THE ROLE OF STAKEHOLDER DIALOGUE IN ENHANCING PRIVATE SECTOR SUPPORT IN ADDRESSING HEALTHCARE ISSUES IN TANZANIA THROUGH CORPORATE SOCIAL RESPONSIBILITY (CSR)

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By

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ABSTRACT

There are limited number of private sector companies practicing Corporate Social Responsibility (CSR) in the Tanzanian health sector due to lack of stakeholder dialogue. As a result, company perceptions about the roles that their CSR interventions could play in addressing stakeholders' health and safety expectations are limited. The lack of dialogue between companies and stakeholders such as customers, employees, communities and the government limits the freedom of both parties to express their concerns and reach a mutually beneficial solution.

To encourage companies' participation, literature shows that through stakeholder dialogue, companies could create positive relationships with their stakeholders, leading to increased employee morale, creativity, operational efficiency, and stakeholder satisfaction and commitment. However, there is limited empirical research that had tested the effect of stakeholder dialogue in facilitating private sector support in healthcare.

To fill the literature gap, this study examines the mediating role of stakeholder dialogue in enhancing private sector CSR interventions in healthcare. Questionnaire survey was used to collect 441 responses from private companies in Tanzania and data were analyzed by using Structural Equation Modeling (SEM) approach. Findings show that while larger companies are more focused on fulfilling their customers' expectations, small and medium companies practiced CSR in healthcare just to fulfill two stakeholders' expectations: communities and

government. Nevertheless, both large and small and medium companies would consider other stakeholders' health and safety expectations if an open and transparent dialogue is arranged.

This study contributes to the body of knowledge by extending Donaldson and Preston's (1995) stakeholder model by including a mediating variable: stakeholder dialogue. The study could also provide useful indication to policy makers and private sector practitioners in planning strategic policies that will increase private sector involvement in healthcare through CSR interventions. In this way, more Tanzanians irrespective of their stakeholder status can get better healthcare services.

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APPROVAL SHEET

This PhD thesis entitled **"THE ROLE OF STAKEHOLDER DIALOGUE IN ENHANCING PRIVATE SECTOR SUPPORT IN ADDRESSING HEALTHCARE ISSUES IN TANZANIA THROUGH CORPORATE SOCIAL RESPONSIBILITY (CSR)"** was prepared by ZACHARIA ELIAS LEMA and submitted as partial fulfillment of the requirements for the degree of Doctor of Philosophy at the Universiti Tunku Abdul Rahman.

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DECLARATION

I, ZACHARIA ELIAS LEMA hereby declare that this thesis is based on my original work except for quotations and citations which have been duly acknowledged. I also declare that it has not been previously or concurrently submitted for any other degree at UTAR or other institutions.

ZACHARIA ELIAS LEMA

Date: 20.03.2018

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ATE	Association of Tanzania Employers
BRELA	Business Registration and Licensing Agency
CGD	Centre for Global Development
CSR	Corporate Social Responsibility
DDH	Designated District Hospitals
FBOs	Faith Based Organizations
GIZ	German Development Cooperation
GRI	Global Reporting Initiative
HIV	Human Immune Virus
ILO	International Labour Organization
ISO	International Standards Organization
LHRC	Legal and Human Rights Centre
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MOL	Ministry of Labour
MTI	Ministry of Trade and Industry
NBS	National Bureau of Statistics
NGO	Non-Governmental Organization
NHSP	National Health Strategic Plan
OHSA	Occupational Health and Safety Agency
SMEs	Small and Medium Enterprises
TIC	Tanzania Investment Centre
TPSF	Tanzania Private Sector Foundation
TRBN	Tanzania Responsible Business Network
URT	United Republic of Tanzania
UNAIDS	United Nations Programme on HIV/AIDS
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

1.1 Background of the Study

This study examines the role of stakeholder dialogue in facilitating private sector support in addressing healthcare issues through Corporate Social Responsibility (CSR). According to the World Health Organization (WHO, 2016), access to healthcare is a fundamental human right. As such, ensuring better healthcare for equitable population is important to both public and private sectors. However, due to challenges such as: prevalence of non-communicable and communicable diseases (such as Malaria, Tuberculosis and HIV/AIDS), rising medical costs, workforce shortages, infrastructure constraints and disruptive technologies, public spending on healthcare is increasing globally (Lema, Lee, & Ng, 2017).

To address these challenges, governments worldwide are calling for private sector support so that strategic healthcare objectives can be achieved and sustained (GIZ, 2014; Thulkanam, 2014). CSR has become an important approach used by the private sector to complement public sector efforts in addressing social-economic challenges (Harley, Metcalf, & Irwin, 2014; Mwamwaja, 2015; Thulkanam, 2014). To ensure that CSR practices in healthcare are well coordinated and its potentials can be realized for equitable population health, a multi-stakeholder collaboration facilitated through stakeholder dialogue is necessary for identification of the

required interventions, mitigation of associated risks and for regular monitoring (White, O'Hanlon, Chee, & Kimambo, 2013; WHO, 2016).

While the practice of CSR and stakeholder involvement in areas such as education (Rattanaphan, 2012; Waite & Mosha, 2006), financial support (Ngowi, 2015), and water and sanitation (GIZ, 2014) have long been argued among policy makers and academics, little attention is given to investigate the potentials of CSR practices in healthcare and the role that stakeholder dialogue could play in enhancing private sector support in this field, particularly in Tanzania. Perhaps this is because healthcare services has traditionally been provided mainly by the government and supported by public funds.

Research shows that the establishment of an effective and sustainable CSR programme requires the participation of all relevant stakeholders who can be called together in an open and transparent dialogue (Allen, Burkholder & Gillenwater, 2013). In this way, organizations and their stakeholders can share and discuss their social-economic concerns and reach a mutual beneficial agreement (Barone, Ranamagar, & Solomon, 2013; Lahtinen, 2014). This study therefore investigates direct and indirect effects of perceived stakeholders' expectations and stakeholder dialogue on company implementation of CSR practices in healthcare.

1.2 Definition of Key Terms

1.2.1 Corporate Social Responsibility (CSR)

Due to its complexity and diversity nature, a universally accepted definition of CSR is rarely found. Previous researchers have defined CSR in contexts that suit their studies. For example, Jamali (2008) defined CSR as a business commitment in contributing to social economic development and wellbeing of its stakeholders and the society at large. It also entails a combination of policies, practices and programs incorporated in business activities aimed at impacting the society positively (Jamali, Hallal, & Abdallah, 2010). Similarly, Brewer (2014), and Snider, Hill and Martin (2003) regarded CSR as a company obligation to use its own resources to perform certain activities beyond the interests of the firm.

According to Carroll and Shabana (2010), the CSR concept embraces combination of economic, legal, ethical and philanthropic responsibilities of business organizations. Consequently, a CSR practicing firm has to adhere to the principles of CSR: making acceptable profits, abide to the law and regulations, be ethical and a good corporate citizen. On top of performing traditional social economic obligations, Abaeian, Yeoh and Khong (2014) asserted that, business organizations need to integrate the expectations of their stakeholders in their corporate decision making.

In this study, CSR is defined as a business commitment that could contribute to sustainable social economic development of its stakeholders by interacting with them in an open and transparent dialogue process (Agudo-Valiente et al., 2015;

Allen et al., 2013). By involving stakeholders in CSR practices, businesses may become closer to their stakeholders and this may have positive effects on the development and sustainability of their operations (Jörg Andriof & Waddock, 2002; Campbell, 2007).

1.2.2 Stakeholders

Stakeholders are defined as individuals or group of individuals who can affect or be affected by a company or an organization's policy (Freeman, 1984, 2004), such as customers, employees, communities, trade associations and governments (Donaldson & Preston, 1995). Through CSR, business organizations are expected to integrate their stakeholder's social and environmental concerns in their operations on voluntary basis (European Commission, 2011).

1.2.3 Stakeholder expectations

Stakeholders' concerns or expectations depict the views and values that have implications on companies' CSR practices. It reflects the claims that stakeholders might have on business practices. On the other hand, companies' perceptions about their stakeholders' expectations reflect the observations and potential actions undertaken by businesses in response to stakeholders' claims.

1.2.4 Stakeholder dialogue

Stakeholder dialogue is used to depict the interactive process between an organization and its stakeholders, where social-economic concerns of both parties are bilaterally shared and discussed (Andriof & Waddock, 2002). It also entails an

attempt that stimulates learning and understanding each party's attitudes, thoughts and values and strengthens relationships by taking collective actions. In CSR practices, the role of stakeholder dialogue is critical in ensuring the sustainability of corporate initiatives that are addressing social economic challenges such as insufficient human resource for health and inadequate drugs and medical supplies (Adams, 2014; Albareda, Tencati, Lozano, & Perrini, 2006; Agle et al., 2008).

1.3 The Current Practice of CSR in Tanzania

CSR is not a completely new phenomenon in Tanzania. Research shows that traditionally the concept has been attributed to companies' philanthropic contributions to local communities (Mader, 2012). It is however dominated by large foreign firms operating mainly in the following sectors: banking, manufacturing, mining, oil and gas, and telecommunications (Fulgence, 2016; Mader, 2012; Mbirigenda, 2015). Ng'eni, Bukwimba, Kwesigabo and Kaaya (2015) asserted that, CSR activities have been practiced in areas such as education, environmental protection, healthcare promotion and welfare protection as well as in sports and entertainments.

According to Tanzania Investment Centre (TIC, 2012), the practice of CSR has had some notable contributions to the country's social economic development. For example, it is estimated that in 2008 and 2009, a total of USD 12.3 million and USD 11.5 million respectively were spent in CSR related activities. The Ministry of State in the President's Office reported that through CSR activities, over 1,074,814 (97.2 percent) desks for primary schools were donated by public and

private sector organizations in 2016/2017 (Mwalimu, 2017). Similarly, over 22 million trees are reported to have been planted by private companies in response to climate change mitigation strategies (Ngowi, 2016).

Despite the notable CSR interventions, its potentials in healthcare are not yet fully explored. Perhaps because the sector was traditionally under full government control (GIZ, 2014; Stott, Lema, Shaba, & Weir, 2011). In addition, due to lack of coordination, legal and regulatory framework for guiding responsible business practices, CSR interventions in Tanzania are regarded as adhoc activities with potential corporate malpractices (Mbirigenda, 2015). Furthermore, there is limited evidence in the literature on stakeholder involvement in CSR interventions particularly in healthcare (GIZ, 2013, 2014; Mader, 2012). As a result, contributions of various stakeholders in realizing CSR potentials in the Tanzanian health sector are limited (Rweyemamu & Mwasongela, 2015).

Present study examines how stakeholder dialogue could motivate private companies in Tanzania to address the country's healthcare issues through CSR practices. In other words, companies' perceptions about their stakeholders' expectations on health and safety and the role of stakeholder dialogue are examined.

Five stakeholder groups: customers, employees, communities, trade associations and the government are selected for this study based on their active roles that could influence companies' CSR activities (GIZ, 2014; Mader, 2012). For

example, customers and employees could play an important role in influencing a company's economic power, legitimacy and trading urgency (Kihiyo, 2007). Trade associations are also influential as they often represent companies in negotiations with public authorities on institutional frameworks that could affect business sustainability (ATE, 2015; Mader, 2012). Similarly, surrounding communities and public agencies can potentially affect companies' operations by virtue of their legitimate public interests (Mitchell, Agle, & Wood, 1997). As such, it is important to examine whether private companies in Tanzania are concerned about their stakeholders' health and safety, and the effect of such concerns on the implementation of their CSR practices.

In summary, dialogue between companies and their stakeholders could play an important role in determining the magnitude and direction of the companies' CSR practices (Fadun, 2014; Mader, 2012; Mitchell et al., 1997). Hence, the present study develops a framework that could strengthen stakeholders' involvement in an open and transparent dialogue. In this way, more companies in Tanzania would be encouraged to engage in supporting healthcare through CSR practices.

1.4 The Tanzanian Healthcare System

The history of Tanzanian healthcare dates back to 1967 when socialist economic system was adopted and the government was fully committed in providing free healthcare services to the country's population (White et al., 2013). However, as the number of people increased, the government begun to face the constraint of financial and human resources. As a result, the government could no longer keep

its social commitment and the provision of healthcare services started to deteriorate (Musau et al., 2011).

In 1990s, the nation's economic policy was revamped to encourage domestic and international companies to support public healthcare services. The government liberalized the health sector and encouraged the establishments of private medical and healthcare services (White et al., 2013). Since then, people are required to pay for public healthcare services.

To date, about 40 percent of the total healthcare services in Tanzania (such as supportive diagnostic, pharmaceutical dispensing services, medical training, commodity supply, and health financing) is provided by the private sector, with majority of the hospitals and facilities owned by non-profit organizations or Faith Based Organizations (FBOs) (MoHCDGEC, 2016b; White et al., 2013). The remaining 60 percent is covered by the government (Musau et al., 2011).

According to the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC, 2016b), the number of private health facilities (hospitals, dispensaries, clinics, labs etc.) has significantly increased from 558 in 1994 to 2468 in 2016. This increment has translated into improved access to basic healthcare services. For example, the Tanzania Demographic and Health Survey of 2016 indicated that infant and under five mortality rates decreased from 92/1000 live births and 141/1000 live births in 1992 to 43 and 67 in 2016 respectively

(MoHCDGEC, 2016c). The World Bank (2015) also noted that over one-third of the rural Tanzanians can now access basic healthcare services.

The operation structure of healthcare provision in Tanzania can be segregated into three levels: (1) the bottom level comprises of health centers and dispensaries located in villages; (2) the middle level is made up of health centers located in districts and provides basic and specialized health services including surgeries; and (3) the top level (also called referral level) consists of consulting and specialized hospitals (Stott et al., 2011).

In areas where no government hospital exists, a designated district hospital (DDH) is established to provide healthcare services to the communities. DDH refers to private sector owned hospitals (whether for profit or not for profit) that are funded by the government under special agreement (GIZ, 2014; MoHCDGEC, 2015). The distribution of human and financial resources for DDH is coordinated by the Ministry of Health. Currently, there are 36 designated hospitals operating in Tanzania (MoHCDGEC, 2016b).

The Tanzanian health sector however, faces a number of challenges including imbalanced healthcare service provision due to workforce shortages; insufficient financial resources to ensure adequate supply of medicines and medical equipments; as well as poor infrastructure system (MoHCDGEC, 2016a; MoHSW, 2008). These challenges are having a profound impact on both public and private sectors. Since the government cannot fully meet health needs of the people with

public resources alone, a multi-stakeholder collaboration is required to address these constraints. The scope and role of the needed multi-stakeholder collaboration in addressing these challenges is elaborated in the following sub-topic.

1.5 Problem Statement

The Tanzanian Ministry of Health and development partners including the World Bank and the World Health Organization (WHO) envisages that the constrains of human and financial resources in healthcare could be lessen if various stakeholders would join their efforts and collaborate (MoHCDGEC, 2015; The World Bank, 2015a; WHO, 2014).

To facilitate the participation of various stakeholders (non-state actors) in healthcare, the Tanzanian government has enacted a number of policies and strategies. For example, the National Health Policy (2007) defined the principles of multi-stakeholder collaborations; National Health Strategic Plan IV (2015-2020) provides the scope and role of private sector in healthcare; Primary Healthcare Development Program (MMAM) (2007-2017) focused on tapping resources from the private sector to strengthen provision of healthcare services to rural residents; and the National Health Service Act (2005) was established to guide both the public and private healthcare service providers. In the National Health Sector Strategic Plan IV (2015/2020), CSR is integrated as an option for private sector support in healthcare promotion and protection (MoHCDGEC, 2015).

Despite of the government efforts, research shows that the interactive process or dialogue between stakeholders especially the private sector is not properly coordinated. Companies may not know precisely what stakeholders are interested in. Similarly, stakeholders might not be aware of the extent to which companies are already meeting their demands, or are willing to do so (Kaptein & Tulder, 2003). For example, while stakeholders might expect the company to carry out promotion for public awareness on communicable diseases such as Malaria, HIV/AIDS and Tuberculosis; or contribute to the needy community (orphans, disabled and elderly), the company may not be aware of such expectations if an open and transparent dialogue is not organized for stakeholders to share their opinions and expectations.

The lack of dialogue between companies and other stakeholders could limit the stakeholder's freedom to express their concerns and expectations on the roles that companies could play in addressing healthcare challenges (Kihiyo, 2007; Ngowi, 2015). Incompatible opinions may arise when the company has wrongly perceived stakeholders' expectations. As a result, a company's CSR programme may be difficult to sustain due to misunderstandings between the management and other stakeholders. For example, it may be difficult to build stakeholders' trust, gain community support for a project or to inform the public on company's CSR contribution to society wellbeing (Holmqvist, 2009; Jackson, 2012; & Schwarzkopf, 2006).

In addition, due to lack of mutual inclusive stakeholder dialogue in the Tanzanian healthcare, the contributions of CSR practices of small and medium enterprises (SMEs) is not recognized, documented and appraised (Ngowi, 2015; White et al., 2013). Despite their significant contribution to the country's economy - 23.4% of the total employment and 27% to the GDP (MTI, 2012), SME's social activities in healthcare promotion and protection receives less attention compared to large firms. This is because large firms have more technical, financial, and human resources to materialize their CSR programmes (GIZ, 2014; Mader, 2012).

Public scrutiny and pressure given by stakeholders may also force large firms to provide more CSR activities (Fassin et al., 2015). As a result, their huge economic contribution to the society (such as creating more job opportunities and additional income); and in terms of tax payment to the government, makes their interventions highly publicized, recognized and appraised (Waris & Muhammad, 2013).

As compared to large companies, SMEs have limited resources and are less pressurized by their stakeholders. Yet, SMEs could organize some CSR programmes that can improve the wellbeing of certain stakeholders, such as providing healthcare support to orphans, disabled and elderly people (Adams, 2011; Gupta & Khanna, 2011; Ngowi, 2015); and providing educational support to poor people (Ngowi, 2015; Waite & Mosha, 2006).

Individual contribution given by each SME could be marginal but their collective contribution could help the government to enhance the provision of healthcare to

the nation. Therefore, in addition to examining the large firms' CSR practices, it is worthwhile to find out whether the management of SMEs would also implement more CSR practices in healthcare as a result of their stakeholders' health and safety expectations. It would also be interesting to find out which stakeholder group would receive SMEs' main attention.

There is adequate evidence in the literature on the direct effects of stakeholders' expectations on companies' implementation of CSR practices (Adams, 2011; Jorg Andriof & Waddock, 2002; Sweeney, 2009; Williams, 2012). Previous studies have also shown that theoretically a positive relationship could exists between stakeholder dialogue and companies' CSR activities (Kaptein & Tulder, 2003; Pedersen, 2006; Thulkanam, 2014). However, there are limited empirical studies that have examined the role of stakeholder dialogue on companies' implementation of CSR practices especially in healthcare.

To address the problems above, this study investigates the direct effects generated by small, medium and large companies' perceptions about their stakeholders' health safety expectations on the implementation of CSR practices in healthcare. It also examines the indirect effect of stakeholder dialogue on companies' CSR practices in healthcare. Stakeholder theory is used to develop a model that allows empirical investigation of the mediating role of stakeholder dialogue.

1.6 Research Questions

To examine the direct and indirect effects of companies' perceptions about their stakeholders' health and safety expectations on CSR practices, the following questions need to be addressed.

1. To what extent are companies concerned about their stakeholders' expectations, and how does this affect their CSR practices in healthcare?
2. Will stakeholder dialogue mediate the impact generated by companies' perceptions about their stakeholder's expectations on the implementation of CSR practices in healthcare?
3. Are there any significant differences between large companies' and SMEs' CSR practices in relation to each of their stakeholders' expectations and the effect of stakeholder dialogue on CSR interventions in healthcare?

1.7 Research Objectives

The overall objective of this research is to determine the extent to which stakeholder dialogue could facilitate private sector support in healthcare through CSR practices. Specifically, the study intended to achieve the following objectives:

1. To estimate the direct effects created by companies' perceptions about their stakeholders' expectations on CSR practices in healthcare.
2. To estimate the mediating effects of stakeholder dialogue on the impact generated by companies' perceptions towards their stakeholder's expectations on CSR practices in healthcare.
3. To examine if there are any significant differences between large companies' and SMEs' CSR practices in relation to each of their

stakeholder's expectations and the effect of stakeholder dialogue on CSR interventions in healthcare.

1.8 Significance of the Study

The uniqueness of this study is derived from two perspectives: to the academics and managerial policy makers.

1.8.1 Significance to the Academics

Stakeholder theory is the fundamental theory used in this study because the theory could solve part of the problems faced by the studied community. Introduced by Freeman (1984), the theory aimed to examine how stakeholders were engaged in strategic management of corporations. The theory was however questioned and modified by Ullmann (1985) and Donaldson and Preston (1995) because it had not incorporated issues of social responsibility in decision making and empirical tests of the theory did not reflect the relationship between firm strategies and social responsibilities (Roberts, 1992) (see sub-topic 2.3.3).

The participatory decision making process - stakeholder dialogue that would take into account stakeholders' attitudes, opinions, expectations and stakeholder collaboration structures is also missing in both the original and the modified stakeholder theories. As a result, an empirical analysis of the achievement of business organizations' social responsibilities and its potential contribution to social economic wellbeing of its stakeholders cannot be examined explicitly (Burchell & Cook, 2006; Roberts, 1992).

This study therefore propose to modify Donaldson and Preston's (1995) stakeholder model by including an intervening variable: stakeholder dialogue, to empirically examine its mediating effect in facilitating private sector support in healthcare while accommodating the varying interests of all stakeholders in corporate decision making. By holding dialogue with stakeholders, the business organizations and their respective stakeholders could reach consensus that are mutually beneficial to both parties.

In addition, while CSR has been studied in the context of stakeholder theory, studies that have empirically examined the role of stakeholder dialogue particularly as a mediating variable are limited. This study augments the literature by carrying out an empirical analysis of the role of stakeholder dialogue in mediating the effect of companies' perceptions about their stakeholders' expectations on the implementation of CSR practices in healthcare.

Furthermore, a comparative analysis of the effects of perceived stakeholders' expectations and stakeholder dialogue on the implementation of CSR practices among large, and medium and small companies is carried out to identify stakeholders that would have significant influence on these companies' CSR practices. This assessment provides insights that could be helpful to the body of knowledge particularly on developing stakeholder management frameworks for both larger firms and SMEs.

1.8.2 Significance to Public Policy Makers and Private Practitioners

The Tanzanian government has developed various policy instruments to motivate private sector participation in healthcare. This policy move has produced positive results. For example: (1) since 1991, local community could access and consume essential pharmaceutical and medical commodities more easily (there is over 9000 private commercial wholesalers, importers and pharmaceutical retailers) (Embrey et al., 2016); (2) more accredited drug dispensing outlets have been established – the number of relevant outlets has increased from 67% in 2003 to 91% in 2014 (Valimba et al., 2014); and (3) the cases of HIV prevalence has dropped from 7.3% in 2000 to 4.7% in 2015 (UNAIDS, 2015).

The rate at which the private sector is engaged in healthcare support is however still low. White et al. (2013) reported that private sector providers, civil society groups and non-governmental organizations have not been sufficiently consulted on strategic healthcare issues e.g. planning and execution of healthcare strategies and objectives. This has probably discouraged private sector support in health.

To complement the ongoing initiatives in promoting private sector support in healthcare, this study examined the role of stakeholder dialogue in motivating private companies in Tanzania to engage in healthcare related CSR practices. If stakeholder dialogue has positive contribution, Tanzania's public agencies could consider using the current research model to develop their CSR specific strategies that involves all stakeholders in planning, decision making, and implementation of CSR programmes. As each stakeholder and corporate management have their own

interests, it is important to reach a mutual beneficial agreement and thereby, hopefully more successful CSR interventions will be implemented in future.

In addition, this study investigated SMEs' CSR practices in healthcare and whether stakeholder dialogue plays an important role in SME - CSR relationship. As argued by Jenkins (2006), SMEs are more flexible in responding to stakeholders' expectations in social and economic challenges. Their "owner-manager" approach puts SMEs in a strategic position to engage in dialogue with stakeholders more easily. If stakeholder dialogue is coordinated, it would mediate the relationship between SMEs and stakeholders' expectations and in turn induce more SMEs to practice CSR in healthcare.

1.9 Organization of the Thesis

This thesis is organized as follows. Chapter one introduces the research focus by highlighting main issues of the study, the objectives and the guiding research questions. It also provides the significance of the research to the academics, policy makers and practitioners. Chapter two provides an overview of relevant literature on CSR and stakeholder dialogue. It highlights the theoretical frameworks used by similar past studies to examine CSR and its related facets. Relevant past studies research methodologies and data analysis techniques are also critically reviewed to guide the present study. Chapter three presents the methodological approach adopted by this study and the data analysis techniques employed. Chapter four presents the results of the study. Chapter Five summarizes the contributions of this research, its implications, limitations and roadmap for future research.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter provides an overview of CSR related literature. Theoretical review is presented to examine the role that stakeholder dialogue could play in motivating private sector support in healthcare through CSR practices. Past studies' research models, methodological approaches and data analysis techniques are reviewed as well to provide the basis for the current research's methodological approach.

2.2 CSR and Stakeholder Dialogue in Healthcare

Prior research showed that the impact of global epidemics and communicable and non-communicable diseases are increasingly alarming (van Cranenburgh, Arenas, & Albareda, 2010; WHO, 2007, 2014, 2016). As a result, companies are becoming more conscious on the impact of healthcare challenges on their stakeholders and society at large (Bharti, 2013). Due to limited human and financial resources particularly in developing countries, there has been uprising public pressure on private sector to be more supportive in promoting health and safety (Asongu, 2007).

Research shows that through dialogue, business organizations' perceptions towards their stakeholders would improve (Thulkanam, 2014). Companies have

been developing their CSR programmes by collaborating with government agencies and non-governmental organizations to address healthcare issues (Jamali, 2008; Werner, 2009). For example, van Cranenburgh et al. (2010) asserted that Heineken company had developed joint healthcare programmes with public health institutions in Sub-Saharan countries to mitigate the impact of diseases such as tuberculosis, malaria, HIV and AIDS that have had negative effects on the company's workforce and their families. Pamba (2013) also noted that in the Democratic Republic of Congo and Kenya, private companies had formed partnerships with NGOs, charities and governments to help children suffering from diseases such as malaria, pneumonia and malnutrition; and to reduce child mortality, improve access to vaccines and medicines particularly in those areas where access to basic healthcare is limited.

Studies by Mader (2012), Mwamwaja (2015) and Ngowi (2015) showed that companies in Tanzania (both large and SMEs) have also started practicing CSR to complement public sector efforts in addressing healthcare issues. For example Vodacom Tanzania (2016) reported that through their CSR interventions, over 2000 women that suffered from obstetric fistula after childbirth received treatment. GIZ (2016) also noted that through private sector support, more than 30,000 rural farmers and their families have been enrolled in community health funds to ensure their access to healthcare services when they fall ill.

Mfaume and Leonard (2004) and Ngowi (2015) asserted that just like large companies, small and medium companies are also becoming more responsible to

their stakeholders needs and interests. For example, through their informal small scale CSR interventions, SMEs in rural areas have (1) facilitated healthcare promotion such as anti-Malaria and HIV/AIDS campaigns; (2) supported the construction of health centers and dispensaries; and (3) helped poor people as well as senior citizens and orphans to access basic healthcare services. These interventions could further be enhanced if collaboration between SMEs and other stakeholders were enhanced. Kazimoto (2004), Lema (2013) and Stevenson and St-Onge (2005) have also noted that more collaborative structures are required to fruitfully make use of SMEs' social activities.

Nevertheless, the potentials of private sector support in healthcare particularly in Tanzania are not fully explored. The lack of open and transparent dialogue mechanisms at national, sectoral and local levels (GIZ, 2014; Mwamwaja, 2015) is perhaps inhibiting companies' CSR interventions in promoting health and safety. For example, White et al. (2013) reported that private healthcare providers, non-governmental organizations and civil society organizations are not involved in the Tanzanian healthcare planning and decision making. This could discourage private sector companies from engaging in healthcare support especially when CSR in healthcare is a voluntary practice.

2.3 Overview of Past Studies' Theoretical Frameworks

A number of theories and research models have been used to study companies' CSR practices and stakeholder involvement in such practices. These theories are grouped in two categories: (1) political theories which comprises of political economy theory, social contract theory, and Habermas's theory of discourse ethics and deliberative democracy; and (2) relational theories which is made up by legitimacy theory, institutional theory and stakeholder theory (Frynas & Stephens, 2015; Garriga & Melé, 2004; Grahovar & Rimmel, 2010). The following sub-topics provide an overview of these theoretical perspectives in relation to company CSR practices and stakeholders' expectations.

2.3.1 The Theoretical Framework of Political Theories

2.3.1.1 The Theoretical Framework of Political Economy Theory

Introduced by Jevon's (1888), the theory of political economy aimed to explain the interaction between business, politics and economics that was constructed by utilitarian theories. In CSR literature, political economy theory has been used to elaborate how the interrelationships between socio-political and economic forces in a society can be balanced (Gjølberg, 2011). Researchers provided a framework to understand social relations of production, division of power between interest groups, and the institutional process in which business interests may be advanced (Abeysekera, 2003; Grahovar & Rimmel, 2010).

Although the theory of political economy could explain the potential influence of corporations on the global governance system as indicated in Table 2.1, it has been criticized for not being able to explicitly justify the resulting pattern of corporate influence on social-political and economic systems due to possible conflict of interests among politicians with business interests that could potentially diminish the regulatory power of the state (Frynas & Stephens, 2015; Scherer & Palazzo, 2008). In addition, the modality through which corporations and political institutions interact (the dialogue process) is not elaborated in this theory (Frynas & Stephens, 2015). As such, the political economy theory is not suitable to address the scope and objectives of this study.

2.3.1.2 The Theoretical Framework of Social Contract Theory

Social contract theory suggests that actual or hypothetical agreements between the society and its members do exist in reality (Garriga & Melé, 2004; Ngowi, 2015). In CSR research, the theory has been used to demonstrate the relationship between society expectations and business operations (Moir, 2001; Sacconi, 2004). Corporations are encouraged to behave responsibly and fulfill their social obligations by setting up an informal contract with the society to secure social license. In this way, the possibility to sustain a business could be higher (Donaldson & Dunfee, 1999; Dunfee, Smith, & Ross, 1999; Ngowi, 2015).

