is a good role model for me to follow	702	3.64	1.50	8	1.1	0	0
TFL-Leads by example	700	3.71	1.41	10	1.4	0	0
TFL-Encourages employees to be “team players”	702	3.94	1.35	8	1.1	38	0
TFL1-Helps collaboration among work groups	700	4.01	1.29	10	1.4	28	0
TFL-Develops a team attitude and spirit among his/her employees	695	3.9	1.32	15	2.1	35	0
TFL-Gets the group to work together for the same goal	696	3.98	1.30	14	2	28	0
TFL-Insists on only the best performance	689	4.14	1.25	21	3	21	0
TFL-Will not settle for second best	686	3.99	1.25	24	3.4	20	0
TFL-Shows that he/she expects a lot from us	691	4.08	1.38	19	2.7	29	0
TFL-Treats me without considering my feelings	689	3.53	1.46	21	3	0	0
TFL-Acts without considering my feelings	683	3.55	1.41	27	3.8	0	0
TFL-Shows respect for my personal feelings	688	3.73	1.30	22	3.1	47	0
TFL-Behaves in a manner that is thoughtful of my personal needs	685	3.73	1.33	25	3.5	42	0
TFL-Has stimulated me to think about old problems in new ways	684	3.68	1.36	26	3.7	0	0
TFL-Asks questions that make me think	685	3.65	1.36	25	3.5	0	0

	N	*M*	*SD*	*MC*	Range		
					Percent	Low	High
TFL-Has provided me with new ways of looking at things that used to be a puzzle	694	3.71	1.36	16	2.3	0	0
TFL-Has ideas that have stimulated me to re-examine my assumptions about my work	696	3.75	1.33	14	2	39	0
POS-The organization values my contributions to its well-being	699	3.61	1.42	11	1.5	0	0
POS-The organization really cares for my well-being	693	3.46	1.30	17	2.4	0	0
POS-The organization cares about my general satisfaction at work	691	3.38	1.33	19	2.7	0	0
POS-The organization takes pride in my accomplishments at work	692	3.37	1.41	18	2.5	0	0
WFB-The demands of my work interfere with my home and work life	701	4.54	1.65	9	1.3	35	0
WFB-The amount of time my job takes up makes it difficult to fulfill my responsibilities	700	4.83	1.61	10	1.4	18	0
WFB-Things I want to do at home do not get done because of the job demands my job puts on me	700	4.61	1.61	10	1.4	17	0
WFB-My job produces strain that makes it difficult to fulfill family duties	695	4.85	1.53	15	2.1	9	0
WFB-Due to work related duties, I have to make changes to my plans for family activities	695	4.95	1.70	15	2.1	25	0
WFB-The demands of my family or spouse/partner interfere with work-related activities	689	3.48	1.72	21	3	0	0
FWB-I have to put off doing things at work because of demands on my time at home	690	3.18	1.67	20	2.8	0	0
FWB-Things I want to do at work don’t get done because of the demands of my family or spouse/partner	686	2.95	1.61	24	3.4	0	0
FWB-My home life interferes with my responsibilities at work such as getting to work on time, accomplishing daily tasks, and working overtime	693	3.17	1.61	17	2.4	0	0
FWB-Family-related strain interferes with my ability to perform my job-related duties	691	3.17	1.55	19	2.7	0	0
SI-I do not intend to quit my job	696	3.61	1.13	14	2	40	0
SI-I still will be working in this organization one year from now	691	3.45	1.12	19	2.7	45	0
SI-I am not thinking about quitting my job	695	3.39	1.18	15	2.1	49	0
ACP-Nursing is important to my self-image	688	5.41	1.56	22	3.1	60	0
ACP-I regret having entered the nursing profession	690	4.21	1.96	20	2.8	0	0
ACP-I am proud to be in the nursing profession	687	4.71	1.78	23	3.2	40	0

	N	*M*	*SD*	*MC*	Range		
					Percent	Low	High
ACP-I dislike being a nurse	685	5.22	1.73	25	3.5	22	0
ACP-I do not identify with the nursing profession	685	5.12	1.90	25	3.5	37	0
ACP-I am enthusiastic about nursing	681	5.11	1.61	29	4.1	25	0
ACO-I would be happy to spend the rest of my career with this organization	674	4.36	1.81	36	5.1	0	0
ACO-I really feel as if this organization's problems are my own	678	4.39	1.68	32	4.5	47	0
ACO-I feel a strong sense of belonging to my organization	677	4.81	1.56	33	4.6	30	0
ACO-I feel emotionally attached to this organization	679	4.74	1.60	31	4.4	32	0
ACO-I feel like part of the family at my organization	678	4.6	1.56	32	4.5	35	0
ACO-This organization has a great deal of personal meaning for me	678	4.59	1.61	32	4.5	39	0
NCF-I would feel guilty if I left my family now	657	5.55	1.51	53	7.5	44	0
NCF-I would not leave my family now because I have a sense of obligation to the people in it	661	5.87	1.36	49	6.9	45	0
NCF-I owe a great deal to my family	669	5.84	1.49	41	5.8	43	0

Note: Number of cases outside the range (Mean – 2*SD, Mean + 2*SD).
N-Number, M-Mean, SD-Standard Deviation, MC-Missing Count, COA – Career opportunities and advancement, NP–Nursing process, SRA-Staffing resource adequacy, NPR-Nurse physician relations, NML-Nurse manager ability and leadership, TFL-Transformational leadership, POS-Perceived organizational support, WFB-Work family balance, FWB-Family work balance, SI-Staying intentions, ACP-Affective commitment to the profession, ACO-Affective commitment to the organization, NCF-Normative commitment to the profession.