The Reasons for migration in the Nigerian health sector: A case study of Lagos University Teaching Hospital (LUTH) and Federal Medical Centre Asaba (FMC)

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Dedication

I would like thank God for His grace upon me and the strength to complete this thesis. I would also like to thank my family and everyone that supported me in the course of this work.

Acknowledgement

An academic work of this magnitude could not have happened without the support of great people around me and for this I am grateful

I would like to first thank my supervisor Ciara Deane for her support and her unwavering determination and constructive advice in ensuring that this dissertation is a success.

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Findings: This study found from referenced materials that income, job satisfaction, and security are major determinants for health workers decision to migrate. People are likely to migrate to where the standard of living is better than what they are currently enjoying.

Practical Implications: This study will give an in-depth if factors that t improves or disprove mass migration of health workers. Government /thought leaders in the international community can use the information provided to improve /advise the government on how to reduce the urge of health workers to migration from Nigeria and other developing countries.

Research Limitations: Data, like the exact number of health practitioners leaving the sending country is difficult to ascertain due to lack of available record online. Also, due to proximity between the researcher and respondents, it was difficult to get as many responses as possible even though the questionnaire would not take more than two minutes to fill.

Originality and value: Previous research on the Nigerian health sector is more focused on the public sector with less focus on the private sector. Hence, not much originality can be sited from the private health sector.

Keywords Health sector funding, Nigerian Health care, Health workers migration, Job satisfying dimensions.

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Abstract:

The migration of health workers from Nigeria to developed countries should be of great worry to all stakeholders because of its impact on the health sector of the economy and the nation's economy at large. This trend has led to a shortage of medical manpower and a deteriorating health sector with no chance of survival unless a drastic action is taken by policy makers. The contributing factor of migration from Nigeria, are security, standard of living, occupation/work satisfaction, the distribution of labor in the health sector between the public and private hospitals and the quality of care.

From our review and analysis, Nigeria's best resource is human capital, but it is not making the best use of it. A growing population with a less developed infrastructure will lead to more migration of the best talents from the country. Migration of skilled labor from developing countries is a form of human capital export and a sector that exports more of its best talents with replacement of the same, will at some point collapse.

Chapter 1:1 Introduction

The health workers in any country are the people whose responsibility it is to enhance the health of the citizens of their country and without them, quality healthcare cannot be guaranteed or efficiently delivered to the populace (World Health Organization, 2006). The main focus of this study is on the migration of health workers of Nigerian origin and the implication this has on other practitioners left behind which is multi-faceted and by extension its impact on the Nigerian economy at large.

It takes an average medical doctor about seven years to study medicine in the university and an additional six to eighteen months to secure a place for house-manship which is a one-year mandatory employment programme for all graduated doctors, or they would have their provisional medical licence revoked. The delaying securing the placement for house-manship is caused mainly by systematic neglect of the health system by successive government administration coupled by poor budgeting, and this has led to many doctors resorting to writing professional exams which would qualify them to practice in the abroad and especially practice in western countries (Abubakar, 2021).

There are many reasons people including health workers migrate from their home country to the abroad. In Nigeria and most low- and middle-income earning countries, the reason is usually economic which reflects in the sub optimal functioning of their economy. Before the 1990s, several people of African

descent had migrated and settled in the abroad out of their own will, with the west topping the list of where people migrated to, this was an unprecedented trend between the 1990s and 2000s and it was made possible by a combination of factors, and we can sum these factors as push and pull factors of international migration. While the major push factors for this move are low standard of living, political instability, insecurity, and lack of opportunities to utilise skills. The pull factors for migrating are higher wages, better job opportunities, relatively good working conditions, freedom from political instability, relaxation of immigration policies and the phenomenon of new globalisation. The main destinations of most health workers are the United States, Asia, United Kingdom, Canada and Europe and this has led to a drastic reduction of health practitioners left back home, poor basic health care delivery and subpar healthcare programmes, inefficient utilisation of external assistance and low level of institutional capacity building are the main effects the loss of highly-skilled Nigerian health workers has on the country's and Africa's health care development (Samson Adesola Adesote, PhD, Olusesan Adewunmi Osunkoya, Ph.D, 2019).

Health governance is the arm of government saddled with the responsibility of making policies that will ensure the effective provision of optimal health service delivery according to universal health care practices (World Health Organization, 2014). In Nigeria, the arm of government whose responsibility it is to ensure the efficient delivery of good health is the ministry of health, they oversee the activities of commissioners of health at the state levels from the federal level of governance. Their inefficiency which is a reflection in the underinvestment as well as the poor administration in the health sector have to a

large extent contributed to the mass exodus of healthcare workers from the country which has in turn left the country's health system in a fragile state. It has been proven by experts that there is a direct correlation between the efficient governance of the health system and the positive output of health workers which in turn reflects in the positive health of the citizens (World Health Organization, 2007) the same assertion was collaborated in a journal of national Library of Medicine (Robert Fryatt, Sara Bennett, and Agnes Soucat, July 2017) .

1.2 Background of study

The Nigerian healthcare system is comprised of both the public and private sectors. The public is owned and managed by government appointed directors while the private sector is owned and managed by private citizens. The public health care which is the focus of this research is divided into Federal Medical Centres, Federal/ State General hospitals, and University teaching hospitals and all these are mostly funded by citizens tax through budget allocation by the government. Since the public health sector is owned and managed by the government, and the challenges associated with one can also be linked to others. The Lagos University Teaching hospital (LUTH) is in Lagos State, which is a major business district in Nigeria, it is owned by the Federal government and is among the foremost University teaching hospitals established in the country. It has eight major departments consisting of Dentistry, Internal medicine, Obstetrics and Gynaecology, laboratory medicine, Paediatrics, Oncology, Surgery and Allied Services and as 2020, it had 4 neonatologists, 10 resident

doctors, 26 nurses and 8 support staff (Fajolu, 2019).While the Federal Medical Centre (FMC), Asaba has the following departments; department of dentistry, Ophthalmology, Pathology, Public health, Family medicine, Paediatrics, Radiology, and Physiotherapy. The reason for picking the afore mentioned hospitals is because of their demographic location in the country. While LUTH is situated in the business capital of the country with huge social economic issues such as over population and high cost of living, the FMC is in Asaba, a suburban state with more docile demography but the same challenges which we would address in the later chapter is a binding factor to both states and more likely throughout the country.

These government health centres, or hospitals are expected to be well equipped and accessible to every citizen regardless of their status. According to Fagite, (Fagite, 2016), stated that the deteriorating socioeconomic conditions and deepening poverty in the late sixties and early seventies gave room for a wide variety of migration option. Immediately the excitement of national sovereignty waned and the early nationalists, who assumed the mantle of leadership with the exit of the colonisers, began to mismanage the collective resources of the nation, and military intervention became inevitable, the country was plunged into the grip and jackboot of military dictators. The situation forced many Nigerian professionals including health workers to relocate to countries that are more conducive and accommodating in their effort to increase their standard of living. But since the inception of the National Health Scheme, only about one percent of the populace have access to health insurance policy (NOIPOLLS, 2017).

Pre Covid and travel bans, the list of people including government officials that travel from Nigeria monthly to the UK, Middle East, China, India and Saudi

Arabia were about 5000 and in 2013, and $ 1.2 billion was lost to other countries for treatments that could have been managed back home if it had been invested at home health sector. So, while other countries are gaining, Nigeria is losing (BBC, 2016) and in another report in 2020, during the peak of the pandemic, it was reported that the Nigerian health sector ranked 142 out of 195 countries as less than 5% of the national budget was allocated to the health sector and as the corona virus incidence continued to rise, it was further reduced to 3.87% from a previous allocation of 4.38% and this is considering that the country has one of the lowest life expectancy rates in the world (BBC, Health care and Quality ranking, 2020).

