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Medical Brain Drain and its Effect on the Nigerian Healthcare Sector

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Abstract

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MS, Strayer University, 2007

BS, University of Maryland, University College, 2003

Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Public Policy and Administration

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Abstract

Nigeria suffers from a huge brain drain issue across different sectors, particularly in the healthcare sector. The WHO assessed that there is a current shortage of 2.8 million physicians in the world A heuristic phenomenological method was used in this study to explore the lived experiences of 12 Nigerian healthcare practitioners that migrated to the United States. The push-pull theory served as the theoretical framework that grounded this study. The central research questions for this study focused primarily on the reasons healthcare practitioners are leaving Nigeria and what the impact of those decisions have on the Nigerian healthcare sector. Qualitative data were collected and analyzed identified three emerging themes: (a) challenges of living in Nigeria; (b) lack of government support; and (c) reality of knowledge gap. The participants were selected by using a purposive and snowball sampling method, and a semi-structure interview was used to collect data from the participants. The study used Moustakas's heuristic phenomenological approach, which allowed the use of thematic analysis to record and identify passages of the text that fell into categories. The finding from the research puts the brain drain phenomenon on the Nigerian government and its lack of support in rebuilding the healthcare system. Recommendations were made based on the emergent themes on how the government can work with Nigerians in the diaspora to help strengthen the Nigerian healthcare sector and to create worthwhile policies/laws/regulations that will help build the country. Implication for positive social change include the creation of jobs for young Nigerians and creating proper policies and wage scale so that they can be on par with their counterpart.

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Dedication

First of all, I want to thank the LORD, GOD for always being good to me. GOD has been with me through this journey and without GOD, I am not sure where I will be.

I dedicate this labor of love to my mom, Janet Osigbesan. She prayed and always wanted a doctor in the family. This is also dedicated to the memories of my dad, Babatunde Osigbesan and my grandma, Dorcas Oyinlola Akande.

I want to dedicate this dissertation to my children, Olalekan, Oluwatobiloba, and Anuoluwapo. Thank you for understanding my journey. Now its Dr. Mom to you guys.

I am grateful to my family and friends who kept asking me every day about the completion of my dissertation. Family like my sister Femi for being my rock and my brother, Yemi. I also dedicate this to my Aunties Lillian, Dolly, Tundun, Sabina, Regina, Cynthia, and my Uncle Justice. Special shout out to my cousins, Folake Ademiluyi, Bukola Laosebikan, Rebecca Matey, Ayo Matey, Ebe Matey, Mayowa Alli, Mike Matey, Temi Matey, and Temi Ogunwale. To my friends like Tope Fajingbesi, Jeff Durowaiye, Adia Sowho, Samuel Ajebon, Buki Adebolu, Tim Shadare, Naomi Aduku, Uchenna Agbo, Samm Ekpo, Vanessa Winfield, Dr. Turnesha Cook, Dr. ‘Toye Akindele, Dr. ‘Bonike Leigh, Dr. Wanda Presley, Dr. Seun Odiase, Dr. Sharon St. Louis, Kayode Fakunle, Ashley-Camille Jackson, Sheri Jones, Lanre Giwa. The list of my family and friends is enormous so please do not be angry for not getting a special shout. Also shout out to the Cool Kids, Real Housewives of FaceBook (trust me they are real), and my All-Stars Sisters. Lastly, it seems a bit odd, but I want to dedicate this to Chadwick Boseman. His death made me take stock of my life and kept me going on. Wakanda Forever!

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There are so many people I want to acknowledge that helped me through my doctoral journey. However, I do not have enough space to name everyone. I just want to say thank to everyone that my life has at one time or another collided.

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Chapter 1: Introduction to the Study

The purpose of this heuristic phenomenological study was to examine medical brain drain in Nigeria and probe the lack of public policy within the healthcare sector. In addition, this study proposed public policy options that could help revitalize the Nigerian healthcare sector. Due to the burgeoning number of healthcare practitioners leaving Nigeria, the role of the Nigerian government was explored to determine the factors that contribute to people leaving Nigeria.

Adesote and Osunkoya (2018) reported that over the last 30 years, Africa has increasingly lost highly skilled workers to developed countries. Dohlman et al. (2019) also identified that over 70% of Africa's healthcare practitioners are lost to migration, where they currently make up one-fifth of physicians in developed countries. Anetoh and Onwudinjo (2020) expressed that as a result of the migration, highly skilled workers are continuing to leave Nigeria at an alarming rate, which has in turn created gaps in several sectors such as the oil and gas industry, and the most glaring gap appeared within the healthcare sector. Atte (2020) further pointed out that the World Health Organization (WHO) in 2016 reported a shortage of 4.3 million healthcare workers worldwide. Sub-Saharan countries are the most affected by this shortage, given that they contain 3% of the world's health workers but are burdened by 24% of the global disease.

The brain drain phenomenon causes highly educated adults to relocate from Nigeria to different parts of the United States. They tend to migrate to major metropolitan areas and leave lower to middle income countries such as Nigeria behind without healthcare practitioners who have the ability to help shape public policies to rebuild the

crumbling to almost non-existent healthcare infrastructure (Ogaboh et al., 2020). Due to the migration phenomenon of healthcare practitioners, Nigeria has experienced a massive brain drain as skilled healthcare workers are moving to other countries to obtain better wages, improved standard of living, and the opportunity to improve their skill set. The government also is not recognizing that there is a problem with brain drain in the country, especially within the healthcare sector. Also, not enough money is being apportioned to the healthcare sector to make a difference. As it stands, only 4% of the national budget in Nigeria is earmarked for health (Abang, 2019).

Brain drain is the movement of highly skilled workers from a developing country to a developed country (Ogaboh et al., 2020). As a phenomenon, brain drain has drained Africa of healthcare practitioners, who make up only 3% of the global workforce on a continent that is burdened with 25% of the global disease (Dohlman et al., 2019). Furthermore, with the drain of healthcare practitioners from Africa, a heavy burden is placed on the healthcare system in Nigeria, resulting in the healthcare needs of constituents not being adequately met. In this heuristic phenomenological qualitative study, I endeavored to diagnose the brain drain problem through the lived experience of Nigerian healthcare practitioners who migrated from Nigeria to the United States. This study also identified the burden that brain drain has placed on Nigeria and may lay out a framework to resolve the brain drain phenomenon.

Chapter 1 focuses on the background of the problem, the problem statement, the purpose of the study, and the significance of the study. Chapter 1 also outlines the nature of the study, the research questions, and the theoretical framework. The definitions of

terms, assumptions, scope, limitations, and delimitations are also included in Chapter 1. At the conclusion of Chapter 1, a summary of the chapter is presented.

Background of the Problem

Nigeria lost a huge part of its highly skilled healthcare practitioners due to brain drain. The corrupt leadership in the country has negatively affected the economy by depleting natural resources (oil and gas) that are an income generator; and as a result, many citizens have escaped Nigeria in order to provide for their family (Moyosore, 2015). Nigeria also lacks human capacity development (Joshua et al., 2014). There are no iron clad labor policies in Nigeria, and the most relatable and most adhered to policy is the year in service policy called the National Youth Service Corps (NYSC; Muogbo et al., 2021). However, even with the implementation of the NYSC, not much has happened in human capacity building in Nigeria. Historically, the NYSC was initially created after the Nigeria civil war for reconstruction efforts of the country using the youth. According to research from Muogbo et al. (2021), in 1970 during General Yakubu Gowon's regime as the President of Nigeria, the NYSC was created as a way to engage young people in the country. As years went by, a new iteration of the NYSC was put in place to help with skill acquisition after college graduation. This mandatory 1-year service is required before one can get a job in Nigeria. However, no stiff penalties or restrictions are placed on graduates after graduation to perform their civic duties, and many of them end up migrating to developed countries due to the mediocre working conditions, poor wages, and the overall economic and political structure of the country (Okey, 2016).

Nigeria also has an unemployment rate of 33%, which makes it the second highest on the global list of countries and their unemployment rates (Olurounbi, 2021). As the most populous country in Africa with about 214 million people, Nigeria simply does not have enough healthcare practitioners to serve its population. Adeloye et al. (2017) estimated that there are 1.9 healthcare practitioners for every 1000 Nigerian citizens, which is far less than what is recommended by WHO. The emergence of brain drain in Nigeria has hindered the development of the medical infrastructure to the standards of other comparable developing countries such as Ghana. Brain drain also increased medical tourism in Nigeria, especially among the upper echelon of society (Orekoya & Oduyoye, 2018). The emigration of highly skilled healthcare practitioners is at an all-time high and therefore depleting Nigeria of its healthcare worker talents that could help build the Nigerian healthcare sector.

Due to brain drain, there has been excessive emigration out of Nigeria by healthcare practitioners to other developed countries. It is estimated that over two million Nigerians currently reside in the US, of which 20,000 are doctors and more than 10,000 are academics (Ogbu, 2019). Brain drain as a phenomenon is not exclusive to a specific industry in Nigeria; however, the healthcare industry may have experienced a significant loss due to the western influence on Nigerian medicine (particularly in the field of neurology). Imam and Akinyemi (2015) expressed that many Nigerian doctors have had a long-standing unofficial tradition of completing courses and training in developed countries. Imam and Akinyemi further explained that many went to developed countries to be educated and often came back to Nigeria to teach what was learned. However, that

is no longer the case because many healthcare practitioners travel to developed countries and end up staying there permanently. They become enamored with better living conditions and good wages that they cannot get in Nigeria. Brock and Blake (2017) further asserted that there is a lack of human capital building in the healthcare field coupled with skilled healthcare practitioner's migration from Nigeria to developed countries for better economics and improved infrastructure.

Another impact brain drain had on Nigeria was the shifting of monetary resources to other countries. Nigeria's healthcare system is almost non-existent, and the elite in Nigeria often travel to developed countries for medical treatment. Abubakar et al. (2018) laid out many reasons why medical tourism is flourishing. One reason cited was inadequate funding by the government for healthcare resources. This has created a gap in healthcare resources in Nigeria, causing a lack of faith in the Nigerian healthcare system, especially among wealthy citizens who travel abroad to receive treatment.

Additionally, Nigeria was always below other developed countries when it comes to benchmarked health indicators. Okafor (2016) identified that Nigeria has not reached its budgetary allocation for health care per suggestions by the WHO and the African Union recommendations in a long time. Abang (2019) further outlined that only 4% of the country's budget is apportioned to healthcare. This has made it hard for Nigeria as a country to meet benchmarked health indicators.

Corruption was another major issue in Nigeria and relates to why many people left Nigeria never to come back. Transparency International has continuously analyzed corruption within Nigeria. As of 2019, Nigeria ranked 146 out of 198 countries in the

corruption perception index (Corruptions Perceptions Index 2019 for Nigeria, 2019). Corruption has hindered the economic growth and development of Nigeria. Arewa (2019) argued that Nigeria has been plundered to the point where it is affecting poverty, education, the development of proper infrastructure, and the shrinking healthcare sector. The degenerated healthcare sector has caused healthcare practitioners to leave the country and created a huge gap in access to healthcare due to the limited number of healthcare practitioners in the country. Moyosore (2015) explained that the management of human and material resources has become very hard due to corruption, and this has caused many to move to another country (brain drain).

Problem Statement

The healthcare system in Nigeria is in a dire state of repair, and if human capacity building continues to be lost at the alarming rate as it is currently, there may not be any healthcare practitioners left to work in Nigeria. The problem also was that while many Nigerians healthcare practitioners moved abroad, the instability of Nigeria made it virtually impossible for many of them to willingly come back home to implement the knowledge acquired overseas. This phenomenon has forced many people to remain in the developed countries despite their unhappiness with the situation back home in Nigeria.

There is a significant brain drain problem in Nigeria, and Arewa (2019) diagnosed the brain drain problem being caused by the "systematic official corruption" (p. 1133) in Nigeria. With this research, I attempted to tackle the brain drain problem and its effect on the healthcare system in Nigeria. Nigeria as a whole had become so problematic from simple governance to the deficiency for the basic amenities (access to healthcare) needed

to survive. Grenier (2015) pointed out that the most basic of human rights is access to healthcare, and Nigerians lack that basic human right, which in turn has made a lot of healthcare workers move to developed countries.

Another byproduct of corruption was that many people in Nigeria travelled to politically stable countries such as the United States, the United Kingdom, and other westernized countries for solace, better living conditions, and security. The General Medical Council (n.d.) analyzed that in the United Kingdom, 205,855 doctors were registered and 7,879 of them were Nigerians. In the United States, it is estimated that the number of practicing Nigerian doctors is greater than 4,000 (Adepoju, 2018).

Additionally, Karan et al. (2016) deduced that currently Sub-Saharan Africa (where Nigeria is located) is experiencing a huge drought of surgeons which is caused by their emigration to developed countries. This created a huge gap in the Nigerian healthcare industry. Many are eager to go back home and help stabilize Nigeria and revitalize the healthcare sector. Many ad-hoc groups have been created in the United States and other countries in order to drive interest in the empowerment of Nigerians in the diaspora. However, there is little research on how the government in Nigeria can help Nigerians in the diaspora who want to come back home so that brain gain or brain circulation can happen.

This was an emerging topic that required further study. There was not a huge body of research about how the government can help bring Nigerians in the diaspora back home. Interest in addressing brain drain does exist, but the logistical and infrastructural requirements for resolving the issue make its resolution difficult.

Purpose of the Study

The purpose of this heuristic phenomenological study was to examine medical brain drain in Nigeria and probe the lack of public policy within the healthcare sector. In addition, this study proposed public policy options that could help revitalize the Nigerian healthcare sector. Due to the burgeoning number of healthcare practitioners leaving Nigeria, the role of the Nigerian government was explored to determine the factors that contribute to people leaving Nigeria.

This study also added literature to the field of public policy and administration by exploring the lived experience of Nigerian healthcare practitioners in the diaspora who relocated to the United States to practice medicine.

Research Questions

In order the understand the cause and effect of medical brain drain in Nigeria, two principal questions arose that guided the study.

1. What are the reasons for healthcare practitioners leaving Nigeria?
2. What are the impact of those decisions on the Nigerian healthcare sector?

Nature of the Study

I employed a heuristic phenomenological design, which helped me examine the phenomenon of brain drain through the lived experience of healthcare practitioners from Nigeria who had settled in developed countries (the United States for this study). The heuristic phenomenological approach was first introduced by Moustakas (1994). This approach was used to understand the experience of humans as it related to a common specific lived experience. Exploring the heuristic phenomenological design allowed an

in-depth understanding of the brain drain phenomenon by focusing on the participants' narration of the phenomenon via rich, descriptive language (see Moustakas, 1994).

Central to the study of brain drain in Nigeria is the understanding of the lived experience of healthcare practitioners that have left Nigeria to developed countries. The healthcare practitioners were co-researchers within the study as they helped me understand the brain drain phenomenon through their lived experience. The heuristic design employed a multiplicity of input to gain a better experience of the brain drain phenomenon (Mihalache, 2019). Furthermore, Rudestam and Newton (2015) pointed out that a heuristic phenomenological study involves examining the phenomenon through the qualitative method of inquiry. It was imperative that I understood the decision that made the Nigerian healthcare practitioners leave Nigeria and why they would not return, and if they do return, under what conditions were they willing to return. The heuristic phenomenological study provided a vantage point into their experience in Nigeria and what prompted them to migrate in the first place.

I used a heuristic qualitative study to gather purposive and snowball sampling of Nigerian healthcare practitioners. I carefully selected participants via purposive and snowball sampling to ensure the recruitment of participants that had experienced the brain drain phenomenon and thus I was able enhance data accuracy. In order to collect data from the participants, I used an interview process. Creswell and Creswell (2018) proposed using an interview process to explore the lived experience of the healthcare practitioners.

I managed and analyzed the collected data using the qualitative computer software, Dedoose (Version 8.3.47). The computer program aided in sorting and analyzing data collected. Dedoose also helped me identify the emerging themes from data collected. The interviews with the participants were conducted using Zoom virtual calls.

Creswell and Creswell (2018) stated that research is subjective depending on the reality of the research and the researcher. In this instance, the Nigerian healthcare practitioners in the diaspora and their proposed contribution to the development of Nigeria were subjective to me. Also, a social constructivism worldview was used to understand participants' views regarding the importance of bringing their specialized skills acquired abroad back to Nigeria.

Theoretical Framework

The theoretical framework that grounded this study was the push-pull theory. The tenets of the theory were first explored by Ravenstein in 1889. Ravenstein (1889) explained that there are several factors that pushed people out of their home country. The factors include oppressive laws, unfavorable climate, and over-taxation. The pull factors influenced the desire to move to another country where labor is needed to develop industry, commerce, or land (Ravenstein, 1899). Decades later, Lee (1966) further assessed Ravenstein's laws of migration and reframed them in his paper "A Theory of Migration." Lee purported that there are four factors that influence the decision to migrate, associated with area of origin, area of destination, intervening obstacles, and personal concerns.

Researchers have continued to explore the migration patterns of humans, and the migration theories coined by Ravenstein (1889), and Lee (1966) have evolved into the push-pull theory of migration due to the push and pull factors that form the reason for migration. Researchers continued to agree that migration is mostly dependent on factors that push migrants out of their home country and pull them to countries that are able to fulfil the deficient factors that forced them out of their home country in the first place (Mohamed & Abdul-Talib, 2020; Olatuyi et al., 2013; Wapmuk et al., 2014). Mohamed and Abdul-Talib (2020) found that in many cases, there were more push factors than there were pull factors. In the case of brain drain in Nigeria, the push factors that contribute to emigration included unstable political climate, poor wages (remuneration), and corruption of the government. The pull factors to developed countries are better wages and a stable non-corrupt government. Olatuyi et al. (2013) also purported that Nigerians encounter the same push and pull factors no matter where they find themselves geographically.