While social contract theory could be useful for resolving ethical issues between business and communities through moral principles, the theory is criticized for being too hypothetical since corporations and individuals depend on the

institutional rules and regulations set by the government and therefore moral obligations cannot stand without a set of official rules and regulations (Rusling, 2007). In brief, the theory does not consider the role that could be played by government as one of the participating stakeholders in business-community relations (Rusling, 2007).

This theory is therefore not suitable for the present study because the government plays an important role in CSR practices in healthcare (Donaldson & Preston, 1995). In Tanzania, many public policies have been established to solve the public healthcare challenges. In addition, while disparities between business and society could be solved through dialogue among participants, social contract theory does not offer this constellation (Sacconi, 2004), which is crucial for balancing business perceptions and stakeholders' expectations.

2.3.1.3 The Theoretical Framework of Habermas's Theory of Discourse Ethics and Deliberative Democracy

The Habermas's theory of discourse ethics and deliberative democracy has been applied in CSR research to explain the legitimacy gap created by the involvement of non-state actors in political decision-making. To elaborate, the theory explains that political power of corporations needs to be coordinated and legitimized in a democratic way so that business interests do not interfere social economic interests of the nation state (Frynas and Stephens, 2014).

The theory conceptualize that for a mutual agreement to be reached between corporations and the state, a dialogue forum is crucial so that affected parties could raise their concerns in an environment that is free of social and political dominations (Stoll-Kleemann & Welp, 2007). As such, this theory offers an alternative democratic explanation of the multi-stakeholder initiatives in managing business-political relations (Scherer and Palazzo 2011).

Nevertheless, as shown in Table 2.1 (see page 29), apart from the state and corporations, Habermas's theory does not provide insights on the existence of other stakeholders e.g. local communities, consumers and employees although corporate operations may have significant impact on them (Barone et al., 2013). In addition, the theory did not clearly explain how the discourse of ethics reflects the concerns of the other aforementioned stakeholders which is crucial for deliberating mutual interests (Aguilera, Rupp, & Williams, 2007).

2.3.2 The Theoretical Framework of Relational Theories

2.3.2.1 The Theoretical Framework of Legitimacy Theory

Derived from the concept of organizational legitimacy, Dowling and Pfeffer (1975) developed legitimacy theory to explain how organizations tend to structure their operations according to the bounds and norms of the society in which they operate. In CSR studies, the theory has been used to examine possible motivations for CSR and environmental disclosures (Devin, 2014; Jupe, 2005; Van Der Laan, 2009).

Guthrie, Suresh and Ward, (2006) asserted that, legitimacy theory signifies that a social contract exists between a company and the society in which it operates.

Such contract enable companies to position their strategies in legitimizing their presence in a particular setting. According to Vourvachis (2008), the idea of legitimacy is pragmatic and is an image-oriented variant. Thus, organizations engaging in CSR activities will provide adequate supplies of legitimacy resource in order to maintain profitability and long term survival. This theory is however criticized for ignoring the involvement of stakeholders in supporting corporations to develop sustainable CSR practices. As such, legitimacy theory is not appropriate to examine the role of stakeholder dialogue in accounting for the relationship between stakeholders and company implementation of CSR practices.

2.3.2.2 The Theoretical Framework of Institutional Theory

Institutional theory was developed in 1970s to explain how modern organizations behave within their environments (DiMaggio & Powell, 1983; Meyer, 2008). In CSR research, institutional theory is used to explain the extent to which organizations and their strategies are substantially influenced and shaped by the broader institutional settings (isomorphic pressures) in which they operate (Aguilera et al., 2007; Allard & Martinez, 2008; Kercher, 2008). Such institutional settings include legacies that reflect culture, history, and polity of the particular country or region (Mathis, 2008).

According to Brammer et al. (2012), institutional theory places CSR in a wider field of economic governance where interactions among corporations and stakeholders are regulated. Thus, the theory could provide a better understanding of the role of national institutional frameworks in coordinating companies' CSR activities (Devin, 2014). However, as shown in Table 2.1, the theory is criticized for failing to consider the level of each stakeholder's interests involved in the business circle. This problem is rather addressed by the stakeholder theory.

2.3.2.3 The Theoretical Framework of Stakeholder Theory

Freeman (1984) developed stakeholder theory to elaborate how organizational behavior can be predicted given the internal and external pressures of various stakeholder groups on organizational decision making process. This theory highlights that as organizations have multiple obligations to their respective stakeholders, the organizations thereby, need to respond to the needs of their stakeholders (Freeman & McVea, 2001; Freeman, 1984, 2004).

In CSR research, stakeholder theory has been used as a framework for aligning the interests and perceptions of corporations and those of their respective stakeholders to develop effective CSR programmes (Pedersen, 2004). Scholars have used the theory to draw business decision makers' attention by arguing that stakeholders' concerns or expectations should be considered in business undertakings (Heath & Norman, 2004; Schwarzkopf, 2006). Previous researchers suggested that organizations should apply stakeholder theory in their internal and external processes to incorporate moral philosophy and ethics (Goel & Ramanathan, 2014).

Nevertheless, the theory is not free from criticism. It assumes the interests of all stakeholders are the same while it is not. The theory does not offer alternative interaction process for compromising the varying stakeholders' interests (Phillips et al., 2007). To address this concern, Deetz (2007) and Lahtinen (2014) recommended that new models that involve stakeholder dialogue should be developed. According to the authors, the dialogue process needs to ensure equal participation of all stakeholders so that their concerns could be addressed in an open and transparent environment.

Despite of Deetz's (2007) and Lahtinen's (2014) recommendations, empirical studies on the role of stakeholder dialogue in CSR research are limited, and the direction of the anticipated impact of stakeholder dialogue is not well documented. Furthermore, studies that have examined the effect of company perceptions about stakeholders' health and safety expectations on the implementation of CSR practices in healthcare are not common. This study attempts to fill the literature gap by extending stakeholder theory. Stakeholder dialogue is incorporated into the stakeholder model to examine the direct and indirect effects of companies' perceptions towards their stakeholders' expectations on the implementation of CSR practices in healthcare.

In summary, various theoretical frameworks have been used to study CSR (see Table 2.1). These different theoretical frameworks provide the basis for understanding how CSR is perceived and the context to which it can further be enhanced. Given that the current study intends to examine the role of stakeholder

dialogue in facilitating private sector support in healthcare through CSR practices, stakeholder theory is used as current study's fundamental theory.

Table 2.1 Relevant Theories Used in CSR Studies

Author(s)	Type of Theory used	Theoretical Rationale	Criticism of the Theory
POLITICAL THEORIES			
Abeysekera (2003); Gjølberg (2011); Grahovar & Rimmel (2007); Jevons (1888); Tilt (2010); Williams (2012)	Political Economy Theory	Explains the extent to which business firms proactively influence the global governance systems, most notably with reference to the posited diminished regulatory power of state institutions.	The theory could not offer sufficient justification on business influence on social political and economic systems due to possible conflict of interests among politicians with business interest
Aguilera et al. (2007); Barone et al. (2013); Frynas & Stephens (2014); Jupe (2005)	Habermas's theory of discourse ethics and deliberative democracy	Explains an alternative solution for legitimizing CSR through deliberative democracy.	The theory ignores other stakeholders apart from the state and corporations. Not clear on how the discourse of ethics can accommodate stakeholders' concerns for deliberating mutual interests.
RELATIONAL THEORIES			
Barkemeyer (2007); Deephouse & Suchman (2008); Guthrie et al. (2006); Sandra Van Der Laan (2009); Tilling (2004)	Legitimacy theory	Explains the essence of using CSR as a strategy to achieve legitimacy via congruence with the norms and values of the society in which business firms operate.	The theory does not offer real insights into the voluntary social and environmental disclosures of corporations.
Aguilera et al. (2007); Brammer et al. (2012); DiMaggio & Powell (1983); Mathis (2008); Scott (1995); Shah (2007)	Institutional theory	Explains the changing function of CSR as a result of the companies' conformity to different institutional pressures.	This theory does not incorporate the expectations of other stakeholder groups in a society apart from the regulators, business associations and the community
Donaldson & Preston (1995); Freeman (1984); Mitchell et al. (1997); Phillips et al. (2007); Tiras et al. (1998)	Stakeholder theory	Explains the changing function of company's CSR practices in terms of its response to stakeholder demands.	The theory assumes the interests of all stakeholders are the same while it is not. It doesn't offer alternative interaction process for compromising varying stakeholders' interests.

Unlike other theories, stakeholder theory provides a unique ground for studying stakeholder dialogue as it offers various dimensions that allow empirical investigation of the relationship between the company perceptions about its respective stakeholders' needs, concerns and expectations, and the effect of such perceptions on company implementation of CSR practices (Donaldson & Preston, 1995; Qiliang & Hongxia, 2008). The theory is modified by including an intervening variable: stakeholder dialogue so that firm-stakeholder relationships can be examined explicitly. The details of the modifications are elaborated in the following sub-topic.

2.3.3 The Conceptual Framework of Stakeholder Theory

In its original version, stakeholder theory has six stakeholder groups explaining the relationship between business firms and their stakeholders (see Figure 2.1). Freeman (1984) argued that companies need to be attentive to these stakeholders not only because it is the right thing to do in business ethics, but because by doing so, companies can strengthen their business operations, market their products, increase their profitability and above all manage their sustainability.

The theory has been modified by previous researchers who suggested improving the definitions of the term stakeholder, visualization of stakeholders, and the process of identifying legitimate from illegitimate stakeholders (Donaldson & Preston, 1995; Mitchell et al., 1997; Ullmann, 1985).

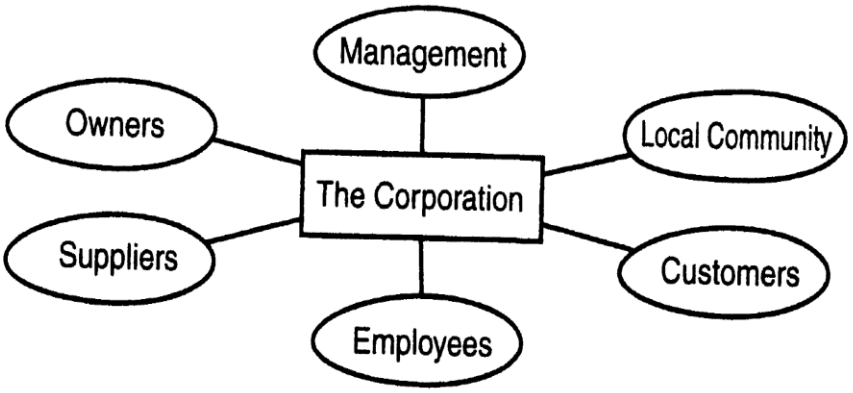

Figure 2.1: Freeman's (1984) Stakeholder Model of the Corporation

For example, in his framework, Ullmann (1985) predicted that social responsibilities of the firm can be determined in three dimensions: the power that stakeholders have over resources needed by the firm; firm strategy to enhance its relationship with key stakeholders; and economic performance. Ullmann (1985) argued that if stakeholders possess critical resources for the survival of the firm, and if the firm has active strategy for keeping relationship with stakeholders given that it has a good financial performance, more social responsibility activities can be anticipated.

Although Freeman's (1984) original stakeholder theory, and Ullmann's (1985) framework assumed that all stakeholders of the firm have the right and responsibility to determine the future achievements of the firm including growth, stability and profit (Dincer, 2011; Roberts, 1992), the participatory decision making process that would take into account stakeholders' attitudes and stakeholder collaboration structures is not discussed. In addition, their frameworks

were built on instrumental and descriptive dimensions of stakeholder theory (Donaldson & Preston, 1995), in which the descriptive and instrumental approaches are inadequate dimensions to ground the stakeholder theory as they are not empirically justifiable. As a result, implementation or achievement of a company's social responsibilities cannot be explicitly examined simply by describing cause-effect relationships: between company stakeholders' power, strategy, and corporate performance (Roberts, 1992).

In response to the argument, Donaldson and Preston (1995) modified the stakeholder theory by introducing three elements (the descriptive, instrumental and normative dimensions) to the theory while holding its main thesis. According to the authors, the descriptive dimension of stakeholder theory gives a general perspective of the firm's management of their stakeholders' interests. The instrumental dimension is attributed to creating links between stakeholder approaches and commonly desired objectives of corporations e.g. profitability, stability and growth. This approach views stakeholders as a "means" and not as an "end" i.e. stakeholders are regarded by the firm as an instrument to achieve its objectives but are not part of the decision making process (Castelo & Rodrigues, 2007).

According to Donaldson and Preston (1995), important aspects such as stakeholder attitude, management strategy and structures were not included in the descriptive and instrumental dimensions of stakeholder theory, hence the ultimate justification for stakeholder theory is based on the normative dimension which is used to

examine the connection between stakeholder management strategies and organizational performance.

In extending the stakeholder theory, Donaldson and Preston (1995) had developed a stakeholder model (see Figure 2.2) by adopting the wide definition of stakeholder theory as suggested by Freeman (1984). According to Donaldson and Preston (1995), all stakeholders (internal and external) have their own legitimate interests and they participate in an enterprise in order to obtain some returns or benefits. Hence, the arrows shown in Figure 2.2 runs in both directions to signify a mutual beneficial relationship between the firm and its stakeholders. Donaldson and Preston's (1995) stakeholder model is criticized as well on the grounds that stakeholders are often scattered around the firm and so their distances from the firm varies - the shorter the distance the more important they are to the firm and vice versa (Figar & Figar, 2011).

Furthermore, Donaldson and Preston's (1995) stakeholder model assumes that stakeholders and the firm share common interests. Nevertheless, stakeholders' interests are sometimes incompatible with socially responsible practices of corporations (Lee, 2005). For example, due to varying stakeholders' needs and expectations, corporate perceptions and decisions might not reflect the interests of all stakeholders (Dunfee, 2006). Hence, an interactive process that could mediate various stakeholders' interests is crucial.

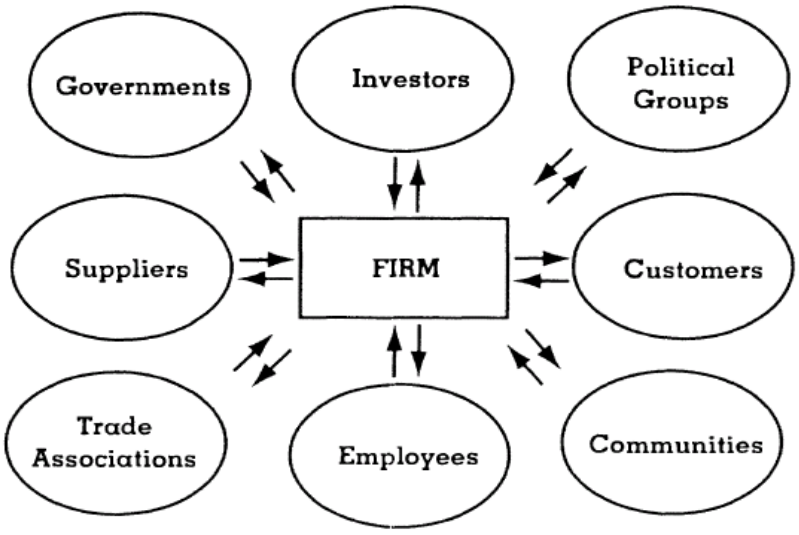

Figure 2.2: Donaldson and Preston's (1995) Stakeholder Model

In responding to the question of which stakeholder group is more important than the other, Mitchell et al. (1997) incorporated the normative and descriptive elements of stakeholder theory and developed a framework for stakeholder identification and salience. Mitchell et al. (1997) introduced the qualitative criteria of power, legitimacy and urgency. According to Mitchell et al. (1997), power indicates the ability of a stakeholder to influence the firm; legitimacy is defined as a generalized perception or assumption that the actions of an entity are desirable; and urgency reflects the extent to which stakeholders' claims call for immediate attention.

Mitchell et al. (1997) asserted that the identification of legitimate stakeholders from illegitimate ones depends on the attributes they possess (i.e. power, legitimacy and urgency). The authors therefore proposed to group the stakeholders

in three main categories according to their attributes: latent, expectant and definitive stakeholders. Figure 2.3 shows that the management of a company is more likely to listen to stakeholders who possess at least two attributes (Mitchell et al., 1997).

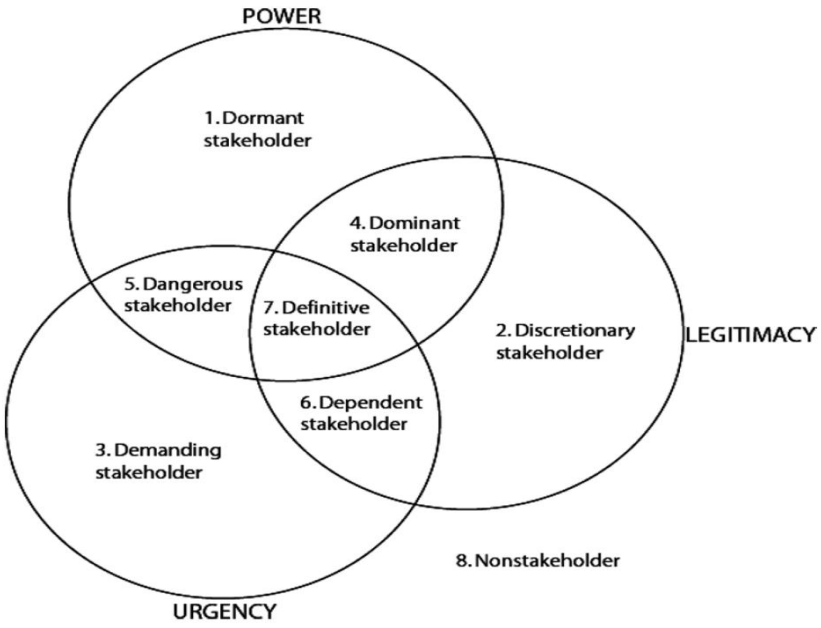

Figure 2.3: Mitchell, Agle and Wood's (1997) Stakeholder Typology

Although Mitchell, Agle and Wood's (1997) stakeholder identification and salience theory could be usefull for studying business firms' perception about stakeholders and to decide which stakeholder group to focus on, the theory is criticized because in empirical research it is difficult to explicitly identify which of the stakeholders' concerns should be prioritized by looking at the cummulative number of attibutes they possess (Neville, Menguc, & Bell, 2003).

By looking at the attibutes of stakeholders, companies could ignore important concerns that could affect the operations of the firm simply because they were raised by less powerful stakeholders e.g. casual employees and the surrounding communities (Stephens, Malone, & Bailey, 2005). In addition, the status of stakeholders could change if they acquire more than one attribute. For example, dormant stakeholders could become dangerous stakeholders if they acquire urgency or even dominant if acquired legitimacy (Figar & Figar, 2011).

To overcome the criticisms highlighted above, the present study extended Donaldson and Preston's (1995) modified stakeholder theory by adding stakeholder dialogue as a mediating variable to test whether the interaction between stakeholders and the companies' management teams could be improved and whether companies would be encouraged to implement more CSR practices in healthcare. Stakeholder dialogue variable in this study comprises of three key elements: knowledge of stakeholders' attitudes, opinions and expectations; interaction process - stakeholder collaboration practices; and commitment - stakeholder management strategy.

The inclusion of stakeholder dialogue could help to accommodate the interests of all stakeholders despite their cumulative number of attributes as proposed by Mitchell et al. (1997). It would also allow examining the direct and indirect effects of the perceived stakeholders' expectations on company implementation of CSR practices in healthcare. Figure 2.4 presents this study's proposed theoretical model. In this model, companies' perceptions about their stakeholders' expectations

represent the independent variables while the implementation of CSR practices in healthcare depicts the current study's dependent variable. It is anticipated that stakeholder dialogue will mediate the relationship between independent and dependent variables. Through stakeholder dialogue the present study's theoretical framework could be useful for enhancing firm-stakeholder collaborations in developing strategic and sustainable CSR practices in healthcare. Details of the present study's model are further elaborated in sub-topic 3.3 - operational framework of the present research.

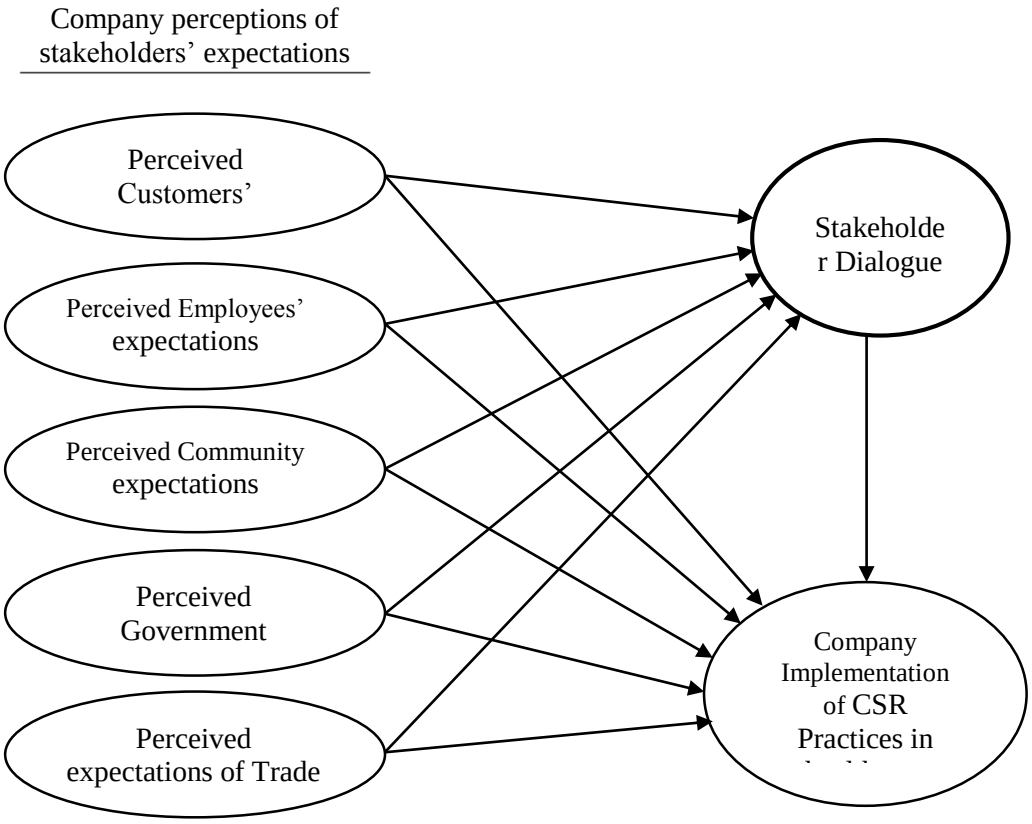

Figure 2.4: Proposed Theoretical Model

In summary, Donaldson and Preston's (1995) modified stakeholder theory is chosen for three reasons. First, unlike Freeman's (1984) original theory whose wide definition of stakeholders did not specifically mention who the stakeholders are in the "other groups", Donaldson and Preston (1995) have clearly specified the stakeholders included in their model. The "other groups" include government, trade associations, political groups and media. In the context of the present study, government and trade associations are crucial for promoting CSR activities; for providing institutional support; and coordinating stakeholder dialogue for effective CSR practices.

Secondly, while Freeman's (1984) and Ullmann's (1985) perspectives provide the basis for understanding stakeholder model, both authors remained somehow silent on which dimension of the theory could better be used to analyze the ethical and responsibility aspects of business firms. This is clearly stated in Donaldson and Preston's (1995) categorization of stakeholder theory who argued that the normative dimension is at the core of the stakeholder theory.

Thirdly, although Mitchell, Agle and Wood (1997) made a substantial contribution towards the development of stakeholder theory with a model of stakeholder salience, their approach is inappropriate for the present study due to lack of empirical aspect for prioritizing stakeholders' concerns. Hence, this study builds on Donaldson & Preston's (1995) normative dimension of stakeholder theory.

2.4 Overview of Past Studies' Research Models

Various past studies have examined the relationship between stakeholders and companies' CSR practices. For example, in their CSR pyramid model, Carroll (1991), and Carroll and Shabana (2010) argued that the relationship between stakeholders and CSR practices of business organizations is determined by the degree to which businesses respond to their stakeholders' expectations.

According to Carroll and Shabana (2010), business organizations have four set of responsibilities: (1) they are required to produce goods and services desired by the society and sell them at the acceptable profit levels (economic responsibility); (2) practice CSR in the manner consistent with government rules and regulations and society bylaws (legal responsibility); (3) behave ethically (ethical responsibility); and (4) be good corporate citizens by supporting community social activities (philanthropic responsibility). These responsibilities altogether form responsible business practices (Carroll & Shabana, 2010). The relationship between business organizations and their stakeholders would therefore be enhanced when businesses fulfill these responsibilities altogether.

Other frameworks by Agudo-Valiente et al. (2015); Johansen and Nielsen (2011) indicated that business organizations tend to use CSR as a strategic tool to respond to their stakeholders' expectations (e.g. response to emerging diseases on workforce), for mitigating business risks (e.g. financial scandals), and for ensuring business sustainability. The benefits derived from CSR interventions such as

psychosocial and value satisfaction determines the strength of the relationship between companies and their stakeholders (Bhattacharya, Korschun, & Sen, 2009).

To strengthen firm-stakeholder relations and to address the legitimacy challenges faced by corporations, scholars introduced the concept of stakeholder dialogue in CSR literature (Fox, Ward, & Howard, 2002; Pedersen, 2006). Various studies suggested that companies could gain effective results by engaging in dialogue with their stakeholders. For example, Lahtinen, (2014); Waris and Muhammad (2013); Deetz (2007) and Elkington (1997) claimed that stakeholder dialogue could increase operational efficiency, stakeholder commitment, employee morale, creativity, product and service customization as well as innovation, and thereby create competitive advantage.

In Agle et al. (2008), Kaptein and Tulder (2003), Nelson (2006), and Pedersen's (2006) study frameworks, they argued that the magnitude of stake owned by different stakeholder groups would determine the degree of their participation in the dialogue process and the dialogue structure. As Pedersen (2006) argued, the dialogue between stakeholders could take different forms including openness, tolerance, stakeholder inclusion, empowerment, and transparency. This way, even the powerless stakeholders could still take part in the company decision making process for social responsibilities.

As shown in Table 2.2, while various studies have examined CSR in the context of stakeholder theory, there is limited empirical research that had tested the effect of

stakeholder dialogue in facilitating stakeholder involvement in CSR practices (Deetz, 2007; Donaldson & Preston, 1995; Lahtinen, 2014, O'Riordan & Fairbrass, 2008). Most past studies had only examined the direct relationship between company CSR practices and stakeholders' expectations on such practices. However, the process through which companies would interact with their stakeholders to familiarize themselves with stakeholders' expectations - stakeholder dialogue is not yet empirically tested in the literature. Hence, an important question still holds: will stakeholder dialogue mediate companies' perceptions about their stakeholder's expectations so that a mutual beneficial agreement can be reached between the company and its stakeholders and thereby more CSR practices be implemented?

This study aims to answer this question by adding an intervening variable - stakeholder dialogue to Donaldson and Preston's (1995) modified stakeholder theory to empirically test the mediation effect played by stakeholder dialogue. If the mediation effect is statistically significant, the current study's results could serve as a useful guideline to public and private sectors in planning and strengthening Tanzania's healthcare system which is currently weak (Musau et al., 2011; White et al., 2013).

Table 2.2: An Overview of Relevant Past Studies Research Models

Authors' name	Original theory used in constructing the author's research model	Additional variables used to improve the original theory	Reasons for the modifications
Ayuso et al. (2006)	Stakeholder Theory & Resource-Based View of the Firm	Integrated stakeholder dialogue into stakeholder model	To examine the relationship between firm's ability to integrate stakeholder insights into organizational innovation processes.
Agudo-Valiente et al. (2015)	Stakeholder Theory	Integrated communication aspect into stakeholder model	To empirically analyze the importance of communication with stakeholders for social responsibility.
Bhattacharya et al. (2009)	Stakeholder Theory & Relationship Marketing Theory	Integrated stakeholder benefits to the model (functional benefits, psychosocial and values satisfaction)	To develop a model that examines when, how and why CSR activity leads individual stakeholders to produce company-favoring outcomes, and how such outcomes affects the quality of firm-stakeholder relationships
Bharti (2013)	Stakeholder Theory	Emphasized on value creation for stakeholders. Also added civil societies and development partners in CSR stakeholder framework	To determine how well partnerships could work to bring about desirable changes in the field of engaging businesses in healthcare
Burchel & Cook (2006)	Stakeholder Theory	Incorporated stakeholder dialogue into corporate communication model	To examine the contribution of stakeholder dialogue in increasing trust and accountability on organizational CSR practices.
Carroll (1991)	Corporate Performance Model	Developed the pyramid of CSR by introducing four principles of CSR: economic responsibility; legal responsibility; ethical responsibility; and discretionary (philanthropic) responsibility	To examine various aspects of corporate social performance by analyzing key responsibilities of business organizations in relation to social issues.

Continue next page

Fontes (2009)	Stakeholder Theory	Incorporated the "fundamental CSR domains" (intentionality, engagement, leadership, commitment and knowledge) into the stakeholder model.	To be able to explain the effects of primary stakeholders support on corporate engagement in healthcare.
Johansen and Nielsen (2011)	Stakeholder Theory	Incorporated stakeholder orientation, corporate identity and communication into the Stakeholder dialogue framework	To determine the effects of stakeholder orientations of the CSR, corporate identity and corporate communication in strengthening stakeholder dialogue.
Pedersen (2006)	Stakeholder Theory	Proposed five dimensions of stakeholder dialogue: inclusion, openness, tolerance, empowerment and transparency.	To be able to operationalize stakeholder model in organizations practicing stakeholder engagement.

2.5 Overview of Past Studies' Research Methodologies

Various methodological approaches have been used to study CSR and its related facets. The methodological approaches that had been used by past studies can be grouped in three categories: quantitative, qualitative and mixed research methods.