In 2016, Price Waterhouse Coopers also reported that about $ 1 billion was spent by Nigerians on medical tourism, this according to the report is 20 percent of government's total spending including salaries of medical officers, nurses, other health practitioners as well as other health programs (PwC, 2016). With the rise of medical tourism, comes a rise in demand for more skilled health practitioners especially doctors and nurses in these developing countries because a rise in demand requires supporting supply.

In August 2021, Saudi Arabia officials came to Nigeria to scout for medical practitioners (Olatunji, 2021) because of the shortage in the supply of their skilled manpower. This kind of move is not peculiar to only Saudi Arabia as another report in 2018 shows that Nigeria loses ten doctors to the UK on a weekly basis (Mwiti, 2018) and the figure has not decreased. This has in turn led to a shortage of doctors and nurses in the sending country and for the purpose of research, health workers from LUTH and FMC through a structured qua analysis method using questionnaire will be adopted.

There is a major crisis within the African continent health workforce which has been reported as perhaps the biggest constraint towards global health system development and sustenance (Health workforce and governance: the crisis in Nigeria, 2017). Nigeria, the most populous African country, possibly contributes even more to this crisis in the region. Increasing annual rates of population growth, as observed in Nigeria, has been adjudged a major factor in countries with severe health workforce crises and the country requires significant increase in the number of additional health workers practicing in the country as against those leaving the country to achieve desired population coverage. The Lancet publication for March 2022, opined those discussions about health is at the centre of the development of any country. Although Nigeria's gross domestic product is the largest in Africa, but its per capita income of about ₦770 000 (US$2000) is very low due to a highly inequitable distribution of income, wealth, and of course, health. What Nigeria's economy represents is a picture of very poor people amidst plenty resources.40% of the citizen live in poverty, in social conditions that create ill health, and with the ever-present risk of catastrophic expenditures from high out-of-pocket spending for health. Even compared with countries with smaller income levels in Africa, Nigeria's population health outcomes are poor, with national statistics masking drastic differences between rich and poor, urban, and rural populations, and different regions (The Lancet Nigeria Commission: investing in health and the future of the nation, March 2022).

1.3 Relevance of this Research: Health is said to be wealth or to put it in the exact words of the American Philosopher Ralph Waldo Emerson, The first wealth is health. This means that a healthy nation can be called wealthy but with the migrating trend of health officials, the health system of the Nigerian nation is at the brink of collapse. Also, Nigeria is projected to be the third most populous country in the world after China and India by 2050 with a population growth of 400 million. The potential gain from this population growth is if the growth is supported by equitable distribution of wealth. A rising population with the absence of reliable access to quality health care, and other public services will serve only to increase the potential for unrest, drive large-scale unplanned migration, and consequent regional and even global instability (Ibrahim Abubakar, Sarah L Dalglish et al, 2022). Hence, the relevance of this work is to analyse the impact this migrating trend has on the health sector and the economy at large. This is because in recent times, there has been an increase in the number of health workers migrating to the United Kingdom, United States and the Arabian Gulf due to economic and professional reason and this has both economic and social implications on the Nigerian system (Oladimeji A, Adufe I, Ayanfe O, et al, 2019).

Another relevance of this research is the brain drain effect that this trend has on health sector's effectiveness, and quality of services available to the public in both public and private health institutions in Nigeria. According to Adepoju, (Adepoju, A) the effect of brain drain has resulted in the inadequate delivery of healthcare services in Nigeria. This has also caused a major effect of back home, because of the disparity in the ratio of health professionals to patients. For example, in some parts of Nigeria, the ratio of healthcare professionals to

patients can be as high as 1: 4,000 (Kaba, A. , 2011). This contrasted with the minimum health standard recommended by the World Health Organisation (WHO) for the developing countries, which emphasised that the doctor versus patient ratio should be 20 physicians per 100,000 to ensure basic healthcare services (Boyo, T.M., 2013). Below are the objectives of this thesis.

Objective 1: To identify the age distribution, gender, and marital status of the health workers.

Objective 2: To determine the effect of years of experience and areas of practice on willingness of the health workers to migrate

Objective 3: To determine the impact of migration on the LUTH and FMC Asaba health workers

1.4 Conclusion

We will review some relatable journals by academic scholars on the social, economic, and the brain drain effect migration has on the Nigerian health sector. Because it is not debatable that a country can achieve its full potential when its best brain is “pushed” into migration to more developed countries in search of better life. The United Nations Economic Commission for Africa (UNECA) for instance states that the migration of African professionals to developed nations is one of the greatest obstacles to Africa’s development. If a solution is not found , soon Nigeria would have lost all its skilled workers to the west (Boyo, T.M., 2013). “The gaps with our findings will provide a rationale for conducting this research.

Chapter 2.0

2.1: Literature Review

The migration of medical workers is often prompted by living and working conditions which can be termed as the push and pull factors because most referenced articles have identified the decision to migrate to be related to income and this is compared to what they need to earn to enjoy good quality of life (Nair M, 2013) . This was followed by the cost of living, the ability to find the job they wanted and security for themselves and their family (Margaret Walton-Roberts, Vivien Runnels, S. Irudaya Rajan etl, 2017).

In either the low- and middle-income countries or developed and wealthy countries, certain competencies and skills are very specialized and are equally in very limited supply but are in high demand globally (Mahroum, 2001). Healthcare professionals especially doctors and nurses fall under this much sought-after skill set. The mass migration of healthcare workers from the Nigerian health sector of which Federal Medical centre and Lagos University Teaching hospital (LUTH) fall in to developed countries is a huge human capacity loss despite the remittance advantage. Their migration matters because their expertise is fundamental for the implementation of reforms needed in the health sector.

There are 72,000 medical doctors registered with the Medical Council of Nigeria but only less than half of this figure are practicing healthcare within the

country in both the public and private sectors. The implication of this is that in a country with a population of about 180 million people it has only 35,000 doctors practicing within its shores, and this means that the ratio available in Nigeria is 1:5000 (1 doctor to 5,000 persons) against the global recommendation of 1:600 (Abiru, 2019). Despite this trend, there is no strategy to manage the outflow or a policy to initiate the return of emigrated health officials. This has a negative effect on the cost and quality of healthcare available in the country and the life expectancy of an average citizen. If we also factor the time it takes for new graduates to be admitted into the association due to the number of years required for them to train and become qualified (seven years). Also, Nigerian trained doctors form a significant proportion of International medical graduates from sub-Saharan Africa (Hagopian A, Thompson MJ, Fordyce M, Johnson KE, Hart LG, 2004) This pattern appears not likely to abate soon with a relative perennial shortage in developed countries (World Health Organization , 2016).

Migration often creates occupational vacuum in the sending country because people leave with their knowledge and work experience, and it would require fresh training to get people to fill the vacuum. There is a human capital crisis in the Nigerian health sector because most of the doctors and nurses are migrating to developed countries for better employment opportunities. The public sector is severely under-funded and the annual budget that is allocated to the sector is never enough (Peggy & Bernard, 2016). The fact that most of the country's low- and middle-income earning citizens rely on the public health sector for treatment of different kinds of illness due to its affordability makes this mass migration very worrisome and calls for urgent attention and possible intervention by the government.