Brain drain as a phenomenon is not only rooted in migration, but it is important in the areas of mathematics, geography, and economics. In mathematics, for example, Dorigo and Tobler (2010) purported that Ravenstein's (1889) laws could be used to explain the distance people travel during migration. Ravenstein's laws revolve mostly around distance and are often used to explain the distance people are willing to travel when migrating between their home and another location. The distance component of migration is very important because it explains how nomadic people can be when it comes to meeting their livelihood.

The factors that pulled a lot of immigrants from Nigeria to developed nations such as the United States and the United Kingdom included the better educational system and the freedom of press, religion, and speech they otherwise did not have in their home country. Siyam and Dal Poz (2014) further explained that there are a lot of factors that cause brain drain. In many cases, migration normally occurs because the home country lacked what the host country could provide and, in some cases, what the host country could provide kept the migrant in the host country. Siyam and Dal Poz asserted that a wide variety of push and pull factors contribute to migration, including opportunity differentials between sending and receiving countries and political, historical, and trade relationships.

Ravenstein's (1889) law of migration and Lee's (1966) theory of migration were very important to researching brain drain as a phenomenon because they helped set a historical precedent for the phenomenon and the reasons why people left their home country to another country. Furthermore, research continued to show that when brain drain occurred, the brain gained by the developed country can become permanent. Due to the push-and-pull factors affecting Nigerians in the diaspora, the push-and-pull theory was used to investigate the brain drain phenomenon.

Operational Definitions

Brain drain: Brain drain is a term first coined by the British Royal Society to describe the migration of highly skilled people from Europe to the United States and Canada in the 1950s to the early 1960s (Cervantes & Guellec, 2002).

Brain gain: Brain gain is the opposite of brain drain. When skilled workers leave their home country, the receiving country gains the brain that was drained from the home country. The "movement of skilled workers internationally represents brain gain for the countries that reap their skills and experience" (Migration Policy Institute, n.d.)

Developed country: A developed country is one with a steady and mature economy that is highly industrialized, like the United States and the United Kingdom. These countries are also sometimes called first world countries (Business Development Bank of Canada, n.d.)

*Medical migratio*n: Medical migration is the movement of medical professionals from one country to another. The reason for this movement often is because the receiving country provides better wages and living conditions (Rutten, 2009).

Significance of the Study

There was a gap in literature regarding the emigration of healthcare practitioners out of Nigeria and the resulting disparities in its healthcare system. This research was significant in that it filled some of the gap by analyzing the lived experience of healthcare practitioners currently outside of Nigeria and how brain drain affected the Nigerian healthcare system.

The findings of this study will potentially lead to a positive social change. By examining the perspectives of healthcare practitioners who had lived through the brain drain phenomenon, this study shed more light on brain drain, and the findings may help the government create attractive incentives for healthcare practitioners that want to leave the country. The result of this study will hopefully lead to the creation of economic

stimulus tools such as a demographic database of emigrant healthcare practitioners that the Nigerian government can implement. Firsing (2017) noted that when South Africa was ready to perform a brain gain from all the brain drain that happened, nine new jobs in the formal and informal sectors were created for every skilled person who returned home. Thus, by implementing these tools, the Nigerian government may be able to boost the economy and fix the healthcare system. India is another country that has implemented a successful brain gain and brain circulation strategy that has brought drained talents from India back to India to explore opportunities because the government provided them with an avenue to come back to the country (Zagade & Desai, 2017).

Assumptions

I assumed that the participants would give detailed and truthful responses to the questions asked during the interview. It was also assumed that the participants would be unbiased in their perceptions of the current state of Nigeria. The reasoning behind this was because some of the participants left Nigeria when it was not completely degenerated. I also assumed that the participants remembered the good times during the interview to form a well-rounded perception of the state of healthcare in Nigeria. As it currently stands, Nigeria is not a homogenous society due to the various tribes. It was assumed that the selection strategy used during the research was not biased toward any tribe or population.

Limitations

Due to the lived experience of the participants, it was expected that the generalizability of the results may be hindered. The biggest limitation was the number of

Nigerians in other parts of the world that were not polled in this study. Nigeria at this time cannot concisely answer the question of how much brain drain has happened in the country. Also, many of the Nigerian healthcare practitioners that moved to the United States may not have been identifiable because they had been unable to transition to the American healthcare sector. This study attempted to ask questions that were able to help determine those who were able to transfer their healthcare skills to the United States and those who could not transition into the healthcare field. This created a limitation as some of the brain drain that happened in Nigeria did not necessarily translate to a brain gain in the healthcare sector for the developed country.

Scope and Delimitations

In this research, I used interviews and documents to explore the problems of brain drain in Nigeria. In a diverse society where opinions were varied, I wanted to determine if the responses of the participants to the interview questions gave validity to the research questions. This research used purposive and snowball sampling; in doing so, the participants were healthcare practitioners who are Nigerians that came to the United States for better opportunities. The study uncovered, analyzed, and interpreted the perceptions of 12 Nigerians in the healthcare profession and their thoughts about brain drain. The group comprised 12 Nigerians that currently lived in the United States. In doing this, I was able to develop recommendations on how to resolve the issues presented. The participants were selected using a brief survey posted on social networking websites such as Twitter and Facebook. The participants who were chosen were then directed to a survey that used the SurveyMonkey tool.

Nigerians on continents other than North America were not within the scope of this study. Additionally, the size of the United States made gathering a large sample impractical; however, in future studies, it would be useful to analyze a larger group to determine how many healthcare practitioners from Nigeria are in the United States and possibly North America (to include Canada) and in which areas they are concentrated in. The collected data would aid the Nigerian government in deciding as to which countries to focus their attention on when working on brain gain and brain circulation strategies.

Summary

Brain drain is a serious threat not only to the healthcare sector in Nigeria but also detrimental to the Nigerian economy. The migration of healthcare practitioners from Nigeria is creating a gap in access to healthcare for Nigerians. Atoyebi (2019) stated that there are currently 40,000 doctors for the population of over 200 million people. When the discussion of brain drain in Nigeria was posed to the Minister of Labor and Employment, Dr. Chris Ngige, he stated that “we have more than enough, quote me” (Atoyebi, 2019). Herein lies the problem of brain drain with Nigeria.

This research provided different suggestions to the Nigerian government about tools that could be implemented to help some Nigerians in the diaspora return to Nigeria to close the gap in Nigeria’s healthcare sector. The background, nature of the study, theoretical framework, problem statement, significance, scope, delimitation, and limitation of the study were discussed extensively in the first chapter. The second chapter details some of the existing literature concerning the effect of brain drain in Nigeria on the healthcare system.

Chapter 2: Literature Review

The purpose of this heuristic phenomenological study was to examine medical brain drain in Nigeria and probe the lack of public policy within the healthcare sector. In addition, this study proposed public policy options that could help revitalize the Nigerian healthcare sector. Due to the burgeoning number of healthcare practitioners leaving Nigeria, the role of the Nigerian government was explored to determine the factors that contribute to people leaving Nigeria.

Chapter 2 explores literature on brain drain in Nigeria and its effect on the Nigerian healthcare system. The intention of the literature review was to synthesize literature on the history of brain drain, the effect of brain drain on the Nigerian healthcare sector and the empirical evidence that revealed the huge disparity in healthcare access due to the subpar Nigerian healthcare system.

Research Documents, Articles, Journals, and Title Searches

The literature research was conducted using several sources of information. Several online resources were accessed using the general search terms “brain drain” and “Nigeria” as the root of all inquiries. With these terms, other search words such as *migration, development, remittance, diaspora, history of brain drain, healthcare practitioners in Nigeria and brain drain, brain gain, brain circulation, emigration and brain drain, healthcare practitioners and Nigeria, corruption and Nigeria, medical tourism and Nigeria, human capacity building and Nigeria, push-and-pull theory,* and *push-and-pull theory of migration* were used to narrow the search. Research using these terms generated many academic articles. Within the articles found, a thorough review

was done of the references that each author had cited. This provided a wealth of information that aided in performing a proper literature review. Many of the cited resources within the journals and articles provided another level of information that would otherwise not have been found during the research stage.

Peer-reviewed journals were used for the majority of research with a few websites and books used to magnify the study of brain drain in Nigeria and its effect on the healthcare system. The following online databases and libraries were searched: Walden online library, Washington University library, Google Scholar, JSTOR, Thoreau Multi-Database, EBSO, PsychINFO, ProQuest Central, ABI/INFORM, and Academic Search Complete. Also, in order for currency of resources, the year range of 2013-2020 was used except in cases where the seminal article was used to highlight the theoretical framework and some terms that were vital to the study.

Theoretical Framework

The theoretical framework that grounded this study was the push-pull theory as first introduced by Ravenstein in 1889 and later reframed by Lee in 1966. In Ravenstein's (1889) initial discussion on the laws of migration, he sought to explain why people migrated from one country to another. Ravenstein pointed out that the land in the European countries under examination had been cultivated and every inch that could accommodate humans was populated. Ravenstein asserted that migration happens as a result of the development of business and industries in certain places or when people emigrate, and those gaps are filled by the new immigrants. Ravenstein noted that the migration pattern in Europe was vastly different from the migration pattern in North

America. In Europe, migrants were a small fraction of the general population. In North America however, Ravenstein noticed that the majority of the migrant populated areas were within the city rather than rural areas and the migrant ratio to the population was much larger than the one in Europe. Ravenstein further stated that undesired laws that were bad and oppressive in nature were one of the reasons why people migrated from one country to another. Furthermore, climate, taxation, and even transportation and slave trade were cited as reasons why people moved from one place to another. Another major reason cited was the deficiency of labor in one place and a superfluity of labor in another; all these reasons account for why many people were moving from one country to another when labor was low in their country and there was an overabundance of labor in a developed country.

Lee (1966) further explored Ravenstein's (1889) research to form the push-pull theory. Lee asserted that while Ravenstein's theory is outdated, it still holds true as the starting point for researching migratory patterns (p. 47). Lee summarized seven major points from Ravenstein's paper: (a) migration happens in short distances, (b) migration happens in stages, (c) migration happens in currents and counter currents, (d) urban-rural differences in propensity to migrate, (e) predominance of females among short distance, (f) technology and migration, and (g) dominance of the economic motive. All the points made by Ravenstein were valid at the time his paper was written. However, as time went on, migratory patterns changed, and Lee needed to account for that. Lee defined migration as a move from one place to another. Distance was no longer a factor as Ravenstein initially expressed. In Lee's paper, the factors that prompt migration fall

under four headings: (a) factors associated with the area of origin, (b) factors associated with the area of destination, (c) intervening obstacles, and (d) personal factors. In outlining those four factors, Lee reworked and created a more condensed version of Ravenstein's migration theory. Ravenstein and Lee both agreed that the factors that lead to migration include the attractiveness of the destination country due to various factors and dissatisfying factors from the source country.

Passaris (1989) further expressed that there was a correlation between migration and economics and stated that historically the economic impact of migration is often neglected when discussing migration theories and the causes. There is a universal consequence as it relates to economics, and this should be measured when defining the appropriate parameters and constructing the theoretical foundations for the systematic analysis and exposition of the causes and consequences of immigration" (p. 525). Passaris also pointed out that there was an economic undertone to what Ravenstein and Lee reported in their individual theories and that the study of economics was overlooked due to the fact that, at the time of the publication of their papers, there was no theoretical framework that used the economic lens to look at immigration as a concept. It was further argued by Passaris that immigration needed to be explored within the concept of economic theory to gain a better understanding of how economic factors drive immigration.

Researchers tend to use Lee's (1966) more contemporary version of early migration theory. Gibson and McKenzie (2011) specified that there is evidentiary support on both the micro and macro level that suggests highly skilled individuals will migrate

from one place to another if their needs are not met in their home country. Migration theorists continue to use the foundation of Ravenstein's (1889) laws of migration and more specifically Lee's theory of migration to outline the migratory pattern of people throughout history. According to Yanai et al. (2020), highly skilled individuals are pushed from their country of origin due the negative factors they find undesirable and are pulled by their destination country due to desirable factors that were provided by the country of origin. As Lee stated, the first set of factors for migration involve "factors associated with an area of origin factors" (p. 50). This factor explained the push factors that formed the basis for the migration of individuals from their source country to the destination country. In Nigeria, the push factors include corruption; overall, bad governance has been a recurring theme amongst migration researchers.

The second set of factors Lee (1966) outlined include "factors associated with the area of destination" (p. 50). Many Nigerians travel to developed countries because of the pull factors the destination country had to offer them. The pull factors such as better wages, better governance, and other elements attract migrants from their developing country to a developed country due to the structure of their labor market and the market segmentation. In Nigeria, the labor market is in poor shape due to low wages and long hours. Many highly skilled workers in turn get pulled by the labor market configuration that aligns more with their skill set, and those labor markets are primarily in developed countries.

Intervening obstacles are the third set of factors in Lee's push-pull theory. Intervening obstacles are obstructions that can hinder migration. Klaus and

Pachocka (2019) stated that “intervening obstacles” could “take the form of various barriers, including physical (walls or fences), financial (costs of a journey), technical (arrangement of a long journey with small kids), and legal ones (strict migration law or policy)” (p. 280). For many Nigerians, physical barriers are not much of an issue. The technical, financial, and legal intervening obstacles are more prominent in Nigeria. Many of the healthcare practitioners that moved to developing countries spent a lot of money for the journey and also for courses they had to take to convert their Nigerian medical degree to follow the licensing regulations of the country they moved to. Strict immigration laws in countries like the United Kingdom and the United States also serve as a deterrent for many people that wanted to migrate.

The last factors are personal factors. Personal factors are the primary cause of emigration from Nigeria. Unlike the other factors, potential migrants have control over personal factors. For example, healthcare practitioners leaving Nigeria hope for better lives for their family.

According to Kajunju (2013, November 1), around the world, Africans in the diaspora live in various parts of North America. Currently in North America, “there are 39 million from the African diaspora; 113 million in Latin America; 13.6 million in the Caribbean; and 3.5 million in Europe.” The numbers continued to grow because of the harsh conditions in Africa which thereby caused a huge brain drain on the African continent. The push-pull theory is very pivotal to the brain drain phenomenon because the push-pull factors are what help people determine what factors pushed them out of their developing country and what factors pulled them into a new country.

Review of the Literature

The review of the literature delved into the impact of brain drain on Nigeria as a country and touched on how other countries have been able to solve their brain drain problem. I also discussed the positive outcome of brain drain as it deals with remittances and its contribution to the gross domestic product (GDP) of Nigeria. This section will also discuss the negative attributes of brain drain such as medical tourism, brain drain in general, and the inability for Nigerian to get brain gain.

Brain Drain

Goga (2020) explained that brain drain is the movement (emigration) of high skilled workers from a developing country to a developed country. The highly skilled workers that move from a developing nation to a developed one move due to factors that are highly desired in the country they are moving to. There are several industries that are affected by brain drain, and when the phenomenon was first conceptualized by the Royal Society of Britain in the 1960s, it was due to the migration of scientists from the United Kingdom to North America (specifically the United States and Canada). Brain drain has become such a huge part of the economies of developing countries, and while the history dates back to the 1960s, it is a phenomenon that has continued to garner interest.

General History/Development

Human migration has been well documented in history. Dell'Amore (2011) revealed that over 20,000 years ago, humans migrated from Africa due to a warm spell during the Ice Age. This warm spell paved the route out of Africa which could possibly be the first documented migration of humans.

The term *brain drain* was first coined by the council of the Royal Society during their inquiry into scientists that were moving from the United Kingdom to North America. Oldfield et al. (1963) reported that in a 10-year period the Royal Society stated, during that 10-year period, many scientists with Ph.D. relocated to North America from the United Kingdom.

Balmer et al. (2009) summarized the 1963 report by the Royal Society to further explain the origin of the brain drain terminology. The Royal Society was a non-government entity that was concerned about the political nature of science in the United Kingdom and was highly critical about the excessive involvement of the government in science-related fields. Balmer et al. (2009) further asserted in the Royal Society's report that it was more of a political discussion that the actual migration problem that was happening. It should be understood from their perspective that the society's 1963 report on emigration of scientists, which was instrumental in the 'brain drain' debate of the 1960s, reflected its desire to raise awareness of this issue but to remain conscientious of the brain drain issue but also remaining adamant that there was a political caution that needed to be taken into consideration.

The subject of brain drain is not new. After the Royal Society reported on their findings about brain drain, researchers started to take greater interest in the topic as the brain drain trend continued to affect areas such as the Caribbean, Asia, and Africa. According to Docquier (2014), there had been a significant shift in foreign born nationals in westernized countries. That number is envisioned to have tripled since the 1960s. This

is about the time that brain drain became a phenomenon in Britain and the study of brain drain began.

Historically, brain drain was an involuntary process. Involuntary brain drain occurred with the transatlantic slave trade in the middle of the 15th century when the first Africans stepped onto European soil. By the year 1518, after America was discovered, slaves were shipped directly from the Western parts of Africa such as what is now modern-day Benin, Nigeria, and Cameroon to America (Adi, 2012). Whatley and Gillezeau (2011) asserted that Africa, with its vast rich resources, suffered a devastating reversal of fortune that is still very prevalent in the dire outlook the continent faces today. Furthermore, Ukwandu (2020) explained that slavery also contributed to the underdevelopment and poverty in Africa.

Present Overview

Brain drain can also be voluntary. In recent times, the migration of highly skilled workers from their developing country to a developed one was done voluntarily due to circumstances presented in their country of origin such as low wages, poor working conditions, inadequate or poor resources, and inadequate governance (Grenier, 2014; Hunter, 2013; Jenkins, 2016). While brain drain is voluntary, current immigration policies of high-income countries had created reverse brain drain. In the United States for example, Silicon Valley constantly attracts highly skilled workers in the field of technology from other parts of the world. However, Kosoff (2017) purported that many highly skilled workers left the United States for other countries such as China, Canada, and Mexico.