Similar past studies have predominantly used quantitative approach to empirically test, confirm, and validate relationships between stakeholders and corporate decisions in CSR practices (Ngowi, 2015; Okon, Ekpo, Akpan, Ibok, & Bassey, 2014; Pedersen, 2004; Peters, 2007; Rais & Goedegebuure, 2009). Qualitative approach on the other hand is criticized for not being able to accommodate large sample sizes and thereby qualitative findings may not represent the studied population's response (Adams, 2011; Ronald Czaja & Blair, 2005; Iatridis, 2011).

Previous researchers have also used mixed methods approach (combination of quantitative and qualitative techniques) to triangulate their data findings (Adams, 2011; Iatridis, 2011; Irikannu, 2013; Isa, 2012; Sweeney, 2009). According to Decrop (1999), this approach is useful as it reduces researcher and methodological biases in a study and could also enhance the generalization of the study findings.

However, if a researcher's intention is to achieve internal validity, external validity, reliability and objectivity of data findings; quantitative methodological approach could still be used provided it attains the above criteria (Decrop, 1999). In brief, triangulation is not the only criterion for good research (Decrop, 1999) as it cannot guarantee answers for the current research problems. Crucially, the quality of research data could be ensured if important research stages involving pre-test of instruments, pilot study, and main survey are followed (Awang, 2015). To attain internal and external validity, reliability and objectivity of data findings, the present study employed quantitative research methods (see sub-topic 3.1).

As shown in Table 2.3, most past studies used probability sampling techniques to select their study respondents (Adams, 2011; Euphemia & Yunusa, 2014; Iatridis, 2011; Ngowi, 2015). Simple random sampling technique was used as the main sampling technique due to its ability to provide equal chance for all observations to be selected (Iatridis, 2011; R. P. Ngowi, 2015; Rattanaphan, 2012).

Table 2.3: An Overview of Similar Past Studies Research Methodologies

Author	Methodological approach	Sample size & sampling technique	Data collection technique	Critics on methodological approach
Hameed, Riaz, Arain and Farooq (2016)	Quantitative research methods	Probability sampling was used to draw a sample of 414 respondents from large multinationals in Pakistan	Cross sectional survey with self-administered questionnaire	No justification is provided for selection of only 5 respondent companies. Results may not be generalized.
Jamali (2008)	Qualitative research methods	Non-probability sampling technique was used to reach a sample of 20 Lebanese and 13 Syrian companies	Used qualitative in-depth interviews	Results obtained cannot be generalized to the population from which the sample was drawn.
Rais & Goedegebuure (2009)	Quantitative research methods	Probability sampling techniques applied to reach a sample of 570 companies drawn from Indonesian manufacturing firms	Survey was used as a primary data source using questionnaires designed with seven-points Likert scale for all items and constructs	No justification is provided for the selection of 5 point-Lickert scale for study questionnaire No justification is provided for the selection of 5 primary stakeholders
Sweeney (2009)	Mixed methods (combination of qualitative & quantitative research methods)	Applied probability sampling technique to reach a total sample of 220 firms for quantitative part.	Semi-structured interviews were used as part of the exploratory research to aid postal mail survey	Researcher is not certain that the targeted respondent took part in the survey.
Peters (2007)	Quantitative research methods	Used longitudinal approach to achieve the sample of 158 firms	Data collected from secondary sources through extensive literature review	Information reported on secondary sources may not be specific for the intended study

Although simple random sampling technique could be useful for generalizing study sample findings to the population, it cannot provide a good representation of the population that has subgroups (Trochim, 2006).

To obtain reliable results, most past studies used large samples ranging between 200 to 400 respondents: based on the formula suggested by Taro Yamane (1967) (Euphemia & Yunusa, 2014; Ngowi, 2015; Phumitharanon, Srivoravilai, & Chanrommanee, 2010). Yamane's formula is predominantly used due to its simplicity when the parameters such as population size and level of precision are known. Similar sample size computation technique was used for the current study since its parameters were known (see details in sub-topic 3.5.1.2).

In terms of data collection, various methods were used by previous researchers: web, postal mail surveys, field survey as well as interviews (Adams, 2011; Rais & Goedegebuure, 2009; Sweeney, 2009). Scholars argued that, compared to telephone and field surveys, web and postal surveys are far way cheaper and more useful when researchers have limited resources (Collie & Jesse, 2009; Losby & Wetmore, 2012; Sweeney, 2009). The authors also argued that mail questionnaires are more appropriate as they are often completed at the respondent's convenience hence the possibility of interviewer's interruption on respondents is eliminated (Adams, 2011; Collie & Jesse, 2009; Sweeney, 2009).

Some limitations are however associated with these data collection techniques as shown in Table 2.3. The absence of an interviewer in the survey may result into

missing data due to limited ability of the respondent to answer questions that may require assistance of the interviewer (Bryman, 1988; Birn, 2000 also cited in Sweeney, 2009). Similarly, due to lack of supervision, there is likelihood that the questionnaire will be filled by a non-targeted respondent. For example, if the survey is intended for CEOs and senior managers, there is a possibility that someone other than the CEO may answer the survey questionnaire, hence response bias would then emerge (Brønn & Belliu, 2001; Sweeney, 2009). To avoid these limitations, the present study used field survey involving face to face contact with the respondents (see details in sub-topic 3.5.1.2).

To ensure the validity and reliability of the survey tools, past studies utilized peer review approach involving academicians and practitioners who assisted in refining the survey tools (Sriramesh, Chew, Soh, & Luo, 2007; Sweeney, 2009). Researchers have also carried out pilot studies to test their data collection instruments (Adams, 2011; Sen, 2011; Sweeney, 2009). This approach was also used in this study to ensure the research instrument is capable of measuring the study's variables and the target population can understand the questionnaire statements.

After reviewing past studies' research methodologies, this study adopted both pre-test procedures (peer review) and pilot study to enhance the validity and reliability of the survey questionnaire. The details are provided in sub-topic 3.5.2. In brief, pre-test was carried out to reduce the risk of incomplete information due to unreliable or confusing study questionnaire, which were faced in past studies

(Peters, 2007; Sriramesh et al., 2007; Zorn, 2009). Pilot study was useful in reducing the weaknesses of unreliable results caused by the use of redundancy items as shown in past studies (Duarte, 2011; Peters, 2007). Through a pilot study, a number of alternative measurement items were tried and those that produced reliable results were retained for the main study (see sub-topic 3.5.3).

2.6 Past Studies' Measurements of CSR and Stakeholder Dialogue

Table 2.4 summarizes the previous studies' measurement items from which the present study's items were drawn. The items that were used to measure the variable of CSR practices were reflecting company activities undertaken in response to relevant stakeholders' interests and demands. On the other hand, items that were used to measure each independent variable – customers, employees, communities, government, and trade associations – were representing companies' perceptions of each stakeholder's expectations on CSR activities that the company should carry out to enhance stakeholder's wellbeing.

Stakeholder dialogue was measured by statements reflecting three dimensions: company familiarity of its stakeholders' interests and demands; willingness to interact with stakeholders; and company commitment to agreements reached between them and the stakeholders.

In this study, where necessary, the structure of sentences for each measurement item was rephrased to suit the context of the study while ensuring that the respondents would understand the initial meaning of the items.

Table 2.4: Past Studies' Measurements of CSR and Stakeholder Dialogue

Variables and their Respective Measurement Items

Company Implementation of CSR Practice [m, n, o]

1. Carry out sole promotion for public awareness on diseases such as Malaria, HIV/AIDS and Tuberculosis
2. Subsidize employees' expenses for major healthcare treatment
3. Collaborate with or supported other organizations (including non-profit oriented companies or government) in public healthcare campaigns
4. Contribute to the wellbeing of the needy community e.g. through material supplies such as bed sheets, mattresses, mosquito nets etc
5. Support social community with physical expansion/ construction of health centers/ clinics/ hospitals
6. Assist non employees who are poor or disabled to get better healthcare services

Customers' Expectations on Company CSR Practice

1. Offer quality and safe products and services [a, c, e, i]
2. Resolve customer complaints in a timely manner [a, c, i]
3. Offer follow up service [c]
4. Conduct customer satisfaction surveys [c, e, i]
5. Customer commitment & protection Rais & Goedegebuure (2009)

Employees' Expectations on Company CSR Practice

1. Provide an equitable reward and wage system for employees [a, c, d, e, f]
2. Engage in open and flexible communication with employees [a]
3. Offer training and career opportunities to employees, [c, d, e, i]
4. Provide work/life balance among employees [a]
5. Promote a dignified and fair treatment of all employees [a, c, d, i]
6. Ensure occupational health and safety at work [a]
7. Often conduct employee satisfaction surveys
8. Fair termination system & retirement plan [c, d, e]
9. Good relationship with unions [c, e]

Community's Expectations on Company CSR Practice

1. Provide generous financial donations to the local communities [a, c, d]
2. Provision of social support to the local community [c, e]
3. Campaign for environmental and social change [c, d, e]
4. Provide job opportunities for the community [a, c, f]
5. Purchasing policy that favors the local communities [a, f]

Government's Expectations on Company CSR Practice

1. Protection of natural resources [e, f]
2. Comply with government regulations [e]
3. Partner with government in social projects

Trade Associations' Expectations on Company CSR Practice

1. CSR specific standard are set within the industry
2. Develops CSR regulation measures
3. Identifies CSR opportunities and challenges
4. Rewarding systems for effective CSR practices

Continue next page

	Stakeholder Dialogue
	Knowledge of Stakeholders' attitudes, opinions and expectations [l]
1.	The company keeps documented information on the previous relationships with stakeholders (important meetings, conflicts, agreements, judicial or extrajudicial demands, etc.)
2.	The company obtains feedback on its repercussions on stakeholders [h]
3.	The company dedicates time and resources to know the characteristics of its stakeholders (relationships between different stakeholders, potential threats, cooperation, etc.)
4.	Company has sufficient information and documentation on stakeholders' demands
	Stakeholders' Interactions - (collaboration practices)
1.	The company has frequent meetings with the stakeholders [h, l]
2.	The company consults the Stakeholders and asks them for information before taking decisions [h, l]
3.	Stakeholders participate in the company's decision making process [h, l]
4.	The company strives to develop new contacts with all the stakeholders [h, l]
	Commitment to Stakeholders (stakeholder management strategy)
1.	The company makes a special effort to prepare the information for the different stakeholders [h, l]
2.	The company dedicates enough time and resources to adapting to Stakeholders' demands
3.	The company's policies and priorities are adapted to Stakeholders' demands [h, l]

Sources:

[a] Sweeney (2009)
[b] Sriramesh et al. (2007)
[c] Rais & Goedegebuure (2009)
[d] Duarte (2011)
[e] Mohd Isa (2011)
[f] Kim (2009)
[g] Iatridis (2011)
[h] Yang, Shen, Ho, Drew, & Chan (2009)
[i] Fatma, Rahman, & Khan (2014)
[j] Murphy (2007)
[k] Black & Hartel (2004)
[l] Plaza-Úbeda, de Burgos-Jiménez, & Carmona-Moreno (2010)
[m] Nishinaga, Lane, & Pluess (2013)
[n] Van Cranenburgh et al. (2010)
[o] Mari-Ripa & Olaizola (2012)

To ensure their items were reliable and valid, scholars used a threshold of 0.4 to 0.9 factor loadings and 0.7 to 0.9 Cronbach Alpha scores for their measurement items. According to Leech, Barrett and Morgan (2005), the use of items with low factor loadings score would create higher error variances and this could make it difficult for the study to produce reliable results. Similarly, Tavakol and Dennick (2011) asserted that lower Cronbach Alpha score would imply very low correlation between items while higher values would result into item redundancy.

In the present study, the measurement items within the range of 0.6 - 0.9 factor loadings are retained to ensure that minimum indexes of unidimensionality, reliability and validity are achieved. Just like past researchers, reliability test for each construct is carried out to ensure the composite reliability is achieved.

2.7 Overview of Past Studies' Data Analysis Techniques

Table 2.5 shows that majority of past studies relied on first generation multivariate data analysis techniques such as Ordinary Least Square (OLS) regressions (Berman, Wicks, Kotha, & Jones, 1999; Fontes, 2009; Isaksson, 2010; Pedersen, 2004). Nevertheless, first generation regression analyses may not be suitable for this study due to its inability to handle multiple relationships among constructs with multiple indicators simultaneously (Awang, 2015). Perhaps that is why recent studies were using Structural Equation Modeling (SEM) to analyze the relationship between stakeholders and CSR activities of the firm (Rais & Goedegebuure, 2009; Sweeney, 2009). According to Awang (2015), unlike other data analysis techniques, SEM can analyze interrelationships between latent constructs and observed variables concurrently.

To avoid the aforementioned limitations of first generation techniques, this study employs SEM to examine the direct effects of companies' perceptions towards their stakeholders' health and safety expectations on the implementation of CSR practice in healthcare; and the mediation effect of stakeholder dialogue (see details in sub-topic 3.5.5).

Table 2.5: An Overview of Past Studies Data Analysis Techniques

Author	Method of Analysis	Intended Measure
Adams (2011)	Simple descriptive statistics	Used to describe the perceptions of senior managers on stakeholders' influence on CSR practices in Australia
Dincer (2011)	Multiple regression analysis	To determine the influence of stakeholders on corporate social disclosure and reporting
Iatridis (2011)	Hierarchical Logistic Regression	Used to analyze the context of International Certifiable Management Standards (ICMS) adoption and the influence of external, internal and market factors on CSR awareness
Isaksson (2010)	Ordinary Least Squares (OLS) regression analysis	Used to measure the relationship between CSR and internal and external orientation
Jamali (2008)	Ethical Performance Score card (EPS) approach	Used to gauge company scores according to their response to stakeholder concerns
Peters (2007)	Path analysis using Structural Equation Modeling (SEM)	Used to test the interrelationships between CSR and Firm Competitive Advantage.
Rais & Goedegebuure (2009)	Path analysis using Structural Equation Modeling (SEM)	Applied to determine the relationship between Corporate Social Performance and Corporate Financial Performance
Sen (2011)	Multiple case study approach	To measure CSR perceptions among SMEs
Sriramesh et al. (2007)	Simple descriptive statistics	Used to describe CSR perceptions and practices in Singapore
Sweeney (2009)	Path analysis using Structural Equation Modeling (SEM)	Used to test the relationship between CSR and firm financial performance

Past studies had also used Statistical Package for Social Science (SPSS) and Analysis of Moment Structures (AMOS) software for data processing and analysis (Peters, 2007; Rais & Goedegebuure, 2009; Sweeney, 2009). The statistical package is suitable for this study as the SEM analysis of this package can process

large amounts of data with minimum errors, as well as friendly interface for data management (Iatridis, 2011; Sweeney, 2009).

To ensure the results obtained are reliable and valid, majority of past studies carried out the confirmatory factor analysis (CFA) to validate their theoretical models and to assess the dimensionality of their latent constructs (Peters, 2007; Rais & Goedegebuure, 2009; Sweeney, 2009). These studies however, ignored the crucial step of running the exploratory factor analysis (EFA) prior to CFA.

According to Williams, Brown, and Onsman (2012), EFA is useful for determining the unidimensionality of a study's constructs and for assessing the validity of a survey instrument. Since the present study is using the measurement items that were compiled from similar past studies but in different contexts (see Table 3.1), EFA needs to be carried out to assess the unidimensionality of the theoretical constructs and to evaluate the construct validity of the current study's instrument. As such, both EFA and CFA are essential for present study. Further details are provided in Chapter 3.

In testing the hypotheses of an intervening variable (or termed as mediator), most past studies used Baron and Kenny's (1986) causal steps approach. This approach suggests that if the total effect (direct effect) of independent variable on dependent variable in the model is statistically significant, and if after the introduction of an intervening variable the direct path is closer to zero, then an intervening variable could mediate the relationship between independent and dependent variables

(Baron & Kenny, 1986). Nevertheless, this approach is criticized by MacKinnon (2000) and Hayes (2009) on the grounds that it is not strong enough to detect the indirect causal path.

According to Hayes (2009), it is possible for the indirect effect to be tested even if the total effect is not significant as claimed by Baron and Kenny (1986). In other words, the researcher could fail to test for indirect effects in the model simply because the direct path is not significantly different from zero. Hayes (2009) proposed a bias corrected bootstrap approach for testing the indirect effect. To avoid the above highlighted limitation, the current study uses Hayes's (2009) bias corrected bootstrap approach to assess the mediating effect of stakeholder dialogue on companies' implementation of CSR practices in healthcare (see details in sub-topic 3.5.5).

In summary, various analytical techniques were used by past studies to test and establish relationships among constructs and their respective observed variables. These techniques ranged from first generation multivariate data analysis methods such as Ordinary Least Square (OLS) to second generation methods i.e. Structural Equation Modeling (SEM). In this research, SEM is more appropriate technique to examine the direct effects of companies' perceptions about their stakeholders' expectations on CSR practices; and to examine the mediation effect of stakeholder dialogue. Details are further provided in Chapter 3.

2.8 Summary of Literature Review

Despite of various conceptual frameworks developed by past studies to examine the relationship between company CSR practices and stakeholders' expectations, empirical studies that have examined the mediating role of dialogue between stakeholders and company implementation of CSR practices in healthcare are limited. Similarly, adoption of original and modified stakeholder theories is not suitable for present study because the interaction effects between stakeholder dialogue and company's perception of each stakeholder's expectation on the implementation of CSR practice cannot be tested empirically.

To address these gaps, the theory needs to be further modified to test the interaction effects. This can be done by including an additional variable: stakeholder dialogue into the theoretical framework. If stakeholder dialogue does play a significant role in mediating the relationship between stakeholders' health and safety expectations and companies' implementation of CSR practices, this study's result shall then be able to provide useful indications to the academics and policy makers to address the challenges of public healthcare provision.

The review of past studies' methodologies and data analysis techniques has enlighten current author in several perspectives. Quantitative method is useful to confirm company-stakeholder relations in the context of CSR. As present research intends to estimate the direct and indirect effects of companies' perceptions towards their stakeholders' expectations on CSR practices, quantitative method is thereby a suitable method.

In literature, first generation data analysis techniques such as OLS regression models were commonly used. However, the technique is lacking the ability to produce results that can show multiple relationships that involve latent constructs and observed variables simultaneously. Structural Equation Modeling can overcome this limitation and thereby is appropriate to examine the multiple interaction relationships in this study. Furthermore, most past studies ignored the conduct of EFA which is useful for current author to determine the unidimensionality of the studied variables and is also useful to assess the validity of this study's instruments.

In brief, past studies' conceptual frameworks – research models, methodology and data analysis techniques – were carefully studied and considered to ensure the internal and external validity, reliability and objectivity of present study's data could be enhanced. The application of these approaches and techniques are further discussed in Chapter 3.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction This study investigates the (1) direct effect generated by companies' perceptions towards their stakeholder's expectations on the implementation of CSR practices in healthcare; and (2) whether stakeholder dialogue could mediate the relationship between the two variables mentioned above. Quantitative methods are employed, and complemented with pre-test and pilot study that involved relevant experts and stakeholders. Details on methods and techniques used to address the main research questions along with the study objectives are presented in this chapter.

3.2 Conceptual Framework of the Present Study

As shown in Figure 2.4 in pg. 37, the conceptual model of this study is developed by extending Donaldson & Preston's (1995) modified stakeholder theory. The model reflects the present study's objectives. Figure 3.1 presents the direct and indirect effects of companies' perceptions about their stakeholders' expectations on the implementation of CSR practices in healthcare. Two groups of companies are considered in this framework, large companies and small and medium firms (SMEs). From Figure 3.1, this study's stakeholder model suggests that direct and indirect relationships exist between perceived stakeholders' expectations and companies' implementation of CSR practices in healthcare. Direct relationship is

reflected by the arrows linking stakeholders with the company implementation of CSR practices in healthcare. The indirect relationship is reflected by stakeholder dialogue - a process through which business organizations interact with their respective stakeholders to understand, discuss and agree on issues of mutual interests (Kaptein & Tulder, 2003; Pedersen, 2006).

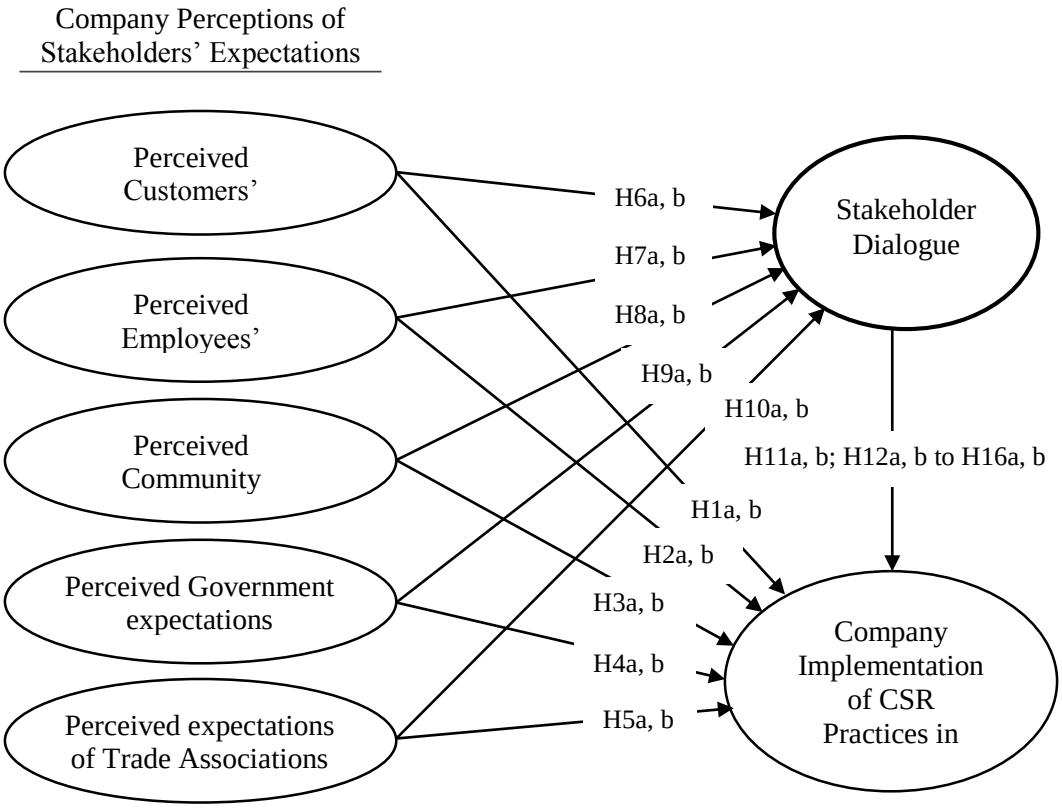

Figure 3.1: Proposed Conceptual model

Note: **"a"** denotes large companies' predictions while **"b"** represents SMEs' predictions.

H12a, b to **H16a, b** represents the predicted mediation effects of stakeholder dialogue on large companies' and SMEs' implementation of CSR practices in healthcare respectively.

3.2.1 The Role of Identified Stakeholders in Health Related CSR Activities

To examine the extent to which companies' perceptions about their stakeholders' health and safety expectations could affect the implementation of CSR practices, present study investigates five stakeholder groups: the government, customers or consumers, employees, communities and trade associations. The stakeholder groups were selected based on their active roles and their influence on motivating companies to implement CSR activities in Tanzania (GIZ, 2014; Mader, 2012; MoHSW, 2008).

According to GIZ (2014); Kihiyo (2007) and Mader (2012), customers and employees through their associations: Consumer Advocacy Group and Association of Tanzania Employers (ATE) have been promoting responsible business campaigns aggressively (such as promotion of responsible eating habits and prevention against communicable diseases such as malaria, HIV or AIDS and Tuberculosis) and sustainable CSR interventions. Figar and Figar (2011); Freeman (2004); and Mitchell et al. (1997) forwarded similar argument. The authors asserted that customers and employees are part of the primary stakeholder groups that possess social and economic powers, legitimacy and urgency and can potentially affect a company's trading performance and reputation.

Trade associations are also reported to be influential as they often represent companies in negotiations with public authorities on institutional frameworks that could affect business sustainability (ATE, 2015; Mader, 2012). Similarly, surrounding communities and public agencies form an important stakeholder

group that can potentially affect companies' operations by virtue of their legitimate public interests (Mitchell et al., 1997).

As Kumar, Rahman and Kazmi (2016) argued, engaging with stakeholders is of paramount importance to sustainability of business firms. It is therefore important to examine whether business organizations in Tanzania are concerned about their stakeholders' health and safety, and the effect of such concerns on companies' implementation of CSR practices in healthcare. In addition, as previously noted, the lack of stakeholder dialogue has limited the contribution of the stakeholders in healthcare matters and their freedom to express their concerns and expectations which could potentially contribute to enhance companies' CSR practices in healthcare. Hence, the relationship between a company and its stakeholders is crucial for development of effective and sustainable CSR practices. These relationships are further elaborated in the following sub-topics.

3.2.2 Research Hypotheses

As stakeholders could have some level of impact on the implementation of CSR practices including in healthcare, previous studies have shown that companies that are concerned about their stakeholders' social and economic wellbeing would have high tendency to implement CSR practices (Bharti, 2013; Nishinaga et al., 2013). In line with literature, this study hypothesizes the following relationships:

3.2.2.1 The direct effects of company perceptions about the following stakeholders' expectations on CSR practices in healthcare

a) Effects of perceived customers' expectations on company's CSR practices in healthcare

Past studies showed that customers form the backbone of the firm (Freeman & McVea, 2001; Pedersen, 2004) as their purchases will determine the company's production sustainability. In exchange of the price paid for goods and services, customers expect the company to produce high quality products that meets health and safety standards (Nishinaga et al., 2013; Pedersen, 2004). Studies by Islam and Rahman (2016) and William, Parida and Patel (2013) asserted that customers can potentially affect social and financial performance of the firm if their concerns are left unattended. For example, responsible consumers could induce a company to avoid forced labour and child labour in the production process (Adams, 2014). Similarly, customers could issue public notice to condemn businesses that behaves irresponsibly (Fadun, 2014).

In response to such concerns, past studies asserted that the following aspects – customer satisfaction surveys, follow up services, compliance with the international quality and safety standards, as well as compliance with workplace standards – could be integrated into companies' responsible business practices. In brief, customers is an important stakeholder group that business managers tend to be attentive to (Jamali, 2008; Nishinaga et al., 2013). Consistent with previous studies, this study predicts that:

H1a, b: There is a significant positive relationship between perceived customers' expectations and company implementation of CSR practices in healthcare.

b) Effects of perceived employees' expectations on company's CSR practices in healthcare

A number of empirical studies suggested that how a firm manages its relationship with employees could affect its CSR practices (Adams, 2014; Berman et al., 1999; Pedersen, 2004; Sweeney, 2009). Scholars argued that employees are the interface between the firm and other stakeholders. By developing a CSR practice that helps to improve the wellbeing of employees, such as ensuring their health and safety at work and improving their productivity through comprehensive workplace programmes, the firm could attract the best talent from the labour pool, regardless of race, ethnicity or gender. This could also enhance firm's relationship with other stakeholders and eventually attain its competitive advantage.

According to WHO (2017) employee health and safety should be prioritized at workplace for a business organization to be successful. Geagea (2015) and Nishinaga et al. (2013) asserted that business interventions in employee' health and safety are the contributing factors for increased productivity, business growth and improved reputation. Study by Andriof and Waddock (2002) also showed that companies that are equipped with proper welfare policy may likely be financially and socially successful. As Adams (2011) and Sweeney (2009) argued, employees possess an important attribute: power to strengthen or ruin the reputation of the

firm, hence they are an important stakeholder group that should not be underestimated.

By complying with the local and international labour standards and incorporating health and safety principles at work (including maintaining safety records and conducting regular employee health and safety satisfaction surveys), business organizations becomes socially responsible. Such practice will benefit companies in terms of committed and motivated employees and eventually attain its business objectives (Broomhill, 2007). Along with the literature, this study tests the following hypothesis:

H2a, b: Perceived concerns on employees' health and safety is positively related to companies' implementation of CSR practices in healthcare.

c) Effects of perceived community expectations on company's CSR practices in healthcare

The relationship between corporations and the surrounding communities is of paramount importance in developing effective CSR programmes (Berman et al., 1999; Jamali, 2008). Freeman (1984) suggested that this stakeholder group can take different forms: employees, customers and suppliers hence a well maintained interaction between business firms and local communities is beneficial to both the corporations and the community itself.

Previous studies asserted that local communities expect to see added value from companies (Jamali, 2008; Mumbo, Korir, Kaseje, Ochieng, & Odera, 2012) such

as community investment projects (construction of public schools and hospitals); pro-poor development initiatives (entrepreneurial projects), and environmental protection measures (anti-pollution strategies). Nishinaga et al. (2013) and Schunselaar (2011) asserted that aligning company interventions with community health and safety expectations significantly strengthened healthcare systems in USA and Netherlands. Similarly, study by Jamali, Hallal and Abdallah (2010) showed that community representation in corporate governance in Lebanese healthcare was crucial to reduce corporate malpractices. Consistent with the previous studies, the present study forecasts that:

H3a, b: There is a significant positive relationship between perceived community expectations and company implementation of CSR practices in healthcare.

d) Effects of perceived government expectations on company's CSR practices in healthcare

Governments have an important role to play when it comes to CSR coordination and implementation. Through public policies and strategies, governments possess power (ability to influence corporate practices), legitimacy (as a regulator) and urgency (ability to seek for immediate attention). With these attributes, government can affect the institutional framework that governs both public and private CSR practices (Frynas & Stephens, 2015). For instance, to ensure sustainable and effective CSR practices of companies in a particular sector or industry, government could establish regulations such as environmental protection laws, labor laws and company social policy disclosure requirements (Tschopp, Wells, & Barney, 2012).

Literature shows that governments have been establishing certain mechanisms such as license to operate, labour inspection reports, and tax and duty exemptions that indeed could encourage private companies to engage in healthcare CSR practices (Bharti, 2013; Bhattacharya et al., 2009; Mwamwaja, 2015; Ngowi, 2015; Rockson, 2009). In summary, government is an important stakeholder that can facilitate desirable CSR practices by controlling the institutional environment. Hence, the following hypothesis is tested:

H4a, b: A company's perception of Government expectations will influence its implementation of CSR practices in healthcare.

e) Effects of perceived trade associations' expectations on a company's implementation of CSR practices in healthcare

Literature shows that trade associations are playing an important role in guiding business firms to handle social and environmental issues, as well as representing firms in negotiations of regulatory and legislative matters with the regulators and the public authorities (Doh & Guay, 2006; Kang & Moon, 2012; Maas, 2007; Maignan & Ferrell, 2004).