The outflow has led to brain drain narratives which is the export of human capital from Nigeria, leaving the domestic economy very vulnerable while the richer countries are benefitting from the investment Nigeria has made on its own people. Striking amongst health workers has become a reoccurring phenomenon and some of the reasons is constant delay in salary payment, non-payment of insurance benefit and poor working facilities that constantly puts them at health risk, this is according to a report by Aljazeera (Al Jazeera, 2021). This in turn is demoralizing to the health workers because it makes the job less satisfying. In an article by the World Medical Journal, factors that affects a doctor's job satisfaction on the job includes job security, finance incentives such as salaries and allowances, interaction with colleagues' number of shifts worked per day, conditions of service, ways conflict are resolved (Buowari). When health workers are perceived not to derive satisfaction in the afore mentioned areas from their job, they would seek for where they can get it and most often it is by moving to better countries where their skills are better appreciated. Before exploring the reason healthcare workers in Nigeria are migrating in their large numbers, it would be proper to begin with the current state of healthcare in Nigeria and this will give an insight to the reason for mass migration by health practitioners in Nigeria.

2.2: Reasons for migration

While sharing my questionnaire, a conversation ensued between a doctor and I and he told me that more health workers are going to leave because every conversation is centred on their plans and what stage they are on in the migration process. He also reiterated what is already a public knowledge, that everyone wants a better life for themselves and their family that has

spent so much training them and the best way to repay is by moving to a country where policies work and they can make a better life for themselves. The reason Nigeria does not fit into the portfolio is because of the reasons stated below:

Underfunding: The African heads of State through the African Union in 2001 agreed that 15 percent of the annual budget will be allocated to the health sector but what the Nigerian government has been allocating is under 10 percent (Babaranti, 2017). This alone tells us how grossly underfunded the public health sector is and even at that, some people still find ways to mismanage the allocated funds. In 2019, it is on record that the country alone was responsible for 20 percent global maternal mortality (WHO, 2019).

Dilapidated structures and outdated medical equipment: Many governments owned hospitals are in bad shape, from the buildings to the structures within the building. Availability of Computed Tomography scans and other modern diagnostic equipment are common and affordable in other developed countries but in Nigeria such equipment are reserved exclusively for the rich and most government hospitals still refer patients to private laboratory for tests and diagnosis (John, 2016) and (Mekwunye, 2016). A 2018 report done on LUTH shows that most of the equipment available in the hospital are in a dilapidated state and patients are often referred to Private hospitals for tests and treatment that could have been done there (Premium Times, 2018).

Lack of trust in the health care system by the wealthy and politicians: Most politicians and people with means do not trust the government health sector, they would rather patronize the private hospitals or in severe cases, be flown travel abroad for their medical attention and this includes the president of the nation.

(BBC, 2016). This, in conjunction with the dearth of robust population-level health and mortality data, insufficient financing for health and health care, sub-optimal deployment of available health funding to purchase health services, and large population inequities which has resulted in low life expectancy when compared with neighbouring African countries (Ibrahim Abubakar, Sarah L Dalglish, Blake Angell, Olutobi Sanuade, Seye Abimbola, Aishatu Lawal Adamu, and others, March 2022)

Gross underpayment of health care workers: According to Docquier and Marfouk (Brain Drain in Developing Countries, 2006), over 10 percent of the highly skilled nurses who were trained in Nigeria are currently working abroad mostly in Organization for Economic Cooperation and Development (OECD) countries. Many of the remaining nurses that stayed back at home are ill-motivated, not only because of their workload, but also because they are poorly paid and equipped, and have limited career opportunities when compared with their colleagues, this further cripple the health system, thereby, placing greater strain on the remaining nurses who themselves seek to migrate from the poor working conditions.

A large health out of pocketing spending: In a report by the World Bank (World Bank, 2018), most Nigerians do not have health insurance plan making them spend out -of -their pocket for medical treatment. The government in turn takes from this spending for the finance of the hospitals and this means that most poor people have limited access to health care since they cannot afford the treatment.

Poor data collection: there is no central data collection system in Nigeria and most sources of data collection is from international NGOs, UN and WHO (this

is obvious from my references). This makes it easy for duplication of figures and harder to track within the system. Most times, patients' files get lost leading to misdiagnosis and duplication of different information for same patient.

Another important factor affecting the state of the country's health sector leading to mass migration of health workers especially doctors is the lack of recognition of their residency by other countries. In his submission, Okonofua (Okonofua, 2018) stated that the degrees offered by the National Postgraduate Medical College of Nigeria and the West African equivalent is not recognized, so doctors do not see the long term benefit of having such certification and would rather migrate to get globally recognized qualification that would advance their profession.

The causes for migration of health workers to developed countries includes better employment condition, more attractive salaries, availability of training opportunities, poor working condition in the sending country especially for those working in highly transmittable diseases section such HIV, Tuberculosis and COVID-19, better training opportunities and career advancement, improved and professional working environment, a stable political environment and attractive retirement benefits (Olorunfemi, Agbo, Olorunfemi, & Okupatat, 2020). One of the biggest factors that influences migration of health workers is the perceived different life prospects that people in developed countries enjoy, improved prospects of raising their children in a better environment and the disparities in income between the developed and the developing countries (Astor, 2005) and (Fagite, Nigerian Nurses on the Run: Increasing the Diaspora and Decreasing Concentration, 2018) .

Some of the impact of migration on health workers in Nigeria includes more workload for those still practicing within the country due to shortage of manpower. This is because unlike the recommended ratio of 1:500 by the World Health Organization, the current ratio for doctor – patient in Nigeria is 1:5000 this means that the doctors are been overworked, with doctors seeing about 200 patients per day (Onyekwere & Egenuka, 2019). No worker will function properly under such strenuous working condition.

2.3: Impact of migrating health workers

The impact migrating has on the remaining health workers is both emotional and psychological. Because colleagues turned friends suddenly get to part ways without knowing when they are likely to meet physically again, one person takes up duties that is usually assigned to more than one person without an equal increment in pay which ultimately leads to weariness. Other impact on the remaining health workers are listed below;

Causes brain drain: Brain drains according to Oyelere, is when a country starts losing skilled workers in a particular field due to migration thus resulting in the economic development of the host/receiving country (Oyelere, R.U, 2007). Nigeria like most developing countries has not been able to attract in equal ratio the number of skilled migrants it has been exporting her skilled workers to the west (Central Intelligence Agency , 2017).The impact of migration of health workers on the health sector is the issue of medical brain drain because they are very few capable hands left to manage the various diseases ravaging the country

such as HIV/AIDs, Malaria, tuberculosis and recently Corona Virus and this has put a strain on the system. We need these professionals to help in the fight, but the vacuum created by their exit is threatening the long-term needs of the country's development (Olorunfemi, Agbo, Olorunfemi, & Okupatat, 2020). In a televised interview conducted on the 14th Dec, 2021, the President of the Association of Resident Doctors, LUTH. Dr. Hassan Jimoh, buttressed the impact the brain drain is having in the sector especially now that they have to deal with challenge of COVID-19 and called for government's urgent intervention especially in the prompt payment of owed salaries. Prior to this interview, there was a nationwide strike of medical workers in the public sector including the FMC Asaba where the president of the resident doctors on the 10th April, expressed the groups' displeasure of at government's unwillingness keep their part of the agreement.