Many of the countries that deteriorated from brain drain are developing countries of all sizes. Douquier (2014) asserted that small-sized countries with a smaller workforce of about one million workers have lost some of their highly skilled workers to developed countries. Countries like Haiti and Jamaica have seen "more than 80% of their brains emigrating abroad" (Douquier, 2014, p. 3).

Hunter (2013) reported that initially, brain drain only examined migrants from scientific fields. At the onset of brain drain, many of the highly skilled workers that migrated were scientists who had Ph.Ds. as highlighted by the Royal Society report in 1963. However, the categories of people who currently migrate in recent times are not limited to Ph.D. holders but also include highly skilled workers in different fields such as the healthcare field. Rubagumaya et al. (2016) stated that the American Medical Association as of 2011 reported that over 17,000 of the medical doctors practicing in the United States were born or trained in Africa. Olutayo (2017) expressed that WHO had identified 56 countries where there is shortage of healthcare workers. Of the 56 countries presented by WHO, the African continent is home of 64% of those countries (36 of the 56 countries cited by WHO).

Limitations of data presented by some studies of brain drain were not precise due to the reality that some of the people who left developing countries may still be under the radar because they are undocumented in their country of destination. In some cases, the immigrant may not even be aware that they are an immigrant in the country they currently live in. Due to being undocumented, some of the highly skilled immigrants that left their home country may not be recorded in population statistics and will thus go

unreported in studies on brain drain. Truman (2018) explained that apart from the typical brain drain as it is understood, immigrant brain drain is another facet of the brain drain phenomenon that some people are facing in the United States. Immigrant brain drain refers to instances where workers who are highly qualified for a position are unable to work in that position because they are undocumented. This type of brain drain further skews data collected on the brain drain phenomenon as a whole.

Causes and Effects

The exact science behind brain drain was not immediately evident. However, research continued to document that the reasons behind the emigration of people from one country to another are deeply rooted in the push-and-pull factors of migration. Adesote and Osunkoya (2018) purported that the push factors that have often been cited as the reasons for highly skilled workers leaving their country of origin vary from poor working conditions, inadequate access to proper healthcare, systematic breakdown in the government, and underutilization of the skills that have been acquired by the individuals. The pull factors are the factors that pull the high skilled workers away from the source of origin and toward the destination country (Osaretin & Eddy, 2012). For many that migrated to developed countries, the pull factors include personal fulfillment in their careers, better wages, and safe environments with no wars or dictatorial governments.

Potential Solutions

In 2003, the WHO global health workforce alliance had a meeting with the commonwealth of health ministers. The global health workforce alliance was tasked with developing and implementing best practices in human resource retention of healthcare

practitioners that are leaving developing countries for developed countries. In the resolution, the global health workforce alliance created the WHA 57.19 titled "International migration of health personnel: a challenge for health systems in developing countries" (WHA 57.19, 2004). The resolution presented salient points about the concerns WHO and member states had about the migratory patterns of healthcare practitioners that was currently affecting the healthcare systems of developing countries. In the resolution, it was further stated that member states need to be cognizant of the work being done in United Nations organizations and other international organizations to enhance the capacity of governments to manage migration movements at local, national, and regional levels; and recognizing the need for additional action to address, at the national and local stages, as part of the sector wide method and other expansion plans, the issue of migration of trained healthcare employees should be addressed. Subsequently, during the 64th world health assembly, WHO recalled the resolution WHA 57.19 and further discussed and addendum called the WHA 59.23 which was enacted to fix the shortage of healthcare practitioners so that the "health related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes" (World Health Organization, 2011, p. 9) can be attained. The goal of the assembly was to discuss the burden that is placed on the healthcare systems of developing countries that were losing their human resources to developed countries.

Cometto et al. (2013) explained that understanding the root cause of migration was very essential when looking for solutions to the brain drain issue. In the United Kingdom, the competing priorities of the National Health Service made it impossible to

see that the country was a part of the world brain drain problem. Cometto (2013) suggested that creating a solution to the brain drain problem involved implementing policy options for international health workforce migration that included understanding. Due to the influx of healthcare practitioners from Sub-Saharan Africa (SSA) to the United Kingdom, the United Kingdom started training healthcare practitioners locally and tightened their immigration policies in order to curb their dependency of migrated healthcare practitioners. The inflow of healthcare practitioners from developing countries declined when the United Kingdom put in place "bilateral agreements with source countries" (Cometto et al., 2013, p. 2).

Closing the gap in the wage disparity between developing and developed countries was also very important. Walton-Roberts et al. (2017) analyzed that poor wages (salaries) had often been cited as one of the push factors that had been responsible for the emigration of people from a developing country to a developed country. Developing countries need to implement strategies in the salary structure so that they can retain the skills of the professionals that are looking to move.

Another possible solution to the issue of brain drain is brain circulation. Zagade and Desai (2017) defined brain circulation as a method in talented immigrants bring capital, management, and institutional expertise back to their homeland to harness its potential. India and China had been very successful in using this strategy to create brain gain in their countries. Nair and Webster (2012) stated that the Chinese government has encouraged their "lost talent to return for short-term assignments or hold concurrent positions in China and abroad to aid research and development in the country" (p. 160).

As a result, the Chinese government was able to recirculate their brain drain by sharing the talent their highly skilled workers in the diaspora had acquired abroad but not necessarily bringing them back fully back to the country.

Nigerian Economy

Nigeria is a country with a very sordid past still recovering from its colonization by the British and its later independence from the British in 1960. Since its independence, Nigeria has moved from a civilian government to a dictatorship by several military heads of state and back to its current civilian rule. Imam and Akinyemi (2015) analyzed that amongst the countries in Africa, Nigeria is by far the most populous with the largest gross domestic product in Africa.

Okunola et al. (2019) outlined that Nigeria is rich in material, human, and natural resources and has the second largest economy in Sub-Saharan Africa. By those metrics, Nigeria should not be struggling economically and dealing with brain drain. Nigeria is the largest exporter of oil in Africa and has a flourishing agricultural sector, but the country has been plunged into abject poverty due to mismanagement by the government (Suberu et al., 2015). The mismanagement by the government has created undue hardship and many of the constituents are emigrating to developed countries for better lives. Moyosore (2015) concluded that with Nigerian's vast natural resources, there are few reasons for Nigeria to be one of the poorest countries in the world. As of the 21st century, about "54% of the population earns less than $1 per day" (p. 22). In 2020, the Trading Economics reported that "the Government Revenues in Nigeria averaged 872.76 NGN Billion [about $232 million U.S. dollars] from 2010 until 2019, reaching an all-time high

of 1738.81 NGN Billion [about $462.45 million U.S. dollars] in the third quarter of 2019" (Trading Economics, 2020). Despite the Nigerian government's vast resources and revenue, Nigeria has a failing economy that has extended into the healthcare industry.

Historical Context of Corruption in Nigeria

The corruption of the Nigerian government stems from the amalgamation of the Southern and Northern Protectorates in 1914. Prior to gaining independence, Nigeria comprised of three different entities known as Lagos, Northern Protectorate, and the Southern Protectorate (Eric, 2016). The Northern Protectorate did not have money in its coffers and for economic and political reasons, Lagos, Northern, and Southern Protectorate were forcibly amalgamated by Great Britain (Mohammed, 2013). What the British did not consider was whether the amalgamation was actually good for Nigeria. Eric (2016) further analyzed that the amalgamation resulted in obstacles that arose from a divide between Nigeria's diverse ethical and religious groups. The amalgamation resulted in one ethic group becoming the alpha group while the minute groups became marginalized. Handelman (2011) analyzed that many of the conflicts around the world was rooted in ethnic difference. Research continued to show that the problem with governance and ill-fitted policies in Nigeria all started with the amalgamation.

Today, the ethnic divides manifest in Nigeria's many political parties (Forsyth, 2007). During the 2019 election, over 91 political parties were registered (Angerbrandt, 2020). As a result of the divisions among the parties, the interests of the people and country are not prioritized.

Nigeria had toggled between military and democratic government since its independence from the British on October 1st, 1960. In the first democratic government of Nigeria, Sir Abubakar Tafawa Balewa was the Prime Minister of the First Republic while Dr. Nnamdi Azikiwe was installed as the informal President (Odeyemi, 2014, p. 1). In a country that had gone through the amalgamation process with no consideration for possible religious and ethical conflicts, the first democratic regime was riddled with regional rivalries, ethnic tensions, declining revenues, and a bitter power struggle until it eventually was overthrown by the military.

Prime Minister Tafawa Balewa was assassinated in a coup by Major-General Johnson Aguiyi-Ironsi in 1966. Barely six months into his regime, Aguiyi-Ironsi was assassinated in another coup and a Hausa (northern) General Yakubu Gowon was installed as the military president of Nigeria. During his military regime, a civil war ensued in Nigeria due to the Igbos living in the north being targeted by the Hausas of the North. The civil war further exacerbated the fragile state of Nigeria as the military kept having coups that toppled the previous head of state.

The next few presidents came in through either a coup d'état or through an assassination (Abumere, 2018). Nigeria's first democratic governance was led by Alhaji Shehu Shagari, but immediately after his tenure, a coup restored military governance and Nigeria did not experience another civilian government until 1999. The first civilian president installed in 1999 was a former military head of state, Major-General Olusegun Obasanjo, who was a civilian at the time of his installation. The current president of Nigeria, President Muhammadu Buhari, was also a former military head of state.

The instability of the government due to its numerous military and civilian leaderships had created gaps in the Nigerian government. The government's systematic policies were never fully implemented, and those that were implemented are done on a partial basis until it is completely scrapped by the next government. Ploch-Blanchard and Husted (2019) compared the political structure of Nigeria to that of the United States. However, the similarities end on the note that Nigeria has a bicameral legislature very much like the United States. The article discussed the political structure, elections, developmental challenges, lack of policies, corruption within the government, and religious/communal tensions within Nigeria. The quick succession with which Nigeria changes its government points to the reasons why Nigeria has still not been able to govern itself in over 60 years of independence.

Nigeria, since the amalgamation, has still not been able to find its footing. In modern times, Presidents are still chosen along religious and ethnic lines. Eric (2016) further pointed out that the "century long existence can be used meaningfully to chart a new course for building a new nation in this new century, and not look back to amalgamation as a [*sic*] Britain's colonial adventurism but a divine connection" (p. 68).

Government Policies

During Yakubu Gowon's military regime, he instituted the National Youth Service Corp (NYSC). This program made it mandatory for college graduates to work a government-mandated job for one year after graduating from college. The program initially was created by Gowon after the civil war to help with capacity building and sustainability development (Muogbo et al., 2021). According to Raimi and Alao (2011),

the main aim of this policy was to have the youths serve outside their home states and contribute to the country's development to promote inter-tribal understanding. A majority of corps members work in schools, health clinics, and other sectors for their 1-year service to the country after graduation. This quasi-labor policy was meant to build future leaders and provide a year in service for future leaders of the country. However, the state of the country is making these future leaders leave Nigeria and move to developed countries.

Nigeria does not have any formal erstwhile policies that are geared toward the development and retention of highly skilled professionals across all sectors. Abumere (2015) pointed out that flexible and balanced policies are needed in Sub-Saharan Africa and specifically in Nigeria. Abumere (2015) further asserted that Sub-Saharan African countries needed a strategy which balances security and job creation resources on one hand and then adjusts them to match particular conflicts within the continent on the other hand.

Another very important policy that Nigeria has not quite gotten a handle on is its foreign policy. Due to the intermittent change in government from military regime to a civilian government and to a period of dictatorship, the “foreign policy of [the] Nigerian state has continued to change under different government and leaders” (Bello et al., 2017, p. 43). Currently, Boko Haram’s continued occupation of Nigeria has afforded the country opportunities for renewed relationships with neighboring African countries so that they can conquer the occupation of Boko Haram. While Nigeria is doing its best in creating a strong foundation for its foreign policies, Enuka & Ojukwu (2016) pointed out

that, Nigeria's foreign policy faces a daunting challenges due to a lack of staff, training, and funding. Despite all the training and funding directed toward the formulation of foreign policies in Nigeria, there is still a huge gap in the formulation and implementation of foreign policies because “evidence has it that Nigerian diplomats and foreign policy practitioners seem not to have received the requisite training and orientation to meet up with the diplomatic realities and challenges of the present global age” (Enuka & Ojukwu, 2016, p. 54). Implementing sturdy foreign policy could bolster Nigeria’s relationships with its international counterparts. As it stands, many international companies have left Nigeria due to the security concerns, and the ease of doing business in Nigeria is low. Lawal and Aluko (2016) expressed that strengthening economic diplomacy will create an avenue for job creation thereby reducing the crime rate which as become a by-product of the high unemployment rate in the country. Subsequently, the current brain drain which has sucked and continues to pull the unspeakable manpower of the country would be reduced.

Another noteworthy policy that was created by the Nigerian government is the local content policy. The policy, which was meant to facilitate skill building and human capacity development, was geared only toward the oil and gas industry. Due to the fact that a large revenue comes from its oil and gas industry, Nigeria was very interested in implementing this policy. According to Balouga (2012), despite some noble intentions, the government has failed to achieve its local content policy objectives. While Nigeria is known as a large exporter of oil and gains wealth from it, Nigerian is still one of the poorest countries in the world. Since the local content policy is only geared towards the

oil and gas industry, it has added value to the industry but not to other sectors in Nigeria as a whole, thus contributing to Nigerians' desires to leave the country and migrate to a country that is able to fulfill their needs.

Education

Nigerians are a very educated group of people and according to Olutayo (2017), the number of "African students seeking higher education abroad grew from 343,370 (in 2006) to 427,311 (in 2014) constituting about 24 % growth in students' mobility abroad" (p. 19). The prevalent push factors in many African countries are the reasons behind the migration to developed countries. Furthermore, the Migration Policy Institute prepared a demographics report for the Rockefeller Foundation-Aspen Institute Diaspora Program (2015) which expressed that

> the Nigerian diaspora in the United States was highly educated, with a large proportion of Nigerian diaspora members holding bachelor's or advanced degrees. Thirty-seven percent age 25 and older had a bachelor's degree as their highest education credential, compared to 20 percent of the general U.S. population. Twenty-nine percent of the Nigerian diaspora aged 25 and older held a master's degree, PhD, or an advanced professional degree compared to 11 percent of the U.S. population overall. (p. 3)

Although many Nigerians are highly educated, Nigeria's education infrastructure in Nigeria is poor. The United Nations Education and Scientific Cultural Organization recommended that 26% of a nation's yearly budget should be allocated to education. Despite that recommendation, Olutayo (2017) reported that the annual report of the

Central Bank of Nigeria showed that there was a 45.7 percent decline in education expenditures ... Nigeria has never allocated up to half the expectations to education.

According to Mogaji (2019), Nigeria has 174 tertiary institutions which comprises federal, state, and private universities. There are a lot of bright minds in Nigeria; however, the low education budget has contributed to the increasing number of students traveling abroad for their studies. According to data presented by the Institute of International Education which is funded in part by the United States Department of State, the total number of Nigerian students enrolled in a tertiary institution for the 2018/2019 academic year was 13,423 and 13.7% of those students were enrolled in majors related to health professions. The number of students increased from 6,568 in 2009 to 13,423 in 2019 (Open Doors, 2001-2019). Thus, not only is brain drain happening to highly skilled professionals, but brain drain is also happening at an alarming rate with students choosing to migrate to developed countries for their education.

Healthcare Industry

The healthcare sector in Nigeria is composed of the public and private sector. The public hospitals are owned on the federal and state level and receive their funding from the government. The private hospitals, as the name denotes, are wholly owned, and operated by private organizations or by a single entity such as a medical doctor. Flood and Gross (2014) reported that while Nigeria has a mixed private and public healthcare system, many people in Nigeria still do not have access to healthcare due to its “gross inequalities and nascent healthcare system” (p. 69). Furthermore, according to Adeloye et al. (2017), the healthcare sector lacks the training, policies, funding, and employment for

people who graduated with healthcare related degrees. The poor administration of the government and lack of funding from the government has rendered state-owned hospitals almost underfunded to the point of extinction. Also, many of the healthcare practitioners are unhappy and will often strike due to non-payment of wages and poor working conditions. Many people who majored in healthcare related fields end up working in other sectors because of the poor wages and inadequate infrastructures of the healthcare facilities in Nigeria.

The biggest challenge in the Nigerian healthcare sector is the lack of policy formulation. Policies are drivers to understanding the process for each given task. For the healthcare sector of Nigeria to work, there needs to be a policy that aligns with the healthcare indicators and the population. According to Omoleke and Taleat (2017), Nigeria's Ministry of Health needs to formulate healthcare policies that are not only driven by the federal government but include input from other agencies and people that the policies will benefit. Omoleke and Taleat (2017) further stated that the policies that are currently in place are outdated and lack proper coordination. Furthermore, (Ogaboh et al., 2020) expressed that a simple implementation of brain drain would be curbed with proper hospital safety policies in place.

Another deficiency in the Nigerian healthcare sector is the systematic corruption within the healthcare system. The poor wages cited earlier are one of the main symptoms of the corruption and primary causes of healthcare disparities. Onwujekwe et al. (2020) purported that the healthcare sector in Nigeria is so corrupted that a lot of attention is being paid to corruption as a threat to attaining the United Nations mandated health-

related sustainable development goals. The types of corruption that were identified by Onwujekwe et al. (2020) included bribery and informal payments for the purpose of providing preferential treatment. Another corruption practice noted in the research was absenteeism. Many patients have died because the doctor had left the facility for the day or did not show up for their shift. Other major corrupt practices found within the healthcare sector was the cost-cutting tactic of purchasing fake or subpar drugs and medical equipment. These cost-cutting tactics employed by healthcare facilities have resulted in the deaths of patients.