In promoting responsible business practices, trade associations do partner with local and international institutions such as the UN Global Compact, Global Reporting Initiative (GRI), and International Standards Organization (ISO). The Association of Tanzania Employers (ATE) for instance has initiated the Employer of the Year Award which among other things promotes business interventions in addressing social economic challenges through CSR (ATE, 2015; GIZ, 2014).

Report by GIZ (2014) showed that trade associations (such as Tanzania Chamber of Mines) in partnership with NGOs, the government and international organizations have developed country specific guidelines for mining companies practicing CSR. According to Mwamwaja (2015) and Waite and Mosha (2006), trade associations are best positioned to steer and enhance business intervensions in addressing social-economic and environmental challenges. Hence, this study predicts that:

H5a, b: Expectations of a trade association could positively affect the company's implementation of CSR practices in healthcare.

3.2.2.2 The mediation effect of stakeholder dialogue

Present study's conceptual model hypothesizes that an indirect relationship exists between perceived stakeholders' expectations on health and safety and company implementation of CSR practices in healthcare via stakeholder dialogue. The anticipated mediation effect may occur if (1) perceived stakeholders' expectations would encourage companies to engage in dialogue with their stakeholders; and (2) the execution of stakeholder dialogue will in turn motivate implementation of CSR practices. Thereby, the discussion of the mediation effect involves two effects that are further described below.

a) Direct effects of perceived stakeholders' health and safety expectations on implementation of stakeholder dialogue

Prior research has shown that if companies are concerned about their stakeholders' expectations on CSR practices, the company's management will execute stakeholder dialogue process (Ayuso, Rodríguez, & Ricart, 2006; Johansen & Nielsen, 2011; Pedersen, 2006). According to Johansen and Nielsen (2011), the size of stake owned by different stakeholder groups is the determinant of the type of stakeholder dialogue. For example, if the company is concerned over the occupational, health and safety of its primary stakeholders (e.g. customers and employees), the dialogue process would be designed to cater for these stakeholders' concerns (Campbell, 2007; Johansen & Nielsen, 2011).

Study by Kaptein and Tulder (2003) showed that if stakeholders' concerns are not taken care of, there is a danger that the dialogue process would be impaired by stakeholders' reactions. Misunderstandings between stakeholders and the company may emerge and eventually, stakeholders' may no longer be interested to participate in company's CSR interventions. This will eventually affect the sustainability of the company's CSR activities (Fatma, Rahman, & Khan, 2015).

According to Kaptein and Tulder (2003), the degree to which stakeholders develop bond with the company is determined by the extent to which the dialogue could address their expectations. Thus, if stakeholders' expectations are well managed, interrelationships among stakeholders could be transformed from confrontational to consultation. Through consultation process, stakeholders' issues could be dealt

with by developing appropriate measures to overcome their effects on the interaction between stakeholders and business firms (Johansen & Nielsen, 2011). Along with the literature, the present study anticipates the following relationships for these stakeholder groups: customers, employees, communities, trade associations and government.

H6a, b: There is a significant positive relationship between perceived customers' expectations and stakeholder dialogue;

H7a, b: There is a significant positive relationship between perceived employees' expectations and stakeholder dialogue;

H8a, b: There is a significant positive relationship between perceived community expectations and stakeholder dialogue;

H9a, b: There is a significant positive relationship between perceived government expectations and stakeholder dialogue; and

H10a, b: There is a significant positive relationship between perceived expectations of trade associations and stakeholder dialogue.

Note: **"a"** denotes predictions of perceived effects on large companies while **"b"** represents predicted effects on SMEs.

b) Direct effects of stakeholder dialogue on company implementation of CSR practices in healthcare

Past studies argued that stakeholder dialogue could motivate company managers to practice CSR in healthcare. For example, Bharti (2013), Burchel and Cook (2006), and Nishinaga et al. (2013) asserted that dialogue between stakeholders would have positive effects on financial and social performance of healthcare companies. Agudo-Valiente et al. (2015) asserted that by arranging a dialogue between certain stakeholder and company's representative, that stakeholder would be more

motivated to take part in CSR project planning and feel that they belong to the corporation and have a social obligation. Both parties should share their interests in the dialogue so that a mutual beneficial agreement can be reached (Bhattacharya et al., 2009; Kumar et al., 2016).

In short, dialogue could induce stakeholders to continue supporting the firm. For example, customers would continue to purchase the company products and employees' intention to retain their jobs or increasing work productivity could eventually motivate company management to engage in healthcare CSR practices. Hence, the present study hypothesizes that:

H11a, b: Stakeholder dialogue has a positive and significant effect on a company's implementation of CSR practices in healthcare.

c) The mediating effect of stakeholder dialogue in the relationship between perceived stakeholders' expectations and company implementation of CSR practices in healthcare

Campbell (2007) and Johansen and Nielsen (2011) asserted that a company may tend to carry out stakeholder dialogue to cater for a certain stakeholder group if that stakeholder's expectations is of the company's prior concern. Burchel and Cook (2006) argued that by carrying out dialogue between stakeholders and company representatives, the company would be more willing to listen and respond to criticisms raised by their stakeholders. If dialogue can be carried out frequently, it is most likely that a company will be able to secure stakeholders' trust, portray accountability and thereby improve firm-stakeholder relationship. Studies by Chaidaroon (2013), Diallo and Ewusie (2011), and Pedersen (2006)

suggested that meaningful CSR initiatives could only emerge if both parties would convey and discuss their concerns openly and transparently.

Despite of the benefits mentioned above which had been supported in literature, little detailed empirical analysis has been carried out to test whether stakeholder dialogue could mediate the effect generated by company's perceptions of each stakeholders' expectation on company implementation of CSR practices particularly in healthcare. To realize the mediation effect generated by stakeholder dialogue, the present study has tested the following hypotheses:

H12a, b: Stakeholder dialogue would mediate the relationship between perceived customers' expectations and company implementation of CSR practices in healthcare

H13a, b: Stakeholder dialogue would mediate the relationship between perceived employees' expectations and company implementation of CSR practices in healthcare;

H14a, b: Stakeholder dialogue would mediate the relationship between perceived community's expectations and company implementation of CSR practices in healthcare;

H15a, b: Stakeholder dialogue would mediate the relationship between perceived government expectations and company implementation of CSR practices in healthcare; and

H16a, b: Stakeholder dialogue would mediate the relationship between perceived expectations of trade associations and company implementation of CSR practices in healthcare.

Note: **"a"** denotes the predicted mediation effect on large companies, while **"b"** represents the predicted mediation effect on SMEs

It is important to note that, CSR contributions of small and medium enterprises (SMEs) particularly in healthcare have not received sufficient attention in literature. Probably this is because individual contributions made by SMEs are too marginal to create large impact on targeted community. Nevertheless, prior research has supported that SMEs could indeed play an important role in healthcare promotion and protection. For example, the Tanzanian Ministry of Trade and Industry (MTI, 2012) acknowledged that SMEs had a contribution of 23.4% to total employment and 27% to the country's GDP. With such contribution it is interesting to find out if SMEs in Tanzania are concerned about their stakeholders; which stakeholder group would affect SMEs' decisions to practice CSR in healthcare; and whether stakeholder dialogue would mediate the relationships between SMEs' perceptions about their stakeholders' expectations and CSR implementation in healthcare.

Undeniably, large companies are often under public scrutiny and constant pressure to meet their stakeholders' demands (Adams, 2011; Gupta & Khanna, 2011). Comparatively, small firms have less obligation to meet public scrutiny and stakeholder attention, and thereby, their decision making is done by the owners/managers who can shape organizational practices directly according to personal values (Fassin et al., 2015; Jamali, Zanhour, & Keshishian, 2009).

Study by Enns and McFarlin (2003) showed that the decision to practice CSR in large firms is influenced by many factors including self-interest, profit seeking, and peer pressure. But in SMEs, executives are generally influenced by personal

feelings (Mousiolis, Zaridis, Karamanis, & Rontogianni, 2015), company finances (Rodgers & Gago, 2004), friends and family (Westerman, Beekun, Stedham, & Yamamura, 2007) and religious perspectives in making decisions on CSR activities (Dincer, 2011). As such, CSR practices of small and medium sized firms goes beyond the legal and regulatory requirements, as well as stakeholders' interests (Dincer, 2011).

In summary, the present study's conceptual model highlighted two sets of positive relationships. Direct relationships are summarized by H1a, b to H5a, b; H6a, b to H10a, b; and H11a, b. Indirect relationship is represented by H12a, b to H16a, b. The indirect relationship is accounted for by stakeholder dialogue as a mediator of perceived stakeholder's expectations on companies' implementation of CSR practices in healthcare. H1b to H5b, H6b to H10b, H11b and H12b to H16b summarizes the third objective of this study by predicting that, just like large firms, small and medium sized firms are concerned about their stakeholders' health and safety, and such concerns had encouraged SMEs to engage in stakeholder dialogue and eventually practice CSR in healthcare. The next sub-topic elaborates how the current research is operationalized by highlighting the measurement items this study adopts.

3.3 Operational Framework of the Present Research

The conceptual model of this research has highlighted the influence of perceived expectations of five stakeholder groups on company implementation of CSR practices in the Tanzanian healthcare. The expectations of these stakeholder groups represent the independent variables of this study while company implementation of CSR practices is the dependent variable. An intervening variable (stakeholder dialogue) is also added to the model to empirically examine its mediation statistical significance.

To operationalize the model, a number of measurement items were compiled from the CSR literature and validated in the present research as summarized in Table 3.1. As noted earlier on, the measurement items were rephrased to suit the context of the present study while holding its original meaning. Each item in the questionnaire was measured using Likert Scale because of its suitability in measuring items related to attitude, belief and behavior (Losby & Wetmore, 2012).

A five-point scale was chosen for two main reasons: first, as the targeted respondents for this study - CEOs and business managers are busy with business operations and therefore have limited time (Phillips & Phillips, 2010), larger scales with seven to ten options would not be appropriate for this study. Secondly, the measurement items for this study were largely adopted from previous studies that had used similar scale points (Duarte, 2011; Iatridis, 2011; Kim, 2009; Plaza-Úbeda et al., 2010; Rais & Goedegebuure, 2009; Sriramesh et al., 2007; Sweeney,

2009), hence it was deem appropriate to use the same level of measurement scale to be able to compare the results of the present study with those of past studies.

To ensure that the questionnaire reached the targeted respondents and is dully filled, field survey approach involving face to face contact with the respondents was used. Respondents were asked to take part in the survey in presence of the researcher. This helped the study to obtain more reliable and valid information and reduced the possibility of missing data.

Table 3.1: Measurement Items Adopted in the Present Study

Codes	Variables and their Measurement Items
Dependent variable:	**Companies' Implementation of CSR Practices in Healthcare:**
CSR1	My company has carried out sole promotion for public awareness on diseases such as Malaria, HIV/AIDS and Tuberculosis [m, n, o]
CSR2	My company subsidized employees' expenses for major healthcare treatment
CSR3	My company has collaborated with or supported other organizations (including non-profit oriented companies or government) in public healthcare campaigns
CSR4	My company has contributed to the wellbeing of the needy community e.g. through material supplies such as bed sheets, mattresses, mosquito nets etc.
CSR5	My company supported social community with physical expansion/ construction of health centers/ clinics/ hospitals
CSR6	My company helped non employees who are poor or disabled to get better healthcare services
Independent variables:	**The following stakeholders' expectations on health and safety as perceived by company respondents are the independent variables.**
	Customers (CUST): My customers expect the company to...:
CUST1	produce high quality and safe products / services that would not deteriorate their health & safety. [a, c, e, i]
CUST2	respond in a timely manner when consumers start to complain about health and safety issues caused by the consumption/ usage of the company's product &/or service. [a, c, i]
CUST3	provide clear and accurate information about the impact of the consumption/ usage of certain products/services on their health & safety.
CUST4	provide continuous services after the purchase of certain products/ services to ensure their health & safety are well taken care of. [c]
CUST5	conduct surveys related to current/ possible health and wellness issues as a result of the consumption/ usage of the company's products/ services and respond accordingly. [c, e, i]
CUST6	provide the opportunity for them to hold a dialogue with the company to discuss their concerns on matters related to health & safety. [c, e, i]
CUST7	comply with the international standards that are related to health/ safety matters**.**
	Employees (EMP): My employees expect the company to...:
EMP1	be committed in addressing their health & safety issues while at work (e.g. through workplace wellness programs).

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EMP2	give them the opportunity to discuss with the company's management team on health & safety issues. [a]
EMP3	integrate employees' health & safety concerns into the company's CSR strategy.
EMP4	provide adequate safety training and preventive gears such as facial masks and safety garments; and compensate workers who are injured when performing assigned tasks. [c, d, e, i]
EMP5	treat them fairly, equally and with dignity irrespective of their health status. [c, d, e]
EMP6	conduct "employee satisfaction surveys" on matters related to health & safety.
EMP7	work closely with workers' union in resolving the past, present and future health & safety issues. [c, e]
	Social Community (COM): Related social community expects the company to...:
COM1	provide some philanthropic contributions such as product/ service donations or staff volunteerism to enhance people's health & safety. [a, c, d]
COM2	give them the opportunity to discuss with the company's management on controversial and sensitive issues such as impact of environmental pollutions on community's health & safety. [c, e]
COM3	provide job opportunities to them so that they can take care of their health and those of their families. [a, c, f]
COM4	work closely with local governments and community groups to understand people's health & safety needs and develop comprehensive solutions.
COM5	review existing & potential CSR programs, practices and policies to incorporate the community's health & safety needs. [a, f]
COM6	invest in the society's environmental and social wellbeing projects such as proper disposal of wastes and hazardous materials. [c, d, e]
	Government (GOV): Government expects the company to...:
GOV1	comply with the relevant government guidelines/ rules/ regulations related to CSR practices in advocating for healthcare services.
GOV2	invest in the society's wellness and prevention projects that could reduce healthcare disparities and/or improve the society's safety. [c, e]
GOV3	comply with the legal and regulatory frameworks that are related to social wellbeing such as Occupational, Health and Safety (OHS) and labour laws that are meant to reduce the discriminant issues related to workers' health-status. [e]
GOV4	collaborate with public authorities to carry out more healthcare & safety campaigns to benefit the society.
GOV5	take preventive measures to reduce the damage on environment such as causing water, air, and noise pollutions. [e, f]

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	Trade Associations (TRA): Trade Associations expect the company to...:
TRA1	assess the positive and negative impacts of its goods and services on consumers, employees and community's health & safety.
TRA2	identify more CSR opportunities that could enhance health & safety of its customers, employees, communities and other stakeholders.
TRA3	participate in healthcare CSR events/ programs initiated by business associations.
TRA4	support the government to achieve the national strategic healthcare objectives which are meant to improve the society's health and safety.
Mediating variable	**Stakeholder Dialogue (DLG): Our company/ organization....:** [h]
DLG1	obtains sufficient information about its stakeholders' interests and demands on health and safety matters
DLG2	document and appraise its previous relationships with stakeholders (important meetings, conflicts, agreements, judicial or extrajudicial demands, etc.) for the planning of future health and safety CSR related programmes
DLG3	engages in dialogue with its stakeholders to develop CSR policies and strategies that can contribute to sustainable healthcare and/or safety programmes.
DLG4	conducts frequent meetings with its employees, customers, community, government, trade associations, and activist groups to review on-going CSR initiatives and develop new avenues that can enhance their health and safety.
DLG5	consult its stakeholders and ask for their opinions before implementing a CSR project in health and safety.
DLG6	has developed effective measures for compromising conflicts of interests among its stakeholders.
DLG7	keep and promotes good relationships with its stakeholders to ensure the achievement and sustainability of its CSR projects in health and safety.
DLG8	put in more effort to prepare specific/ additional information that could enhance each stakeholders' understanding and comprehension of its current/ proposed CSR project in healthcare services.
DLG9	align its health and safety policies to map each stakeholders' interests and concerns.
DLG10	conduct regular dialogues to inform and update its stakeholders of the importance and progress of its current/future CSR activities in healthcare and safety.

Sources:

[a] Sweeney (2009); [b] Sriramesh et al. (2007); [c] Rais & Goedegebuure (2009); [d] Duarte (2011); [e] Mohd Isa (2011); [f] Kim (2009); [g] Iatridis (2011); [h] Yang, Shen, Ho, Drew, & Chan (2009); [i] Fatma, Rahman, & Khan (2014); [j] Murphy (2007); [k] Black & Hartel (2004); [l] Plaza-Úbeda, de Burgos-Jiménez, & Carmona-Moreno (2010); [m] Nishinaga, Lane, & Pluess (2013); [n] Van Cranenburgh et al. (2010); [o] Mari-Ripa & Olaizola (2012)

3.4 Definition of Target Population

In Tanzania, companies are categorized into four groups: large, medium, small, and micro enterprises (see Table 3.2) (MTI, 2012). The Association of Tanzania Employers (ATE, 2015) asserted that most CSR programmes in Tanzania had been carried out by small, medium and large companies, less CSR programmes were activated by micro enterprises. In addition, the micro businesses are widely scattered and the number is unknown (MTI, 2012). Therefore, this study selected the company respondents from small, medium and large companies and disregarded micro enterprises as shown in Table 3.2.

Table 3.2: Tanzania's Government Categorization of Business Size

Business size	Number of employees	Capital investment in machinery (TZS)
Micro enterprise	1 to 4	Up to 5 million
Small enterprise	5 to 49	Above 5 to 200 million
Medium enterprise	50 to 99	Above 200 to 800 million
Large enterprise	100+	Above 800 million

Source: Ministry of Trade and Industry (MTI, 2012)

Respondents of the present study included: Chief Executive Officers (CEO), business managers, company spokespersons, and officers responsible for CSR practices. This group of respondents was selected on the basis of their responsibilities related to CSR matters within companies. CEOs, managers and company spokespersons are the key informers of the company's willingness and commitment to CSR practices as they take part in planning and decision making process (Burchell & Cook, 2006).

3.5 Present Study's Research Design

Quantitative approach is adopted in this study because it allows researchers to collect specific, unbiased information and to empirically test, confirm and validate relationships between the studied variables. Unlike qualitative approach where the results cannot be generalized to the studied population (Ronald Czaja & Blair, 2005), the quantitative methods allow generalization of study findings. The current study methodology is therefore carefully planned to attain the internal validity, external validity, reliability and objectivity of its data findings using quantitative approach while observing all the necessary research procedures including: pre-test and pilot survey to test the study instrument before the main survey.

3.5.1 Data Elicitation

This study applied field survey method involving face to face contact with the study respondents. Survey questionnaires were addressed to top executives of private sector companies operating in Tanzania. This data collection technique was chosen to overcome the following limitations: occurrence of missing data due to absence of the interviewer (Sweeney, 2009) and response bias that may happen when the questionnaire is answered by non-targeted respondents (Brønn & Belliu, 2001; Sweeney, 2009).

The list of private companies was obtained from Tanzania Business Directory (ZoomTanzania, 2016). Qualified research facilitators were hired to support the principal researcher in gathering respective information by using instruments with close ended questions.

3.5.1.1 Survey Location

Data was collected in United Republic of Tanzania from private sector companies operating in the country. Data was collected in Dar es Salaam city because most of the public sector offices including government ministries, departments and agencies that plays a key role in facilitating business operations are located there (ZoomTanzania, 2016). In addition, the city is the country's business center where most private sector companies have their offices there due to availability of air and marine services, and other important services such as finance, insurance, legal services, business registration and licensing, and public utilities (InterNations, 2016; MTI, 2012).

3.5.1.2 Sample Size

Yamane's (1967) simplified formula was used to determine the sample size of the present study. This formula was chosen because the required parameters of the formula were known. Yamane's formula requires that the population size and level of precision to be known so that study sample can be calculated (Israel, 2013).

From the Tanzanian Business Directory, the population size of active private sector companies that suited the criteria of this study at the time of survey was 3501 (ZoomTanzania, 2016). The study used 0.05 level of precision (95% confidence interval) because of two main reasons: firstly, as noted above, this study employed field survey which involved face to face contact with the respondents hence the possibility of sampling error could be reduced.

Secondly, the facilitators of this study have well-established relationship with the business managers of the private sector companies in Tanzania. This enhanced the relevance of the study and trusts among respondents hence the increased participation of the targeted respondents in the survey. In addition, similar past studies also applied the same precision level (Adams, 2011; Euphemia & Yunusa, 2014; Iatridis, 2011; Rais & Goedegebuure, 2009), hence the present study allowed an error margin of 0.05 for comparison purposes.

Having fulfilled the two preliminary requirements of Yamane's (1967) formula, the sample size of the present study was calculated as shown below:

$$n = \frac{3{,}501}{1 + 3{,}501(0.05)^2} = 358.98$$

Where n = sample size of private sector companies

From Yamane's formula, a minimum sample of nearly 360 respondent firms was required for this study. However, following the response rate obtained during the pilot survey (see sub-topic 3.5.3), the sample size for the main survey had been adjusted to 505 so that at least 360 answered and completed questionnaire could be collected and analyzed. Nevertheless, current author managed to collect four hundred and forty one (441) responses.

3.5.1.3 Sampling Technique

Companies were categorized according to the sectors they belong to (sector affiliation). In this context, companies in those sectors that had provided significant contribution to the country's economic growth were chosen. The Tanzanian Bureau of Statistics (NBS, 2016), reported that the country's main economic activities that also accounted for its GDP growth in year 2015 included: agriculture (29%), construction (13.6%), finance and insurance (3.6%), manufacturing (5.2%), mining and quarrying (4%), trade and services (10.7%), tourism, transport and communication.

For simplicity and clarity of the research questionnaire, all the sectors were grouped into four categories: (1) primary sector that involves the extraction and harvesting of natural products from the earth (for example, agriculture, mining and forestry activities); (2) secondary sector consists of processing, manufacturing and construction; (3) tertiary sectors that provide services, such as healthcare, retail sales, transportation, telecommunication, hospitality or tourism; and (4) quaternary sector made up of intellectual pursuits such as training institutions, research and consultancy firms.

Respondents in each sector were drawn from the list of private sector companies shown in Tanzanian Business Directory (ZoomTanzania, 2016). Given that companies operate in various economic sectors, stratified random sampling was used to obtain representative sample by dividing the population of companies into two strata: health and non-health sector companies. According to GIZ (2012), non-

health sector companies are playing an important role in improving healthcare services through various initiatives (such as occupational health and safety and comprehensive workplace programmes). As such, both health and non-health sector companies were considered in this study. Proportionate samples were chosen from each category (see Table 3.3). Simple random sampling was used to choose respondents in each category so that the sampling bias could be reduced (Blair, Czaja, & Blair, 2014).

Table 3.3: Computation of Proportionate Sample Size

Sector	Population	Proportionate Sample	Number of collected questionnaire
Primary sector	451	65	49
Secondary sector	1477	213	197
Tertiary sector	1372	198	182
Quaternary sector	201	29	13
Total Population	**3501**	**505**	**441**

Note: proportionate sample formula: $x = \frac{y}{z} \times m$ where: x is the proportionate sample, y is the population of companies in the respective sector, z is the total population of companies and m is the sample size previously determined by using Yamane's formula.

3.5.1.4 Data Collection Time Period

Data collection for this cross sectional study was carried out from July to November, 2016 because a large a number of social, cultural and political events that includes trade fairs and festivals, parliamentary budget sessions, religious celebrations, and public holidays are conducted in other time periods (GPCC, 2013).

3.5.1.5 Questionnaire's Design and Distribution

The survey questionnaire was designed to obtain information about the company respondents' personal background and to measure the studied variables. The questionnaire had six parts: part (a) sought to obtain relevant information in regards to company ownership structure (local or foreign); sectoral affiliation (primary, secondary, tertiary and quaternary); and company size in terms of the number of employees and annual revenue.

Part (b) examined company involvement in CSR practices. Specifically, respondents were asked to indicate if their companies practiced CSR in general and the extent to which they were engaged in health related CSR practices in particular. Respondents were also asked to indicate the number of times in a year that their companies had practiced CSR in health. A five points Lickert scale was used for measurement items in this part. This information would help the current author to determine the activeness of companies' CSR activities in healthcare.

Part (c) of the questionnaire measured the relevance of companies' stakeholders in CSR practices. Respondents would use a five points Lickert scale to indicate the effectiveness of the role played by their stakeholders in supporting companies' CSR activities. On top of that, respondents were asked to indicate their level of agreement (from 1 strongly disagree to 5 strongly agree) in regards to various stakeholders' expectations on company implementation of CSR practices.

Part (d) sought to examine firm-stakeholder engagement strategies and the role of stakeholder dialogue in CSR practices. This part had three sub-sections: (1) company familiarity of stakeholders' health and safety expectations in a company CSR practice - this would provide insights on how often a company obtains information about its stakeholders' interests and demands and how it responds to such demands; (2) the interaction process between the firm and its stakeholders - the stakeholder dialogue process; and (3) company response and commitment to deliberations of stakeholder dialogue. The information in all three sub-sections was measured by using five points Lickert scale (from 1 never to 5 very frequent).

Part (e) of the survey asked respondents to indicate their level of agreement (from strongly disagree to strongly agree) on benefits that would be obtained from business CSR interventions and challenges that would inhibit companies from practicing CSR in healthcare. The last part of the questionnaire was meant to collect respondents' demographic information: gender, age, level of education and current occupation. A combination of nominal and ordinal scales was used in this part accordingly.

As previously noted in Chapter 2, the measurement items used in this study were compiled from various similar past studies (Duarte, 2011; Iatridis, 2011; Rais & Goedegebuure, 2009; Sriramesh et al., 2007; Sweeney, 2009), see also Table 2.4. Where necessary the items were reworded to fit in the context of the present study and to enable the targeted respondents understand the original meaning of the questions. For a complete questionnaire see Appendix B of this study.

Field survey approach involving face to face contact with the respondents was used to distribute the questionnaires. However, in case the respondents were not at their work stations during the survey, drop and collect technique was used. This approach enabled the questionnaire to reach many respondents on time.

A few challenges needed to be confronted while distributing current study's questionnaire. One of the challenges experienced during the survey was to gain access to targeted respondents. As is commonly known, top business executives are often difficult to reach due to their business commitments. Similarly, company bureaucracies: ranging from security gates to complex internal procedures tends to limit researchers' access to the responsible officers. To overcome these challenges, the current study was supported by facilitators who had personal connections with respondents. This allowed the targeted respondents to be reached and take part in the survey. More details are provided in Chapter five of this study.

3.5.1.6 Facilitators of Research Instrument

To ensure high quality, reliable and valid data are gathered, two research facilitators were recruited for this study. The facilitators were selected on the basis of their knowledge and experience in social research data collection. The facilitators were selected from the pool of researchers in the department of research and development at the Tanzania Responsible Business Network - a business association responsible for promoting responsible business practices, integrity and accountability. This enabled the present study to collect the relevant information on a timely manner since both facilitators had a well-established

relationship with the business managers of the private sector companies in Tanzania.

The selection of the facilitators was done after consultation with the respective head of department who recommended the most reliable facilitators suitable for the study. After the recruitment process, the selected facilitators were enlightened on the research objectives; research instrument; the targeted study population and its respective sample size and design; as well as the research ethics. Importantly, the facilitators were trained on how to reduce missing data from the survey. For example, answered questionnaire was cross-checked once received. In other words, facilitators needed to ensure the distributed questionnaires are dully filled by targeted respondents.

Facilitators were provided with the survey questionnaires to distribute according to the sample frames. The principal investigator numbered each questionnaire consecutively according to the sample size so that the investigator could trace the response rate in each sub-location and to make the necessary follow-ups on unreturned questionnaires.

3.5.2 Pre-test of instrument

The questionnaire of the present study was pre-tested to ensure that it is capable to measure the studied variables. Ron Czaja (1998) suggested two pre-test procedures, instrument screening through research professionals, and pilot study. Both procedures were followed in this research. The initial stage of pretest was the

consultation with academic supervisors and other academic experts for crafting of questionnaire statements. Specifically, the instrument was checked for overall design, length and clarity of questions and instructions, as well as the estimated time needed to complete the questionnaire.

After incorporating comments received from academic supervisors and other research experts, the instrument was given to five industry experts (including business managers and officials responsible for CSR practices and promotion of business ethics) for final checking, before the commencement of pilot survey. The industry experts were contacted after they had attended a CSR experts focused group discussion that was organized by the UN Global Compact Local Chapter.

The experts assisted in assessing the validity of the questions and instructions. They also assisted in identifying specific questions that would trouble respondents or cause any concern and suggested better formulation. In addition, experts were asked to suggest any additional questions they think should be included in the questionnaire. Responses from the pre-test of instrument were examined and minor changes were incorporated in the questionnaire. In brief, by pre-testing the survey instrument, reliability and validity of the measurement items were enhanced.

3.5.3 Pilot Study and Exploratory Factor Analysis (EFA)

After the survey questionnaire was reviewed by the academic and industry experts, pilot test was carried out to ensure that the survey instrument could truly measure

the variables of the present study. Pilot survey was crucial for determining appropriate measurement items for the present study and reducing their dimensionality as were compiled from various sources (Woken, 2005).

During the pilot survey, a total of 150 questionnaires were distributed to top business managers and CSR responsible officers in small, medium and large private enterprises. A response rate of 71 percent (107 out of 150) was obtained. Data was screened for identification of missing values. The missing values were imputed by replacing them with mean values (Gasking, 2016).

An Exploratory Factor Analysis (EFA) was then carried out using SPSS. EFA process was necessary for assessing the unidimensionality of the theoretical constructs; for evaluating the construct validity of the study instrument (Williams et al., 2012); and for determining factor structure in the study constructs (Suhr, 2006). Maximum Likelihood (ML) approach was used to extract and determine the appropriate factors in the study constructs. Data were also checked for normality. The assessment exhibited that sample data for the pilot survey were normally distributed as shown in Table 3.4.