It has led to the dearth of healthcare practices in the rural areas: It has become increasingly difficult to recruit health workers to the rural areas due to shortfall in supply of workers in the cities coupled with the unwillingness of those who have not migrated to work in rural areas, this is because working in urban areas provides an upward carrier projection is higher .This also means that the rural areas are mostly underserved (Fagite, Nigerian Nurses on the Run: Increasing the Diaspora and Decreasing Concentration, 2018)

It reduces work satisfaction: Due to the difficulty of getting replacement for migrated officials, the remaining health workers feel over stretched in their

duties which usually causes a friction between their work/life balance and this reduces the pleasure derived on the job which can also cause professional isolation which in turn leads a lot of them to depression and the desire to migrate thereby causing a vicious circle (Esan, et al., 2014) and (Buowari). This also leads to high burnout and presenteeism amongst the health worker, this adversely affects them and the patients they are tending to.

Causes Burnout and Presenteeism: Burnout happens when there is stress caused by intense work demands in the setting of inadequate resources (HJ., Freudenberger, 1974). Due to the interplay between emotional intense interaction, workdays, and workload, the healthcare industry is burnout prone. (Arinze D.G. Nwosu, Edmund Ossai, Okechukwu Onwuasoigwe et al, 2021) Presenteeism on the other hand, is a work-related behaviour where one shows up for work when ill but is unable to perform his duties optimally due to weakness of the body or health impairment. Burnout and presenteeism happens because there are not enough workers to cater for the high number of patients needing medical care and this leads to low productivity, medical errors such as misdiagnosis and lowers patient satisfaction (Arinze D.G. Nwosu, Edmund Ossai, Okechukwu Onwuasoigwe et al, 2021).

2.4: Literature Review Conclusion:

The significance of Nigeria to the global health and health in the African continent is self-evident given its large and mobile population A large population of healthy people with the right policies can make Nigeria a global superpower. Major health gains in Nigeria will by extension improve health outcomes in the African continent by

improving the health security and by sharing good health practice and policies to neighbouring African countries (Ibrahim Abubakar, Sarah L Dalglish et al, 2022). But according to all the health metrics, Nigeria's health system is faced with her inability to achieve any of the health-related Millennium Development Goals. No adequate health progress has been made in the last three decades with budgetary allocation to health being as low as 4% in 2018, whereas resources are spent fighting other vices like insecurity without addressing the root cause of the issues. This means that government at all levels need to prioritise the health of citizens by creating sustainable policies for each region and through adequate funding (Ibrahim Abubakar, Sarah L Dalglish et al, 2022).

Due to the underfunding of the health sector, the capacity and quality of government health facilities and health services dwindled due to the persistent unavailability of drugs and equipment, resulting in increasing strain among the health practitioners (Ibrahim Abubakar, Sarah L Dalglish et al, 2022). If Nigeria wants to deliver on its universal health coverage, then the health financing reform is essential. The reform should focus on increasing government funding for health, improving resource management through strategic purchasing, and altering the National Health Insurance Scheme (NHIS) legislation to require using a revised and more robust benefit package, and establishing strong systems for oversight and regulation of providers such as Health Maintenance Organisations (Ibrahim Abubakar, Sarah L Dalglish et al, 2022). The pull factors attributed to emigration of health workers includes better working environment, better salary, advanced research facilities, better security. To address this, the government can start by providing a more conducive environment by providing adequate wages, ensure better security and provide adequate training for health

workers. Government intervention to providing these services will go a long way in retaining medical workers (Mansur A. Ramalan, Rayyan M. Garba, Sept - Oct 2021).

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Chapter 3: Research Methodology

3.1: Overview

This chapter contains the overall methodological framework adopted in conducting this research. Data was collected using a primary survey, semi-structured questionnaire. The questions were divided into three sections consisting of respondents' demographics, work experience and questions pertaining to the research work. These will be structured in a tabular form. The study population consists of medical practitioners' resident in Nigeria, and they consist of early career doctors and those who have spent more years in practice, and they were recruited from FMC and LUTH respectively. This chapter is very essential because it contains the framework adopted in achieving the objective of this thesis.

3.2 Research Questions

Research question 1: What is the age distribution, gender, and marital status of the health workers

Research question 2: How many years of experience and area of current practice do the respondents possess

Research question 3: What are the main causes of the health workers migration and its effect on LUTH and FMC?

The above research questions are designed to achieve the following objectives.

Objective 1: To identify the age distribution, gender, and marital status of the health workers.

Objective 2: To determine the effect of years of experience and areas of practice on willingness of the health workers to migrate

Objective 3: To determine the impact of migration on the LUTH and FMC Asaba health workers

Hypothesis 2a: There is a significant relationship between the years of experience of the migrating health workers and their areas of practice H_o

2b: There is no significant relationship between the years of experience of the migrating health workers and their areas of practice H_1

Hypothesis 3a: Migration of health workers has no impact on FMC Asaba and LUTH H_o

3b: Migration of health workers has an impact on FMC Asaba and LUTH? H_1

3.3 Research Philosophy: This refers to a belief system and assumption about the development of knowledge. What we are engaged in when we embark on research is developing knowledge in a particular field. This happens whether we are aware them or not. This may not be a new theory of human motivation but by answering a specific question in a particular organisation, we are developing new knowledge (Mark NK Saunders, P Lewis et al, 2009). Hence, working on understanding the implication of migrating health workers to the sending country is a way of answering some health specific questions during the data collecting stage in this thesis.

While writing research, we will make some type of assumptions. These include inferences about human knowledge also known as epistemological inferences, the assumption about the realities we encounter during our research also known as ontological inference, the extent to which our values influence our research process. All these assumptions shape how we understand our research, the method we adopt and how we interpret our findings (Crotty M, 1998). Another aspect of research philosophy where the afore mentioned assumptions is derived is known as Positivism, this according to (The Positivism Paradigm of Research, 2020) is defined as the hypothetic – deductive method to verify a hypothesis that are often stated quantitatively, where functional relationship can be derived between independent and dependent variables. Positivism has been used in this research for providing guidelines that was needed in the period of information gathering regarding the causes of migration in the Nigerian health sector and its impact on remaining practitioners.

3.4 **Research Design**: This refers to the strategy adopted by the researcher to bring together the different aspects of the study in an understandable and logical way, ensuring that the research problem is effectively addressed. The role of the research design is to ensure that the evidence we obtain enables us to address the research problem in a logical and unambiguous way as possible (De Vaus, D. A. , 2001). Considering the proximity between the researcher and the respondents, descriptive research design shows to be the most appropriate for this research purpose of understanding the causes of migration in the Nigerian health sector and its impact on the remaining health practitioners.

3.5 **Sampling size and technique:** 100 respondents were invited to take part in the questionnaire but not all of them took part in the survey. While some made promises to partake but did not, others could not, due to circumstances they were not willing to share.

Random sampling technique was adopted for the purpose of identifying the causes of migration in the Nigerian health care sector. According to (Paul, J.L, 2008) random sampling technique is effective for providing equal opportunity to all participants to respond in the survey. The minimum age limit of the participants was set at 18 years to accommodate health workers that are not medically inclined.

3.6 **Data analysis technique**: The technique adopted in this thesis is the primary quantitative data in the form of questionnaire. To be able to analyse quantitative data, it is important to have some numerical and statistical skills needed for conducting the research work (Jung, Y.M., 2019). A total of 19 survey questions was prepared and shared into different sections. The result of the data collated was analysed in a tabular form using SPSS (Statistical Package for Social Science)

3.7: **Ethical Consideration**: The college's research guideline was strictly adhered to. The identities and personal information were kept anonymous to avoid breach of personal data. All the participants were given the freedom of choice to either participate or desist and none was pressured into responding and this reflects in the final response achieved.