Economically, Nigeria is not equipped to provide adequate healthcare delivery and access and the last recession in Nigeria did not bode well for the healthcare sector. Ebi Eko (2017) asserted that the Nigerian healthcare system is riddled with issues and stated that a number of limitations continue to plague the Nigerian health system. The constraints include inadequate healthcare infrastructure; the ratio of healthcare practitioners to patients is low, thereby causing long lines at the subpar facilities. The healthcare sector is also underfunded and therefore cannot function properly. Currently, the most utilized method of payment in Nigeria continues to be out-of-pocket payments. The Nigerian government continues to manage the country along political, tribal, and religious lines. If a new government does not deem access to healthcare a basic human right, then funding will not be earmarked for healthcare and policies will not be put in place to protect the healthcare sector. As a result of the poor healthcare delivery and access in Nigeria, medical tourism has gone up where the upper echelon of society are able to travel abroad for treatment. Poor healthcare delivery and access has also prompted

the brain drain of highly skilled workers within the healthcare sector from Nigeria to developed countries. Abubakar et al. (2018) summarized the dire state of the healthcare sector in Nigeria by stating that according to a 2016 Price Waterhouse Cooper report, a lot of money to the tune of $1 billion is expended yearly on medical treatments abroad. It was further stated by Abubakar et al. that as of 2018, the WHO ranks Nigeria at 187 out of 191 countries in world healthcare systems.

Due to these issues, there is a pressing need to address Nigeria's brain drain dilemma within the healthcare sector because it is a sector that could aid in the economic development of Nigeria by adding to the GDP of the country. Also, if care is not taken, soon enough there would not be a healthcare sector to deliver healthcare access and services to the constituents of Nigeria.

Brain Drain in Nigeria

Woldegiorgis (2017) quoted the deputy executive secretary of the United Nations Economic Commission for Africa Dr. Lalla Ben Barka when she stated that it is the responsibility of the government of African countries to ensure that brains stay on the continent; if this does not happen, Africa will be short on brains 25 years from now. The situation of brain drain in Africa is so alarming that many African countries are starting to notice and delve deep into the root cause of the problem (Joshua et al., 2014). Unfortunately, one of the countries riddled with the brain drain dilemma is Nigeria.

Nigeria is the most populous country on the African continent. While it boasts of many natural resources, many of its citizens find themselves running to other countries for solace. The government in Nigeria is so corrupt that the transparency international

corruption index of 2020 ranked Nigeria 149 out of 180 countries. Nigeria had a Corruption Perceptions Index (CPI) score of 25 in comparison to a country like Denmark which has the highest CPI score of 88 out of 100 and ranked number 1 with New Zealand on the 2020 corruption index. Unfortunately, the state of the country has made it unbearable for many people to continue to live in Nigeria and therefore an influx of migration to developed countries has happened.

One of the problems brain drain causes in Nigeria is the loss of revenue that contributes to the GDP of the country. According to Joshua (2014), countries like Nigeria end losing significant tax revenue due to migration of highly skilled workers. Consequently, the brain drain is causing a gap in the economic development of Nigeria.

Causes and Effects of Brain Drain in Nigeria

The history of brain drain in Nigeria first started during slavery, colonization, post-colonial Nigeria, and the civil war that arose from the tribal war in Nigeria (Wapmuk et al., 2014). As a result of slavery, some Nigerians found themselves in developed countries. Years later, Nigeria was colonized by the British and some Nigerians migrated to Nigeria as a result of colonization. Shortly after Nigeria gained its independence, some Nigerians migrated to developed countries to find a better life. In recent times, Nigerians have emigrated to developed countries due to previously cited push factors.

Nigeria faces numerous problems that exacerbate brain drain such as a corrupt government and the deficiency of the basic amenities such as medical supplies, water, electricity, and clean water, needed to survive (Ogaboh et al., 2020). The first problem

with governance started during the 1980s when Nigeria went through several military leaderships (Ojo et al., 2011). The military governance forced many people to leave Nigeria because of its brutal dictatorship.

Currently, there are many Nigerians outside of the country. Suleiman and Mikail (2020) estimated that as of 2020, there were 1.2 million Nigerians in the diaspora. While the actual number of Nigerians in the United States cannot currently be accurately appraised, a 2015 report from the Migration Policy Institute prepared for the Rockefeller Foundation-Aspen Institute Diaspora Program showed that as of 2015 there were "approximately 376,000 Nigerian immigrants and their children" (Migration Policy Institute, 2015, p. 1) in the United States. The report further asserted that Nigeria is currently the largest migrants of African origin in the United States.

One of the major causes of brain drain in Africa and especially in Nigeria is the mismanagement of the country by the past and current leadership of the country. At one time, Nigeria was one of the largest exporters of oil to the rest of the world and currently, the income actualized from exporting oil is nowhere to be found. According to Ploch-Blanchard and Husted (2019), the political unrest, bad economy, and corruption are the leading causes of why the oil resources are no longer a big income generator for Nigeria. Many of the workers in the oil and gas industry are losing their jobs due to the stalled oil and gas sector and are moving to countries in the Middle East for jobs that align with their skill set.

The brain drain problem has hit Nigeria's healthcare sector the hardest. The Nigerian healthcare system hosts poor insurance, inadequate facilities, and low human

capacity building. Obokoh (2020) expressed that the healthcare sector is in such bad shape that the Nigerian health-care quality and accessibility have long been acknowledged to have an unbalanced force on the welfare of the people and even the economy as a whole. As a result of the poor governmental participation in strengthening the healthcare sector, many highly skilled workers in the healthcare sector are leaving Nigeria to get trained in developed countries.

Potential Solutions

The major solution to brain drain in Nigeria starts with the overhaul of the Nigerian government. The bad educational system, inadequate infrastructures across all the sectors, and the government's disregard for the growth of the country are the reasons for the mass exodus of Nigerians to developed countries. The government needs to proffer solutions to retain the talent in their country or encourage brain gain.

The first major cause of the brain drain phenomenon is Nigeria's poor educational system. Joy and Agala (2019) explained that if a nation's educational foundation is untrustworthy, then "it becomes a big challenge to the school itself and the society at large. There is a common phrase we now hear around the circle of universities. … and that is 'las las school na scam' [loosely translated, schooling is a scam]" (p. 240). Students, educational institutions, and society at large seeing education as a scam is the foundation of Nigeria's brain drain problem. The infrastructure and teaching tools of Nigerian colleges are outdated and sometimes obsolete, further contributing to student brain drain in Nigeria. If the Nigerian government starts to pay attention to the migrations of its students abroad, the government may be spurred to modify its current education

policies. Manzuma-Ndaaba (2015) further stated that the educational policy in Nigeria is rife with irregularities, instability, reversals of policy by the previous government, and government insecurity.

Another solution that could resolve brain drain in Nigeria is the implementation of Bhagwati's tax system as proposed by Rapoport (2017). The United States currently taxes American expatriates working abroad and that is a practice that does not currently happen in Nigeria when their lost talents migrate to other countries. In the 1970s, Bhagwati proposed a taxation system that helps curb brain drain and at the same time helps the source country economically. In what is now known as the Bhagwati tax, citizens who have left their source country still pay their source country's taxes. Bhagwati and Dellalfar (1973) expressed that emigration cannot be stopped by any country. However, Bhagwati and Dellalfar further stated that the developing (source) country should not have to suffer because it has experienced significant brain drain. Citizens in Nigeria barely have a solid taxation policy due to the duplication and multiplicity of the current Nigerian tax system. Simeon et al. (2017) cited the bad administration in Nigeria and the multi-faceted taxation system as the issues surrounding current taxation in Nigeria which happens on the federal, state, and local government level. If the Bhagwati tax system is implemented properly, it could help provide financial relief to Nigeria and slow down brain drain by acting as a deterrent to emigration.

Darkwa (2018) explained that in most cases, professionals that have left developing countries for a developed one create a potential resource and expertise pool for their home country. Currently, a database of Nigerians in the diaspora has been

created by virtue of executive order number 5 signed by President Muhammadu Buhari in 2018. In this executive order, it was mandated that the National Office for Technology Acquisition and Promotion develop a database of Nigerians in the diaspora. Specifically, this database was to record the emigration of Nigerians with skill sets in science, engineering, technology, and other fields. This database could be a game changer for Nigeria if implemented and utilized to its full extent. The database can aid in human capacity building especially in the healthcare sector. While this database alone may not be able to fix the huge vacuum in the healthcare sector, if the government adds incentives and creates a brain circulation package that brings in highly skilled healthcare practitioners to Nigeria, it will be a start in not only revitalizing the healthcare sector but in attracting highly skilled workers that can impart the knowledge acquired in the diaspora to the abysmal educational system in Nigeria. As Majeed et al. (2017) expressed, international migration of highly skilled workers is perhaps a blessing in disguise that is meant to not only revive a dying economy but to usher in new best medical practices in Nigeria.

While much of the discussion surrounding the brain drain problem looks at the negative aspect of what it does to Nigeria, an argument that has been made for brain drain is the remittance that comes into the country. A positive attribute of brain drain is the huge amount of remittance that comes into Nigeria as a result of Nigerians in the diaspora. Welde et al. (2020) argue that while brain drain is rampant, Africans in the diaspora are inadvertently aiding in the economic growth of Africa. They specifically looked at Ethiopia and Nigeria due to the huge population of both countries abroad.

Currently according to Welde et al. (2020), the number of African Immigrants is about 2.1 million and of that Nigerians constitute about 25% (p. 2). A portion of the GDP of Nigeria can also be attributed to the remittance that is coming from Nigerians in the Diaspora. As a result of this remittance, brain gain happens in terms of economic enrichment of Nigeria and not necessary through human resources. Therefore, remittance is still not a foolproof solution to the human resource depletion in the healthcare sector.

Summary

Research has shown that migration is inevitable and perhaps cannot be stopped. However, migration resulted in brain drain that diverts the resources from one country to another, then brain drain needs to be studied fully before it creates a drought in the source (developing) country and an overabundance in the host (developed) country. Brain drain may never be fully eradicated; however, putting tools in place to alleviate the burden on the developing country that has lost its resources is vital for survival.

The literature review shows that brain drain is a phenomenon that has been around for many years and does not seem to be slowing down anytime soon. Anetoh and Onwudinjo (2020) agreed that there is a mass exodus of people leaving Nigeria every year and the reasons cited were poor leadership coupled with the poor economy. Many of the people exiting Nigeria were highly skilled and educated workers. Anetoh and Onwudinjo further stated that Nigeria's brain drain problem can be curbed as long as proper tools are put in place to retain highly skilled and educated workers. Of the often-cited reasons for leaving Nigeria, the lack of government policies, corruption,

unemployment rate, lack of quality education (knowledge gap), and poor infrastructure were the top reasons.

The migration of healthcare practitioners has become a huge concern in global and public health (Okeke, 2013). The brain drain issue especially in the healthcare sector is a priority concern for Nigeria. Brain drain as a phenomenon cannot cease to exist but the ability to finesse a brain gain or even brain circulation is very crucial in Nigeria not only for the healthcare sector but the economy as a whole. This brain drain phenomenon was best explained with the heuristic phenomenological qualitative design because it was pivotal in exploring the lived experiences of migrant healthcare practitioners. Chapter 3 will discuss the heuristic phenomenological qualitative design, the population and sample, data collection, data analysis and the summary of the methodology.

Chapter 3: Methodology

The purpose of this heuristic phenomenological study was to examine medical brain drain in Nigeria and probe the lack of public policy within the healthcare sector. In addition, this study proposed public policy options that could help revitalize the Nigerian healthcare sector. Due to the burgeoning number of healthcare practitioners leaving Nigeria, the role of the Nigerian government was explored to determine the factors that contribute to people leaving Nigeria.

Moustakas (1990) pointed out that the researcher's experience of the phenomenon is vital to the research. Furthermore, a heuristic phenomenology study helped me obtain answers to the research questions through the experience of healthcare practitioners that had gone through the brain drain phenomenon.

The brain drain phenomenon has caused human capacity building problem in Nigeria (Joshua et al., 2014). Joshua et al. (2014) further identified that highly skilled workers are moving from Africa to developed countries in the west, by arguing that the major cause of brain drain is failed leadership on the African continent and Nigeria is no exception. Nigeria has especially been plagued with lack of human capacity building which is needed for the development of the country. The Nigerian healthcare sector is lacking in human capacity building, and the purpose of this study is to add more literature to the field of public policy and administration by providing a study that explored the lived experiences of medical personnel that were born in Nigeria and moved to a developed country. The healthcare practitioners' lived experiences of migration from Nigeria to the United States was crucial to understand the push factors that pushed them

out of Nigeria and the pull factors that brought them to the United States. This chapter describes the methodology that I used for the research, the type of research design I used, the research population and sample size, data collection method, data analysis procedure, the method of data storage, and the protection and destruction of data.

Research Design

I considered a range of qualitative approaches for this research. However, I ended up employing a heuristic phenomenological design that helped me examine the phenomenon of brain drain through the lived experiences of healthcare practitioners from Nigeria who had settled in the United States. The heuristic phenomenological approach was used to understand the experiences of humans as they relate to a common specific lived experience (Moustakas, 1990). Exploring the heuristic phenomenological design allowed for an in-depth understanding of the brain drain phenomenon by focusing on the lived experience of the healthcare practitioners by the wide range of stories they told in rich, evocative, and precise language. The reason for choosing the qualitative method over the quantitative method was solely due to the fact that the qualitative method produced richer information through the lived experiences of healthcare practitioners that experienced the phenomenon. Gerring (2017) asserted that qualitative and quantitative methods are both valid and both have their place in research. Furthermore, Gerring stated that in simplistic terms that, while quantitative work uses numbers and statistics to explain a problem, qualitative uses language that is easily understood. Also, when conducting a qualitative method uses a small sample whereas the quantitative method requires the use of a large dataset to gain insight to be problem to be solved. I used the

heuristic phenomenological approach to study the research problem by focusing on the lived experience of healthcare practitioners that have left Nigeria for the United States.

While the brain drain phenomenon is not new, Mihalache (2019) purported that heuristic inquiry may serve its purpose in the exploration of the brain drain phenomenon because heuristic inquiry is appropriate in "any research endeavor where the inquiry is on the cutting edge of new territory being explored" (p. 136). I used the heuristic phenomenological approach to explore the brain drain issue in Nigeria through healthcare practitioners that experienced brain drain and currently live in the United States.

Research Population and Sample

Population

The Nigerian community in the United States is large. So, restricting the selection of participants to one geographic location was not necessary since the study was only interested in the lived experiences of healthcare practitioners in the United States that had experienced brain drain. While the population in this research seemed small, the sample was adequate for the phenomenological study used. Furthermore, Rudestam and Newton (2015) pointed out that it is very important to determine what type of selection will be used to identify the sample most appropriate for the study.

Sample

I used a purposive and snowball sampling for this study. Purposive sampling, "also referred to as judgmental or selective or subjective sampling, aims to focus on the specific characteristics of a population that are of interest to me as the researcher" (Aparasu & Bentley, 2019, p. 59). The purposive sampling technique was the most

appropriate for this study because it allowed me to deliberately focus on a specific population; in the case of this study, the specific sample needed was healthcare practitioners who would be able to contribute to this study due to having lived through the brain drain phenomenon. In order to make sure that data saturation was attained, a minimum sample of 12 healthcare practitioners in the United States were recruited for this study and included in the research. The heuristic phenomenological research heavily benefited from gathering data from a smaller sample, a practice which is standard in phenomenological studies. Rudestam and Newton (2015) purported that a phenomenological study requires a smaller sample that can be used to gather meaningful data. Given the population of Nigerians in the United States that currently work in the healthcare sector, the number of recruited participants was an adequate sample subset of the general Nigerians within the population this research addresses.

Furthermore, Aparasu and Bentley (2019) explained that the appropriateness of the sample used for research can help determine whether too little or too much data was gathered from the participants. While it is the practice in phenomenological research to use a small sample, I continued to add participants from the sample pool until data saturation was reached. The concept of data saturation or data redundancy was essential as a quality control measure in this study.

The inclusion/exclusion criteria for this research were the following: the sample consisted of healthcare practitioners who were born in Nigeria, got their healthcare degree in Nigeria, practiced in Nigeria, and then migrated to the United States. The sample consisted of both men and women, and there were no age criteria so that rich

information was gathered without the hindrance of the age criteria. The graduation age in Nigeria is very different from the one in the United States and so is the retirement age. So, having age criteria did not add any weight or substance to the research. The research limited the term healthcare practitioners to just doctors and nurses that migrated from Nigeria and those who graduated with a nursing or medical degree and worked in Nigeria before migrating to the United States.

Another form of sampling that was used was the snowball sampling technique. A contingency plan was put in place with the snowball sampling technique when some of the original participants were not available. Snowball sampling is a type of "nonprobability sampling technique in which existing study participants nominate, refer or recruit future participants in the study" (Aparasu & Bentley, 2019, p. 30). A couple of the participants that were in this study were recruited through the snowball sampling technique.

Data Collection

Data was gathered for this heuristic phenomenological study through the use of a semi-structured interview guide that consisted of open-ended questions. Seidman (2019) expressed that interviewing using phenomenological method concentrates on the lived experiences of participants and the interpretations they make of those experiences. I used open-ended questions in order to allow the use of life history interviews and centered, in-depth interviews based on phenomenological assumptions. Given the research questions and the depth of this research, the best approach for gathering information on the participants' lived experiences was through one-on-one interviews with the participants.

The interview questions were not guiding questions, and I allowed the participants the ability to express themselves freely without reticence. Since these interview questions were aimed at helping me understand the lived experiences of the participants and the phenomenon, the questions were not crafted in a way that guided the participants to answer the question the way I wanted. Zahavi (2019) also pointed out that as a researcher, there is the need to understand how certain events and life experiences are experienced by individuals in question, so it is important that the interviewees may express their own experiences without being unduly influenced by the interviewer's research.

The interview questions covered biographical and demographic information, which helped me understand what shaped the participant's life choices. The primary questions from the interview guide were asked in the same order to facilitate the alignment of responses between interviews. After the interviews were completed, I had a follow up session to ask some basic questions that were not asked in the initial interviews.