Table 3.4: Assessment of Normality for Pilot Survey

Descriptive Statistics							
	N	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
CUST1	107	4.45	.500	.210	.234	-1.994	.463
CUST2	107	4.45	.500	.210	.234	-1.994	.463
CUST3	107	4.43	.497	.287	.234	-1.954	.463
CUST4	107	4.25	.478	.615	.234	-.347	.463
CUST5	107	4.16	.438	.791	.234	1.126	.463
CUST7	107	4.25	.478	.615	.234	-.347	.463
EMP1	107	4.56	.499	-.248	.234	-1.976	.463
EMP2	107	4.57	.497	-.287	.234	-1.954	.463
EMP3	107	4.36	.536	.044	.234	-.892	.463
EMP4	107	4.51	.538	-.426	.234	-1.063	.463
EMP5	107	4.46	.519	-.035	.234	-1.533	.463
COM1	107	4.22	.419	1.341	.234	-.206	.463
COM2	107	4.30	.460	.890	.234	-1.231	.463
COM3	107	4.36	.484	.571	.234	-1.706	.463
GOV1	107	4.50	.502	.019	.234	-2.038	.463
GOV2	107	4.42	.496	.326	.234	-1.930	.463
GOV3	107	4.50	.502	-.019	.234	-2.038	.463
GOV4	107	4.28	.451	.992	.234	-1.036	.463
GOV5	107	4.36	.484	.571	.234	-1.706	.463
TRA1	107	3.93	.544	-.054	.234	.402	.463
TRA2	107	3.93	.603	-.237	.234	.583	.463
TRA3	107	3.99	.505	-.467	.234	2.880	.463
TRA4	107	3.90	.598	-.234	.234	.546	.463
CSR1	107	3.66	.890	-.017	.234	-.792	.463
CSR2	107	3.49	1.058	-.060	.234	-1.208	.463
CSR3	107	3.78	.850	-.676	.234	.043	.463
CSR6	107	3.86	.745	-.045	.234	-.599	.463
DLG1	107	3.42	.701	-.298	.234	-.343	.463
DLG2	107	3.55	.743	-.461	.234	-.140	.463
DLG3	107	3.45	.815	-.896	.234	.916	.463
DLG4	107	3.62	.748	-.754	.234	.939	.463
DLG5	107	3.36	.827	-.850	.234	.850	.463
DLG6	107	3.20	.782	-.362	.234	.004	.463
DLG7	107	3.59	.752	-1.056	.234	1.708	.463
DLG8	107	3.52	.744	-.921	.234	1.413	.463
Valid N (listwise)	107						

To attain the unidimensionality for factor analysis, a combination of multiple extraction tests including Kaiser-Meyer-Olkin (KMO) and Bartlett's tests of Sphericity were used (Lowry & Gaskin, 2014). Both tests provided acceptable indications of sampling adequacy as summarized in Table 3.5. The KMO at 0.746 and a Bartlett's of 2697.467 at the 0.000 level of significance provided evidence of adequate sample for EFA. These results also provide an indication of convergence among items, thus supporting emergence of underlying factors.

Table 3.5: Sampling Adequacy Test

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.746
Bartlett's Test of Sphericity	Approx. Chi-Square	2697.467
	df	703
	Sig.	.000

Factor analysis was carried out based on ML, Promax oblique rotation while observing eigenvalue greater than 1 criterion. The initial solution (Appendix E) yielded a 12 factor solution but with some cross loadings. A suppression of factor loadings of 0.6 had to be applied to avoid factor cross-loading and low loadings. The solution was repeated until appropriate pattern matrix was obtained. Finally the 7 factor solution (as anticipated) with 35 measurement items was obtained as shown in Table 3.6 (see page 95). The total variance explained (see Appendix F) indicated 60 percent which is above the required threshold of 50 percent (Hair et al., 2010).

From Table 3.6 only those measurement items with factor loadings above the threshold of 0.6 (bold loadings) were retained for the main survey to ensure reliability and construct validity for the study (Gasking, 2016). The use of items with low factor loadings could have created higher error variances which could make it difficult for the study to produce reliable results (Leech et al., 2005). Overall, the results at this exploratory stage indicated an acceptable level of correlation among the measurement items (Hair, Black, Babin, & Anderson, 2010). The reliability assessment also indicated a good level as evidenced by an average score of 0.871 Cronbach Alpha.

3.5.4 Common Method Variance Test

To ensure this study's measurement model does not suffer from the issue of measurement error, the model was checked for the common method variance (CMV). According to Podsakoff et al. (2003), common method variance is one of the measurement errors that could inflict the validity of the conclusion reached in a research model. To test for CMV of the data, this study applied Harman's one factor model (Podsakoff et al., 2003). Principal axis factoring method was used in combination with Promax rotation technique and fixed number of factors to 1 (Arif, Afshan, & Sharif, 2016). The result indicated that the total number of variance explained was below 50% (i.e. 39.59%). Hence the measurement model of the present study is free of CMV concern.

Table 3.6: Items Retained in Exploratory Factor Analysis (EFA)

	Factors						
	DLG	**CUST**	**GOV**	**TRA**	**EMP**	**CSRI**	**COM**
Cronbach Alpha	**0.915**	**0.908**	**0.889**	**0.870**	**0.817**	**0.821**	**0.878**
DLG5	**.826**	.003	.104	-.063	-.137	.045	-.019
DLG4	**.815**	-.071	-.019	-.130	-.086	.031	.072
DLG7	**.773**	-.076	.011	.006	.057	.047	.010
DLG6	**.773**	.065	.130	-.046	-.097	-.025	-.115
DLG3	**.757**	.085	.063	-.121	-.037	-.007	-.053
DLG8	**.645**	.014	-.092	.112	-.006	-.123	-.017
DLG1	**.582**	-.023	-.087	.181	.170	.015	-.055
DLG2	**.563**	.036	-.215	-.004	.189	-.080	.149
CUST2	-.093	**.888**	-.126	-.118	.106	-.143	-.002
CUST1	-.063	**.799**	-.045	-.033	.112	-.103	-.005
CUST3	.063	**.751**	.009	.040	.089	-.040	-.057
CUST4	.049	**.733**	.001	.011	-.047	.129	.076
CUST7	.052	**.729**	.020	-.060	-.091	.054	.026
CUST5	.018	**.674**	.059	.053	-.018	.112	.018
GOV1	.043	-.062	**.941**	-.023	.051	-.054	-.076
GOV2	-.096	-.035	**.837**	.136	.016	.041	.031
GOV3	.030	.118	**.784**	-.126	.071	-.021	-.011
GOV5	.067	-.046	**.636**	-.001	.003	-.045	.159
GOV4	-.067	.018	**.572**	.074	.005	.062	.101
TRA2	-.023	-.059	.078	**.849**	-.047	-.017	-.070
TRA4	.085	.028	-.007	**.820**	-.119	.000	.000
TRA3	.012	-.053	-.002	**.756**	.080	.014	.099
TRA1	-.049	.073	-.018	**.749**	.036	.028	.004
EMP4	-.073	.020	-.083	-.082	**.733**	.189	.068
EMP2	.019	-.017	.108	.132	**.713**	-.044	-.013
EMP3	.109	-.096	.077	-.205	**.675**	.113	-.048
EMP1	-.062	.127	.174	.044	**.634**	-.030	-.015
EMP5	-.026	.039	-.026	.075	**.609**	-.124	-.041
CSR1	.058	.066	.116	-.103	-.103	**.805**	-.055
CSR3	-.140	.117	-.058	.093	-.057	**.801**	-.026
CSR2	.029	.036	-.024	.081	.088	**.703**	-.059
CSR6	.055	-.176	-.083	-.056	.239	**.675**	.082
COM2	-.006	.110	.038	-.041	-.066	-.053	**.961**
COM3	.018	-.005	.099	-.068	.029	-.019	**.835**
COM1	-.013	-.070	.021	.133	.003	-.003	**.702**

3.5.5 Data Analysis Techniques

As noted earlier in Chapter 2, this study employed covariance based Structural Equation Modeling (CB-SEM) approach to examine direct and indirect effects of perceived stakeholders' expectations on company implementation of CSR practices in healthcare. SEM was chosen for its unique ability to analyze and test multiple relationships among variables simultaneously (Awang, 2015; Sweeney, 2009).

Compared to other multivariate data analysis techniques such as Partial Least Square (PLS-SEM) which is appropriate for exploratory research, CB-SEM is more appropriate for testing the hypotheses for mediating and moderating variables in explanatory researches (Awang, 2015). As such, through CB-SEM, the present study could validate direct and indirect firm-stakeholder relationships and determine the significance of the intervening variable - stakeholder dialogue.

In addition, similar past studies utilized CB-SEM to examine multiple stakeholder relationships with respect to corporate CSR practices (Peters, 2007; Rais & Goedegebuure, 2009; Sweeney, 2009). For comparative reasons, the author finds it appropriate to employ CB-SEM in succeeding the objectives of this research as it provides more justifiable arguments in testing simultaneous relationships among latent constructs with respective indicators and observed variables in one structural model.

To extract and determine appropriate factors in this study, a Maximum Likelihood (ML) approach was used for both pilot and main surveys. Literature shows that ML is more appropriate for studies attempting to contribute to theoretical development and for studies intending to undertake Confirmatory Factor Analysis (Lowry & Gaskin, 2014; Williams et al., 2012). Baglin (2014) and Costello & Osborne (2005) suggested that ML is the most commonly used method in EFA provided data are normally distributed.

To avoid deviations of the present study's data from normality which could affect the results of analysis and harm the conclusions reached in this research (Arbuckle, 1997), data for both pilot and main survey were tested using skewness and kurtosis indicators (Awang, 2015; Hair et al., 2010). The assessment indicated that both data sets were normally distributed (see Table 3.4 and Table 4.9). In short, normality assessment enabled the study to justify conclusions reached and generalized over the studied population.

The mediation effect is tested by using bias corrected bootstrap approach suggested by Hayes (2009). This approach allows researchers to proceed testing the indirect effect without necessarily relying on the significance of the total effect (direct effect). Unlike Baron and Kenny's (1986) causal path steps approach which could possibly cause biasness in the model by limiting some potentially interesting observation of the intervening variable, the new approach offered by Hayes (2009) eliminates the problem of estimation bias as it uses bootstrap analytical technique.

3.5.6 Data Screening and Imputation of Missing Values

Data for both pilot and main surveys were screened to ensure that there are no missing values which could affect the statistical analysis such as estimation of modification indexes and bootstrap analysis (Gasking, 2016). Identification of missing values was done by examining the frequency table for all the variables in this study (see Appendix G).

Since the missing data were less than five percent of the total data, the missing values were imputed by replacing them with the computed median values for ordinal variables and mean values for continuous variables (Gasking, 2016). Data were also checked for unengaged responses and outliers by using graphic identification approach. There were only two outliers in the data set which were omitted during the analysis.

3.6 Delimitations of the Adopted Methodology

One of the limitations of this study is in regards to the responses given by the respondents who are top business executives. Some respondents may not be able to recall correctly or willing to give detailed information on CSR activities and stakeholders' dialogue that had been undertaken by their companies. To verify the responses, a few answered questionnaires were selected for cross-checking. For example, employees were interviewed when the company respondents claimed that it practiced CSR for its employees' wellbeing.

Government representatives in the ministry of health, trade association, and the related community were also interviewed to verify if companies had carried out activities such as free health screening as part of their CSR practices in healthcare. If the company's claim is not supported by stakeholders, the respondent's answered questionnaire would be voided. Nevertheless, under certain circumstances such as minor CSR contribution (e.g. small financial donation) or when donors did not want to reveal their identity, cross-checking was not feasible. Overall, none of the collected answered questionnaire was voided due to the reasons above.

In addition, stakeholders' opinions and impression on the need to have a stakeholder dialogue for effective CSR practices in the Tanzanian healthcare were explored as well. The responses are incorporated in the discussion of the present study's findings. In brief, such move was taken to enhance data validity.

Furthermore, to ensure that this study attained internal validity, external validity, reliability and objectivity of its data findings, pre-test of instruments, pilot study, and main survey were carried out, and current research facilitators were given sufficient instructions to ensure a well-managed data collection process. As previously stated both facilitators had sufficient knowledge on CSR practices and were recruited from the private sector association responsible for promoting business ethics and accountability. Further details on the limitations of the present study are presented in Chapter Five.

3.7 Summary of Present Study's Research Methodology

To achieve the study's objectives, hypotheses were developed based on the current study's conceptual model. Two sets of positive relationships were hypothesized: direct and indirect relationships between companies' perceptions of their stakeholders' health and safety expectations, and the implementation of CSR practices in healthcare. Direct relationships were summarized according to the number of stakeholders identified. Indirect relationship is accounted for by an intervening variable - stakeholder dialogue.

To operationalize the current research model, a number of measurement items were compiled from the CSR literature. A threshold of 0.6 factor loadings and a Cronbach Alpha score ranging between 0.7 and 0.9 was adopted to ensure the measurement items are adequate and suitable for the current research.

Yamane's (1967) formula was used to determine the study sample size. A minimum of 360 respondents were required for this research. However, to increase the chances of higher response rate, questionnaires were addressed to the business managers of about 505 companies. Stratified random sampling technique was used to enhance the representativeness of the selected respondents. Four hundred and forty one (441) responses were obtained and used in the statistical analysis presented in Chapter four.

To ensure that the study instrument could truly measure what was intended to measure, pre-test of instruments was carried out. Similarly, pilot study was

conducted to determine the appropriate measurement items for this study. Lastly this study used covariance based Structural Equation Modeling (SEM) with AMOS graphics for data analysis to examine the direct effects of perceived stakeholders' expectations on companies implementation of CSR practices in the Tanzanian healthcare system; and indirect effects generated by stakeholder dialogue. Data analysis and interpretation of study findings are presented in Chapter Four.

CHAPTER 4

RESULTS AND DISCUSSION

4.1 Introduction

This study investigates the direct and indirect effects generated by companies' perceptions about their stakeholders' health and safety expectations on the implementation of CSR practices in the Tanzanian healthcare system. Out of 505 questionnaires that had been distributed, 441 were collected by using field survey approach that involved face to face contact with respondents and drop and collect techniques. After performing data filtering and imputation of missing values, 437 responses were retained for statistical analysis which is presented in the subsequent sub-topics.

4.2 Descriptive Statistics

The descriptive statistics of the respondents' profiles and the relationships between demographic variables are presented in the following sub-topics.

4.2.1 Respondents' Profiles

The targeted respondents of this study were: Chief Executive Officers, Departmental Directors, Managers and Officers who are responsible for CSR practices and business ethics in private sector companies operating in Tanzania.

Table 4.1 summarizes the respondents' demographic statistics. It is interesting to note that 294 (67.28%) of the respondents are male and 143 (32.72%) are female respondents. This is perhaps an indication of male dominance in leadership positions in Tanzania (Kitakule & Cummings, 2015; Mushi, 2016). Almost half of the respondents were aged between 36 and 50 years. A high percentage of the respondents (60%) had attained a University Degree (262), 27% (119) are Postgraduate Degree graduates and few of them (12%) are college diploma graduates. Table 4.1 also indicates that 55.38% of the respondents were holding managerial positions.

Table 4.1: Respondents' Demographic Data

		Number of Respondents	Percentage
Gender	Male	294	67.28%
	Female	143	32.72%
Age	18 – 35	178	40.73%
	36 – 50	248	56.75%
	51 – 60	11	2.52%
	>60		
Education	Postgraduate Degree	119	27.23%
	Bachelor Degree	262	59.95%
	Diploma	56	12.82%
Position	Top Management	242	55.38%
	Middle Management	195	44.62%

4.2.2 Respondents' Company Profiles

Respondents were asked to provide three indicators related to their company profile: (1) sectoral affiliation: this is meant to help the author determine which type of industry had implemented more CSR practices; (2) ownership structure (foreign or local company): the response is useful to determine the level of policy

engagement and strategies that may be required to enhance the implementation of CSR practices in healthcare; and (3) annual revenue and number of employees: to check whether firm size could potentially affect CSR implementation in healthcare. The descriptive relationships are presented in the following sub-topics. For a table of 2x2 rows and columns, phi coefficient is used to confirm the association between variables, while in a table with more rows and columns Cramer's V will be used for the same purpose.

4.2.3 Relationship between Ownership Structure and CSR in Healthcare

Cross tabulation result in Table 4.2 shows that majority (319 or 73%) of the companies were locally owned, the remaining 118 companies are foreign owned. Among the foreign owned firms, 67.8% had engaged in healthcare CSR practices compared to 69.0% of the locally owned firms. Nevertheless, Chi-square result show that there is no statistically significant association between ownership structure and company involvement in CSR practices in healthcare. In other words, both foreign and locally owned companies could be said to have CSR interventions in healthcare.

It could also be possible that the respondents had different understanding on what constitutes a CSR practice. Some respondents may think that if the company did not implement a comprehensive health and safety programme at workplace but provided only small assistance like mosquito nets donation or pasting health posters in the company, they would choose "no". On the other hand, it is also possible that respondents may feel that they were involved even though the

assistance is very marginal. In summary, the association could be tested again in future research if there is a common understanding among respondents on the definition and measurement of CSR practices.

Table 4.2: The Relationship between Ownership Structure and CSR Practices in Healthcare

Ownership Structure	Details	CSR Practices in Healthcare		Total
		Yes	No	
Foreign	Count	80	38	118
	% within Ownership Structure	67.8%	32.2%	100.0%
	% within CSR in Health	26.7%	27.7%	27.0%
Local	Count	220	99	319
	% within Ownership Structure	69.0%	31.0%	100.0%
	% within CSR in Health	73.3%	72.3%	73.0%
Total	Count	300	137	437
	% within Ownership Structure	68.6%	31.4%	100.0%
	% within CSR in Health	100.0%	100.0%	100.0%
		Symmetric Measure		
	Phi			0.011
	Approx. Sig			0.815

4.2.4 Relationship between Sectoral Affiliation and CSR in Healthcare

In this study, respondent companies were grouped according to the sectors they are affiliated to. The sectors were further categorized into four main groups: primary sector that involves the extraction and harvesting of natural products from the earth (for example agriculture, mining and forestry); secondary sector consists of processing, manufacturing and construction; tertiary sectors that provide services, such as healthcare, retail sales, transportation, telecommunication, hospitality or tourism; and quaternary sector made up of intellectual pursuits such as training institutions, research and consultancy firms.

In testing the association between sector affiliation and company implementation of CSR practices in healthcare (see Table 4.3), the result shows that companies within secondary and tertiary sectors (75% and 70% respectively), were more engaged in health related CSR practices compared to those in primary (44%) and quaternary (38%) sectors. The statistical significant result is consistent with the reports published by the Association of Tanzania Employers (ATE, 2015), KPMG (2015) and GIZ (2012, 2013, 2014) showing that, companies in secondary and tertiary sectors (e.g. telecommunication, manufacturing, financial intermediation, tourism and trade & services) were at the forefront of CSR practicing in healthcare particularly in supporting communities with access to better healthcare services.

Table 4.3: The Relationship between Sectoral Affiliation and CSR in Health

Sector	Details	CSR Practices in Health		Total
		Yes	No	
Primary	Count	22	27	49
	% within Sector	44.9%	55.1%	100.0%
	% within CSR in Health	7.3%	19.7%	11.2%
Secondary	Count	148	49	197
	% within Sector	75.1%	24.9%	100.0%
	% within CSR in Health	49.3%	35.8%	45.1%
Tertiary	Count	125	53	178
	% within Sector	70.2%	29.8%	100.0%
	% within CSR in Health	52.2%	63.9%	40.73%
Quaternary	Count	5	8	13
	% within Sector	38.5%	61.5%	100.0%
	% within CSR in Health	1.7%	5.8%	3.0%
Total	Count	300	137	437
	% within Sector	68.6%	31.4%	100.00%
	% within CSR in Health	100.0%	100.0%	100.00%
		Symmetric Measure		
	Cramer's V			0.226
	Approx. Sig			0.000

Babeiya (2011) and Legal and Human Rights Centre (LHRC, 2013) reported that the labour unions of manufacturing and service sectors were more influential in arguing for the provision of better health and safety standards to their workers, hence, the significant results for companies in secondary and tertiary sectors. On the other hand, the involvement of primary and quaternary sectors in CSR should also be encouraged to increase more private sector support in healthcare so that more people can benefit from the CSR interventions in public healthcare. The details are discussed under sub-topic 5.3.

4.2.5 Relationship between Firm Size and CSR in Healthcare

To ensure that firms of all sizes were captured in this study, the Tanzanian government categorization of business size was adopted. Companies were grouped in three categories (small, medium and large) according to their annual turnover and the number of employees (see Table 3.2 in page 80).

Data findings shown in Table 4.4 indicate that firm size and CSR implementation in healthcare have no statistical significant association at 95% confidence level. In other words, it is difficult to claim which of the following firm size: small, medium or large has more significant effect on CSR practices in healthcare. Nevertheless, the results show that firms of all sizes have some CSR interventions in the Tanzanian healthcare. Perhaps the uprising awareness campaigns such as Employer of the Year Award, KPMG's Top 100 mid-sized firms and Presidential CSR Award (ATE, 2015; GIZ, 2014; KPMG, 2015) might have encouraged companies to engage in health related CSR practices.

Table 4.4: The Relationship between Firm Size and CSR in Health

Firm Size	Details	CSR Practices in Health		Total
		Yes	No	
Small	Count	145	74	219
	% within Firm Size	66.2%	33.8%	100.0%
	% within CSR in Health	48.3%	54.0%	50.1%
Medium	Count	98	44	142
	% within Firm Size	69.0%	31.0%	100.0%
	% within CSR in Health	32.7%	32.1%	32.5%
Large	Count	57	19	76
	% within Firm Size	75.0%	25.0%	100.0%
	% within CSR in Health	19.0%	13.9%	17.4%
Total	Count	300	137	437
	% within Firm Size	68.6%	31.4%	100.0%
	% within CSR in Health	100.0%	100.0%	100.0%
		Symmetric Measure		
	Cramer's V			0.068
	Approx. Sig			0.361

4.2.6 Relationship between Firm Size and Stakeholder Dialogue

Statistical results in Table 4.5 show that larger companies were more engaged in dialogue with their stakeholders compared to small and medium firms. The statistical significant association suggests that stakeholder dialogue particularly among SMEs is marginally executed.

There are few possible explanations for this result. Burton (2009) and Vo (2011) argued that due to public scrutiny and constant stakeholder pressures for corporate accountability, larger firms have more tendency to: (1) establish CSR policies to guide their CSR interventions and, (2) manage their interactions with stakeholders. In addition, the availability of sufficient human and financial resources in larger firms may have driven these firms to engage in dialogue with their stakeholders.

Table 4.5: The Relationship between Firm Size and Stakeholder Dialogue

Firm Size	Details	Dialogue with Stakeholders (SDLG)		Total
		Yes	No	
Small	Count	68	151	219
	% within Firm Size	31.1%	68.9%	100.0%
	% within SDLG	43.0%	54.1%	50.1%
Medium	Count	49	93	142
	% within Firm Size	34.5%	65.5%	100.0%
	% within SDLG	31.0%	33.3%	32.5%
Large	Count	41	35	76
	% within Firm Size	53.9%	46.1%	100.0%
	% within SDLG	25.9%	12.5%	17.4%
Total	Count	158	279	437
	% within Firm Size	36.2%	63.8%	100.00%
	% within SDLG	100.0%	100.0%	100.00%
		Symmetric Measure		
	Cramer's V			0.173
	Approx. Sig			0.001

Comparatively, majority of SMEs could be less dedicated to engage in dialogue because the implementation of the dialogue process may require financial and human resource expertise. In brief, resource constraints could limit SMEs ability to formally engage with their stakeholders.

Other possible explanations include lacking of dialogue mechanisms at both national and sectoral levels and CSR coordinating units at the national, ministerial and local levels. Weaker trade unions or business associations also could have undermined stakeholders' influence in dialogue requisition (GIZ, 2014; LHRC, 2013; Mwamwaja, 2015). In summary, strategic institutional and business mechanisms that could facilitate stakeholder interaction processes for sustainability of CSR interventions particularly in healthcare should be promoted in Tanzania.

4.2.7 Relationship between Social-Economic Benefits and CSR in Health

In this study, the original five points Likert scale for the measurement of both social and economic benefits is transformed to three points categorical data (the first two points, 1 and 2 represent disagree, point 3 is neutral, while points 4 and 5 represent agree) to meet the requirements of cross tabulation (Nowrouzi, Sim, Zareian, & Nimehchisalem, 2014; Rajab & Nimehchisalem, 2016).

Significant results in Table 4.6 and Table 4.7 shows that social and economic benefits are related to companies' implementation of CSR practices in healthcare. In other words, companies would be more willing to engage in CSR practices if they could gain some social and economic benefits. Among the social benefits that can be generated by CSR practices include: public recognition, improved image and mitigation of pressure caused by external stakeholders (Deng, Kang, & Low, 2013).

On the other hand, economic benefits that firms could gain include: customer loyalty, employee retention and motivation, sales performance and public incentives such as tax exemptions (Jenkins, 2006; Waddock & Graves, 1997). In summary, respondents of this study did acknowledge that the potential social and economic benefits that can be generated by practicing CSR in healthcare both in short term and long term.

Table 4.6: The Relationship between Social Benefits and CSR Practices in Healthcare

Social Benefits	Details	CSR Practices in Health		Total
		Yes	No	
Disagree	Count	0	1	1
	% within Social Benefits	0.0%	100.0%	100.0%
	% within CSR in Health	0.0%	0.7%	0.2%
Neutral	Count	52	39	91
	% within Social Benefits	57.1%	42.9%	100.0%
	% within CSR in Health	17.3%	28.5%	20.8%
Agree	Count	248	97	345
	% within Social Benefits	71.9%	28.1%	100.0%
	% within CSR in Health	82.7%	70.8%	78.9%
Total	Count	300	137	437
	% within Social Benefits	68.6%	31.4%	100.00%
	% within CSR in Health	100.0%	100.0%	100.00%
	Symmetric Measure			
	Cramer's V			0.147
	Approx. Sig			0.009

Table 4.7: The Relationship between Economic Benefits and CSR Practices in Healthcare

Economic Benefits	Details	CSR Practices in Health		Total
		Yes	No	
Disagree	Count	11	3	14
	% within Economic Benefits	78.6%	21.4%	100.0%
	% within CSR in Health	3.7%	2.2%	3.2%
Neutral	Count	105	73	178
	% within Economic Benefits	59.0%	41.0%	100.0%
	% within CSR in Health	35.0%	53.3%	40.7%
Agree	Count	184	61	245
	% within Economic Benefits	75.1%	24.9%	100.0%
	% within CSR in Health	61.3%	44.5%	56.1%
Total	Count	300	137	437
	% within Economic Benefits	68.6%	31.4%	100.00%
	% within CSR in Health	100.0%	100.0%	100.00%
	Symmetric Measure			
	Cramer's V			0.173
	Approx. Sig			0.001

4.3 Inferential Statistics: Structural Equation Modeling (SEM)

After identifying the relevant measurement items for the variables of the present study using Exploratory Factor Analysis (EFA), the next step was to test the overall measurement model through a Confirmatory Factor Analysis (CFA) (Awang, 2015; Hair et al., 2010). In this sub-topic, inferential statistics of the present study's measurement and structural models are presented.

The analysis begins with presentation of the measurement model for all variables (exogenous and endogenous) and how the model was validated and tested before the structural model is developed. A covariance based SEM with the help of AMOS tool is used to examine the direct effects of perceived stakeholders' health and safety expectations on companies' implementation of CSR practices in healthcare; and the indirect effects caused by stakeholder dialogue in accounting for firm-stakeholder relationships.

4.3.1 Validation of the Measurement Model

After data cleaning and filtering, 437 final responses were retained for Confirmatory Factor Analysis (CFA). The initial measurement model is shown in Figure 4.1. However, the initial model had to be adjusted to address validity concerns, which were characterized by cross loaded items and items that had scored low loadings below the acceptable threshold of 0.6 (Gasking, 2016; Lowry & Gaskin, 2014).

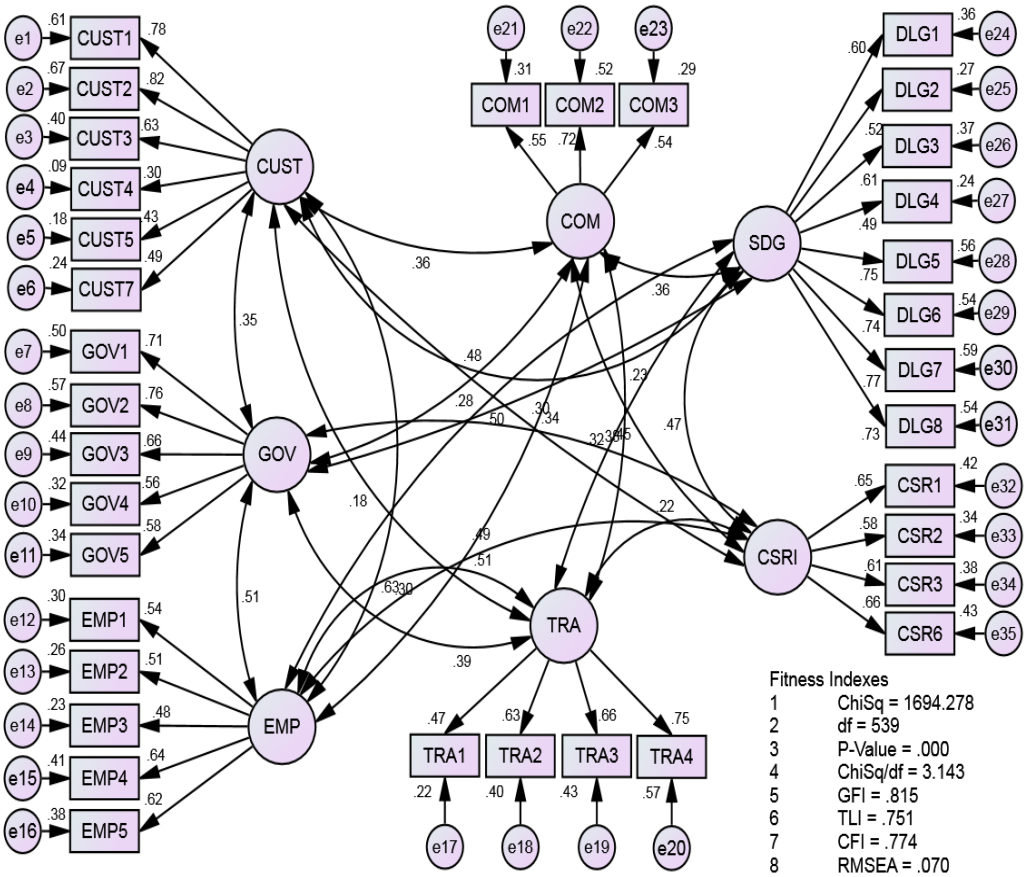

Figure 4.1: Initial CFA Measurement Model

Note: COM = perceived community expectations; CUST = perceived customers' expectations; GOV = perceived government expectations; EMP = perceived employees' expectations; TRA = perceived expectations of trade associations; CSRI = CSR implementation; SDG = stakeholder dialogue

To validate the measurement model, only measurement items with greater than 0.6 factor loadings were retained (Hair, Celsi, Money, Samouel, & Page, 2011). The following items were deleted because their respective factor loadings were below the recommended threshold: CUST5, CUST7, GOV5, EMP3, EMP5, TRA1 and DLG5. The deleted items accounted for twenty percent which is within the recommended cut-off point as suggested by Awang (2015). Twenty eight items were retained for further analysis. The final measurement model is shown in Figure 4.2.