3.8: Limitation of Research: The exact number of health practitioners leaving Nigeria is difficult to ascertain due to lack of available data online. Also, due to proximity between the researcher and respondents, it was difficult to get as many responses as possible even though the questionnaire would not take more than two minutes to fill.

3.9 **Chapter summary**: This chapter has addressed the source and process of data used in this research work. The approach used has enabled us to understand the causes of migration in the Nigerian health sector. The quantitative approach has also been considered as the most suitable method of analysing our data in this thesis.

The data gathering approach as already mentioned is through questionnaire from different health workers at the various departments both at LUTH and FMC Asaba. The result from their responses will assist in offering viable recommendations on how the challenges identified can be managed.

Chapter 4: Data Analysis:

This chapter of the study will highlight the result of the survey collected. In all, 74 respondents were asked and out of the 100 questions sent out, 74 were returned, these will be theoretically analysed to find out the result of the data.

4.1 Analysis of the Primary Data

4.2.1: To identify the age distribution, gender, and marital status of the health workers.

Table 1: Age distribution, gender, and marital status of the health workers

Variable	Frequency (n = 74)	Percent
Age (years)		
≤ 25	4	5.4
26 - 35	33	44.6
36 - 45	22	29.7
> 45	15	20.3
Sex		
Female	36	48.6
Male	38	51.4
Marital status		
Married	48	64.9
Separated/ Divorced	1	1.4
Single	24	32.4
Widowed	1	1.4

The age distribution, gender, and marital status of the health workers is as shown in the table above. Almost half of the health workers (44.6%) were within the age range of 26 – 35 years while only four (5.4%) of them were less than or equal to 25 years old.

The male to female ratio of the health workers is almost 1:1 although there were more males (51.4%). Most of the health worker were married (48, 64.9%) while only 1 of them reported to be separated/divorced and another one is widowed. A third of the health workers (32.4%) were single.

4.2.2: To determine the effect of years of experience and areas of practice on willingness of the health workers to migrate

Hypothesis 2a: There is a significant relationship between the years of experience of the migrating health workers and their areas of practice

Hypothesis 2b: There is no significant relationship between the years of experience of the migrating health workers

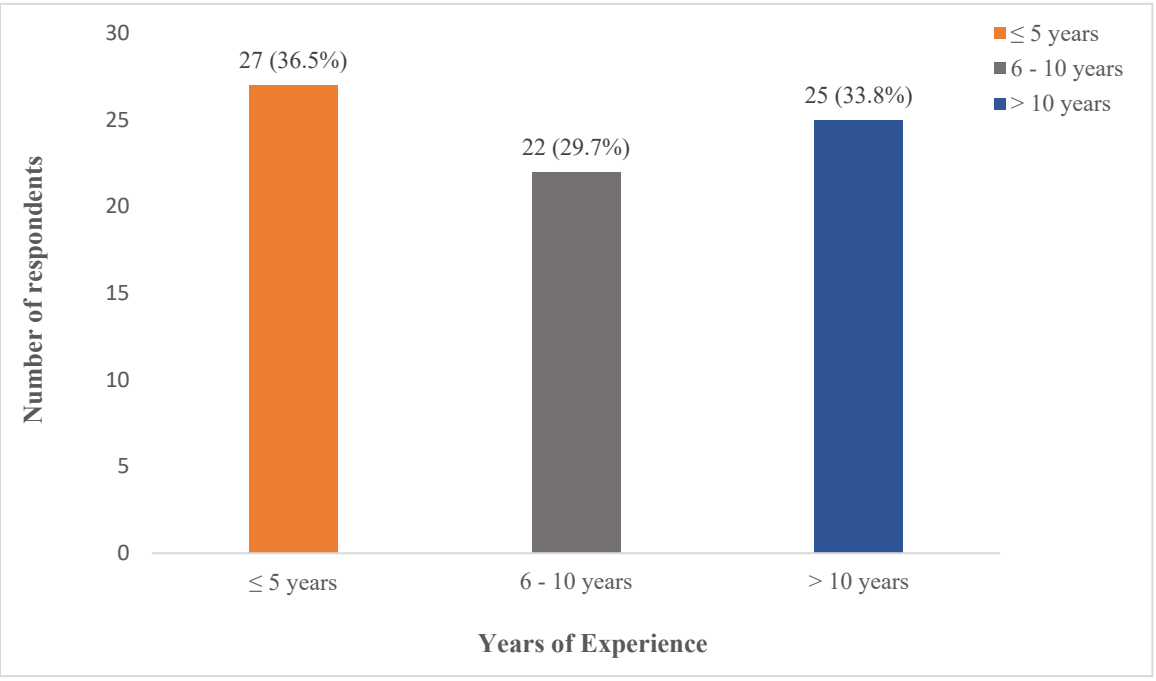

Chart 1: Years of experience of the health workers

Table 2: Area of specialization of health workers

Variable	**Frequency (n = 74)**	**Percent**
Internal medicine	29	39.2
Community medicine	16	21.6
Family medicine	13	17.6
Surgery and Obstetrics	6	8.1
Psychiatry	4	5.4
Nursing	4	5.4
Others	2	2.7

.

In table 3 above, no statistically significant association was found between willingness of healthcare workers to migrate and years of experience (p value 0.845). Twenty-one health care workers (77.8%) among those who have less than or equal to 5 years of experience were willing to migrate as compared with 77.3% of those who have 6 -10 years and 76.0% of those with more than 10 years of experience.

In addition, the association between willingness to migrate among health care workers and area of specialization were also not found to be statistically significant (*p* value 0.124). All the health workers in Psychiatry, Nursing and others (laboratory and administrative posts) were found to be willing to migrate as compared with 50.0%, 61.5%, 75.9% and 87.5% of those in surgery, family medicine, internal medicine and community medicine respectively.

Table 3: Association between willingness of healthcare workers to migrate and years of experience and areas of practice

	Willingness to Migrate					
Variable	**Not willing n=9(%)**	**Indifferent n=8(%)**	**Willing n=57(%)**	**Total N=74**	**χ^2**	***p*-value**
Years of experience					1.611^F	0.845
≤ 5 years	4(14.8)	2(7.4)	21(77.8)	27		
6 – 10 years	3(13.6)	2(9.1)	17(77.3)	22		
> 10 years	2(8.0)	4(16.0)	19(76.0)	25		
Specialty					14.820^F	0.124
Internal medicine	1(3.4)	6(20.7)	22(75.9)	29		
Community medicine	1(6.2)	1(6.2)	14(87.5)	16		
Family medicine	4(30.8)	1(7.7)	8(61.5)	13		
Surgery and Obstetrics	3(50.0)	0(0.0)	3(50.0)	6		
Psychiatry	0(0.0)	0(0.0)	4(100.0)	4		
Nursing	0(0.0)	0(0.0)	4(100.0)	4		
Others	0(0.0)	0(0.0)	2(100.0)	2		