Each participant's confidentiality was ensured because during the course of the research. Seidman (2019) expressed that the participant has the right to request that their identity be kept confidential. The interview process involved sending out an online flyer to the online platform for the Association of Nigerian Physicians in the Americas (ANPA) and other online groups on Facebook. I used a recruitment flyer (Appendix D) that included the inclusion criteria and a link to a demographic survey that was created using the typeform survey tool, solely for the purpose of this research. The demographic

survey had an automated notification alert mechanism that notified me whenever a survey was completed. After I received the notification, I pulled down the information and then used the contact information provided to reach out to the participant (based on their selected mode of communication) to set up a date and time for the interview.

Participants were interviewed via Zoom virtual calls. The participants' responses were audio recorded using Zoom's cloud recording feature. Vagle (2018) pointed out that one-on-one interviews need to be conducted with the understanding on the part of the participant, and I notified each participant that a follow-up interview may occur if clarification was needed.

I ensured that I did not bias the findings through the use of member checking (Birt et al., 2016). Member checking, also known as participant validation, is a technique used for exploring the credibility or truthfulness of results by allowing the participants the opportunity to review and change statements provided during the interview. Birt et al. (2016) explained that member checking is essential not only to me as the researcher but to the participant as it ensures that the gathered information is verifiable and authentic. The audio recordings gathered from the interviews were dated and coded for anonymity and confidentiality, and each participant's information was analyzed independently and accurately (Seidman, 2019). I stored each recording according to the date and the participant code; furthermore, the Microsoft transcription function was used to transcribe data gathered. The transcription of data happened within 24 hours of each interview, which allowed me to remember the details that were given during the interview.

At the conclusion of the interviews, data were analyzed, and the lived experiences of the participants were examined as the underpinning of the brain drain phenomenon. The responses were categorized and probed for emerging themes that helped me understand the brain drain phenomenon and provided credibility to data I collected.

Instrument and Field Test

Data from the participants was gathered using semi structured qualitative interview questions. The interview protocol was created by me to fit the research questions and the literature that had been gathered prior to the interviews. Creswell and Creswell (2018) pointed out that qualitative research is an approach that attempts to understand the human problem and make some meaning out of it. The semi structured interview questions were open ended so that the participants are not guided with a simple yes or no responses.

The instrument was field tested twice: first with three terminally degree persons to ensure the logic, clarity, and structure of the instrument, and it was tested a second with three persons similar to the research participants but who were not part of the study, to ensure the instrument was clear, complete, and concise.

The interview protocol was created using an interview guide. The interview guide proved to be an effective tool because it helped me structure the questions to fit the research and also gave the participants the opportunity to give in-depth responses to the questions. Seidman (2019) also identified that researchers should be mindful of not imposing their thoughts and views on the participants. So, during the interview guide

preparation, I was very mindful of asking questions that related to the study and not questions that created any researcher bias.

Data Analysis Procedures

The procedure for analyzing data was crucial to the validity of the results. Once data collection occurred, the collected data was organized in such a way where every participant's information was kept together and in order. Creswell and Creswell (2018) proposed that it is important to prepare for the analysis of data that has been collected by making sure that all notes are transcribed manually or via computer software. Data collected was synthesized and through the research, I was able to understand the meaning behind the collected data. I used the thematic data analysis approach for this study. According to Aparasu and Bentley (2019), thematic analysis approach analyzes all presented data in order to pinpoint the significance and patterns of the produced data. Once the information was organized and prepared for analysis, the collected data was interpreted and coded to identify patterns and themes and I also analyzed concepts that were very vital to the overall research. During this process, I was able to present the findings in a manner that did not reflect my prejudice but presented the voices of the participants.

Once the themes emerged, I used this information data interpretation. Over the course of the one-on-one interviews, a lot of data was collected, and data was organized by using a filing procedure that was simple and easily accessible. I used folders within Dropbox which is a cloud-based storage system. Given the possibility of gathering a large amount of data, it was "important to reduce data inductively rather than deductively"

(Seidman, 2019, p. 124). While the push-pull theory grounded this research, I applied my keen observational skills to see the patterns and not test the hypothesis or theory. While I was well versed in the brain drain phenomenon, I went into the collection of data and interviewing process with an open mind to embrace new information that materialized as a result of data collection process (Seidman, 2019).

Data Storage, Protection and Destruction

Technology is often seen as a blessing during the information storage stage. Due to the emergence of cloud computing, the recordings and other data obtained during the interviews were backed up in Dropbox. Dropbox is a storage platform that can be used to stage information such as the interview notes and recordings gathered during data collection. The collected data are going to be stored for five years (Creswell & Creswell, 2018). The participants were notified as part of the boilerplate language during the interview that after five years, data collected and stored will be destroyed so that they are not used in a manner that has not been sanctioned by the participants. Also, they were informed that if such a time arose that another researcher in the future wanted to use data gathered from this study, the participants will first be notified for their informed consent before this information can be released. This boilerplate language was included in the informed consent which each participant signed before they participated in the study.

Summary and Conclusion

Chapter 3 detailed the methodology that was used for this study of medical brain drain in Nigeria and its impact on the healthcare sector in Nigeria. A heuristic phenomenological design was utilized because it was appropriate for examining

individuals' lived experiences of the brain drain phenomenon. A purposive and snowball sampling technique was employed in order to recruit 10 healthcare practitioners who provided meaningful data that drove this research. Two more participants were added to the study to make sure that data saturation was achieved. So, a total of 12 healthcare practitioners were interviewed. After the completion of the interviews, the information presented by the participants were gathered and analyzed by using Dedoose (Version 8.3.47) to transcribe and code data collected. A conclusion was drawn from the patterns and themes that emerged as a result of the process of data analysis. At the end of data analysis, analyzed data will be stored for five years in a safe and password protected environment.

Chapter 4: Results

Introduction

In Chapter 4, the results of the analyzed data are presented. The first portion of this chapter describes data collection, data analysis, and the trustworthiness of the study. The second portion of the chapter presents data organization. The third portion of Chapter 4 discusses data analysis, which includes the construction of the emergent themes from the coding. The last portion details the trustworthiness of the study and a summary of the chapter.

The research questions that guided the research were, “what are the reasons for healthcare practitioners leaving Nigeria and what are the impact of those decisions on the Nigerian healthcare sector?” While this seems like an easy question, it is a huge problem to solve. The purpose of this heuristic phenomenological qualitative study was to explore the brain drain phenomenon and to gain a deeper understanding of healthcare practitioners who have moved from Nigeria to developed countries, specifically the United States, by gaining insight into their lived experiences. Through this study, I was able to better understand how brain drain affects the Nigerian healthcare sector.

The Research Setting

Due to the COVID-19 pandemic, there were restrictions on the research setting protocol that made it impossible to have in-person interviews. The study setting was limited to using the Zoom video conferencing application, which has both audio and visual recording capability. The interviews occurred within a 3-week time period. Through their informed consent, participants agreed to being recorded during the

interview sessions. Each participant agreed on the specific time and date based on their availability. A Zoom meeting link was created for each participant. Once the participant and I agreed to a date and time, I sent them the Zoom meeting link and their participant identification number ahead of the agreed upon interview time.

At the beginning of each interview, I explained the purpose of the study, after which I explained that all information would be kept private and in a locked computer file and that their information is being kept confidential. Prior to, during, and after the call, participants were allowed to ask questions. The interview sessions lasted between 25 and 90 minutes. After each interview, the recordings were transcribed and stored on my computer. A log showing the date, time, and participant identification number was kept for all the study participants. This log matched each participant with a participant identification number for their privacy. During the interview, each participant was told their participant identification number because it would be used to identify them again during later communication and member checking. The participants were also advised that their interview sessions would be recorded and transcribed for data analysis. At the conclusion of each meeting, the meeting notes were transcribed to get them ready for data analysis.

Participants Demographic

The sampling method used for this research was the purposive sampling method. Due to the nature of this research, the purposive sampling method was the most logical to use since there were pre-determined criteria. In research from Bakkalbasioglu (2020), the purposive sampling technique is appropriate because most often, researchers want to

track the process by interviewing a pre-distinct and observable set of people that are selected based on specific criteria, which necessitates researchers to speak with specific interviewees. I needed to deliberately focus on a specific population; in the case of this study, that population included healthcare practitioners who were able to contribute to this study due to having lived through the brain drain phenomenon. However, because data saturation had to be achieved in order to obtain rich and vital information, another sample technique was also employed after the initial 10 participants were interviewed. The second sampling method used was the snowball sampling technique. Snowball sampling is a type of "nonprobability sampling technique in which existing study participants nominate, refer or recruit future participants in the study" (Aparasu & Bentley, 2019, p. 30). In research, a contingency plan must be in place to be executed in the event that the original participants are not available. Snowball sampling helps create a network from the pool of participants that were initially sampled with the purposive sampling (Audemard, 2020).

The participants were recruited via healthcare groups that were located on social media sites such as Facebook and Instagram and through snowball sampling. Once permission was received from the group administrators, the recruitment flyer, which included the inclusion criteria, was posted in various groups on social media. Also included in the flyer was a link to the demographic survey. The demographic survey, which also included the informed consent, was used to determine which participants met the inclusionary criteria needed to participate in the study. Once the demographic survey was completed by each participant, I received email notifications from the typeform

survey tool, which is the survey platform that was used to create the demographic survey form. That determined the eligibility of the participant. Once the participant was found eligible to participate in the study, the participant was contacted through their preferred communication medium (telephone or email) to set a date and time for the interview. While it was determined that only 10 participants were needed due to the nature of phenomenological studies, I continued to accept participants until data saturation occurred.

Table 1 shows participations' identification number, gender, medical specialty, college they graduated from, year they graduated from college, informed consent status, and date the informed consent was obtained. I also collected data relating to the year they migrated to the United States and the time between their graduation and migration. Table 1 summarizes the profile of each participant.

Table 1

Summary of Participant Demographics

Participant ID	College	Year of graduation	Year of migration	Difference in year of graduation to migration	Time spent in the United States	Specialty	Gender
BD00001	Ogun State University	1983	1987	4	34	Nurse	F
BD00002	University of Lagos, College of Medicine	1987	1989	2	32	Internist	M
BD00003	University of Ibadan	1995	1998	3	23	Psychiatry	M
BD00004	University of Benin	1988	1995	7	26	Internist	M
BD00005	Lagos State University College of medicine	2008	2011	3	10	Internist	F
BD00006	University of Benin	1998	2000	2	21	Internist	M
BD00007	University of Lagos, College of Medicine	1988	1998	10	23	Internist/ geriatric medicine	F
BD00008	University of Lagos, College of Medicine	1987	1988	1	33	Family medicine	F
BD00009	University of Ibadan School of Nursing	1987	2003	16	18	Nurse	F
BD00010	University of Ibadan	1994	1997	3	24	Internist	M
BD00011	University of Benin	1998	2004	6	17	Internist	M
BD00012	University of Ibadan	2014	2018	4	3	Healthcare marketing	M

Selection of Participants

Twelve healthcare practitioners were selected for study, and data saturation was reached by the 12th participant. The purposive and snowball sampling method was vital

to choosing the participants because based on the inclusion criteria, I was able to gather participants that were able to add a lot of information to the study.

The total number of participants after data saturation was 12. The participants were chosen based on the following criteria.

1. Male or female born in Nigeria
2. Obtained a healthcare related degree from Nigeria
3. Practiced in the healthcare field in Nigeria
4. Migrated from Nigeria and currently practicing or retired from the healthcare field.

Interview of Participants

All the interviews were conducted via Zoom due to the pandemic and partly due to the geographic location of most of the participants. The length of the interview ranged from 25 minutes to 90 minutes. Zoom has the capacity to record both visual and audio output from the interviews, and these features were used during each of the interviews.

The questions asked during the interview were developed by me, and there were nine open ended questions. This gave the participants the ability to freely express themselves in detailed information based on their lived experience. Weller et al. (2018) purported that open-ended questions should be used when exploring the topic at hand fully and understanding processes, identifying causal factors in correlations observed, and understanding their origin. When a response was short, probing questions were asked to help fully understand the response. The probing questions were not leading and were not asked to help sway the response of the participant. Due to the phenomenological nature

of the study, the questions asked related to their lived experience both in Nigeria and the United States. The probing questions were asked to gain a better understanding of the phenomenon under study.

Data Organization

I created a password protected file to save and store the participant responses and recordings. Included in this folder was the interview protocol, the list of participants (per the participant identification number), the audio files which were labeled with the participants identification number, and the transcribed files. Each audio file was transcribed within 24 hours of the interview. The filing system made it easy for me to find each person's information and match their audio file to their transcribed file.

Data Collection

The approval to collect data was received from the Walden University Institutional Review Board (IRB). My IRB approval number is 02-15-2021-0136044. Data collection for the study lasted about three weeks. A total of 12 participants were recruited for this study. The participants were recruited using a purposive and snowball sampling through healthcare social media groups. The recruitment flyers were posted in the Facebook and Instagram social group which I belong to. The flyer invited participants to participate in a study that involves the medical brain drain in Nigeria and its effect on the Nigerian healthcare sector. The flyer specified that the interview was going to be virtual using the Zoom platform, and the inclusion criteria was also included on the recruitment flyer. The participants were directed on the flyer to click on the demographic survey if they met the inclusion criteria. Prior to the start of the interviews, the

participants through the informed consent were assured that their privacy will be protected. Also, at the beginning of the interview, the participants were read the informed consent that assures them that their personal identifiable information will be protected. Participants were allowed to express themselves freely, and any broken English or Nigerian dialects used during the interview were also noted in the transcribed data. The data collection was conducted using the following steps:

Data Collection Steps

1. Identification of research sites: Due to COVID-19 restriction, the interviews were conducted using Zoom.
2. Identification of prospective participants: To determine the inclusion criteria was being met, I started with the collection of demographical information which was done using the Typeform survey tool.
3. Acquisition of signed consent forms: The informed consent and the details of the consent was embedded on the first page of the tool. Typeform was also used to collect their informed consent to participate in the study.
4. Interview scheduling: Once the demographic online form was completed, I got an email notification letting me know that a form has been completed. I then log into Typeform to view the communication medium (phone or email) chosen. That communication medium is then used to contact the participants so that we can confirm a meeting date and time.
5. Conduction of interviews: The interviews were conducted using Zoom and the responses were audio recorded and later transcribed using the Microsoft Office

Transcription tool. Each response was stored in the cloud and were reviewed and coded within 24-hours of the interview.

6. Transcription of Data: The responses were audio recorded and later transcribed using the Microsoft Office Transcription tool.
7. Members checking for accuracy: To ensure there was no research bias by the researcher, the researcher performed member-checking. The member-checking was used for data accuracy and to validate the responses of the participants.

Data Analysis

Data gathered from the participant interviews were analyzed immediately after each interview. Due to the phenomenological nature of this study, the analysis of this data was done by using the thematic analysis method. The thematic analysis allows data linkage by common themes which were then indexed together into allowed me to record and identify passages of the text that fell into categories. Kiger and Varpio (2020) defined thematic analysis as a "method for analyzing qualitative data that entails searching across a data set to identify, analyze, and report repeated patterns. It is a method for describing data, but it also involves interpretation in the process of selecting codes and constructing themes" (p. 847).

Kiger and Varpio (2020) identified six steps for conducting a thematic analysis which were followed during data analysis and coding process:

1. Familiarizing yourself with the data
2. Generating initial codes
3. Searching for themes

4. Reviewing themes
5. Defining and naming themes
6. Producing the report/manuscript

The first step of data analysis required a deep dive into the collected data. Since the collected data was transcribed, it became easy to understand and know the collected data inside out. Kiger and Varpio advise against coding immediately as it is first important to understand the collected data and orient yourself with the information collected. The second step entailed generating initial codes. The codes were done manually initially, and then the Dedoose software (Version 8.3.47) was used to help set up the codes and organize them in the software. Inductive coding analysis was used to draw out the common theme from the analyzed data from the participants. Lester et al. (2020) expressed that the inductive coding engagement allowed patterns, themes, and categories of analysis derived from the analyzed data; they arose from the analyzed data rather than being imposed on it before data collection and analysis.

The initial proposed sampling was for 10 participants. However, I continued to interview until I got to the 12th participant, which is the point at which data saturation occurred. No new information emerged by the time the 12th interview happened.

Coding

The participants' interview responses were first obtained in an audio format. The interviews data collected were then transcribed into text and coded line-by-line to discover patterns and recurring words throughout all data collected. The coding exercise included examining the collected data for repeated words that were pivotal to the research

questions. Saldana (2021) points out that coding is very vital in organizing the information collected during an interview as it helps organize data into categories due to shared attributes. Saldana (2021) further expressed that coding as an exercise during research is heuristic in nature as it is during the coding of the collected that I was able to discover the patterns throughout the study.

The sole second cycle coding method utilized for this study is the patterns coding. Saldana (2021) expressed that pattern coding allows a researcher to develop a “meta-code – the category label that identifies similarly coded data" (p. 367). The questions that were asked during the interviews were three questions but could be divided into three phases. The first phase deals with the participants' lived experience in Nigeria as it relates to their college, work experience, the government’s roles in the Nigerian healthcare system and the participants' understanding of the Nigerian healthcare system from the vantage point of a healthcare practitioner in Nigeria. The second phase of the questions was about the pivotal moment the participants decided to migrate to Nigeria. The third phase of the interview questions was about the lived experience of the participants after their migration to the United States as it relates to the work experience and the role, they feel the United States government plays in the healthcare system in the United States. The fourth and last phase of the interview questions was on their understanding of the brain drain phenomenon and their thoughts on brain gain and brain circulation.

Once the questions were categorized into phases, the pattern coding was used to code the responses into four emerging themes which encapsulates corpus data provided while constructing them in a way that can be understood easily.