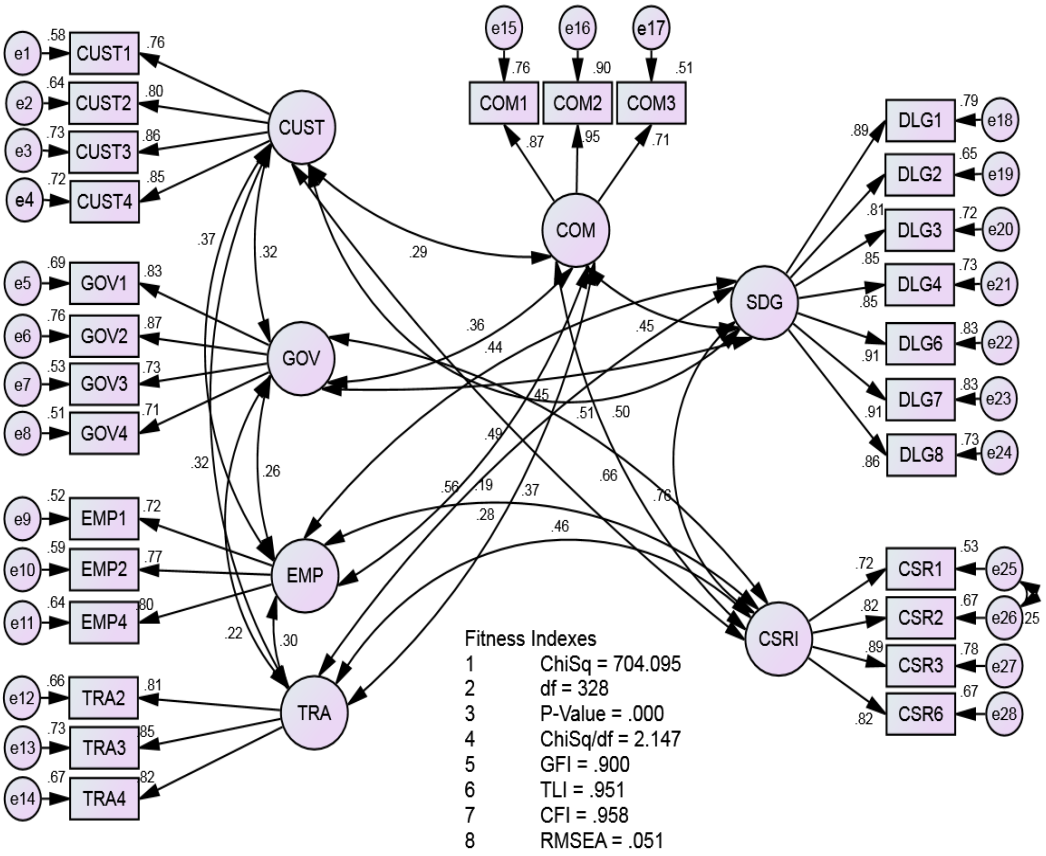

Figure 4.2: Final CFA Measurement Model

Note: COM = perceived community expectations; CUST = perceived customers' expectations; GOV = perceived government expectations; EMP = perceived employees' expectations; TRA = perceived expectations of trade associations; CSRI = CSR implementation; SDG = stakeholder dialogue

To ensure that data findings could be generalized, validity and reliability tests were undertaken. Three types of validity tests were carried out: convergent validity, construct validity and discriminant validity.

Construct validity was determined to ensure that the items were sufficiently fit to measure the study constructs. Each measurement item used in this study was examined to see if its corresponding standardized factor loading reached the required threshold of 0.6 and above (Hair et al., 2010, 2011; Lowry & Gaskin,

2014). As shown in Figure 4.2, construct validity is achieved since all the corresponding measurement items have factor loadings above 0.6.

The discriminant validity on the other hand was checked to ensure that the model does not suffer the problem of multicollinearity. In this respect, the factor loadings for each measurement item were examined and compared to the Average Variance Extracted (AVE) of each variable in the study (Fornell & Larcker, 1981; Hair et al., 2010). From Table 4.8, the diagonal items in the table represent the square root of AVE, which measures the variance between a variable and its measurement items.

Table 4.8: Factor Correlations Matrix

	CR	AVE	MSV	COM	CUST	GOV	EMP	TRA	CSRI	SDG
COM	0.886	0.725	0.433	**0.851**						
CUST	0.890	0.669	0.252	0.295	**0.818**					
GOV	0.868	0.623	0.261	0.358	0.324	**0.789**				
EMP	0.807	0.582	0.195	0.192	0.375	0.264	**0.763**			
TRA	0.885	0.659	0.287	0.268	0.330	0.233	0.335	**0.812**		
CSRI	0.886	0.661	0.569	0.658	0.487	0.511	0.374	0.441	**0.813**	
SDG	0.963	0.746	0.569	0.444	0.502	0.449	0.442	0.536	0.754	**0.864**

Note: CR = composite reliability; AVE = average variance extracted; MSV = maximum shared variance; COM = perceived community expectations; CUST = perceived customers' expectations; GOV = perceived government expectations; EMP = perceived employees' expectations; TRA = perceived expectations of trade associations; CSRI = CSR implementation; SDG = stakeholder dialogue

The off diagonal items represent squared correlation between constructs (see Table 4.8). Since the diagonal items are higher than the squared correlations between constructs, it can be concluded that the discriminant validity for the present study is achieved (Awang, 2015; Gasking, 2016; Hair et al., 2011). In addition, for all the variables of this study, the corresponding measurement items have higher loadings and shares more variance within their respective variables than with any

other variable, hence the variables are discriminant of each other (Awang, 2015; Gasking, 2016).

Convergent validity was employed to check the statistical significance of the measurement model. To test the convergent validity, this study examined standardized factor loadings, Cronbach's Alpha, composite reliability, and Average Variance Extracted (AVE) for each of the study variables to determine the amount of variance captured by the random measurement error (Fornell & Larcker, 1981). An AVE that is higher than 0.50 indicates a good internal consistency (Awang, 2015). Table 4.8 indicates that the convergent validity is achieved since all the variables used in this study had the AVE of 0.5 and above (Fornell & Larcker, 1981; Hair et al., 2010). This suggests that all the measurement items in the present study converged to their respective factors.

To ensure that the measurement model is reliable and could measure the study constructs, reliability test was carried out. Two criteria were used to check for internal consistency of the constructs: the Composite Reliability (CR $\geq$ 0.6) and Average Variance Extracted (AVE $\geq$ 0.5) (Awang, 2015; Gasking, 2016; Lowry & Gaskin, 2014). As evidenced by Table 4.8, all the variables indicated CR and AVE values are above the required thresholds suggesting that the model and its variables are adequately reliable.

4.3.2 Confirmation of the Measurement Model Using CFA

After the validity of the measurement items was achieved, the model was further examined to see if it achieved the goodness of fit indexes. Figure 4.2 (see page 114) shows that the measurement model of this thesis comprises of seven factors. Each factor is measured by a minimum of two observed variables that satisfies the model fitness requirements (Gasking, 2016; Lowry & Gaskin, 2014). Each of these observed variables is regressed into its respective factor as shown in Table 4.8 as inter-correlated.

Assessment of data normality was carried out by looking at the skewness and kurtosis indicators to ensure that data is normal and can be further analyzed by using maximum likelihood estimation for CFA. Results shown in Table 4.9 indicate that current data are normally distributed with skewness and kurtosis values falling within the acceptable threshold of (+/-1) and (+/-7) respectively (Curran, West, & Finch, 1996; Finney, Sara.J; DiStefano, 2006).

Table 4.9: Assessment of Normality - Main Survey

Variable	min	max	skew	c.r.	kurtosis	c.r.
CUST4	1.000	5.000	-.163	-1.394	-.729	-3.111
COM3	2.000	5.000	-.918	-7.832	1.969	8.403
DLG8	3.000	5.000	.096	.822	.234	.997
DLG7	3.000	5.000	.107	.915	.308	1.313
DLG6	3.000	5.000	.088	.750	-.024	-.101
DLG4	3.000	5.000	.110	.940	.277	1.180
DLG3	3.000	5.000	.084	.717	.620	2.647
DLG2	3.000	5.000	.086	.731	.749	3.194
DLG1	3.000	5.000	.124	1.062	.380	1.621
COM1	2.000	5.000	-.283	-2.417	.199	.850
COM2	2.000	5.000	-.300	-2.562	.171	.732
CSR1	3.000	5.000	.070	.594	-.331	-1.411
CSR2	3.000	5.000	.131	1.118	-.363	-1.549
CSR3	3.000	5.000	.184	1.569	-.589	-2.513
CSR6	3.000	5.000	.259	2.211	-.176	-.752
TRA4	2.000	5.000	-.252	-2.155	-.802	-3.424
TRA3	2.000	5.000	-.478	-4.080	-.414	-1.767
TRA2	2.000	5.000	-.412	-3.515	-.335	-1.429
EMP4	2.000	5.000	-.062	-.525	-.188	-.802
EMP2	2.000	5.000	.318	2.716	-.638	-2.723
EMP1	2.000	5.000	-.111	-.947	-.132	-.564
GOV4	2.000	5.000	-.532	-4.544	-.009	-.040
GOV3	2.000	5.000	-.469	-4.001	.660	2.816
GOV2	2.000	5.000	-.496	-4.231	.181	.773
GOV1	2.000	5.000	-.563	-4.806	.122	.519
CUST3	1.000	5.000	-.075	-.639	-.557	-2.378
CUST2	1.000	5.000	-.155	-1.320	-.708	-3.020
CUST1	1.000	5.000	-.457	-3.896	-.797	-3.402

Given that data is normally distributed, the measurement model was then estimated by using the Maximum Likelihood approach (Finney, Sara; DiStefano, 2006). This approach enabled all the estimates of the model parameters to be calculated simultaneously (Winner, Brown, & Michels, 1991).

The model fitting process involves determination of goodness-of fit between the hypothesized model and the sample data. Three categories of model fit indexes were evaluated: absolute fitness indexes; parsimonious fit; and incremental fit (Awang, 2015). The model was carefully iterated until the minimum requirements

of the goodness of fit indexes were achieved. This way, the admissible solution could be obtained and thereby the issue of multicollinearity could be avoided.

All the three fitness measures are represented by fitness indexes summarized in Table 4.10. From Table 4.10, the absolute fit indexes: goodness-of-fit (GFI=0.900) and adjusted goodness-of-fit (AGFI=0.876) indicated that model has fitted the data well. The lower values of the Root Mean Square Residual (RMR=0.024) indicated that the average residual value derived from filling the variance-covariance matrix for the hypothesized model to the variance covariance matrix of the sample data are a better fit.

Table 4.10: Measurement Model Fitness Indexes

Fitness Index	Recommended Threshold [a]	Obtained Index
Chi-square (X^2)	-	704.095
Degrees of freedom (df)	-	328
X^2 significance	p<0.05	0.000
Chi-square/ df	<3	2.147
GFI	>0.90	0.900
AGFI	>0.80	0.876
SRMR	<0.09	0.024
CFI	>0.90	0.958
TLI	>0.90	0.951
NFI	>0.90	0.924
RMSEA	<0.06	0.051
PCLOSE	>0.05	0.336

[a] Source: Hair et al. (2010); Hu and Bentler (1998)

In regards to parsimonious fit indexes, Chi-square index was used to assess the correspondence between theoretical specification and empirical data in a CFA. Two residual matrices were compared and yielded a chi-square value of 2.147 which indicates a good fit between the hypothetical model and the sample data (Awang, 2015; Carmines & McIver, 1981).

On the other hand, the incremental fitness indexes: comparative fit index (CFI=0.958); Normed Fit Index (NFI=0.924), and Tucker-Lewis Index (TLI=0.951) suggest good model fit (Bentler, 1990; Hu & Bentler, 1998). Root Mean Square Error Approximation (RMSEA) was also assessed to see how well a model fits the population and not just the sample used for estimation. Bentler (1990), Hu & Bentler (1998) and Steiger (2000) have suggested RMSEA value of less than 0.06 as indication of good fit. Thus, a lower score of RMSEA (0.051) obtained in this study thereby indicates a good fit.

In summary, the confirmatory factor analysis of this study shows an acceptable model fit. Therefore, it can be concluded that the hypothesized seven factor CFA model fits the sample data very well. In the next sub-topic, the results of structural model with hypothesis testing are presented.

4.3.3 Assessment of Structural Model

Figure 4.3 represents the structural path diagram of the present study. The causal paths in the diagram represent the hypotheses developed for this study. Each hypothesis is reviewed here and tested by using the structural path model. From Figure 4.3, the structural model is assessed first to ensure fitness indexes are achieved. The assessment criteria for the structural model are similar to that of the measurement model evaluated in sub-topic 4.3.2.

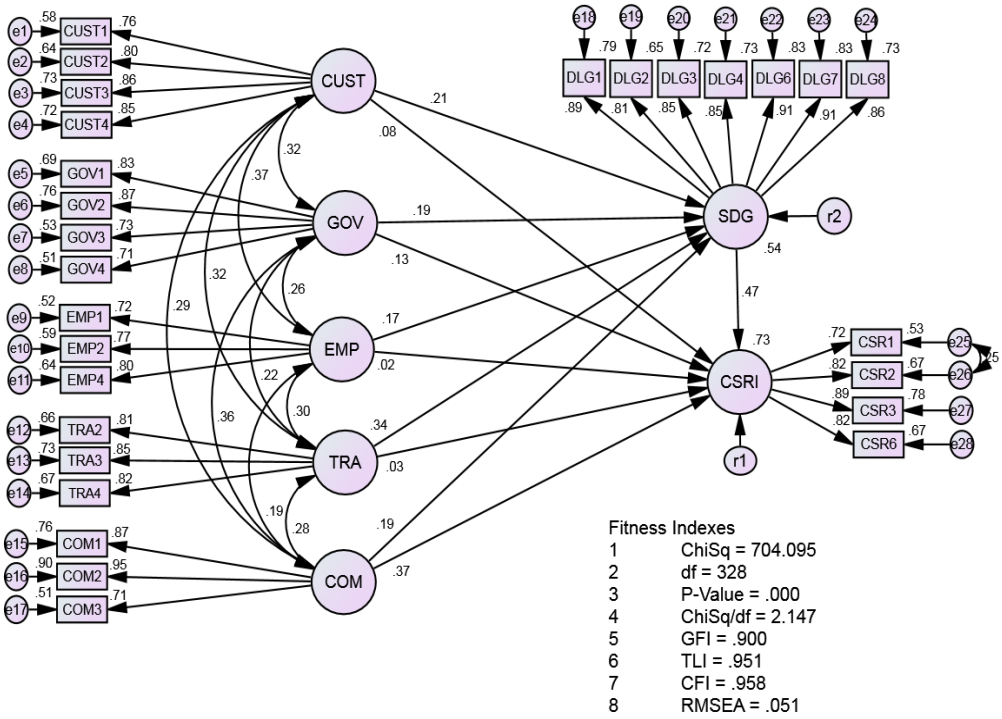

Figure 4.3: Results of Structural Model Analysis

From Table 4.11, all the fitness indexes exceed the recommended thresholds, suggesting that the structural model fits the data reasonably. Hence, the hypotheses can now be examined.

Table 4.11: Structural Model Fitness Indexes

Fitness Index	Recommended Threshold [b]	Obtained Index
Chi-square (X^2)	-	705.095
Degrees of freedom (df)	-	328
X^2 significance	p<0.05	0.000
Chi-square/ df	<3	2.147
GFI	>0.90	0.900
AGFI	>0.80	0.876
SRMR	<0.09	0.024
CFI	>0.90	0.958
TLI	>0.90	0.951
NFI	>0.90	0.924
RMSEA	<0.06	0.051
PCLOSE	>0.05	0.336

[b] Source: Hair et al. (2010); Hu and Bentler (1998)

4.3.4 Hypotheses Testing

In this sub-topic the SEM results of the hypotheses tested are presented. The results are divided into three sub-topics as per present study's objectives. As noted earlier on, two groups of companies were examined in this study: large companies and SMEs. A SEM multi-group analysis technique was employed to examine if there is any significant difference between large companies' and SMEs' CSR practices in relation to each of their stakeholders' expectations and the effect of stakeholder dialogue on CSR interventions in healthcare.

4.3.4.1 Direct effects generated by companies' perceptions about stakeholders' expectations on the implementation of CSR practices in healthcare

To attain the first objective of this study: estimating direct effects of perceived stakeholders' expectations on company implementation of CSR practices in healthcare, hypotheses H1a to H5a were tested (see Table 4.12). Results show that all the hypotheses are supported except H2a and H5a. The results indicate that companies are particularly concerned about the expectations of three main stakeholder groups, namely: customers, communities and the government, which in turn fostered companies to implement CSR practices in healthcare. In other words, the concerns raised by these stakeholder groups are more influential on companies' implementation of CSR practices.

Table 4.12: Effects of Perceived Stakeholders' Expectations on Companies' CSR Practices in Healthcare

			Estimate	S.E.	C.R.	Result	Remarks
CUST	--->	CSRI	.083**	.019	2.040	Significant	H1a Supported
EMP	--->	CSRI	.023	.039	.557	Non-significant	H2a Not supported
COM	--->	CSRI	.366**	.036	9.321	Significant	H3a Supported
GOV	--->	CSRI	.130**	.028	3.317	Significant	H4a Supported
TRA	--->	CSRI	.031	.030	.747	Non-significant	H5a Not supported

Note: ** p<0.01

CUST = perceived customers' expectations; EMP = perceived employees' expectations; COM = perceived community expectations; GOV = perceived government expectations; TRA = perceived expectations of trade associations; CSRI = CSR implementation; S.E. = standard error; C.R. = critical region

As previously noted, customers, communities and the government are powerful stakeholders that may affect the operations of the firm. For example, GIZ (2014); Kihiyo (2007) and Mader (2012) reported that Tanzanian customers through their association: Consumer Advocacy Group are promoting responsible business campaigns aggressively through measures such as promotion of responsible eating habits and prevention against communicable diseases such as malaria, HIV or AIDS and Tuberculosis. Figar and Figar (2011); Freeman (2004); and Mitchell et al. (1997) have also noted that customers are part of the primary stakeholder group that possess social and economic powers, legitimacy and urgency and can potentially affect a company's trading performance and reputation.

Similarly, governments possess power (ability to influence corporate practices), legitimacy (as a regulator) and urgency (ability to seek for immediate attention). Through the institutional frameworks (public policies, laws and regulations) such as license to operate that governs both public and private CSR practices, the government can directly influence CSR practices of companies in a particular

sector or industry (Frynas & Stephens, 2015). In summary, government is an important stakeholder that can facilitate desirable CSR practices by controlling the institutional environment.

If companies are concerned about these stakeholder groups, it is most likely that companies will engage in CSR practices in response to their stakeholders' expectations. Hence, CSR practices undertaken by companies would enhance their respective stakeholders' well-being.

Current finding supports literature on CSR practices and stakeholders' expectations. Study by Hillman & Klein (2001) showed that by building good relationships with stakeholders such as: customers, suppliers, and communities, shareholders' wealth and valuable firm assets could increase and thereby more competitive advantages can be built. William, Parida, & Patel (2013) argued that responding to stakeholders' expectations through philanthropic contributions could positively affect the reputation of the firm, that would in turn affect the purchasing decisions of customers, employees, government etc. and eventually firm's financial performance.

Similarly, Berman et. al, (1999); Pedersen (2006) and Tiras, Ruf, and Brown (1998) observed that stakeholders' expectations could impact companies' CSR interventions positively. Hence, in line with the literature, current study's finding continue to support the argument that, understanding each stakeholders' interests and demands is very essential for successful CSR interventions.

On the other hand, this study found that, company perceptions about employees' and trade associations' expectations have no significant influence on the implementation of CSR practices in healthcare. This is contrary to previous studies findings (Alfermann, 2011; Anene & Anene, 2013; De Bussy & Suprawan, 2012; Duarte, 2011; Esmaeelinezhad, 2015).

According to the Tanzanian Ministry of Labour (MOL, 2004), indicators of employee wellbeing including: occupational health and safety of workers; compliance with labour standards; ensuring equal and fair treatment of all employees; and conducting workplace prevention and care programs (e.g. education on employee responsible sexual behavior, voluntary HIV testing and counseling), are integrated in the country's Employment and Labour Relations Act as well as in the Employment Policy into which every organization in Tanzania must abide.

Although commitment to employee wellbeing is an implicit CSR practice (Carroll & Shabana, 2010; Tilakasiri, 2012), it is possible that the respondents of this study considered employee health and safety indicators as a legal requirement rather than a CSR contribution simply because those indicators are currently institutionalized in the country's legal and regulatory framework.

Nevertheless, it is worth mentioning that a legitimate firm is expected to perform in a manner that complies with government rules and regulations. As such, ensuring employee wellbeing and quality of life is one of the important elements

of CSR (Carroll, 1991; Carroll & Shabana, 2010). The non-significant result could therefore be due to limited understanding among the present study's respondents on implicit and explicit meanings of the CSR concept.

As argued by Carroll and Shabana (2010), the fact that legitimate CSR practice entails legal responsibility in addition to economic, ethical and philanthropic, businesses should be operating according to the society's law because the law defines the acceptable and unacceptable behavior of its members including business organizations.

The constraints of financial resources and business experts in the Tanzanian business associations, as well as the lack of appropriate dialogue mechanisms between companies and their stakeholders (GIZ, 2014; Waite & Mosha, 2006) could possibly account for non-statistical significant influence of perceived trade associations' expectations on companies implementation of CSR practices in healthcare. According to the Tanzanian Responsible Business Network (TRBN, 2014), business associations are dependent on financial contributions from member companies, hence it is most likely that the respondent companies perceived business associations as a non-influential stakeholder group in CSR practices.

4.3.4.2 The mediation effect of stakeholder dialogue on companies' implementation of CSR practices in healthcare

To answer the question of whether stakeholder dialogue could mediate the effects created by companies' perceptions about their stakeholders' expectations on CSR practices in healthcare, hypotheses H6a to H10a, H11a and H12a to H16a are tested. The results in this sub-topic are useful to measure the achievement of the second research objective. To estimate the mediation effect, it is necessary to first find out whether: (1) perceived stakeholders' expectations could motivate companies to activate stakeholder dialogue (H6a to H10a); and (2) if the respondent companies would implement CSR practices in healthcare as a result of stakeholder dialogue (H11a).

a) Effects of perceived stakeholders' expectations on companies' activation of stakeholder dialogue

Table 4.13 shows that hypotheses H6a to H10a are supported. In other words, perceived stakeholders' expectations on health and safety could encourage companies to establish dialogue with stakeholders that will eventually motivate companies to practice CSR in healthcare. For example, through consultation with their respective stakeholders, companies will be familiar with stakeholders' health and safety expectations and reactions. This could be useful for companies to plan future CSR interventions in healthcare and to avoid conflict of interest among stakeholders. Similarly, the form of dialogue to be used to engage with stakeholders will be known so that companies would be able to develop appropriate CSR policies and strategies.

Table 4.13: Effects of Perceived Stakeholders' Expectations on Stakeholder Dialogue

			Estimate	S.E.	C.R.	Result	Remarks
CUST	--->	SDG	.211**	.021	4.670	Significant	H6a Supported
EMP	--->	SDG	.171**	.044	3.732	Significant	H7a Supported
COM	--->	SDG	.187**	.039	4.501	Significant	H8a Supported
GOV	--->	SDG	.191**	.031	4.401	Significant	H9aSupported
TRA	--->	SDG	.343**	.032	7.673	Significant	H10a Supported
SDG	--->	CSRI	.469**	.052	9.046	Significant	H11a Supported

Note: ** p<0.01

CUST = perceived customers' expectations; EMP = perceived employees' expectations; COM = perceived community expectations; GOV = perceived government expectations; TRA = perceived expectations of trade associations; CSRI = CSR implementation; SDG = stakeholder dialogue; S.E. = standard error; C.R. = critical region

These findings reaffirm previous studies' proposition that to ensure companies and their stakeholders are fully engaged, each participant should be given an opportunity to convey their opinions and suggestions in the stakeholder dialogue event and thereby, a consensual agreement can be reached (Arya & Zhang, 2009; Clements & Bowrey, 2010; Fox et al. 2002; Rockson (2009); Ward et al. 2007).

As Ismail (2009) argued, the establishment of positive relationships between companies and stakeholders is an economic asset that could lead to peace and harmony; and is an essential factor for social and economic development. Thus, along with Ni et al's. (2015) suggestion, regular communication between companies and their stakeholders could be an effective strategy to reduce anxiety among stakeholders.

b) Effects of stakeholder dialogue on company implementation of CSR practices in healthcare

As shown in Table 4.13, statistical result shows that stakeholder dialogue has positive and significant effect on companies' implementation of CSR practices. In other words, hypothesis H11a is supported. The execution of stakeholder dialogue allows companies and their respective stakeholders to learn from one another and share issues of mutual interest (Burchell & Cook, 2006). Through stakeholder dialogue, a company could consult its stakeholders and ask for their opinions before implementing a CSR program and align its policies and strategies to match stakeholders' interests. As a result, through dialogue companies could be motivated to further engage in health related CSR practices to meet their stakeholders' needs and expectations and mitigate the negative pressure that may be caused by stakeholders.

c) Confirmation of mediating effect of stakeholder dialogue

The mediation effect of each stakeholder is computed using Hayes's (2009) bootstrap bias corrected approach. In detail, the scores of mediation effect for each stakeholder are computed by multiplying the path values that represent the relationship between each stakeholder's expectation and stakeholder dialogue, and path value that shows the relationship between stakeholder dialogue and CSR implementation. As per Preacher's and Hayes's (2008) suggestion, for mediation to occur, the lower and upper limits of the non-bias bootstrap results for indirect effect should not straddle at 0 in between.

Table 4.14 shows that the mediation hypotheses for all stakeholder groups in this study (H12a to H16a) are supported since both upper and lower limits are not astride zero in between. Hence it can be concluded that mediation effects exist and are statistically significant for all of the five stakeholder groups.

The significant results of the mediation tests indicate that once companies are familiar of their stakeholders' interests and demands, and if the stakeholders are given the chance to raise their voices through the dialogue, companies would likely be willing and committed to engage in health related CSR practices. For example, companies would start/ continue engaging in healthcare promotion and protection campaigns; supporting the needy communities such as orphans, disabled and elder people; and collaborate with other stakeholders to achieve the country's strategic healthcare objectives.

Table 4.14: Mediating Role of Stakeholder Dialogue

Constructs	Parameter	Estimate	Lower	Upper	Remarks
CUST	A x B	.045**	.025	.065	H12a Supported
EMP	A x B	.075**	.040	.125	H13a Supported
COM	A x B	.083**	.048	.122	H14a Supported
GOV	A x B	.064**	.040	.099	H15a Supported
TRA	A x B	.107**	.076	.149	H16a Supported

Note: ** $p<0.01$
"A" represents the path values of perceived stakeholders' expectations on stakeholder dialogue; while "B" depicts the path value of the influence of stakeholder dialogue on companies' CSR practices in healthcare.

The present findings support the arguments given by Burchel and Cook (2006), Kaptein and Tulder (2003), and Pedersen (2006). Stakeholder dialogue is an important tool that could be used by companies to increase their legitimacy, trust

and accountability to their stakeholders. Nelson, Torres-Rahman, Stibbe and Prato (2015) noted that, private sector in general needs to engage in active dialogue with government, civil society and other stakeholders to reap meaningful results out of their CSR practices. Through dialogue, firms and their stakeholders could identify and debate on each other's needs and interests so that a mutual beneficial solution can be developed (O'Riordan & Fairbrass, 2008).

In summary, the effects of perceived stakeholders' expectations on large companies' implementation of CSR practices in healthcare are validated by the present study's supported hypotheses: H1a, H2a and H4a, H6a to H10a, H11a and H12a to H16a. The implications of the study findings are presented in chapter five. The next sub-topic presents direct and indirect effects of SMEs perceptions about their stakeholders' expectations on the implementation of CSR practices in healthcare.

4.3.4.3 The direct and indirect effects of SMEs' perceptions about their stakeholders' expectations on the implementation of CSR practices in healthcare

In estimating the effects generated by SMEs' perceptions about stakeholders' expectations and stakeholder dialogue on the implementation of CSR practices in healthcare, hypotheses H1b to H5b, H6b to H10b, H11b and H12b to H16b were tested. This analysis allows determining if there are any significant differences between large companies' and SMEs' CSR interventions in healthcare in relation to each of their stakeholders' expectations.

a) The direct effects of SMEs' perceptions about their stakeholders' expectations on the implementation of CSR practices in healthcare

Table 4.16 shows that H3b and H4b are supported. The statistical significant results indicate that SMEs' decision to engage in health related CSR practices is significantly influenced by its perceptions on communities' and government's expectations. On the other hand, SMEs' perceptions about their customers, employees and trade associations do not seem to have significant influence on their implementation of CSR practices in healthcare.

A plausible explanation for the non-significant statistical result could be that, SMEs are not often under public and stakeholders' pressure to engage in social activities and therefore their CSR activities are more embedded to the wellbeing of the community in which they operate. Study by Murillo and Lozano (2006) also underlines that SMEs are highly inter-related to their communities and they often act as benefactors.