χ^2: Chi square test; F: Fisher's exact test

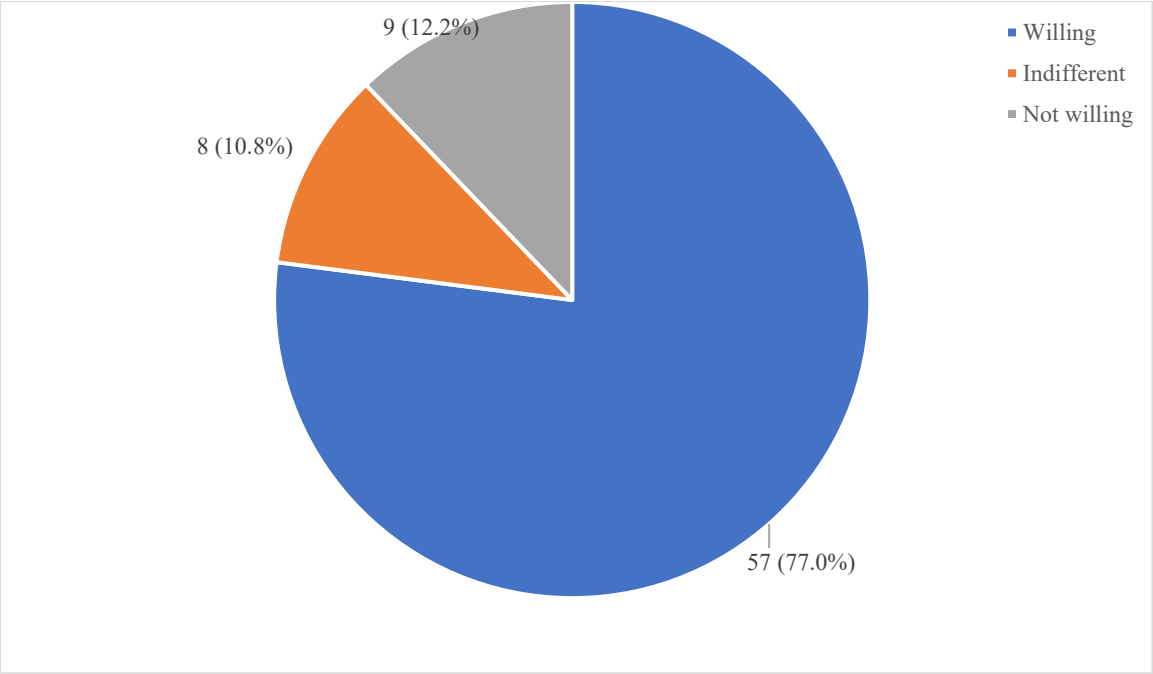

Table 3: Respondents' willingness to migrate

In table 3 above, no statistically significant association was found between willingness of healthcare workers to migrate and years of experience (*p* value 0.845). Twenty-one health care workers (77.8%) among those who have less than or equal to 5 years of experience were willing to migrate as compared with 77.3% of those who have 6 -10 years and 76.0% of those with more than 10 years of experience.

In addition, the association between willingness to migrate among health care workers and area of specialization were also not found to be statistically significant (*p* value 0.124). All the health workers in Psychiatry, Nursing and others (laboratory and administrative posts) were found to be willing to migrate as compared with 50.0%, 61.5%, 75.9% and 87.5% of those in surgery, family medicine, internal medicine and community medicine respectively

4.2.3 To determine the impact of migration on the LUTH and FMC Asaba health workers

Hypothesis 3a: Migration of health workers has no impact on FMC Asaba and LUTH H_o

3b: Migration of health workers has an impact on FMC Asaba and LUTH? H_1

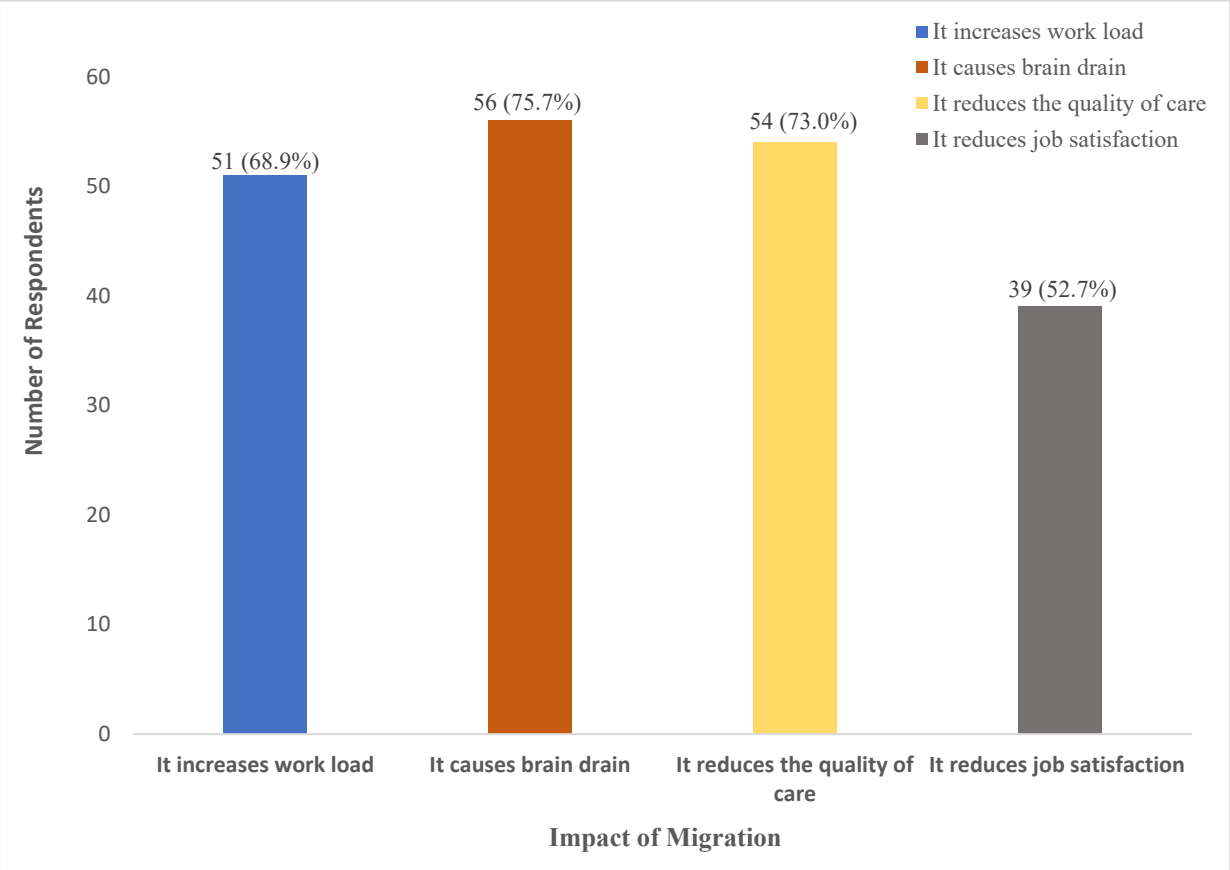

Chart 3: Impact of Migration on the remaining health workers

In the chart above, the choice of response was a multi choice option. Which means that respondents were given the option of picking more than one choice response. To determine the impact of migration on the LUTH and FMC Asaba health workers, 68.9% of the respondents agreed that it causes increase in the workload, 75.7% agreed that it causes brain drain while 73% are of the opinion that it reduces care and 52.7% said it reduces job satisfaction.

4.2.4: Discussion: From our findings, the level of experience of health workers does not have an impact of their determination to migrate. However, some previous research has shown that early health workers are more likely to migrate from Nigeria than those that have stayed long in practice. The most critical push factors among medical practitioners for migration from many African countries, including Nigeria, are challenges in personnel training, welfare and social stability, availability of funding, employment, capacity building and efficient deployment of healthcare personnel. Other studies in sub-Saharan Africa on critical determinants of migration among health professionals, for instance in Ghana, showed that most professionals were in the early phase of their career, and majority worked in government-owned hospitals with heavy workload, other contributing factors to migration are the pursuit of higher education and family considerations were key determinants (Anarfi J, Quartey P, Agyei J., 2010). Interestingly, the topmost destination for most African health official migrants follows the earlier established observed pattern among the Nigerian health workers with leading destination being countries like the United Kingdom, USA, Canada, the middle East and India where we have a high proportion of Nigerian medical practitioners.