Trustworthiness of the Study

Trustworthiness and Credibility

The notion of trustworthiness and credibility can be subjective from individual to individual both from my perspective and the study participants. Seidman (2019) analyzed that the word trustworthiness might better be served if it is replaced with the notion of validity. However, even replacing trustworthiness still does not make whatever is said by the participants credible. The first level of trustworthiness in this research was to check the certification of each participant. I was able to locate the certification standing of each medical doctor in my research by using the Certification Matters web engine to locate their names and specialty. I was also able to determine the State of Maryland licensure standing of the two nurses that were participants of this study. The second level of trustworthiness involved the response of each participants in this study. Their responses were analyzed and connected to see if there is a corroboration that the stories check out. By the time I got to the 10th participant, data saturation had occurred, and I was able to reveal a theme from the responses provided during the interviews. Seidman (2019) further asserts that having several participants to interview for a significant period of time allows the researcher the ability to relate their experiences and compare the narratives of all the participants.

To make sure that there was validity to the whole process, I participated in the interview in such a way that the participants were comfortable sharing truthful information. The trustworthiness on my part and that of the participants is very important to producing a rich research. The important thing to note is that “the quality in qualitative

research is contingent upon demonstration of trustworthiness.” (Mitchell et al., 2017). The participants were carried along during the analysis of data component of the study so that the information included in the final study is accurate and true.

Transferability

The foundation of a good study is the ability to be able to apply the results of a study to a situation that is similar to the subject of the study. This process is known as transferability. Korstjen and Moser (2017) define transferability as “the degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents. The researcher facilitates the transferability judgment by a potential user through thick descriptions" (p. 121). To ensure that transferability was achieved in this study, due process was employed by capturing rich data that will add value to the research. The collected data was analyzed by using the qualitative analysis software, Dedoose. Through the analysis, themes were identified by the proper coding of the received data from the participant interviews. Also, to ensure transferability, various research was done on other countries that are experiencing the medical brain drain phenomenon. It is worthy to note that transferability is mainly determined by the reader because as discussed by Korstjen and Moser, transferability “implies that the reader, not you, makes the transferability judgment because you do not know their specific settings" (p. 122). In other words, the knowledge gained from this research can be utilized to develop conclusions from other related topics by other researchers.

Dependability and Confirmability

One of the tenets of good research is the dependability of data provided. Haven and Van Grootel (2019) identified that the main reason for dependability is to make sure the collection of data processes is sensible and within set protocols. The participants were asked the same questions on different days and while the interview mode remained the same and the location of each participant was different. The participants were all asked to fill out a demographic survey to help determine that the complete data was collected from each participant. Haven & Van Grootel further determined that it was very important to determine that the behind-the-scenes information remained the same for each participant that was a part of this research. The research questions for the study aligned with the interview protocol that was used during the interview to determine the lived experience of the participants.

While transferability is mostly seen through the eyes of the reader, the confirmability was my responsibility as the researcher. At the conclusion of each interview, I aligned each response to the questions asked. At the inception of the study, a recurring theme kept occurring. The theme was when the participants were asked to "describe their college experience in Nigeria and explain how it prepared them for the medical field in Nigeria?" The responses were varied between all the participants and as a researcher, I had to confirm what theme was appearing during data analysis. So, member checking was done to confirm and correct the interpretation I had. Follow up questions were asked about their year of graduation, the year they migrated to the United States and the university/college they graduated from. Through this process, I was able to determine

why their responses were different. Confirmability is very essential during research because it allows me to show that the research has validity and reliability. Abdalla et al. (2018) stated that care has to be taken to make sure that in reality, the conclusions derived from the research are based on the experiences and ideas of the participants and not based on the researcher's thought process.

Results

The purpose of this heuristic phenomenological study was to examine medical brain drain in Nigeria and probed the lack of public policy within the healthcare sector. In addition, this study proposed public policy options that could help revitalize the Nigerian healthcare sector. Due to the burgeoning number of healthcare practitioners leaving Nigeria, the role of the Nigerian government was explored to determine the factors that contributed to people leaving Nigeria.

After the interview of each participant was concluded, I transcribed the auto to text and did a deep dive into the collected data. The rationale behind reading the transcript was to identify patterns as it relates to words, phrases and themes that were significant to answering the research questions and to see if the chosen theoretical framework was applicable. During the review and categorization process, I discovered three high level themes (Table 2) and then discovered sub-themes which included the lived experience in college, as healthcare practitioners and then their migration to the United States.

The participant responses were transcribed in the exact words of the participants. Once the audio to text transcription was completed, data analysis commenced with the

participants allowed to read through their transcript and they were requested to make changes to the transcript if they so desired. All of the participants approved of what was presented to them. Once their approval had been gained, data was studied for any recurring themes since it was a lot of data that was gathered from the sample size. Specific attention was paid to the themes that aligned with the research questions and the theoretical framework that was used for this research. Data analysis produced the following themes that were related to both the theoretical framework and the research questions.

Table 2

Summary of Themes and Sub-Themes

Theme	Sub-themes
Theme 1: Challenges of Living in Nigeria	● Poor Remuneration ● Power Distance ● Bad Healthcare Infrastructure ● Job Satisfaction ● Education ● Insecurity
Theme 2: Lack of Government Support	● Lack of Funding ● Lack of Policies ● Economy ● Overhaul of the current Healthcare Infrastructure in Nigeria ● Nigerians in the Diaspora and Nigerian Government Liaison ● Shortage of Healthcare Practitioners
Theme 3: Reality of Knowledge Gap	● Nigerian Training versus American Training

Theme 1: Challenges of Living in Nigeria

There were a total of nine questions that I was able to categorize into three different themes after the conclusion of the interview and data analysis. The first four questions were about their lived experiences before the participants moved left Nigeria and through the first theme. The participants were able to discuss their lived experience

in vivid details and how the education prepared them for entry into the workforce. The rationale for their college, work, government's role, and the description of the Nigerian healthcare system is to determine if the information provided by the participants aligns with the information provided in the literature review. From the participant responses, 4 sub-themes emerged from their responses.

All of the participants were born, raised, and trained (healthcare degree) in Nigeria; however, their current status as professionals in the US healthcare system means that at some point in their lives a decision was made to leave Nigeria. I was therefore interested in understanding the challenges they faced in Nigeria and the pivotal moment that they decided to leave their home country and the factors that influenced such decisions. Some of the factors highlighted were categorized based on the following five sub themes.

Sub-Theme 1: Poor Remuneration

All of the 12 participants (100%) cited poor remuneration as a sore point of healthcare practice in Nigeria for them. Omoleke and Taleat (2017) asserted that poor remuneration was one of the burgeoning problems encountered in the healthcare sector. Many of the consultants too were also not paid enough money and therefore ended up going the route of holding other positions to be able to make ends meet. Participant BD00005 stated unequivocally that,

> Like you would see people who were, "senior colleagues" who held administrative positions or politically appointed positions, and they were leaning more to their political ambitions than actually being a doctor, and they just had

> very shitty practice, which was very infuriating. So that was a horrible experience. And somewhat I am glad I had that experience. Because if I was slacking off on my plans to leave Nigeria, it was like the catapult because I am like, no, I cannot Continue to work in an environment or in a hospital that is not equipped to save lives, not equipped to help me to save lives is in no way trying is in no way I when I say in no way trying, I will give you some very horrid experience…… This person came in that had a gunshot wound to the face and the bullet had grazed and tore through the side of the mouth. So literally all the muscle of this person's mouth was open, and the surgeon was there, doing nothing but writing a list of things the patient had to get. And I was like how the brrrrr!

Participant BD00006 further said that,

> The consultants only work at the government hospitals, and that is maybe for two hours out of eight hours, but they get paid the entire eight hours. And someone is looking away, and not holding them accountable. So, there is just no accountability. So, if you are a professor or consultant, you get to do anything that you want, and get away with it. Okay, and of course, who suffers? It is the patients.

Participant BD00007 stated that they were fortunate to have worked in a private hospital which paid considerably more than government owned or teaching hospitals. Participant BD00007 stated that,

> I worked more in the private sector. You know, I belonged to the group of medical officers who would just say, 'Oh, well, who is paying more?' And then

> we will shift there. So, we were more beholden to medical directors and their willingness to pay us a little bit extra, you know, we were all young medical officers and so on.

Participant BD00012 spoke about "the underpaid aspect. The healthcare practitioners in Nigeria were grossly underpaid. And what makes it even more challenging is that even though in absolute terms doctors are not well paid, especially for those who work."

Each of the 12 participants (100%) believed that the experience they have gained does not commensurate with salary being paid. Oshotse (2019) pointed out that migration happens from low and middle-income countries (LMICs) to developed countries known as high-income countries for several reasons. The most cited of those reasons is poor wages for healthcare practitioners in LMICs. Currently many healthcare practitioners leave Nigeria "better employment opportunities, to earn higher wages, and to secure the future of their family" (p. 1). Participant BD00005 mentioned that,

> Specifically related to health practitioner's remuneration, even outside the country, people think, the people think Doctors have money and I was like No. It is my education that has gotten me to where I am today. Maybe if they are paying me per month may be $50,000 per month, it will begin to match up to the education that got me to where I am.

Participant BD00010 expressed that,

> And the remunerations were very, very poor. And so, you came to a point we realized that if we did not go out of the country, you might find these difficulties in being able to, you know, be by yourself, you know, take care of yourself,

> despite being a physician, I have been able to improve yourself, improve your knowledge and get good or better training.

For some of the participants they came out of medical school and there were no jobs waiting for them. The much-revered vocation of being a healthcare practitioner had no job waiting for them after graduation and their houseman-ship. Furthermore, two of the 12 participants (16.7%) in this research stated it took some time before they were finally able to get a job and that they still know their classmates who were never able to make it into the healthcare sector and ended up with other jobs. In research from Ofekeze (2020), "the rate of poverty in Nigeria as at the 2nd Quarter of 2020 is estimated at 27.1 % which invariable translates to the fact that at least 21.7 million Nigerians are as it stands, unemployed" (p. 579). Participant BD00008 expressed that,

> Maybe about five, eight years before I graduated, doctors were graduating with the guarantee that you know, that they were getting them cars, the government was contributing to helping them get cars and settle down and get a clinic and just do stuff to encourage them to want to be in the profession. By the time I graduated, the jobs were not even existent. You know, you had to scramble to get a job as a physician. And it was like No, I cannot do this, you know? And for me, I said, okay, initially I decided, okay, let me just go, I will spend a year between the UK and the US and just, you know, look around, see what it is that is out there. But once I came here, and I realized, this is how medicine should be practiced, this is where I want to be. And since then, there has been no looking back."

Participant BD00010 also indicated that,

> So, after I finished my internship, I wanted to do my houseman-ship, I went to my youth service, which was around 1995 or 1996. And I think one of the things that was very glaring there was that if I wanted to really expose myself, improve myself, I needed further training. So, I was trying to decide between, you know, staying in Nigeria to do my residency or going outside of the country. But one of the major factors then was that as a young physician, who just graduated, the economy in Nigeria was also becoming very hard, at the time it was becoming very harsh. And you being a young person wanting to start your own life and you realize, realizing that wow, things are so hard. And the remunerations were very, very poor. And so, you came to a point we realized that if we did not go out of the country, you might find these difficulties in being able to, you know, be by yourself, you know, take care of yourself, despite being a physician.

Sub-Theme 2: Power Distance

Out of the 12 participants, 50% of the participants stated that there was power distance between them and their professors and supervisors which hindered their ability to work and learn. All 100% of the participants agreed that the reverence and respect for doctors made them go into the profession but at the same time the high-power distance in Nigeria can be a deterrent. The participants also discussed how power distance and reverence of healthcare practitioners was either why they wanted to be a doctor or helped shape their experience. Hofstede (2011) analyzed organizational cultures. In his research, Hofstede created a model of six dimensions of national cultures namely: “Power

Distance, Uncertainty Avoidance, Individualism/Collectivism, Masculinity/Femininity, Long/ Short Term Orientation, and Indulgence/Restraint" (Hofstede, 2011, p. 2). The power distance dimension is applicable as it relates to employee/employer and mentor/mentee (student) relationships. According to Hofstede, power distance certainly creates a basic problem for human inequality. Oruh and Dibia (2020) further asserted that in a country like Nigeria, the ability to demand basic rights in a working environment can be a daunting if not an impossible task. Nigeria in comparison to other countries has a high-power distance dimension. Oruh and Dibia expressed that employees have a difficult time asserting their rights. This also translates to the educational sector where students find it challenging to question what they are being taught. People in high-power distance countries are more inclined to accept mediocrity and will not question anything they are told or tasked with as long as the instructions are coming from a person of a higher status and power. Doctors are very revered in Nigeria but culturally when in a teaching environment, that reverence is passed to the student and teacher relationship. Participant BD00006 specified that,

> there is a lot of power distance in the training. And so, you could not question what the professor was saying. You just took whatever you were told. And I think that is, I think that is, that is something that limits us. They just limit the training. Because you do not have a quest to investigate or question the diagnosis of a senior colleague. So, because of the power distance there, I think that made you a little bit more passive as a physician.

Participant BD00003 also stated that,

> culturally, doctors are very revered in Nigeria. They are very respected. And I think, um, and because there is a shortage of physicians, an acute shortage in Nigeria, your, you know, I felt very respected, I felt very, you know, I felt very comfortable. However, economically, what I was being paid, I, you know, I think I was being paid the equivalent of $50 a month as my salary. I think I calculated it back then. And the equivalent amount of what I was earning, um, as, as a physician was, about $50 a month, and, you know, it is barely enough to survive on economically. But in terms of the collegial atmosphere, the respect you get in society, the respect you get from patients, the appreciation, the thanks; all of it was top notch, and that is one of the things that I really, really miss.

Sub-Theme 3: Bad Healthcare Infrastructure

In this section, I sought to gain insight into the professional experience of the participants in Nigeria and how the participants perceived the current Nigerian healthcare system in terms of access to care and infrastructure. The general perception of the participants was skewed towards negative descriptions and ratings of the Nigerian healthcare system.

Out of the 12 participants, 33.3% of the participants stated that the Nigerian healthcare system was so inadequate that basic materials needed for healthcare did not exist. Oladigbolu et al. (2018) analyzed that access to healthcare in Nigeria can often be determined by the ability to pay for drugs and medical supplies in order to receive treatment. The participants stated at one point or the other where they experienced patients paying out of pocket when faced with a dire health crisis. Patients were denied

care until payment was made. Also, supplies needed for patient care also had to be purchased at point of care in order for the patient to be treated or there is the potential to lose the patient due to inadequate funds to pay for needed supplies.

Participant BD00002 recalled a personal experience they faced when a friend got into an accident. For example, Participant BD00002 stated that,

> One of the times during my youth service years, I actually had a fellow club member who was injured in an accident, who was transferred to the Regional Hospital, and I had to take my own personal money to buy supplies, in the teaching hospital, or otherwise, the doctors there will not have had the supplies to work on my friend.

Participant BD00002 further stated that "unfortunately, because they cannot supply what is required, then their death rate just goes up exponentially. So it is, it is unfortunate, and what it is what, unfortunately, is still going on even at this point in time."

Participant BD00010 also stated that,

> Back in Nigeria, when I was training, when I was doing my Houseman-ship (internship), during my year of service, Patients had to go and buy their own intravenous fluids because the hospital simply did not have any on hand. I mean, I have been in a situation where a young woman who is dying, I had to tell her to buy these materials.

Out of the 12 participants, 92% of them indicated that the Nigerian healthcare was so dysfunctional and inadequate for the general populace and contributed to the rich seeking treatments out of the country. The participants also stated that the dysfunctional

healthcare system was a catalyst for their migration to a developed country. Agha et al. (2020) stated that a multitude of health complications and lives are lost every year in Nigeria due to incessant barriers in the healthcare sector. Furthermore, the rich constituents travel for medical tourism simply because of the inadequate healthcare system in Nigeria. For example, Participant BD00005 stated that,

> The Nigerian health system is completely inadequate. It is set up to fail. It is not set up to save lives. The entire system is a sham. We do not have enough personnel, the personnel are not trained optimally, we do not have proper equipment, we do not have people to manage the equipment, and we do not have infrastructure.

Participant BD00011 stated,

> Dysfunctional! That is probably the word that comes to mind when I think of healthcare in Nigeria. The point is that a rich person or somebody in the right city might just get better treatment while other unfortunate ones get poor healthcare due to poverty or inaccessibility to good healthcare in their area. And so again, the word that comes to mind is dysfunctional.

Participant BD00003 also further stated that,

> It (healthcare system) is really, really, really below par. I mean, the technology and the drugs that are available are below par. The type of equipment that they have available is really sub-optimal. Also, the quality of the medication they are able to purchase in Nigeria, is not as effective as medicines purchased in America. So, I think, you know, the government does a poor job of, of screening and

> tracking fake medications. The infrastructure has really fallen apart. Constant electricity is just something that is nonexistent in Nigeria.

Two of the 12 (16.7%) participants noted that some people within the community were not well versed with health education or the many ways they can alleviate some of their health issues. Many of the community members lacked the basic health education knowledge to manage their ailments. This and some other healthcare access issues are some of the things the participants believe is an indictment of the government and their inability to make public health a priority in the communities. Adam and Aigbokhaode (2018) proposed that communities should be educated on the ills of self-treatment and to regularly learn to visit clinics, thus improving their overall health. Participant BD00001 stated that,

> I would like to say it has a lot of factors that influence my experience with the one the community was not well educated for what health is all about. The government was not given what it was supposed to give us. People will go to school to become doctors to become nurses, when they come out, they are not able to practice. So, it was a multiple, you know, multiple factors that I will say influence the poor healthcare outcomes that we might be seeing in a country like Nigeria.

Participant BD00001 further indicated that,

> the government is not really helping. It is even difficult to get common water. The availability of good water is part of good healthcare outcomes. Many hospitals

> have to get water from the well. You can imagine having to get water from the well, with the risk of bacteria and other diseases.