Table 4.15: Effects of Perceived Stakeholders' Expectations on SMEs' Implementation of CSR Practices in Healthcare

			Estimate	S.E.	C.R.	Remarks
CUST	--->	CSRI	0.037	0.02	0.653	H1b Not-supported
EMP	--->	CSRI	0.002	0.055	0.045	H2b Not-supported
COM	--->	CSRI	0.336**	0.049	6.021	H3b Supported
GOV	--->	CSRI	0.161**	0.035	2.903	H4b Supported
TRA	--->	CSRI	0.114	0.040	1.992	H5b Not-supported

Note: ** $p<0.01$

CUST = perceived customers' expectations; EMP = perceived employees' expectations; COM = perceived community expectations; GOV = perceived government expectations; TRA = perceived expectations of trade associations; CSRI = CSR implementation; S.E. = standard error; C.R. = critical region

In addition, owner or manager is the final decision maker in SMEs (Jenkins, 2006). This could affect a company's approach to CSR practices as owners' or managers' decision to practice CSR is influenced by: personal feelings (Mousiolis et al., 2015), company finances (Rodgers & Gago, 2004), friends and family (Westerman et al., 2007) and religious perspectives. Thus, the above mentioned reasons combined with weak business associations (as noted in sub-topic 4.3.4) could account for non-significant influence of customers, employees and trade association stakeholder groups on SMEs' implementation of CSR practices in healthcare.

In comparing with the results of large companies category, the current findings show that SMEs are more concerned about communities and government's expectations on their CSR implementation. While larger companies react in the same way, their customers' expectations are important as well. As Fassin et al. (2015) argued, the influence of owners and shareholders in larger companies tend to put pressure on these companies to focus on company growth, profit maximization and business sustainability, hence more priority tends to be given to primary stakeholders including: customers, employees, communities and the government.

While all these stakeholders are equally important to SMEs, CSR interventions of SMEs do not seem to be so much affected by stakeholders other than communities and government's expectations. As previously noted, SME's owners or managers'

decisions are more influenced by other factors apart from enterprise growth and can also sacrifice their profits for a greater goal (Vives, 2006).

b) The mediation effect of stakeholder dialogue on SMEs' implementation of CSR practices in healthcare

To examine the mediation effect of stakeholder dialogue on CSR practices carried out by SMEs, it is important to (1) estimate the direct effects caused by SMEs' perceptions about each stakeholder's expectations on SMEs' decision of whether or not to hold stakeholder dialogue (represented by H6b to H10b); and (2) the direct effect of stakeholder dialogue on SMEs' implementation of CSR practices (denoted by H11b).

b1) Effects of SMEs' perceptions about stakeholder's expectations on stakeholder dialogue

As shown in Table 4.17, all direct hypotheses H6b to H10b and H11b are supported. In other words, SMEs are willing to hold dialogue with all the stakeholders: customers, employees, communities, trade associations and government, even when a stakeholder has no influence on SMEs' CSR decision.

As noted earlier on, the decision making process in SMEs is made by owner or manager. This provides SMEs with a unique flexibility to acquire relevant information about stakeholders and interact with them. Once the business owner /manager is familiar with stakeholders' needs, and if mechanism for dialogue is

enhanced, it is likely that SMEs would activate stakeholder dialogue and thereby listen and respond to their stakeholders' expectations.

Table 4.16: Effects of Perceived Stakeholders' Expectations on SMEs' Activation of Stakeholder Dialogue

			Estimate	S.E.	C.R.	Remarks
CUST	--->	SDG	0.276**	0.028	4.412	H6b Supported
EMP	--->	SDG	0.108**	0.064	1.804	H7b Supported
COM	--->	SDG	0.241**	0.054	3.961	H8b Supported
GOV	--->	SDG	0.172*	0.040	2.716	H9b Supported
TRA	--->	SDG	0.338**	0.045	5.356	H10b Supported
SDG	--->	CSRI	0.497**	0.071	7.004	H11b Supported

Note: ** $p<0.01$; * $p<0.05$

CUST = perceived customers' expectations; EMP = perceived employees' expectations; COM = perceived community expectations; GOV = perceived government expectations; TRA = perceived expectations of trade associations; SDG = stakeholder dialogue; CSRI = CSR implementation; S.E. = standard error; C.R. = critical region

b2) Effect of stakeholder dialogue on SMEs' implementation of CSR practices in healthcare

From Table 4.17, H11b is also supported. This suggests that dialogue between SMEs and their respective stakeholders would motivate SMEs to practice CSR in healthcare. As Burchel and Cook (2006) pointed out, interaction between a company and its stakeholders allows both parties to reach mutual beneficial agreements and sets the premise for further collaboration. Thus, present study underlines the need to include SMEs in the Tanzanian healthcare dialogue process so that they may be motivated to further engage in CSR practices that will enhance healthcare promotion and protection for their stakeholders and the society at large.

c) Confirmation of mediation effect of stakeholder dialogue in SMEs' CSR practices

To confirm the mediating role of stakeholder dialogue for each stakeholder's perceived expectation, hypotheses H12b to H16b were formulated and tested by using Hayes's (2009) bias corrected bootstrap approach. As shown in Table 4.18 the statistical significant results of stakeholder dialogue as a mediating variable are validated by supported hypotheses H12b to H16b. In other words, stakeholder dialogue mediates the relationship between perceived stakeholders' expectations and SMEs' implementation of CSR practices in healthcare.

Table 4.17: Testing the Mediation Effect of Stakeholder Dialogue in Small and Medium Firms

Constructs	Parameter	Estimate	Lower Limit	Upper Limit	Remarks
CUST	A × B	.044**	.028	.066	H12b Supported
EMP	A × B	.074**	.036	.021	H13b Supported
COM	A × B	.093**	.057	.139	H14b Supported
GOV	A × B	.042**	.021	.075	H15b Supported
TRA	A × B	.114**	.079	.165	H16b Supported

Note: ** $p<0.01$
"A" represents the path values of perceived stakeholders' expectations on stakeholder dialogue; while "B" depicts the path value of the influence of stakeholder dialogue on SMEs' implementation of CSR practices in healthcare.

The findings of this study reaffirms the arguments of Jenkins (2006); Lund-Thomsen et al. (2014) and Sweeney (2009), that SMEs have developed own ways to keep good relationships with stakeholders through informal dialogue mechanisms that are built on trust. Unlike large firms that have to be careful in planning their engagement with stakeholders, dialogue mechanisms for SMEs are informal and this can reduces the gap between power and influence of company

and stakeholders (Jenkins, 2006; Mousiolis et al., 2015). With the view that small and medium firms are not often under public scrutiny, current findings imply that SMEs are concerned about their stakeholders' health and safety, and therefore recognizing and strengthening their informal dialogue mechanisms could further enhance their participation in public healthcare support.

The stakeholder dialogue mediation results for SMEs are similar to those of larger firms. However, it is interesting to note that the confirmation of H1b to H5b in Table 4.16 showed that SMEs would implement CSR practices in healthcare just to fulfill two stakeholders' expectations: communities and government, but when all stakeholders were given an opportunity to voice their interest and opinions in a stakeholder dialogue, results show that the management of SMEs may become more receptive to other stakeholders' wellbeing: customers, employees, and trade associations (see Table 4.17).

The relationship between SMEs and their stakeholders could be similar to those of larger firms. For example, validation of hypotheses H1a, H3a and H4a in Table 4.12 indicated that larger firms would implement CSR because they are concerned about their customers in addition to communities and government's expectations as applies to SMEs. Table 4.13 showed that if the dialogue is arranged and all stakeholders are included, large firms would also be willing to take into account all the stakeholders' concerns.

In achieving the third objective of this study: examining if there is any significant difference between large companies' and SMEs' CSR interventions in relation to each of their stakeholders' expectations and the effect of stakeholder dialogue on CSR interventions in healthcare. A multi-group SEM model comparison technique was used in this study. For each path in the model, results indicated that there is no significant difference between the two groups of companies (large and SMEs). In other words, both large companies and SMEs are concerned about their stakeholders' expectations, although SMEs are significantly influenced by their concerns over communities and governments, large companies are more concerned about their customers in addition to the two aforementioned stakeholder groups.

The management of firm-stakeholder relationship among larger companies and SMEs is however, likely to be different. As Jenkins (2006) argued, SME and stakeholder relationship tends to be more informal, bonded based on mutual trust and largely dominated by personal commitment. As a result, SMEs could be keen to engage in dialogue with all stakeholders more easily despite of limited resources unlike larger firms that have to follow complex strategy and procedures for engaging with their stakeholders (Vives, 2006).

In brief, despite of the varying influence of different stakeholder groups' perceived expectations on both large firms and SMEs' implementation of CSR practices in healthcare, holding dialogue with all the stakeholders would motivate both SMEs and large firms to practice more CSR in healthcare and hopefully this will have significant impact in supporting the Tanzanian government to achieve its

healthcare mission: ensuring better healthcare to the nation. More details on policy recommendations are provided in Chapter Five.

4.4 Chapter Summary

In summary, the descriptive result shows that companies operating in secondary and tertiary sectors are more engaged in health related CSR practices and is motivated by the potential social and economic benefits that can be earned. Irrespective of company respondents' ownership structure and firm size, both foreign and locally owned firms have been providing CSR in healthcare. This also applies to small, medium and large companies.

Generally, inferential statistical results support present study's hypotheses. Statistical results show that the following perceived stakeholders' expectations: customers (H1a), communities (H3a), and government (H4a) on companies' implementation of CSR practices in healthcare are supported and thereby validated the study's first objective (see Table 4.19). Company's perception of employee's (H2a) and trade associations' (H5a) expectations' on the implementation of CSR practices were however not supported (see Table 4.19) due to following explanations. First, present study's respondents had limited knowledge on the fact that legal responsibility is an important part of CSR (Carroll & Shabana, 2010). In other words, respondents had perceived that ensuring employee's health and safety is an obligation that must be performed by company rather than a CSR contribution. Secondly, most trade associations are financially supported by companies which could undermine their influential ability in persuading

companies to activate CSR in healthcare. Thirdly, the mechanism that could harness employees' and trade associations' expectations and opinions in corporate decision making is weak.

Although company perceptions on employees' and trade associations' expectations did not produce significant effects on companies' CSR practices in healthcare, the stakeholders could affect a company's business practice. Employees are the interface of the firm; they play an important role of linking an organization with other stakeholders such as customers and suppliers. If employees' expectations are not taken into consideration, unnecessary misunderstandings between the company and their employees may occur. Company image could then be tarnished and work productivity may decrease. Similarly, trade associations could play an important role in facilitating successful and effective CSR interventions as they may represent their member companies in various business related negotiations and dialogue forums.

Table 4.18: Summary of Hypothesis Testing Results

Hypothesis				Result	Remark
a)	Direct Effects of Large Companies' Perceptions about Stakeholders' Expectations on the Implementation of CSR Practices in Healthcare				
H1a	CUST	--->	CSRI	Significant	H1a Supported
H2a	EMP	--->	CSRI	Non-significant	H2a Not supported
H3a	COM	--->	CSRI	Significant	H3a Supported
H4a	GOV	--->	CSRI	Significant	H4a Supported
H5a	TRA	--->	CSRI	Non-significant	H5a Not supported
b)	Direct Effects of Perceived Stakeholders' Expectations on Stakeholder Dialogue				
H6a	CUST	--->	SDG	Significant	H6a Supported
H7a	EMP	--->	SDG	Significant	H7a Supported
H8a	COM	--->	SDG	Significant	H8a Supported
H9a	GOV	--->	SDG	Significant	H9a Supported
H10a	TRA	--->	SDG	Significant	H10a Supported
c)	Direct Effect of Stakeholder Dialogue on Large Firms Implementation of CSR Practices in Healthcare				
H11a	SDG	--->	CSRI	Significant	H11a Supported
d)	Mediating Effects of Stakeholder Dialogue on the Large Firms Implementation of CSR Practices in Healthcare				
H12a	CUST	A x B		Mediation found	H12a Supported
H13a	EMP	A x B		Mediation found	H13a Supported
H14a	COM	A x B		Mediation found	H14a Supported
H15a	GOV	A x B		Mediation found	H15a Supported
H16a	TRA	A x B		Mediation found	H16a Supported
e)	Direct Effect of SMEs' Perceptions about Stakeholders' Expectations on the Implementation of CSR Practices in Healthcare				
H1b	CUST	--->	CSRI	Non-significant	H1b Not-supported
H2b	EMP	--->	CSRI	Non-significant	H2b Not-supported
H3b	COM	--->	CSRI	Significant	H3b Supported
H4b	GOV	--->	CSRI	Significant	H4b Supported
H5b	TRA	--->	CSRI	Non-significant	H5b Not-supported
f)	Direct Effects of SMEs' Perceived Stakeholders' Expectations on Stakeholder Dialogue				
H6b	CUST	--->	SDG	Significant	H6b Supported
H7b	EMP	--->	SDG	Significant	H7b Supported
H8b	COM	--->	SDG	Significant	H8b Supported
H9b	GOV	--->	SDG	Significant	H9b Supported
H10b	TRA	--->	SDG	Significant	H10b Supported
g)	Direct Effect of Stakeholder Dialogue on SMEs' Implementation of CSR Practices in Healthcare				
H11b	SDG	--->	CSRI	Significant	H11b Supported

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Hypothesis			Result	Remarks
h)	Mediating Effect of Stakeholder Dialogue on SMEs' Perceptions about Stakeholders' Expectations on the Implementation of CSR Practices in Healthcare			
H12b	CUST	A × B	Mediation found	H12b Supported
H13b	EMP	A × B	Mediation found	H13b Supported
H14b	COM	A × B	Mediation found	H14b Supported
H15b	GOV	A × B	Mediation found	H15b Supported
H16b	TRA	A × B	Mediation found	H16b Supported

Statistical results are supporting the following current study's hypotheses: H6a, b to H10a, b; H11a, b; and H12a, b to H16a, b as well (see Table 4.19). This indicate that stakeholder dialogue indeed plays an important role in helping all stakeholders, including the employees and trade association to convey their expectations to the companies' management. If all stakeholders could reach a consensual agreement in a dialogue, companies shall be more obliged to implement CSR practices in healthcare.

The support of hypotheses H3b and H4b (see Table 4.19) showed that SMEs are significantly influenced by communities and government to engage in healthcare CSR practices. Hypotheses H1b, H2b and H5b were however not supported. Probably this is because SMEs are more motivated to perform social responsibilities related to their surrounding communities and if requested by the government. Interestingly, the results also showed that when all stakeholders were involved in the dialogue process, SMEs would be willing to take their expectations into account and implement more CSR practices in healthcare (this is supported by the significant result of hypotheses H6b to H10b, H11b and H12b to H16b).

Larger companies are significantly influenced by the expectations raised by the following stakeholder groups: customers, communities and government while SMEs' CSR interventions are influenced by the latter two stakeholder groups. This is perhaps due to shareholders' pressure on large firms to increase profit ratios and business sustainability which doesn't seem to be of much concern to SMEs. Nevertheless, findings show that if the mechanism for dialogue is enhanced, both large firms and SEMs would be willing to listen to all stakeholders (stakeholder familiarity), interact with them (stakeholder interaction), commit themselves to the dialogue process (dialogue commitment) and eventually engage in more CSR practices in healthcare.

Achievement of the present study's objectives and recommended approaches on how the public policy makers and practitioners could use current study findings to promote CSR practices for both large firms and SMEs is further discussed in Chapter Five.

CHAPTER 5

CONCLUSIONS AND IMPLICATIONS OF THE STUDY

5.1 Accomplishment of Research Objectives

This study had three objectives: (1) to estimate the direct effects generated by companies' perceptions about their stakeholders' expectations on the implementation of CSR practices in healthcare; (2) to estimate the mediating effect of stakeholder dialogue on the impact of companies' perceptions about their stakeholder's expectations on the company's CSR practices in healthcare; and (3) to examine if there is any significant difference between large companies' and SMEs' implementation of CSR practices in relation to each of their stakeholders' expectations and the effect of stakeholder dialogue on CSR interventions in healthcare.

The first research objective aim to answer the following question: to what extent private companies are concerned about their stakeholders' health and safety expectations and how such concerns could affect the implementation of CSR practices in healthcare? The results show that companies are concerned about their stakeholders' health and safety. This is evidenced by a significant influence of companies' perceptions about the following stakeholders on CSR implementation in healthcare: customers (β=0.083; p=0.041), communities (β=0.366; p=0.001) and the government (β=0.130; p=0.001). Given the significant influence of these

stakeholder groups, it is most likely that companies will engage in CSR practices in healthcare to fulfill their responsibilities to these stakeholders' expectations.

Current findings support relevant literature: significant positive relationship between the aforementioned stakeholder groups and companies' implementation of CSR practices exist (Adams, 2011; Adeyanju Olanrewaju, 2012; Sriramesh et al., 2007; Sweeney, 2009). Nevertheless, contrary to some past studies, the relationship between perceived employees' expectations and CSR implementation is not supported and the relationship between trade associations' expectations and CSR implementation is not supported as well.

The non-significant influence of company perceptions about employee health and safety on company's CSR implementation in healthcare could be due to present study's respondents' understanding on the explicit and implicit meaning of CSR concept. Legitimately, CSR includes compliance to legal responsibilities (Carroll, 1991; Carroll & Shabana, 2010). However, because employee wellbeing indicators are institutionalized in Tanzania, it is possible that respondents of this study regarded commitment to employees' health and safety as a legal responsibility rather than a CSR contribution.

On the other hand, not all trade associations are strong enough to convince companies to practice CSR. Possibly this is due to lack of dialogue mechanism that could inform companies on important roles that trade associations could play in supporting CSR interventions. If companies are aware of contributions and

expectations raised by trade associations, perhaps the management could consider this stakeholder group in future. In brief, companies are becoming more sensitive and empathy in responding to their stakeholders' health and safety expectations. If the relationship between these two parties is strengthened, more CSR interventions in healthcare could be implemented which will eventually lead to a healthier population.

The second objective was developed to answer the following question: would stakeholder dialogue mediate the impact generated by companies' perceptions about their stakeholder's expectations on CSR practices in healthcare? Findings from this study support literature proposition: effective stakeholder dialogue could mediate companies' perceptions about their stakeholders' concerns. In other words, if companies are familiar with their stakeholders' interests and demands, and if stakeholders are provided with an opportunity to interact with the company management and voice their expectations, it is most likely that companies would be willing and committed to sustain the dialogue process. Thus, encouraging each stakeholder and companies' representatives to participate in a stakeholder dialogue could lead to a culture of sharing responsibilities and thereby, companies' CSR interventions in the Tanzanian healthcare system could be enhanced.

The third research objective is meant to solve the third question: are there any significant differences between large companies' and SMEs' CSR practices in relation to each of their stakeholders' expectations and the effect of stakeholder dialogue on CSR interventions in healthcare? The results show that there are no

significant differences between the two groups of companies on how they respond to their stakeholders' expectations through CSR interventions in healthcare. While large companies are significantly concerned about their customers, communities and the government, SMEs are significantly concerned about the later two stakeholder groups. Other stakeholder groups: customers, employees and trade associations' expectations did not have significant influence on SME's implementation of CSR practices in healthcare.

A plausible explanation could be due to the nature of SMEs' social activities which are often times focused on community wellbeing and complying to the government rules and regulations. It is interesting to note that although only two stakeholder groups: communities and government's expectations would receive SME's direct attention in CSR implementation, other stakeholders' expectations would be considered as well if all stakeholders have the chance to participate in a stakeholder dialogue. In other words, stakeholder dialogue could mediate SMEs' perceptions about their stakeholders' expectations on the implementation of CSR practices in healthcare.

Overall, this study has empirically shown that company' perceptions about their stakeholders' health and safety expectations have direct and indirect effects on the implementation of CSR practices in healthcare. It has also shown that stakeholder dialogue is an important instrument that could mediate perceived stakeholders' expectations and encourage private sector support in addressing healthcare issues through CSR.

In informing the research objectives, significant and non-significant statistical results have given useful indications to the current author to fill literature gap and to find plausible reasons that could explain the relationships between the examined variables: perceived stakeholders' expectations, stakeholder dialogue and CSR implementation. The plausible explanations are useful in discussing how the current results could help the private companies and policy makers in Tanzania to develop tactical planning that could further improve the country's healthcare system.

5.2 Theoretical Contributions

This study has identified the following literature gaps: (1) discussion on the link between perceived stakeholders' expectations and corporate decision making process is limited; and (2) empirical analysis on the mediation effect that could be played by stakeholder dialogue as an intervening variable between perceived stakeholders' expectations and firm decisions towards CSR practices particularly in healthcare is lacking.

Freeman's (1984) original stakeholder theory and Ullmann's (1985) modified stakeholder theory were criticized because both theories did not incorporate the issues of social responsibility in companies' decision making. Furthermore, past empirical studies that used the theories to test the relationships between social responsibility and corporate decision making are limited. In response to the literature gap, current author has used Donaldson's and Preston's (1995) stakeholder model as the fundamental model of this study. Donaldson's and

Preston's (1995) model was used because the model's normative dimension incorporates stakeholder attitudes, stakeholder management structures and practices that altogether provides the basis for examining stakeholders' interests and concerns.

Nevertheless, the theory had to be modified because it assumes that, stakeholders and companies' management share similar interests and thereby a unified corporate decision making could be materialized without consulting the stakeholders. In fact, it is undeniable that discrepancy between the stakeholders and companies may exist (Lee, 2005). Therefore, the current author extended the theory by including an intervening variable: stakeholder dialogue: to test whether more CSR practices would be implemented if dialogue between the companies' representatives and stakeholders is arranged.

The stakeholder dialogue variable in this study entails an attempt that stimulates learning and understanding of each party's attitudes, thoughts and values that strengthens relationships by taking collective actions. In examining company perceptions of their stakeholders' expectations in CSR practices, three elements of stakeholder dialogue were researched in this study: company knowledge of stakeholders' interests, opinions and expectations; stakeholder collaboration practices; and stakeholder management strategy - commitment to dialogue outcomes. The three components altogether provides the basis for understanding stakeholders' interests and demands. This is particularly important for policy makers and practitioners in designing the correct form of dialogue to use in the

process of attaining common goals (e.g. information gathering/ sharing dialogue; bounded /exploratory dialogue - finding support for readymade decisions; or open dialogue - consensus building in finding mutual solutions to problems) (Rob Van, Muel, Eveline, & Rutger, 2004).

The empirical testing of the mediation effect of stakeholder dialogue in this study helps to fill the literature gap. There are limited previous studies that had empirically tested the role of stakeholder dialogue in CSR research particularly in healthcare. The results of present study therefore suggest that inclusion of stakeholder dialogue as a mediating variable in Donaldson and Preston's (1995) model allows an empirical analysis of the relationship between stakeholders' needs and companies' CSR interventions. The modified stakeholder model therefore paves the way for future researchers to further conform the mediating role that can be played by stakeholder dialogue in strengthening firm-stakeholder relationships.

5.3 Policy Implications

This study found that to enhance the participation of private sector companies in healthcare through CSR interventions, a more coherent and effective interaction between stakeholders is necessary. A thorough literature review, pilot survey complemented with pre-test procedures involving CSR experts and stakeholders of the Tanzanian healthcare, and field survey revealed that significant contributions of CSR interventions in strengthening the country's health care system could be achieved if stakeholder dialogue is arranged and coordinated.

Various strategic policy initiatives – revision of institutional, legal and regulatory framework to encourage the participation of private sector – have been undertaken by the Tanzanian government to facilitate private sector support in attaining the country's strategic healthcare objectives (MoHCDGEC, 2015; MoHSW, 2008; Musau et al., 2011; The World Bank, 2015b). Nevertheless, the mechanism for dialogue process between stakeholders and companies particularly in private sector is not well coordinated and arranged. Research has further shown that private service providers, civil society organizations and NGOs are not involved in strategic health care planning and decision making in the recently established public-private partnership technical working group (PPP-TWG) which is dominated by the representation of government officials and donor community (Rweyemamu & Mwasongela, 2015; Stott et al., 2011; White et al., 2013). This could possibly limit the potentials of CSR in strengthening the country's healthcare system.

To create a genuine dialogue structure, this study recommends that all relevant stakeholders should be involved in the dialogue process. This is supported by current results: both large firms and SMEs are willing to consider each stakeholder's expectation if the dialogue between companies and their respective stakeholders is arranged.

One of the ways to ensure each stakeholder's participation is through opening up a public-private dialogue forum that can represent each stakeholder's interest. Such forum could include government healthcare officials, representatives from the

private sector associations, NGOs, CSOs, and donor community. For example, existing consumer association such as Tanzania Consumers Advocacy could be appointed to convey consumers' health and safety expectations; Trade unions like Trade Unions Congress of Tanzania could represent employees; and civil society organizations and NGOs represent communities. Meanwhile, government could be represented by its officials from ministries, departments and agencies; and companies could be represented by their respective associations such as Tanzania Private Sector Foundation, Tanzania Chamber of Commerce, Industry and Agriculture, and the Association of Tanzania Employers.

In such forum, an open dialogue approach should be used, i.e. consensus building technique needs to be applied in finding mutual solutions to problems. The government could lead the discussion by emphasizing its strategic healthcare priorities and clearly showing the areas that needs additional support. An interactive session could follow allowing non-state actors to intervene. Similar approach has worked in Kenya, Zambia and South Africa where governments encourage private service providers both for profit and non for profit, NGOs, CSOs and other relevant stakeholders to take part in healthcare planning, policy and strategy development (GIZ, 2012, 2016). The stakeholder dialogue model developed in this study could be used as guidance for the required forum to enhance collaboration in strengthening the country's healthcare system.

In addition to creating stakeholder dialogue forum, establishing strategic partnerships that involves stakeholders' representatives from both larger and, small

and medium companies is recommended. GIZ for instance uses similar approach to help building public-private collaboration structures that have helped Ghana, Kenya, South Africa and other developing countries to strengthen competence and effectiveness of governmental and non-governmental partner organizations engaged in prevention of communicable diseases, Malaria, HIV&AIDS and tuberculosis through outreach programmes and health promotion at workplace (GIZ, 2018). In such partnerships, a joint approach is used where governments provide the required infrastructure while private sector brings experts, disruptive technology and use their core business to support the ongoing initiatives. For example companies with large distribution networks and logistics capabilities could help improve the supply and logistics management of key health products such as medical supplies or services; companies in the information and communications technology as well as the media could use their competencies to spread public health messages such as anti-malaria and HIV&AIDS campaigns or strengthen information systems in hospitals. Similar approach could be replicated in other sectors of the economy and lead to significant impact.

Public healthcare policy has been set-up and revised to encourage private sector support in healthcare (MoHCDGEC, 2015; MoHSW, 2008; Rweyemamu & Mwasongela, 2015). For example, under the current healthcare strategic plan (HSSP IV 2015-2020), government has declared its intention to support more private sector to practice CSR in healthcare. However, tactical planning is not disclosed in public policy. The lack of institutional framework for overseeing such business interventions could possibly limit the contribution of business community

in strengthening the country's healthcare system (GIZ, 2014; Nelson, 2008). Therefore, this study recommends that a CSR coordination unit at the ministerial level should be established to oversee all CSR related practices in healthcare support.

Such unit could have a coordinator and one or two programme assistant(s) who are both funded by the government or in collaboration with non-state stakeholders such as donors or business organizations. It could be responsible for: preparing consultation with business associations, chambers or industry initiatives to discuss development and implementation of country health plans and strategies; mobilize non-state actors to engage in content development and project proposals of country coordinating mechanisms in the case of threatening communicable and non-communicable diseases; providing secretariat or other services for such national level mechanisms and roundtables; publicly advocating for CSR practices in supporting government efforts to implement key public health initiatives; encouraging the private sector to participate in discussions about economic benefits of health in national economic forums, roundtables and economic development meetings (Nelson, 2008). Without such structure and strong political support, sustainability of CSR initiatives at all levels in healthcare cannot be ensured.

Promotion and nurture of sector-specific CSR interventions is of paramount importance in making CSR practices in healthcare more effective. This study found that firms operating in tertiary and secondary sectors were more active in

health related CSR practices. Since improving healthcare is one of the nation's missions, further research should be undertaken to find out why companies from other sectors are not motivated to engage in health related CSR practices. In this way, hopefully attractive strategies (such as establishment of a CSR award or tax exemption for an effective CSR practicing firm) would be found to motivate more companies particularly those in primary and quaternary sectors to contribute in improving the nation's healthcare.

This study also noted that despite of limited resource capacities in CSR interventions particularly in healthcare, SMEs have played important roles in supporting Tanzania's healthcare system. Current results show that SMEs are strongly concerned about the community and government's expectations on their implementation of CSR practices in healthcare. Nevertheless, because of their limited financial and human resource capabilities, their CSR interventions are not visible and often not considered as important. It is therefore recommended that specific measures should be taken to motivate SMEs to continue engaging in healthcare promotion and health protection. For instance, the already established CSR awards such as Presidential CSR Award could be extended to include SMEs that are actively supporting healthcare through CSR interventions. In addition, while large firms enjoy public incentives such as tax exemptions in response to their CSR interventions, such incentives could be extended to SMEs as well. This could motivate their participation in CSR practices and make them feel appreciated.

5.4 Managerial Implications

Cross tabulation result of this study shows that only 36% of the company respondents had engaged in dialogue with their stakeholders on CSR matters (see Table 4.5). Limiting the stakeholders' opportunity to voice their concerns may limit companies' access to certain resources. For example, communities may offer their resources such as land and manpower to certain company if the company could create more job opportunities to local community, or improve local healthcare services, or provide more educational support.

Thus, to reinforce the participatory nature of stakeholder dialogue in CSR decision making, CSR practitioners are suggested to internalize their stakeholders' concerns by involving them in the entire process of CSR development and implementation phases. For example, a joint CSR program could be developed. The company management could provide technical and financial resources while other stakeholders such as employees and communities would monitor its implementation. In this way, practitioners would be able to divide the roles and responsibilities among stakeholders and instill stakeholder ownership of CSR activities that could eventually ensure the sustainability of companies' interventions. It will also help to build and improve social and economic relations between companies and their stakeholders.

It is however important to note that large companies may have sufficient resources such as space, dialogue experts (moderators and facilitators), and funds for implementing mutually agreed goals and project activities, such companies could

engage in a more open and consultative form of dialogue. This type of dialogue allows consensus building in finding mutual solutions to problems (Kaptein & Tulder, 2003). On the other hand, SMEs could start with information sharing (bilateral discussion) form of dialogue to learn and understand their stakeholders' interests, opinions and expectations in regards to health and safety and adopt other forms of dialogue gradually. This form of dialogue is suitable for small business firms that do not yet have robust resource base to engage in more consultative dialogue structures that require dedicated human and financial resources (Eurofound, 2014).