Also, an analysis conducted by the American Medical Association physician master file showed that Nigerian health workers are the most populous foreign-trained and foreign-born from sub-Saharan Africa currently practicing in the United States of America. This observation, therefore, is not a mitigating factor but would rather, and most likely further hemorrhage the inadequate human resources for health in Nigeria (Adebayo O, Labiran A, Emerenini CF, Omoruyi L, 2016). The General Medical Council which licenses and maintains the official register of medical practitioners in the United Kingdom licensed at least 266 Nigerian doctors in June and July, 2022.The implication is that at least three Nigerian doctors were licensed per day in June and July 2022 despite the moves by the Federal

Government to stop the exodus of doctors and health workers in the country amidst worsening brain drain of the professionals in the country and currently the number of Nigerian trained medical doctors alone stands at 9,976 and this excludes other health workers (Deborah Tolu-Kolawole, 2022).

These countries which are common destination to health workers provide favorable economic and professional milieu which are in tandem with the independent predictors, reasons found to be statistically significant in our study which included better living condition, a better quality of postgraduate training, better remuneration, a better quality of practice, better economic prospect after training, professional satisfaction, and desire to settle abroad. These constitute significant and unabated pull factors in the last four decades which are like findings from other sub-Saharan countries (Anarfi J, Quartey P, Agyei J., 2010).

Other factors that are major determinants for health workers willingness to migrate, which were not tested in this work but have been cited by some academia are factors such as lack of employment opportunities, appropriate work environment and wages in developing countries (which Nigeria falls into), growing demand in high-income countries due to demographic transition, favourable country policies for financial remittances by migrant workers and medical education system of developing countries (Manisha Nair, 2013). Psychiatry, nursing and others (laboratory officers and administrative staffs) have the highest mean rank on willingness to travel, the reason for this can be attributed to the high demand and insufficient supply of health workers (doctors and nurses) in psychiatry department. An official NHS report report in 2021, shows that the United Kingdom has a shortage of psychiatry doctors. At least 1.5 million people in England are waiting for treatment but a tenth of consultant psychiatrist posts (568 out of 5,317) are not filled. The vacancies are causing some patients to wait 18 weeks or longer for treatment. Official NHS workforce data

shows that there are 4,500 full-time consultant psychiatrists for 56.5 million people, one consultant per 12,567. Addictions, eating disorders and child and adolescent psychiatry have the highest vacancy rates, even though the numbers of those needing support from these specialties are overwhelmingly high (RC PSYCH, 2021).

Another important observation is the fact that, there is a likely adverse implication on the specialist capacity of the home country arising from the migratory tendency. A quarter of participants reported having formed the desire to migrate during their undergraduate medical program while half had decided to emigrate before the commencement of residency training. This no doubt will have a negative impact on both the postgraduate and undergraduate training of medical doctors and medical students respectively (Gbenga Omotade Popoola, Gbenga Popoola et al, 2022).

4.2.5: Summary

This study found that a very high proportion of Nigerian health workers have the intention to migrate, and this has enormous capacity to further worsen the poor health indices in the country and overburden the remaining health workers with the intention to stay or are still preparing to migrate from the country. It is anticipated that this research work would help policymakers make informed, evidence-based decisions that would halt the damning consequences of mass migration of health worker from Nigeria (Gbenga Omotade Popoola, Gbenga Popoola et al, 2022)

Chapter 5: Conclusion

5.1 Overview: We have examined the dysfunctional state of the Nigerian health system both at Public and private levels. This is mostly associated to training, funding, and deployment in the health workforce. The state of dysfunctionality has led most health workers to search for better life using migration as their preferred medium of escape. In this chapter, we will discuss all the causes of migration in the health workers from Nigeria and the impact of this movement on the Nigerian health sector.

5.2 Conclusion: All persons involved in activities primarily devoted to enhancing the health of the people in any country is an essential block of any functioning health system in any country, without this, clinical and public health cannot be optimally delivered to the populace (World Health Organization, 2006).

The challenges in the Nigerian health sector are many and has been lingering for a long while. These include, inadequate training, lack of funding which has led to owed salaries, poor welfare, lack of good health facilities and crisis among health workers and all these have prevented optimal health care delivery. Low and inequitable distribution of health workers in the country can also be attributed to brain drain experienced in the health sector in the form of migration of health workers to high-income countries. The latest statistics shows that 1in 4 doctors and 1 in 20 nurses trained in Nigeria are currently practicing in developed countries (World Health Organization, 2016) and this inequality in distribution is worsened by the fact that there is no national policy guiding the posting and transfers of health workers. This is

done at the discretion of administrative officers with influences and competing interests (Abimbola S, Olanipekun T, Schaaf M et al, 2016).

A strong health system has a robust finance structure, well paid and trained workforce, highly maintained and enough facilities, logistics for medicine, vaccines and technologies as well as a reliable and regularly updated health information system. These will ensure accessible and timely health delivery process/system (World Health Organization, 2010). But the repeated strikes and protests by health workers, poor management of health facilities, sub-optimal management of common diseases and the high rate of medical tourism shows that the Nigerian health system is not fulfilling her obligation.

The private hospitals seem to be doing better than government owned hospitals, for example most kidney transplants in Nigeria have been conducted in private hospitals because they have better medical equipment to carry out the procedure (Daily Trust, 2016). However, the concern of stakeholders is that some activities of several private hospitals are not fully regulated and fall short of standard practice. Also, the private hospitals cannot employ all the health workers (Davies Adeloye,Rotimi Adedeji David, Adenike Ayobola Olaogun,Asa Auta, 2017)

Another crisis in the Nigerian health sector is the rivalry for supremacy between the doctors and other health officers with the other officers accusing the health administrators of favouritism. The strikes that disrupted the health sector in 2014 were based on doctors versus pharmacists, doctors versus nurses, doctors versus laboratory workers. The reason for the dispute is complaint of the doctors being given preferential treatment in terms of wages above other health workers (Wale Odunsi, 2014).

Poor reward and welfare system of the health workers is another challenge that has saddled the health care system in Nigeria. For every strike action embarked on, renumeration and welfare are key in their requests, workers cannot be expected to put in their best if their welfare is not treated as priority. There has also been accusation of discrepancies in renumeration for healthcare workers in the same grade levels across the different states of the Federation which is usually orchestrated by chief medical directors (Omoluabi E, 2014).

In several hospitals, there is an under-supply of manpower as well as working materials, training needed in some of these centres are not provided despite the financial allocation been assigned for the purpose and the credit units needed by regulators to ensure continuing professional development of the health workers and mandatory for renewal of practicing licence. While this can be blamed on the leadership style of health directors, the government also plays a role by leaving the health workers to the mercy of these health directors until the health workers result to taking strike actions before government intervenes (Davies Adeloye,Rotimi Adedeji David, Adenike Ayobola Olaogun,Asa Auta, 2017).

This implies that many stakeholders in the health sector are beneficiaries from the under investment in the health sector because they divert the funds and aids received from international donors and even the government for their personal gain. Thereby leaving the hospitals in very deteriorating state and making medical practice very difficult for health workers (Enabulele O, Enabulele JE, 2016). It is imperative to note that the reasons for migration by health workers in Nigeria and its impact cannot be exhausted in this research work, we are however, hopeful that the government and all stakeholders will rise to their responsibilities in ensuring that a timely solution is given to avoid a total collapse of the health sector.