Participant BD00009 also indicated that,

> Sure, health and health workers were trained to be able to manage basic cases in basic health to health problems like malaria, diarrhea, and everything. Apart from managing it, you have to train or educate the people you feel the community to be able to manage themselves, like when a child has diarrhea, the model should be able to prepare something like you know what… So instead of losing that baby, if you are able to put some pinch of salt and sugar and everything you are able to get that baby might survive that process.

Another issue with the healthcare infrastructure in Nigeria is the limited access to healthcare. There is a huge disparity in access to healthcare in Nigeria. 100% of the participants pointed out that many Nigerian citizens do not have access to healthcare simply because they lack the monetary resource to afford it. First of all, the access to good healthcare in Nigeria is based on the patient's socio-economic status. Secondly, the geography of the patient is also important in gaining access to healthcare. Oladigbolu et al. (2018) expressed that there is inequality in access to health based on the rural-urban in Nigeria. The rural-urban divide is accentuated by the fact that the lower-class people usually live-in rural areas, and healthcare expense options are also more limited in rural areas. Participant BD00004 indicated that,

> There is no nothing like Medicare for the elderly in Nigeria. So pretty much you are on your own, and you just pay out of pocket for your health care needs.

> Sometimes the government runs hospitals, like the general hospitals, a lot depends on how they are funded. But many of them lack basic things. And so, the patient ends up buying supplies from needles or syringes to, you know, cancer medications out of pocket. So, it is really very challenging. And in a nutshell, that is what it is in Nigeria. You have to pay out of pocket for medical expenses. Those rural areas do not have good access. For those in urban areas many times they can afford health care. And then very few companies provide health insurance for their workers.

Participant BD00008 further stated that,

> You know, you see that anybody that wants health care, can get health care, you know, which is not saying that they are still not some people who, you know, cannot be bothered with their health, you know, they are still people who go 10-15 years without seeing a doctor, even as accessible as healthcare is here.

Participant BD00010 expressed that,

> We had to wait longer to get MRIs done. And so, it is sad and disheartening when you compare and see that these are things that should be available in Nigeria, are not. People should want to have ready access to health care and emergency health care.

Sub-Theme 4: Job Satisfaction

The view of work experience and job satisfaction of the participants as healthcare practitioners in Nigeria before leaving for the United States of America were sought.

Their experiences in this regard were provided using vivid description of events, third party reports, and personal experiences.

Some of the participants (92%) felt that they had bad work experience working both on the private and public hospital levels in Nigeria. El Saghir et al. (2020) expressed that "approximately 86% of African international medical graduates practicing in the United States originate from three countries: Nigeria, South Africa, and Ghana. Key reasons influencing doctors to emigrate are many, including poor salary, bad working conditions" (p. 185-186). Participant BD00005 expressed that, "my horrible experience at the government, I mean general hospital in Lagos took me back to my original plan, and I just went back to my plan of leaving the country."

Participant BD00003 said that,

> I was working as a house officer at the University College Hospital. And I remember halfway through my one year of Houseman-ship, the attending physicians, and we used to call them consultants, registrars and senior registrars went on strike. But you had all these patients in the hospital, and you have the lowly house officer like me who is fresh out of medical school, and I am being expected to take care of these people. So, we had to take care of them and so you know, the way the labor laws work in Nigeria, there was this debate versus what liability the house officer would have if they continued to treat patients without the supervision of the registrars and the senior registrars. And it really made me feel very helpless as a house officer, I am fresh out of medical school, you know, when you come out of medical school, you have this view that you want to

> change the world and help people, and then the doctors go on strike, and I have no guidance, I have no supervision. I made up my mind then to leave Nigeria.

Out of the 12 participants, 83.3% felt that they felt that the healthcare facilities lacked the proper amenities and equipment to adequately teach them and treat patients. Due to lack of proper facilities and equipment many of the patient's deaths during the participants' clinicals (residency) that were otherwise preventable happened. Omoleke and Taleat (2017) analyzed that one of the many issues plaguing the Nigerian healthcare sector is weak facilities and obsolete infrastructure. Omoleke and Taleat further stated that as a result of blatant underfunding of the Nigerian health sector, the infrastructure and logistical support are weak, outdated, and downright defective. All this is as a result of Nigeria not having a maintenance culture where they appropriately maintain medical equipment's, vehicles or even the buildings. As earlier mentioned, the participants highlighted various incidents and cases that supported the lack of basic medical and technologically advanced facilities to facilitate practical training and enhance the skilled utilization of these equipment. Participant BD0006 stated that,

> in Nigeria, we have got a preclinical stage and the clinical stage. So pre clinicals, usually your first three years. So that is usually a big deal. Typically, you are just studying in order to be able to make it to the clinical stage, because a lot of people get dropped off. The clinical stages were basically not great in clinical acumen. In terms of clinical skills, I think we are really up there, we are really good. But when it comes to interpretation of data, imaging studies, we are so like, so behind……. At the time, when I was training, I had no idea that I did not know

> anything; until I got here (to the US). … I never saw any EKG as a medical student.

Participant BD00007 further indicated that,

> I was fortunate enough to attend the University, where we had a lot of community participation; and the medical curriculum was actually designated by the WHO as one of the leading collaborative centers for community-based education. And so, each year a whole group of us in the same grade or the same class would go off to a rural community, we would see what service projects we could participate in, we would do the lecturing, you know, about the benefit of good, portable, you know, drinking water, but at the same time, we were given the medical knowledge, but we are also trying to solve problems. And I found that very useful in the period that I worked in Nigeria.

Out of the 12 participants, 75% agreed that there is a cultural aspect with medicine in Nigeria. Many patients tend to use traditional means or would look at traditional reasons (voodoo) as a reason why they have a particular ailment. The participants stated that when practicing in the healthcare field in Nigeria, a lot of culture has to be taken into consideration in order to be able to properly care for your patients. A sub-theme that emerged was how culture played a role in healthcare in Nigeria both as a recipient of care and as healthcare providers. Li et al., (2020) analyzed that by estimate, "80% of the world population relies on complementary and alternative medicine, or traditional medicine, which includes all healing practices indigenous medicine to different cultures. Traditional medicine is often juxtaposed with modern biomedicine. In

Nigeria and other parts of West Africa, herbal remedies and spiritual healing are particularly common" (p. 1). The cultural factors in Nigeria were very crucial in the workplace in Nigeria. Participant BD00006 followed up their power distance response with insight to how cultural factors also played a role in their workplace experience as newly minted healthcare practitioners. Participant BD00006 indicated that,

> You have to acknowledge the role of cultural beliefs in the system. For instance, somebody with a seizure disorder could feel like it is his/her sister or stepmother that is responsible. Some might have been given a vision in a church about their ailments and might have been instructed to go and wash in a pool. You can't say, 'Oh, no, no, that's a fallacy. Don't believe that?' No, you have to acknowledge it. 'Okay, I appreciate that is definitely a possibility. But I want you to also look at this other possibility. Okay, other things that could cause that seizure to be happening in your child. And so, I want us to explore that without disregarding what you are also trying to Okay'.

Participant BD00011 also said that,

> But I do not know how much you know, is allocated to, to ensure that the rules and laws governing medical practice are actually enforced. Because you tend to see a lot of people who are not doctors practicing medicine. And there are blurred lines between actual medical practitioners, others, and the native doctors, for example, and then in between, you have all kinds of quarks and chemists, and, the ones that pretend to be doctors, or certain doctors who do not have enough training performing above their level of training. So, there is a lot of abnormality,

> and the government cannot provide the required level of enforcement. And even the legal system back in Nigeria is not enough of a deterrent to people practicing outside their scope of practice.

Sub-Theme 5: Education

Out of the 12 participants, 83.3% believed that Nigeria does not have an enabling learning environment. Awire and Okumagba (2020) expressed that recruitment of healthcare practitioners in Nigeria can be quite daunting as recruiters would normally favor foreign degrees and certificates over those acquired in Nigeria. In their research, Awire and Okumgba mentioned that one of the participants in their study indicated that the Nigerian students and recent graduates are left out of the labor system because preference is given people with foreign certificates which renders their training and credentials are inadequate. Participant BD00002 corroborated the point Awire and Okumgba mentioned in their study by stating that,

> People will be willing to stay if they have the right academic environment in which their skills can be improved upon. Also, if they have the right hospital or hospital environment in which they can operate with such that you are not really operating in a vacuum; and if you are at par with all other medical professionals in other parts of the world. I do not think everybody would necessarily want to leave the shores of the country if they are comfortable and happy with what they are doing.

Participant BD00005 also stated that “honestly, things will fall in place, the job of the government is to create an enabling environment.”

All of the participants (100%) agreed that their education was good. Given the challenges faced with the lack of resources that would have given them an equal footing with their counterparts in other countries. Awire and Okumagba outlined in their study that despite the survey results showing that the Nigerian medical education was of sufficiently high quality, interview participants still felt that their Nigerian medical education was behind that of their peers in developed countries. Many of the participants described the quality of teaching as being relatively good, describing it as robust, intense, hands-on, adequate, and decent. 83.3% of the participants stated that the quality of teaching prepared many of them for the rigors of medical practice and facilitated their skills in 'thinking outside the box' when making clinical decisions. The healthcare training was also tailored along cultural dimensions which enabled the medical students to learn to interact effectively with both elite groups and rural dwellers. Participant BD00002 declared,

> You know, the college experience, I think was, was pretty adequate enough in terms of a baseline, you know, science program that we had to undertake. So, you know, it definitely was actually adequate in terms of bringing us up to par on what to expect to do in medical school.

Participant BD00005 continued describing their college experience by declaring that,

> In Nigeria, I think my medical education was good, I felt like it was pretty decent. Of course, as with Nigerian education itself, everything is kind of like cramming. And sometimes they are making you learn things that, as a doctor, you are not

> really important and applicable to you. It was pretty intense, some parts of it were unnecessary, but I feel like just the intensity of it, the expectations, how high it was, for us at that time, really helped a lot of us and me in particular, to just prepare you and the expectation and how you go into the world. So, when I got into practice, I would see my other colleagues and I am like, how do you not know that? How do you not do that? Like, um, so yeah, so I think my education was okay.

Participant BD00003 stated that,

> Yeah, the training was adequate. It was great. I felt you know, I felt that I was well prepared to, to work as a physician in Nigeria. I worked at a University College Hospital, and I think my training as a medical student prepared me for that position. And I learned a lot during that one year.

Participant BD00006 also expressed that,

> Yeah, I think it is the schools. So, the schools are bad, they are worse now, compared to when I went. When I went, we at least had clinical skills. You went but you did not have the tools. Because, in medicine, it is not just book knowledge, you really need the skill to know how to recognize the signs and symptoms and be able to put it together to treat the patient.

Out of the 12 participants, 42% stated that the reason the education was great was because their professors had migrated back from the United States and the United Kingdom, so the level of their expertise made the quality of their teaching good. Awire and Okumagba (2020) further pointed out that teachers in the Nigerian Medical schools

are not well versed in teaching methods that creates a viable learning environment. Some of the participants suggested that the quality of training was quite high because of the availability of skilled professors, many of whom had been trained abroad. Participant BD00008 specified that,

> I did medical school through the Lagos University Teaching Hospital. And I felt the well roundedness of the program, and the quality and caliber of the professors that we had teaching at that time. My training made transitioning into the US so much easier than it would have been. But in the schools today in Nigeria, good quality professors are lacking. Lots of our professors at that time were trained here in the US. They found it easy at that time to come back and give back to the country because things really were much easier. You know, the government was a little more stable than it has been in the last two or three decades. You know, I mean, we did not have all that we could have, you know, technology wise, but the little that we had actually worked. We had an OR that functioned well, we had incubators, we had stuff for kids, and it was so important, you know, at that time… Believe it or not, the generators that we had at the teaching hospital at that time were always constant. We never had to suffer through power outages in the hospital itself. I am very grateful, very, very grateful for the education that Nigeria gave me; and the fact that it was public education, it was quality education.

The quality of the professor's was further discussed by participant BD00004, who stated that,

> I attended the University of Benin, one of the top medical schools in Nigeria. We had very good teachers, and we had hands-on experience. Our training was for six years. So, a lot of our teachers trained both in Nigeria and abroad. So, they brought in, you know, different experiences. The training back home prepares you to do as much as possible, do surgeries, do cesarean sections, deliver babies, take care of children, treat everybody from when they are born to the age of 100; because not many of us cannot afford to specialize.

Out of the 12 participants, 25% expressed that the Nigerian educational system seemed to value theory (classroom learning) over hands-on experience which made it difficult for them to practice what was taught in the classroom.

In research from Abdu-Aguye et al. (2018), it was analyzed in their study that many Nigerian medical students polled stated that students cited two reasons for the difference between theory (in-class teaching) and practice. There was a major limitation in the place where they are practicing due to deficient infrastructure and the classroom knowledge was also faulty.

A subset of the participants stated that the learning was more theoretical than practical. There were indications that the college training received by most of the participants while in Nigeria was based more on theory than on hands-on practice. This was borne out of the lack of amenities, equipment, and resources needed for practical perspectives of the training. Some of the participants mentioned that after training, many of the consultants who are the supervisors leave most of the work to the new residents

and allow them to use their theoretical learning in the real world. Participant BD00010 asserted that,

> I went to University of Ibadan. And the medical training itself was extremely rigorous. It was very demanding and very rigorous. You are up all day for lectures and then come back in the evening and study like half of the night before getting some sleep. Then you are up early in the morning to go back to the school; it was very tedious. But the lecturers were very, very good. And so, they prepared you for hard work. That was the main thing. You were prepared for the gruesome work of the medical field, the long hours and some of the things that it involved. The training back in Nigeria was good, though there were some deficiencies in terms of exposures to the modern technologies that were not available back home. But we were fortunate enough having studied in Ibadan where some of those things were available. So, we are able to take advantage of that. I had some decent experience coming to the US... When I look back over the years, I realized the fact that there are so many things that we saw in Nigeria, that we heard about, in theory, but could never really make a diagnosis because the things we needed there were not available. We are here when things are readily made.

Furthermore, Participant BD00001 specified that,

> Now, I will say, being trained as a nurse in Nigeria was one of the greatest experiences I have. So, I was well prepared, even though it was more of a theory session. We also had the adaptive session, and also had the hands-on session. We did more hands-on sessions, which actually helped us in our clinical decision

> making, which prepared us for clinical reasoning and connected faster with the theory… I just want to say thank you to my training. It was a different kind of training; mostly based on constantly conceptualizing in abstract… And I will give you an example. If you are a woman just delivered in Nigeria, and she has postpartum bleeding, the first thing that comes to mind is to put our legs up because you want to allow circulation straight to the brain. So, in terms of that training back in Nigeria, the foundation for you to know was to think outside the box immediately in caring for your patient.

Participant BD00011 said that,

> I think it did a very good job of preparing me for practice. The main thing, when perhaps in medicine is to have good exposure, also substantial exposure to, to the cases you likely will have to deal with when you leave medical school. And I think my medical school did a good job of exposing me to such cases, and we had good teachers who were interested, vested in making sure we learn.

Participant BD00006 stated that there was reliance on the new doctor's acumen to treat patients without supervision,

> We do not have all the ancillary services that complement our ability to practice the best medicine that that one knows now. So, our skills are heavily reliant on just clerical acumen, good judgment skills and your ability to be innovative at complementing both the cultural aspect of the society with medical facts.

All 12 participants (100%) cited the quest for improved knowledge and technology and their reason for migration. Many of participants felt they were not only

treated badly by their senior colleagues because they were equally frustrated, but they also had to move out of the country to fill the knowledge and skills gap they had as a result of inadequate facilities to train new up and coming healthcare practitioners. Specifically, Awire and Okumagba (2020) analyzed that

> Nigerian medical students and doctors aspired to be the best in their fields, as well as to be relevant in any sphere of life in which they find themselves. Consequently, they felt the need to develop and improve themselves beyond what was available to them through the system in Nigeria. (p. 7)

Participant BD00002 indicated that,

> Due to experiences of deficiency in supplies and skilled knowledge, I felt that I was not adequately prepared to be able to take care of individuals, as much as I think I will want to do. So, I felt it was really necessary for me to travel overseas to continue their medical education.

Also, participant BD00007 mentioned that,

> One of the partners in a private hospital where I worked was a young, very vivacious pediatrician who had just come back from abroad. She trained in Howard University, you know, we used to call her Auntie. And so, as a medical officer, I just used to watch her with admiration. Whoa, this lady is on fire. I mean, just look at the way she is conducting herself. The diagnoses are flowing, she is a no-nonsense woman, she is getting her stuff done. And, you know, myself and another two of us that are now here in the United States and, another close friend of mine, who is now in California, I said, hey, Lizzie, see Auntie, Auntie is

> on fire. Look at the way she is just, you know, and we just used to look at her and admire her. Seeing her just inspired me and made me say wow, you know, this is doable. This is what I will do, you know, instead of me waiting for this next medical officer position to come up where I could get a little bit more money, I will travel and continue my studies. I registered for the exams to enter the United States. At that time, there were no exam centers in Nigeria. One had to travel to Ghana to do the exam. So, another friend of mine and I, we both decided to do the exams at the same time. We took a taxi, all the way from Mile 2, all the way up along the West African coast. There is a road that goes from country to country. So, we got to Ghana and stayed at the University Hostel overnight and took the exam the next day. We went twice because there were two parts to the exam.

Participant BD00004 expressed that,

> Well, for my generation, the main reason people decided to leave the country, and go abroad was one, the healthcare system was really in disarray and not well funded. Doctors were underpaid. Second reason is that you would like to get more robust training abroad because of the facilities and, and advancements abroad.