Majority of the study's respondents agreed that their firms did not have any concrete CSR policy and thereby, they rarely engaged with their stakeholders to develop such policies and strategies. Effective CSR practices can be implemented if a policy, strategy or guidelines, finance and dedicated human resource to manage CSR interventions in consultation with their stakeholders are carefully planned. This would also help transforming stakeholder relationships from confrontational to consultation and henceforth, mutual beneficial and sustainable CSR interventions could be established.

Although the impact of CSR interventions of large firms and SMEs was not measured as it was not within the scope of this study, findings show that both types of firms do practice CSR in the Tanzanian healthcare. Literature indicated that CSR practices activated by large firms could create larger impact to society compared to their medium and small counterparts (Mousiolis et al., 2015;

Sweeney, 2009). Not only because large firms are under constant public scrutiny and stakeholders pressure, but also, the availability of financial and human resource are supporting these companies to implement large scale CSR practices in healthcare. Nevertheless, despite of SMEs' marginal size, collectively the companies are taking active part to develop sustainable CSR interventions with bigger impact. Therefore, this thesis suggests the establishment of strategic alliances among the small, medium and large companies to mitigate healthcare challenges.

Through the stakeholder dialogue framework developed in this study, companies (irrespective of their firm size) could collaborate in their interventions. For example, once a common CSR idea is developed and implementation strategy is worked out, firms could focus their attention in inviting and partnering with stakeholders who have the required capacities and expertise. In brief, establishing an effective alliance through business linkages could be of mutual benefits to all companies, irrespective of the firm size while at the same time providing pragmatic contributions in strengthening Tanzania's healthcare system.

5.5 Limitations of the Study

One of the limitations faced by current author is pertaining to responses given by study respondents: corporate executives. They may not be able to reveal detailed information on the relationship between companies' CSR practices and stakeholders' opinions. To overcome this challenge, after the main survey, focused group discussion was carried out with selected respondents including the

representatives of the ministry of health, trade association and community. The purpose was to find out their opinions in regards to their expectations on companies' CSR practices in healthcare and the need for stakeholder dialogue. This approach enabled the present author to capture the firm managers' and stakeholders' perspectives. Their responses were incorporated when discussing findings of the present study.

Data collection for the present study was indeed challenging due to the nature of the targeted respondents that included top business executives (CEOs, directors, managers and company spokespersons). Getting direct response from them could be difficult due to their tight schedules. As a result, 55 percent of the respondents were top managers while the remaining 45 percent were from the middle management. However, the responses were sufficient since both top executives and middle managers do take part in company decision making.

To reduce the risk of non-response and biased response, field survey technique involving face to face contact with the respondents were adopted. In addition, research officers from trade associations assisted the current author to collect data from respondents. Their personal relationships with majority of business managers of the private sector companies in Tanzania enabled the current author to collect data from targeted respondents. This approach enhanced the validity and reliability of collected data.

Literature review showed that large companies have more resource capabilities as compared to small and medium firms, therefore larger firms could organize effective CSR practices (Burton, 2009; Carlisle & Faulkner, 2004; Vo, 2011). Contrary to literature, this study found that a significant number of respondent companies, irrespective of the company size, had implemented CSR practices in the Tanzanian healthcare. However, the magnitude and impact of companies' CSR interventions on stakeholders' wellbeing were not examined and documented in this thesis as it is not in the scope of present study.

It may be true that some company respondents may not know how often had the company activated each of the items used to measure CSR's implementation in this study. Answers given could be based on their instinct rather than spending some effort to get the true answer. Counter checking the respondents' answer is useful but is challenging. For example, it is not easy to cross check how many times the company had subsidized their employee's healthcare. Numerous efforts were however taken to enhance the validity and reliability of collected data such as: pre-testing of the survey questionnaire to reduce the risk of incomplete information due to unreliable or confusing statements; pilot testing to enhance the applicability of questionnaire's statements; statistical analyses to reduce outliers and impute the missing data; and interviewing some employees to cross check their company's CSR practices on employees.

In addition, the present research facilitators had some knowledge on CSR practices that had been practiced by certain companies, such as the number of times that the

company had collaborated or supported the government or non-profit organization in public healthcare campaigns. In this way, reliability, validity and objectivity of data findings were achieved.

5.6 Suggestions for Future Research

To lessen or overcome the limitations faced by current study, the followings considerations for future research are suggested. In this study, effects of companies' senior management's perceptions about their stakeholders' health and safety expectations on implementation of CSR practices in healthcare were examined. Future studies are recommended to confirm present study's finding by investigating the stakeholders' response instead. Then, the current and future results can be compared and discussed, irrespective of convergent or contradicting results.

Current finding shows that companies are concerned about their stakeholders' health and safety and would implement CSR practices in healthcare in response to stakeholders' expectations. However, the impact of such CSR interventions on stakeholders' wellbeing is not documented in this thesis as it was not the focus of the study. Future research could empirically investigate the impact of CSR interventions of small, medium and large firms on stakeholders: customers, employees and communities' health and safety by taking into account companies' resource capacity differences, ownership structure, and stakeholder engagement strategies. This could provide useful insights for both policy makers and CSR

practitioners to estimate how the implemented CSR healthcare practices had improved stakeholders' wellbeing.

Current cross-tabulation results show that sector affiliation and CSR implementation in healthcare are significantly associated. To elaborate, companies from the secondary and tertiary sectors were found to be more engaged in CSR interventions in healthcare compared to those in primary and quaternary sectors. Since, improving public healthcare is indeed important to Tanzanians, future research should be conducted to find out why companies in the primary and quaternary sectors are not motivated to implement CSR particularly in healthcare. By understanding the underlying reasons, future researchers could suggest tactical ways to encourage the sectors' companies to assist the government in improving the nation's healthcare provision.

The unit of analysis for this study was private sector companies operating in Tanzania. Public sector companies and other government ministries, agencies and departments were not the primary target in this study. Nevertheless, some of these institutions had implemented CSR in various areas including health. Therefore, studying public sector institutions' response to CSR in healthcare could provide useful insights for policy makers and practitioners in the field of CSR to estimate the contribution of public agencies in improving the implementation of CSR practices in healthcare.

Finally, this study's results were generated from cross sectional data. Social and economic conditions of businesses change over time, these conditions might have significant impact on companies' CSR practices. The institutional framework that governs CSR interventions of companies might also change and influence companies' management decisions towards their CSR implementation. Therefore, longitudinal study could be useful to detect the changes and help policy makers and practitioners to forecast future CSR interventions and develop viable CSR strategies that can enable more Tanzanians especially poor people to get better healthcare services.

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LIST OF APPENDIXES

APPENDIX A: QUESTIONNAIRE COVER LETTER

Dear Participant,

I am a PhD student from the Univesiti Tunku Abdul Rahman in Malaysia. I am currently collecting data for my research "The Role of Stakeholder Dialogue in Motivating Private Companies in Tanzania to Promote Healthcare through Corporate Social Responsibility (CSR)".

I would greatly appreciate your support by completing the attached questionnaire which will take only 10 minutes of your time. Please be assured that your feedback will be treated with maximum confidentiality.

Thank you, in anticipation of your response.

Yours sincerely,

Zacharia Elias Lema

APPENDIX B: RESEARCH QUESTIONNAIRE

The Role of Stakeholder Dialogue in Motivating Private Companies in Tanzania to Promote Healthcare through Corporate Social Responsibility (CSR) Practices

Definition of key terms:

- **Corporate Social Responsibility (CSR)** is the continuing commitment by a company or an organization to deliver economic, social and environmental benefits (such as economic development, human rights, health and safety issues, environmental effects, and working conditions) to all of its stakeholders.

- **Stakeholders** are individuals or group of individuals who can affect or be affected by an organization's policy. They may include customers, employees, social communities, governments, NGOs, trade associations, academia, media etc.

- **Stakeholder dialogue** is an interactive process between a business company and its stakeholders, where social-economic concerns of both parties are bilaterally shared and discussed to reach a mutual beneficial agreement.

A. Information About Your Company

1. Your company operates in which of the following business sectors?
   - ☐ **Primary sector** that involves the extraction and harvesting of natural products from the earth (e.g., agriculture, mining and forestry).
   - ☐ **Secondary sector** consists of processing, manufacturing and construction.
   - ☐ **Tertiary sector** provides services, such as retail sales, transportation, telecommunication, hospitality/ tourism, professional services e.g. auditing, financial services, healthcare, information technology, waste disposal, real estate, franchising and mass media.
   - ☐ **Quaternary sector** is made up of intellectual pursuits, like education.

2. Please estimate the *number of employees* who are currently working in your company.
   - ☐ 1 to 4 employees
   - ☐ 5 to 49 employees
   - ☐ 50 to 99 employees
   - ☐ 100+ employees

3. Please indicate your company's ownership structure.
   - ☐ Foreign
   - ☐ Local

4. Please provide the estimation of your company's latest annual sales revenue.
   - ☐ Up to 5 million TZS
   - ☐ Above 5 to 200 million TZS
   - ☐ Above 200 to 800 million TZS
   - ☐ Above 800 million TZS

B. Company Involvement in CSR Practices

1. Is your company practicing CSR? *Please tick*
   - ☐ Yes
   - ☐ No

2. To what extent does your company promote healthcare services as part of its CSR program?

☐ Not at all ☐ To a less extent ☐ To some extent ☐ To a great extent ☐ To a very great extent

3. Please tick the box that you feel can best describe your views.

	Never	1 time	2 times	3 times	4 times and more
How many times per year on average had your company …					
• carried out sole promotion for public awareness on diseases such as Malaria, HIV/AIDS, Tuberculosis?	☐	☐	☐	☐	☐
• subsidized employees' expenses for major healthcare treatment?	☐	☐	☐	☐	☐
• collaborated with or supported other organizations (including non-profit oriented companies or government) in public healthcare campaigns?	☐	☐	☐	☐	☐
• contributed to the wellbeing of the needy community e.g. through material supplies such as bed sheets, mattresses, mosquito nets etc?	☐	☐	☐	☐	☐
• supported social community with physical expansion/ construction of health centres/ clinics/ hospitals?	☐	☐	☐	☐	☐
• helped non employees who are poor or disabled to get better healthcare services?	☐	☐	☐	☐	☐

C. Relevance of Stakeholders in Supporting your CSR Practices

1. How effective is the role played by each of the following stakeholders in motivating/ encouraging your company to practice CSR? *Please tick*	Very Ineffective	Ineffective	Neutral	Effective	Very Effective
Customers	☐	☐	☐	☐	☐
Employees	☐	☐	☐	☐	☐
Social Community / Neighbours	☐	☐	☐	☐	☐
Government	☐	☐	☐	☐	☐
Trade Associations (e.g. ATE, CTI, TCCIA, TPSF)	☐	☐	☐	☐	☐
Non-government Organizations (NGOs)	☐	☐	☐	☐	☐
Media Providers (e.g. radios, TVs, Newspapers etc)	☐	☐	☐	☐	☐
Academic Institutions (e.g. Universities, colleges, schools)	☐	☐	☐	☐	☐
Other stakeholders, please specify:	☐	☐	☐	☐	☐

2. For each of the following statements, please tick the box that you feel can best describe your view.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I. Customers' Expectations					
My customers expect the company to …					
• produce high quality and safe products / services that would not deteriorate their health.	☐	☐	☐	☐	☐
• respond in a timely manner when consumers start to complain about health issues caused by the consumption/ usage of the company's product &/or service.	☐	☐	☐	☐	☐
• provide clear and accurate information about the impact of the consumption/ usage of certain products/services on their health.	☐	☐	☐	☐	☐
• provide continuous services after the purchase of certain products/ services to ensure their health are well taken care of.	☐	☐	☐	☐	☐
• conduct surveys related to current/ possible health and wellness issues as a result of the consumption/ usage of the company's products**/** services and respond accordingly.	☐	☐	☐	☐	☐
• provide the opportunity for them to hold a dialogue with the company to discuss their concerns on matters related to healthcare.	☐	☐	☐	☐	☐
• comply with the international standards that are related to healthcare matters**.**	☐	☐	☐	☐	☐
II. Employees' Expectations					
My employees expect the company to …					
• be committed in addressing their health issues while at work (e.g. through workplace wellness programs).	☐	☐	☐	☐	☐
• give them the opportunity to discuss with the company's management team on health & wellness issues.	☐	☐	☐	☐	☐
• integrate employees' health & wellness concerns into the company's CSR strategy.	☐	☐	☐	☐	☐
• provide adequate safety training and preventive equipments such as facial masks and safety garments (*if the work may deteriorate their health*); and compensate workers who are injured when performing assigned tasks.	☐	☐	☐	☐	☐
• treat them fairly, equally and with dignity irrespective of their health status.	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
III. Social Community / Neighbors' Expectations					
The social community expect the company to …					
• provide some philanthropic contributions such as product/ service donations or staff volunteerism to enhance people's health.	☐	☐	☐	☐	☐
• give them the opportunity to discuss with the company's management on controversial and sensitive issues such as impact of environmental pollutions on community's health.	☐	☐	☐	☐	☐
• provide job opportunities to them so that they can take care of their health and those of their families.	☐	☐	☐	☐	☐
IV. Government Expectations					
The Government expects the company to …					
• comply with the relevant government guidelines/ rules/ regulations related to CSR practices in advocating for healthcare services.	☐	☐	☐	☐	☐
• invest in the society's wellness and prevention projects that could reduce healthcare disparities and/or improve the society's wellbeing.	☐	☐	☐	☐	☐
• comply with the legal and regulatory frameworks that are related to social wellbeing such as Occupational, Health and Safety (OHS) and labour laws that are meant to reduce the discriminant issues related to workers' health-status.	☐	☐	☐	☐	☐
• take preventive measures to reduce the damage on environment such as causing water, air, and noise pollutions.	☐	☐	☐	☐	☐
V. Expectations of Trade Associations					
Trade associations expect the company to …					
• assess the positive and negative impacts of its goods and services on consumers, employees and community's health.	☐	☐	☐	☐	☐
• identify more CSR opportunities that could enhance health & wellbeing of its customers, employees, communities and other stakeholders.	☐	☐	☐	☐	☐
• participate in healthcare CSR events/ programs initiated by business associations.	☐	☐	☐	☐	☐
• support the government to achieve the national strategic healthcare objectives which are meant to improve the society's health.	☐	☐	☐	☐	☐

D. The Role of Stakeholders' Dialogue in CSR Practices.

1. Does your company engage in dialogue with stakeholders on CSR matters? ☐ Yes ☐ No

2. How often does your company engage in dialogue with its stakeholders? *(Please tick)*

   ☐ Not at all ☐ Not often ☐ Sometimes ☐ Often ☐ Very often

3. For each of the following statements, please tick the box that you feel can best describe your view of the company's familiarity & interaction with stakeholders, and commitment to the dialogue process.

Stakeholder's Dialogue	**Never**	**Rarely**	**Sometimes**	**Always**	**Very Frequent**
I. Company familiarity of its stakeholders' attitudes, opinions and expectations on health issues					
Our company/ organization…					
• obtains sufficient information about its stakeholders' interests and demands on health matters.	☐	☐	☐	☐	☐
• document and appraise its previous relationships with stakeholders (important meetings, conflicts, agreements, judicial or extrajudicial demands, etc.) for the planning of future health related CSR programmes.	☐	☐	☐	☐	☐
II. The interaction process between the company and its stakeholders - (collaboration practices)					
Our company /organization…					
• engages in dialogue with its stakeholders to develop CSR policies and strategies that can contribute to sustainable healthcare programmes.	☐	☐	☐	☐	☐
• conducts frequent meetings with its employees, customers, community, government, trade associations, and activist groups to review on-going CSR initiatives and develop new avenues that can enhance their health and wellbeing.	☐	☐	☐	☐	☐
• consult its stakeholders and ask for their opinions before implementing a CSR project in healthcare.	☐	☐	☐	☐	☐
• has developed effective measures for compromising conflicts of interests among its stakeholders.	☐	☐	☐	☐	☐
• keep and promote good relationships with its stakeholders to ensure the achievement and sustainability of its CSR projects in health and wellbeing.	☐	☐	☐	☐	☐

Stakeholder's Dialogue	Never	Rarely	Sometimes	Always	Very Frequent
III. Commitment to stakeholders - management strategy **Our company /organization is committed to …**					
• put in more effort to prepare specific/ additional information that could enhance each stakeholders' understanding and comprehension of its current/ proposed CSR project in healthcare services.	☐	☐	☐	☐	☐
• align its health and wellbeing policies to map each stakeholders' interests and concerns.	☐	☐	☐	☐	☐
• conduct regular dialogues to inform and update its stakeholders of the importance and progress of its current/future CSR activities in healthcare.	☐	☐	☐	☐	☐

E. Benefits and Challenges in CSR Practices.

1. For each of the following statements, please tick the box that you feel can best describe your view

The following are the benefits I gain from business CSR interventions	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. My company gets more public recognition by implementing/ upholding ethical and moral obligations.	☐	☐	☐	☐	☐
2. The image of my company improved after establishing stronger ties with relevant social community including disabled people.	☐	☐	☐	☐	☐
3. My company's CSR practices in healthcare makes my customers more loyal.	☐	☐	☐	☐	☐
4. My CSR practices in healthcare motivate my employees to improve their work performance and retain in the company.	☐	☐	☐	☐	☐
5. My company's sales performance improves because of the CSR interventions in healthcare.	☐	☐	☐	☐	☐
6. It is possible for my company to mitigate the negative pressures that may be forwarded by external stakeholders (customers, communities, government, trade associations, and activist groups).	☐	☐	☐	☐	☐
7. My company enjoys public incentives such as tax exemptions.	☐	☐	☐	☐	☐
8. Other, please specify:	☐	☐	☐	☐	☐

2. For each of the following statements, please tick the box that you feel can best describe your view.

The following challenges inhibit my company interventions in healthcare	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. I don't have sufficient time and resources to take care of stakeholders' needs and interests.	☐	☐	☐	☐	☐
2. My company has no sufficient knowledge of how CSR can be practiced to promote healthcare services.	☐	☐	☐	☐	☐
3. The promotion of healthcare services is not related to my company's priorities and strategies.	☐	☐	☐	☐	☐
4. My company is too small to engage in CSR practices in healthcare services.	☐	☐	☐	☐	☐
5. My company cannot practice CSR in healthcare because the government does not provide any support.	☐	☐	☐	☐	☐
6. Other, please specify:	☐	☐	☐	☐	☐

Finally, for our statistical purpose, please indicate by ticking the appropriate box that corresponds to the information about yourself

1) Gender ☐ Male ☐ Female

2) Age ☐ < 18 years old ☐ 18-35 years old ☐ 36-50 years old ☐ 51-60 years old ☐ >60 years old

3) Highest qualification attained ☐ Primary School ☐ High School ☐ College Diploma ☐ Degree ☐ Post Graduate Degree

4) Current occupation ☐ Managerial ☐ Supervisor/ Executive/ Middle Management ☐ Others, please specify:

Thank you for completing this questionnaire. Your participation in this study is very much appreciated.
In case you are interested to receive the results of this survey please fill in the following information:

Name: _____
E-mail: _____
All individual details shall be held with the utmost confidentiality.

Please return your completed questionnaire to the person who gave it to you.

APPENDIX C: RESEARCH ETHICAL APPROVAL LETTER

UNIVERSITI TUNKU ABDUL RAHMAN
Wholly Owned by UTAR Education Foundation (Company No. 578227-M)

Re: U/SERC/48/2016

12 July 2016

Dr Chong Yee Lee
Department of Marketing
Faculty of Business and Finance
Universiti Tunku Abdul Rahman
Jalan Universiti, Bandar Baru Barat
31900 Kampar
Perak

Dear Dr Chong,

Ethical Approval For Research Project/Protocol

We refer to your application dated 6 June 2016 for ethical approval for your research project (PhD candidate's project) and are pleased to inform you that your application has been approved under expedited review.

The details of your research project are as follows:

Research Title	Stakeholders and Corporate Social Responsibility Practices in Tanzanian Healthcare Services: The Role of Stakeholders Dialogue
Investigator(s)	Dr Chong Yee Lee (PI) Mr Zacharia Elias Lema (UTAR Postgraduate Student)
Research Area	Social Sciences
Research Location	United Republic of Tanzania
No of Participants	400 participants (Age: 18 and above)
Research Costs	Self-funded
Approval Validity	12 July 2016 - 11 July 2017

The conduct of this research is subject to the following:

(1) The participants' informed consent be obtained prior to the commencement of the research,

(2) Confidentiality of participants' personal data must be maintained; and

(3) Compliance with procedures set out in related policies of UTAR such as the UTAR Research Ethics and Code of Conduct, Code of Practice for Research Involving Humans and other related policies/guidelines.

Address: Jalan Sg. Long, Bandar Sg. Long, Cheras, 43000 Kajang, Selangor D.E. **Postal Address:** P O Box 11384, 50744 Kuala Lumpur, Malaysia
Tel: (603) 9086 0288 **Fax:** (603) 9019 8868 **Homepage:** http://www.utar.edu.my

Should you collect personal data of participants in your study, please have the participants sign the attached Personal Data Protection Statement for your records.

The University wishes you all the best in your research.

Thank you.

Yours sincerely,

Professor Ir Dr Lee Sze Wei
Chairman
UTAR Scientific and Ethical Review Committee

c.c Dean, Faculty of Business and Finance
Director, Institute of Postgraduate Studies and Research

APPENDIX D1: INTRODUCTION LETTER 1

CHUO CHA USIMAMIZI WA FEDHA
THE INSTITUTE OF FINANCE MANAGEMENT
(ESTABLISHED UNDER THE ACT No. 3 OF 1972)

SHAABAN ROBERT STREET
P. O. BOX 3918
TEL: 2112931 - 4; 2114817
FAX: 2112935
RECTOR@IFM.AC.TZ
DAR ES SALAAM
TANZANIA

Our Ref.No.IFM/PF.975 11th July, 2016

TO WHOM IT MAY CONCERN.

RE: INTRODUCTION LETTER FOR MR. ZACHARIA ELIAS LEMA

This is to certify that the above named person is an employee of the Institute of Finance Management, employed on permanent and pensionable terms as Assistant Lecturer. Currently, he is on research to accomplish his PhD studies. His research topic is "Stakeholders and Corporate Social Responsibility (CSR) practices in the Tanzanian healthcare: The role of stakeholders dialogue".

Please assist him with data collection to accomplish his study.

Thank you for your good cooperation.

Lucy W. Morenje
For: RECTOR

APPENDIX D2: INTRODUCTION LETTER 2

UNIVERSITI TUNKU ABDUL RAHMAN
Wholly Owned by UTAR Education Foundation (Company No. 578227-M)

15th June 2016

To Whom It May Concern

Dear Sir/Madam,

Permission to Conduct Survey

This is to confirm that the following student is currently pursuing the *Doctor of Philosophy (PhD)* program at the Faculty of Business and Finance, Universiti Tunku Abdul Rahman (UTAR) Perak Campus.

We would be most grateful if you could assist the student by allowing the student to conduct the research at your institution. All information collected will be kept confidential and used only for academic purposes.

The student name is Zacharia Elias Lema and the student registration number is 15ABD06506.

If you need further verification, please do not hesitate to contact us.

Thank you.

Yours sincerely,

Dr Chen, I-Chi
Head of Department,
Faculty of Business and Finance
Email: chenic@utar.edu.my

Dr Chong Yee Lee
Supervisor,
Faculty of Business and Finance
Email: chongyl@utar.edu.my

APPENDIX E: FACTOR ANALYSIS - INITIAL SOLUTION

	Factor											
	1	2	3	4	5	6	7	8	9	10	11	12
DLG5	.817											
DLG4	.797											
DLG7	.768											
DLG6	.767											
DLG3	.755											
DLG10	.711											
DLG9	.672											
DLG1	.623											
DLG8	.611											
DLG2	.588											
GOV1		.966										
GOV2		.867										
GOV3		.766										
GOV4		.549										
EMP3			.819									
EMP5			.663									
EMP2			.628									
EMP4			.620									
EMP1			.589									
EMP6			.500									
EMP7												
CUST6				.947								.509
CUST5				.803								
CUST7				.690								
CUST4				.659								
TRA4					.851							
TRA2					.792							
TRA3					.764							
TRA1					.719							
CSR5												
CSR1						.801						
CSR3						.792						
CSR2						.687						
CSR6						.681						
CSR4												
COM2							.918					
COM3							.819					
COM1							.651					
COM6												
CUST2								.996				
CUST1								.766				
CUST3								.658				
ACTV2									.897			
ACTV1									.858			
ACTV4										.874		
ACTV3										.711		
COM4											.777	
COM5											.722	
GOV5												.767

Extraction Method: Maximum Likelihood.
Rotation Method: Promax with Kaiser Normalization.

APPENDIX F: FACTOR ANALYSIS - TOTAL VARIANCE EXPLAINED

	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings[a]
Factor	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total
1	8.707	22.913	22.913	7.352	19.347	19.347	6.282
2	4.619	12.154	35.067	4.453	11.718	31.065	5.958
3	3.253	8.560	43.626	2.445	6.434	37.500	4.333
4	2.700	7.107	50.733	2.746	7.225	44.725	3.815
5	2.557	6.728	57.461	2.302	6.057	50.782	4.198
6	2.150	5.659	63.120	2.054	5.405	56.187	2.566
7	1.712	4.506	67.626	1.642	4.320	60.507	3.474
8	1.100	2.895	70.521				
9	1.015	2.670	73.191				
10	.815	2.144	75.335				
11	.745	1.962	77.296				
12	.743	1.954	79.250				
13	.699	1.839	81.089				
14	.633	1.665	82.754				
15	.577	1.519	84.273				
16	.510	1.342	85.614				
17	.488	1.284	86.898				
18	.451	1.186	88.084				
19	.440	1.157	89.241				
20	.409	1.077	90.319				
21	.387	1.019	91.337				
22	.361	.950	92.287				
23	.345	.907	93.194				
24	.329	.866	94.060				
25	.275	.722	94.782				
26	.256	.674	95.457				
27	.247	.651	96.107				
28	.231	.607	96.714				
29	.208	.548	97.263				
30	.195	.512	97.775				
31	.157	.413	98.188				
32	.144	.379	98.567				
33	.137	.362	98.928				
34	.107	.283	99.211				
35	.095	.249	99.461				
36	.081	.214	99.675				
37	.067	.178	99.852				
38	.056	.148	100.000				

Extraction Method: Maximum Likelihood.

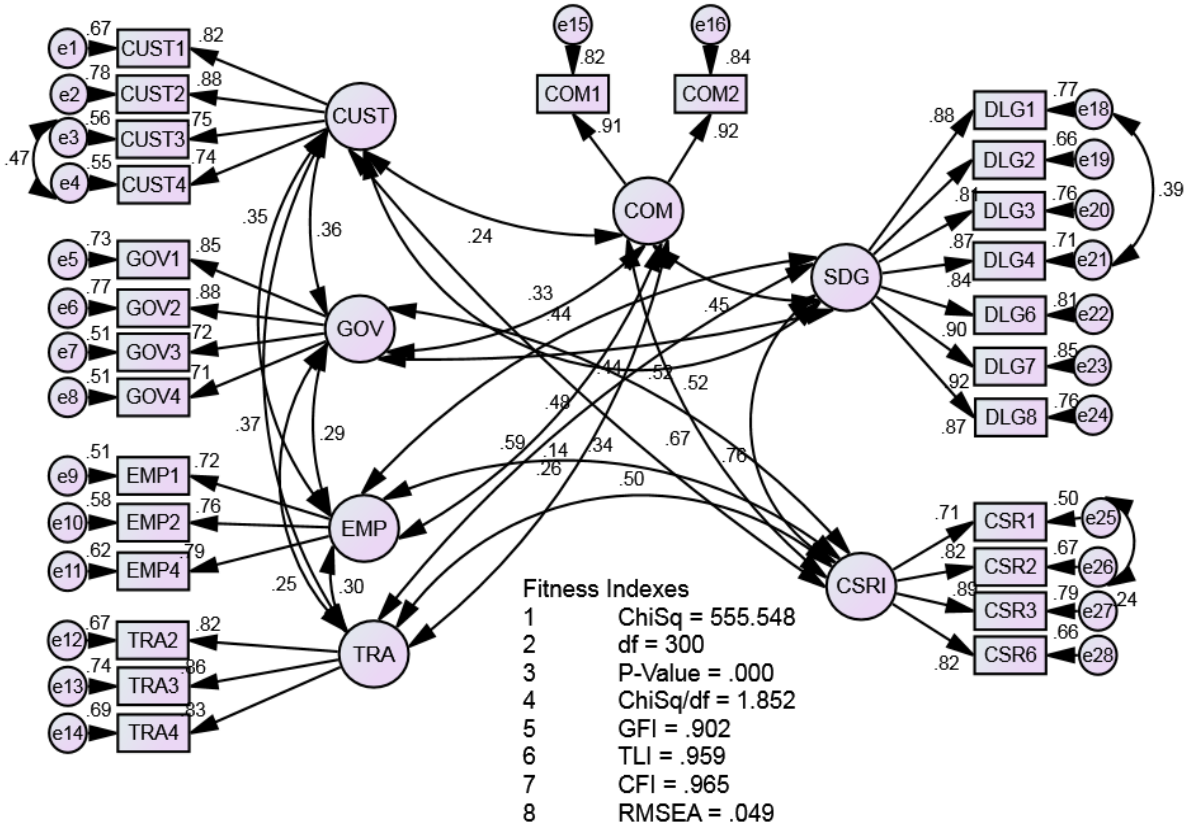
a. When factors are correlated, sums of squared loadings cannot be added to obtain a total variance.

APPENDIX G: IDENTIFICATION OF MISSING VALUES

Frequency Table - Missing Values

		EMP2	EMP7	COM3	GOV2	GOV3	GOV4	TRA3	TRA4	BNF6	CHL2	Education
N	Valid	441	441	441	441	441	441	441	441	441	441	441
	Missing	1	1	1	1	1	1	1	1	1	1	1

APPENDIX H1: CFA MEASUREMENT MODEL FOR SMES



APPENDIX H2: STRUCTURAL MODEL FOR SMES