Chapter 6

6.1: Overview

The discussion has been centred on the reasons for the migration of health workers from their home country (Nigeria) to other developed countries. During this analysis, we have identified some of the reasons which are human made, because if stakeholders and policy makers are willing to work together, the Nigeria health sector will be the envy of its global contemporaries considering the great feats the migrated health workers are achieving abroad.

I would like to share what prompted me to choosing this topic. I could go for years without visiting the hospital because I hardly fall ill, and I hate taking drugs so any physician that treats me when I am ill understand this. When it became possible for me to afford it, I registered in a private hospital where my mediation preference is respected. It was, however, surprising when I took ill and rushed to the hospital with the hope of meeting my favourite doctor. Not only was he no longer working in the hospital about three nurses were also said to work there no longer. When I probed further, I found out that they have all left the country to continue their practice. It was very painful for me because I had to start explaining to the new doctor that attended to me why I preferred being administered injection instead of being given drugs to swallow. While I was doing this, I kept asking myself if she would also be gone by the next time I visit. Thankfully I did not have to visit the hospital again till I got into Ireland. Mine is just one story out of many who have felt the impact of migration in the Nigerian health sector.

6.2 Recommendation

The government may not be able to fully stop migration, but it can be controlled. Health workers who have migrated for several reasons are recoverable assets to their home country (Nigeria), they can play a part in developing opportunities back at home. The recovery process requires the opening of diverse and creative channels of operation. The willingness of most health workers to want to leave the country if given the opportunity is a big threat to Nigeria's health sector growth and development. Since we have identified the common push and pull factors in this thesis and other referenced materials, there is a need for governments at all levels to, as a matter of urgency, take evidence-based actions to address the factors responsible for this brain drain. Some helpful recommendation include:

The health service sector in Nigeria must be supported by the government at all levels and all stakeholders to maintain their skilled personnel. Because it is only when health staff, in whatever their cadre, have the necessary tools they require to do their job, adequate and relevant training opportunities, a network of supportive colleagues, and equal recognition for the difficult job they do without nepotism, are they likely to feel motivated to stay back in their home country even when opportunity beckons from elsewhere (in this case developed countries) (Sunita Dodani, Ronald E LaPorte, 2005).

Those that are already foreign based professionals could with the support of the Nigerian government be used to develop innovative graduate education opportunities at home and technology to be transferred to areas of national priorities for research and development. In the long run, involving health officials who are living and practicing abroad in creating opportunities at home favours both the retention and repatriation move of national talent. Building an enlightened leadership and an enabling national scientific community, with the help of expatriate citizens, for the coherent development of scientific and technological

capacity in developing countries will be mutually beneficial (Sunita Dodani, Ronald E LaPorte, 2005).

We cannot over emphasis the role good governance plays in helping a country to achieve a sound national health system, especially with regards to human resources for health. Since the Nigerian health system is lacking full capacity in leadership and governance, with this reflecting in the health workforce crises and poor health service delivery in recent years. Although the Nigerian government can be responsive to population health needs, without a driving, visionary, systemic and structural change in health governance, the prevailing crises in the health workforce and service delivery has no end in sight (Davies Adeloye,Rotimi Adedeji David, Adenike Ayobola Olaogun,Asa Auta, 2017).

We would also recommend a stricter compliance on the WHO recommendation on acceptable global health practice and defaulters should be severely punished. This would lessen the burden of the workload most health workers especially in the public hospitals are made to bear. And there should be an up to date data of all health workers in the country to ensure accountability.

6.3 Limitation

One hundred survey was sent out but only seventy-four responses were received, what the researcher discovered was that using two hospitals as a case study served as a major limitation. If the survey had been shared without restricting it to workers in LUTH and FMC, the responses would have been more and response time faster. In the future, this limitation will be mitigated by expanding the scope of research. Also, while health workers relate to all departments in the health sector, most of our findings and discussions as well as respondents are centred on doctors and nurses.

6.4: Future Scope

We are hopeful that if the recommendations provided are implemented, the revamp of the Nigerian health sector would help not just the economy. The future scope of study hopefully will be centred on measures recommended here that were adopted that brought about a positive change in the Nigerian health sector.

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APPENDIX

Dear Respondent

My name is Ifeoma and I am postgraduate student of the National College of Ireland. Kindly fill out this survey on **the reasons for Migration in the Nigerian health sector and its impact on remaining practitioners: A case study of Lagos University Teaching Hospital (LUTH) and Federal medical centre (FMC) Asaba**. This is being done in partial fulfilment of the requirements for the award of Master's Degree in International Business at the National college of Ireland. It will take about 4 minutes to fill, and all personal information provided remains confidential. Participation is also strictly voluntary, and you may opt out from participating if you do not feel comfortable participating.

Thank you for taking the time to assist me in my educational endeavours.

Warm Regards

Questions

1 Gender

a. Male
b. Female
c. Other
d. Prefer not to say

2. Age Range

a. 18 – 25 years
b. 26 – 35 years
c. 36- 45 years
d. Above 45 years

3. Marital Status

a. Single
b. Married
c. Separated /Divorced
d. Widowed

4. Cadre

a. Clinical (Doctors, Nurses, Pharmacists, Lab. Scientists
b. Non Clinical (Administrative officers)
c. Others

5. Additional Post graduate qualifications

a. Yes
b. No

6.Area of speciality
a. Internal medicine
b. Community medicine
c. Family medicine
d. Surgery and Obstetrics
e. Psychiatry
f. Nursing
g. Others

7. Respondents' willingness to practice in a foreign country
a. Willing
b. Non willing
c. Indifferent

8. Reasons for not willing (Select all that Apply)
a. I am comfortable practicing in Nigeria
b. Due to family and other personal reasons
c. Due to Financial constraints
d. Professional Satisfaction
e. Desire to serve the country

9. Respondents' reasons for willing to migrate: Push factors (select all that apply)
a. Poor working environment
b. Insecurity
c. Poor salary and other financial incentives
d. Inter-professional rivalry in the health sector
e. Lack of government interest in health sector capacity building
f. lack of government interest in research at all levels
g. Does not apply

10. Respondents' reasons for willing to practice in a foreign country: Pull factors (Select all that Apply)
a. Better salary and other financial incentives
b. Better security
c. Better working environment
e. Advanced Research facilities
f. Does not apply
g. Professional Satisfaction

11. Respondents preferred country of practice
a. United states of America
b. United Kingdom
c. United Arab Emirates
d. Canada
e. Australia

12. Do you plan on returning to Nigeria anytime soon
a. Yes

b. No
c. Maybe
d. I do not plan on leaving Nigeria

13. Impact of migration on the remaining health workers
a. It has no impact
b. It increases workload
c. It causes brain drain
d. It reduces job satisfaction
e. It reduces the quality of care

14. Average number of hours worked per week
a. < 48 hours at a stretch
b. 48- 80 hours at a stretch
c. > 80 hours

15. Call days
a. < 10 days
b. > 10 days

16. Mode of call
a. Staggered
b. Consecutively
c. No order

17. Health Practitioners / Patient ratio per shift
a. In accordance with international practice
b. Not in accordance with international practice

18. Perceived satisfaction on the job
a. Satisfied
b. Non satisfied

19. Years of Practice
a. ≤ 5 years
b. 6-10 years
c. > 10 yeas