Furthermore, the participants stated that the abysmal training many of them received from their medical training in Nigeria was a reason for them to migrate. Out of the 12 participants, 83.3% expressed that part of the reason they migrated was for personal growth and the subpar training they received in Nigeria. At the time when they were in Nigeria and had not been exposed to training abroad, many of the participants felt

that they got good training. However, when they migrated, they saw that there was a huge gap in their skill set. Participant BD00010 indicated that,

> When I was in medical school, I remember then that we had professors of medicine, professors of surgery, who had their offices in the hospitals locked up, because they were not in the country. And we found out later that some of them were in Saudi Arabia, or they were in, in Kuwait, or they were in some Middle Eastern countries working and training. And we found out that it was because their income in Nigeria was terrible, so they had to find a way to provide for their own family. So, they decided to leave the country.

Participant BD00006 expressed that,

> And some of them are also finding out that they do not know that much. Some I find out now that the internet is a lot, it is more of a global village. Now, it makes you really look really bad. Like, you are like you are talking to colleagues, and you will see that oh, my God, I do not know anything. So, I think it is also making the people who are in medicine for the right reason going, like, man, I need to, I need to up my game, I am really deficient. Like, I need to go somewhere where I can really fill the knowledge gap.

Sub-Theme 6: Insecurity

There is also a security problem in Nigeria. Out of the 12 participants, 100% expressed that they do not feel like Nigeria has a safe environment and they cited that not only as a concern but as the reason why they migrated. Ogaboh et al., (2020) asserted that the push factors mentioned by their research participants were: limited career

opportunities, wages were low, conditions of service were poor, inadequate management, incessant occurrence of civil unrest, and compromised personal security. During the interview, Participant BD00011 indicated that,

> You know, the Chief Medical Officer, of the biggest hospital in my hometown was kidnapped. I have had doctors robbed and killed, a friend of mine, who is a urologist, his wife was killed in front of him by robbers, because they felt they had money. So, I could go on and on and on about the secondary situation. So those are some of the things that will prevent you from staying or going back to Nigeria and practice.

Participant BD00012 also stated that, "I think the government has to start living up to its responsibilities and a very big part of that recently what is becoming a major issue is the issue of security." Participant BD00005 expressed that, "you have to pay people better, you have to equip the hospitals, you have to provide security. So again, the government still has to do what the government has to do."

Theme 2: Lack of Government Support

The role of the Nigerian Government in the healthcare sector was sought. Two perspectives were addressed in this section. I wanted to obtain insight into (a) the ideal expectations from the government in improving and maintaining the quality of the health sector, and (b) the realities on ground in the form of the collaboration of the Nigerian government and healthcare practitioners in the diaspora. Emergent subthemes were identified under both perspectives and categorized accordingly.

All of the participants stated that the government is heavily involved in the healthcare sector but are not funding nor supporting it the way they should. Orekoya and Oduyoye (2018) reported that provision and delivery of health service in Nigeria must be modernized and streamlined toward efficient and cost-effective delivery to the constituents. The participants discussed how the funding and lack of the government support was also a contributing factor to the frustration they felt.

Sub-Theme 1: Lack of Funding

Out of the 12 participants, 100% stated that the government is heavily involved in the healthcare sector but are not funding nor supporting it the way they should. The participants discussed how the funding and lack thereof the government support was also a contributing factor to the frustration they felt working as new healthcare practitioners.

Basic amenities are also taken for granted in developed countries are a scarce resource in Nigeria due to the negligence of the government. Uzomba et al. (2021) reported that in their study, the majority of the participants stated that access to basic amenities was a major factor mitigating quality healthcare. The amenities cited were electricity, good roads, and water supply.

Out of the 12 participants, 66.7% stated that access to basic amenities was quite troubling. For example, Participant BD00012 said that,

> Even in some of the best hospitals at any point in time see, there is always the case of machines breaking down and not being properly maintained. All stemming from mismanagements there is always the case of quality. Issues because of lack of amenities necessary for the hospital to function. Like, the

> hospital theater (operating room) not having access to power, and doctors having to work or perform surgeries using a torch light (flashlight).

Participant BD00011 mentioned that,

> Most diseases are infectious diseases such as malaria, diarrheal diseases, pneumonia, you know, and all that. And these diseases are easily addressed not through medications, and through clean water, for example, clean water, mosquito nets, sanitation. And so, when we do not have a national plan for clean water supply, we do not have a state plan, a statewide plan for clean water supply, it will look good to tackle this at a local government or city level. We are going to have a preponderance of these diseases; they will never go away. You know, most people are using the bathroom, for example, they do not have any water to wash their hands.

Participant BD00011 stated that,

> I think it was a bittersweet experience. Let me start with the sweet part. The sweet part was, you got to take care of, you know, people and even family members and neighbors. And Nigerians, obviously, you got to see people get better and recover from illnesses. That is the level of satisfaction you get from that. That experience, you know, but the better part was majorly the lack of equipment, lack of governmental support in the practice of medicine, back in Nigeria, you know, one thing about health care, right. I think the main crux of health care in Nigeria is public health. Right? Is this a dominant factor that really determines the health of a population? Okay, especially in the tropical parts of the world. You know, I am

> sure we will probably come to talk about this later on, but bilateral is my experience with it as with experience and beat up it was because of poor public health policies by the government.

Participant BD00006 further buttressed the role of the government in underfunding the hospital by stating that,

> The government just does not fund the hospitals. They do not provide appropriate amounts of infrastructure and equipment. For instance, a hospital might have that same government, that government whatever in Lagos, Marina, you if you came overnight, and you needed to do an urgent ultrasound, there was no way in the hospital, if you were bleeding and an ultrasound is what will diagnose you, you probably will die.

Five of the 12 participants (42%) expressed that a lot of deaths due to ailments are preventable in Nigeria. However, because the government is not playing a vital role in the healthcare sector, the lack of process, poor facilities and poor execution of healthcare delivery makes it easy to die from very simple preventable ailments. Orekoya and Oduyoye (2018) stated that the mortality rate in Nigeria is high. Especially as it relates to maternal mortality. According to Orekoya and Oduyoye expressed that Nigeria's mortality rate is very high and one of the worst in the world. In one instance, participant BD00005 talked about a preventable death of their friend and co-worker at work. The participant was so frustrated while relating the story that they broke down in tears during the interview process. Participant BD00005 recounted the non-functional facility by stating that,

> I remember one of my colleagues, my very close friend had a stroke while on the job overnight, and they had to do a CT scan for him, and I cannot remember where exactly it was done because everything was in a haze, we were just trying to save his life and he died. He died and this is, this is something that people have. This was a young healthy guy. This is what people have and they survived? And why did he die? He died because obviously, he was bleeding in his brain, his body was reacting, and his brain was swelling up. The neurosurgeon was ready to go to the OR, but the anesthetics team was too afraid to put him under because 'he was too unstable'. I was like, that is the fucking point. He is unstable. I am sorry, I am swearing. Because I remember his death really touched me (participant is in tears).

Participant BD00001 also stated,

> The availability of good water is part of good healthcare outcomes. We do not even have that most of the time. Most of us have to get water from the well. You can imagine having to get water from the well, there may be bacteria. By the time you realize it in the neighborhood, they might tell you, oh, you know, somebody, they have a death incident of five children that died. What happened? They were just vomiting and having diarrhea, from what, probably from the water. And of course, in a country like Nigeria, we do not have a tracking system, where we can actually maybe say we want to track the incidents. There is nothing to state that I am going to go ahead and track what is the reason for the cause of the death and

> stuff like that. So, this complicates the Nigerian healthcare system, resulting in high mortality in both infants and adults. So, our mortality rate is pretty high.

Out of the 12 participants, 75% felt that the Nigerian government should participate in a healthcare scheme that will provide healthcare access for low-income constituents. Oladigbolu et al. (2018) analyzed that many of the world's poorest countries still do not provide access to the most basic healthcare. Oladigbolu et al. furthered stated that Nigeria as a country has seen their progress regress due to periods of government instability at various points in the country's history. The volatility of the government has in turn caused a myriad of problems within the healthcare sector and other industries in the country. Participant BD00002 stated that,

> Well, you know, the government's role actually, should be to take care of those who are not actually able to take care of themselves. So those which I would classify as the lower middle class, and in even a lower class than that, who will not have the resource to be able to afford healthcare in itself. You know, the government, should have that safety net, in which there should be some basic measures in terms of emergency care, that should be rendered.

Participant BD00001 also expressed that,

> The government has a lot to do. First, the government needs to do a complete assessment. What are the health needs of the society? The government needs to provide more health care centers, the government needs to go back and focus more on prevention and health education. And you know, I will be honest, I will really give it to them. They are really improving on health education lately. I have

seen a lot of videos that talk about, you know, diabetes, that talk about how to prevent high blood pressure."

Sub-Theme 2: Lack of Policies

Out of the 12 participants, 92% felt there was a lack of accountability from the government. They also stated that there are poor healthcare policies and regulation, and that the whole country including the healthcare system is riddled with corruption. Okunola et al., (2019) expressed that one of the byproducts of the dictatorship experienced by Nigeria during the various military regimes has rendered it unaccountable to anyone. Okunola et al. further pointed out that there should be an overhaul of the government as a whole in order to make them serve the people of the country by being transparent and having accountability to the people. Okafor (2016) conveyed that there is something inherently missing in Nigeria and "the missing link is leadership and good governance. This is the desideratum for responsible and accountable health sector governance (and in other sectors) and the effective application of the framework to improve health outcomes in the country" (p.14). Corruption is also very prevalent in the society making it almost virtually impossible to govern all aspects of Nigeria properly. Corruption has eroded the core of the Nigerian government that they lack health care policies and are not particularly eager to enact policies that will drive the healthcare sector. According to Okey (2016), the absence of healthcare policies in Nigeria are an added layer of the corruption problem in Nigeria and in order for brain drain to be eradicated or minimized, the fight against corruption might be just where to start in

Nigeria. On the topic of corruption, the participants stated the following. Participant BD00011 indicated that,

> But when you have a politician, for example, you know, you went to college together, this guy made third class, because he was not serious, was always partying, right? Next thing, this guy becomes a politician. And he starts climbing. Next thing, you know, he becomes super wealthy. He does not have a business he runs, you know, he does not have any other source of income, just from politics and you begin to wonder what is going on here? You know, so the fact that there's so much corruption plays a huge role in brain drain. The fact that there's corruption, allows for the budget not to be properly implemented and reduces the quality of the healthcare.

Participant BD00006 explained the role of the government in medical tourism by stating that,

> Government basically aided and abetted the degeneration of the Nigerian health care system by promoting medical tourism.

Participant BD00008 also stated that,

> They obviously tried as much as they could to, you know, put in place, policies and procedures and you know, keep healthcare affordable for the general population. But, you know, it is sad to say that, you know, even at that time, there is corruption. I mean, that the policies will come from the top and, by the time it trickle down to the physicians who needed it, they would have been so many middlemen that have would have, you know, corrupted things, and just took

> things in different directions that they did not want, like, if they approved for some specific equipment to be delivered to a hospital. And, you know, you saw the approval, I mean, that the paperwork came through, and you saw the approval, but for some reason, or the other, it just would not get to you.

With regards to policies and regulations, the participants stated the following. Participant BD00006 indicated that,

> Leaders and politicians who have some influence on lawmakers and policymakers have not used their experience with healthcare in the developed countries to push for healthcare policies in Nigeria. I do not want to say they do not care. I want to say it is just not a priority."

Participant BD00004 also expressed that,

> my main take on that will be the laws are there but there is poor enforcement. Such enforcement should extend that to pharmacies in relation to fake drugs. I do not know if there is now a uniform way to make sure that drugs are genuine in society. I think people always find a way to bypass that. In this area of regulation, I will say the government has not really performed well.

Out of the 12 participants, 25% stated that getting through any task within any sector in Nigeria can be quite cumbersome due to limitless red tape one has to get through to get anything done. According to the research conducted, some participants agreed that bureaucracy can be a huge problem when trying to get anything done in Nigeria. This in turn has created a roadblock in providing or even receiving healthcare in Nigeria. Omoleke and Taleat (2017) referred to the Nigerian healthcare state simply by

stating that “health matters should not be subjected to political rhetoric and bureaucratic red tapism or rigmarole as life has no duplicate” (p. 216). Participant BD00008 stated that,

> There are a lot of red-tape and bureaucratic limitations in the Nigerian health sector. A friend of mine is in psychiatry, she is actually a pediatric psychiatrist, went home to, you know, start an autism clinic. And she traveled back and forth for a while trying to, you know, gauge the temperature of how things were there. So, she opened up a clinic and just a whole lot of red tape that she had to go through to be able to actually get the government involved because obviously, the government needs to be involved when it comes to things that concern children. All the red tape she had to go through discouraged her that after a year, she just packed up and went back to England.

Participant BD00004 also stated that,

> Well, the government sets all the regulations and all the policies. There is a lot of private involvement as well, a lot of private hospitals. But the government pretty much sets the policies and the expectations for all the services. Now, the government is supposed to fund teaching hospitals and the state governments are supposed to fund general hospitals. But many times, you know, they are underfunded. And so, the gaps are filled up by private healthcare systems, which also can be very exorbitant. So, the government has a large role to play. But oftentimes, the health care facilities owned by the government are not well

> funded, so it leaves you at the mercy of the private hospitals and private health care system.

Participant BD0005 further said that,

> There are so many opportunities. There are people who are willing to approach the healthcare sector in Nigeria, but they have been burned. They have been burnt. You see people who want to bring research programs and either the hospital administration, the government's whatever, or the health professionals themselves, are like, what is in it for us, you know, what is in it for us? So, everybody is, the government needs you to have to make things work and pay people well enough that money will not be the issue.

Sub-Theme 3: Economy

Out of the 12 participants, 100% spoke bitterly about the poor economic conditions in Nigeria. Maijama'a and Saidu Musa (2020) assert that the poor economic condition has been one of the push factors plaguing Nigeria as a country. In Nigeria, the volatility of the price of oil has dealt a devastating blow to Nigeria and has in turn affected every other sector within the Nigerian economy. This is felt especially in the healthcare sector as healthcare practitioners are leaving in droves to developed countries to further their career. Participant BD00005 expressed that,

> Brain drain is driven by poverty in terms of inflation and cost of living. Honestly, whatever extra income people are making is to provide basic stuff for themselves, and basic amenities and cushion a little bit. There is no power, you want to buy inverters but cannot afford it. You want to provide your own water but cannot

> afford it? Honestly, there are a lot of people who just want to be able to practice in an environment where their services are financially rewarding.

Participant BD00003 further buttressed the economic standpoint by stating that,

> Nigeria is losing those people for economic reasons. It is a purely economic reason, I would not sit here and say, there were some political, ideological, or religious reasons why I left the country, it was purely an economic argument, I needed to survive, I needed, you know, I needed to fund my training."

Participant BD00003 also stated that,

> And, you know, the sad thing is that we essentially go to school for free in Nigeria. The government pays for our training to be doctors. So, the government has paid all this money. The average doctor who graduates in the United States, has about $200,000 in student loans. So, if that is how much it costs to train a doctor then Nigeria is losing a huge percentage of that every year due to brain drain. That is a huge economic loss. How can a country survive with losing that kind of money? I am not an economist. But that has got to be huge.

Another issue that has emerged as a result of poor economic conditions is the inability to remunerate the healthcare practitioners their monthly salaries. Out of the 12 participants, 33.3% expressed that the government's lack of payment to the doctors contributed to healthcare practitioners going on strike. On the private and governmental level, Nigeria is prone to strikes. According to Orekoya and Oduyoye (2018), "The government at different levels including the health sector go on strikes and stop work… This has led to innumerable disabilities, complications and deaths of patients left

unattended to because of lack of health professionals on ground" (p. 362). Since many of the hospitals are government funded, sometimes the government hospitals both on the federal and local government level are prone to constant strikes because they are owed back payments by their employers. Participant BD00003 said that,

> There is a constant pattern of going on strike, coming back from a strike, and going on strike again. I have even had family members who have been sick, who went to the hospital and the doctors were on strike. My father, before he died, he had a period where he got sick, it was in the middle of the night, you know, I got this call. And I said, we will take him to the hospital. And they said the doctors were on strike.

Participant BD00012 also went further by stating that,

> Payments can be very irregular and sometimes doctors are owed for months on end… It happens frequently recently; house officers were going on strike in different health centers because some of them had not been paid for four months.

Sub-Theme 4: Overhaul of the current Healthcare Infrastructure in Nigeria

The most important atrocity in the Nigerian healthcare sector for the participants is the overall healthcare structure or lack thereof the Nigerian healthcare system. All the participants (100%) felt that not only does the healthcare system need to be refurbished, but the Nigerian medical educational curriculum also needs to be revamped. Nwadiuko et al. (2016) expressed the medical curriculum in Nigeria is simply not enough for them to compete with and participate in where healthcare currently is right now. Nwadiuko et al. further stated that they are enlisting the help of different diaspora organizations in

overhauling the current medical curriculum given the knowledge and skills they have acquired in developed countries. Epundu et al. (2017) also pointed out that in order for the healthcare system in Nigeria to work, Nigeria needs to halt its current healthcare sector in order the revert, analyze, and revamp the system. Participant BD00002 expressed that "government should have a culture of maintaining basic essential primary care facilities that can take care of a lot of things before they degenerate or get worse. The government has a very large role to play in those areas." Participant BD00012 stated that,

> I do not know, I think, you know, until everything gets an overhaul in the government, the way the government passes their policies and actually enact these policies, healthcare wise, nothing would change. So, people would always, you know, continue to go, and do their own thing and try and, find a way to get the government out of it, though, they still find a way to get in there one way or the other.

Participant BD00002 expressed that,

> Government commitment is needed to provide the right infrastructure. I think the infrastructure is really so important. If the right infrastructure is available, then the skills of medical professionals would be fully utilized. Having the right infrastructure will be one of the important things that can bring people back who have left, while retaining professionals currently in the country.

Sub-Theme 5: Nigerians in the Diaspora and Nigerian Government Liaison

Out of the 12 participants, 83.3% did not feel like the government is doing enough to encourage brain gain through diaspora support from healthcare practitioners that have migrated. While it is highly debated by some scholars that brain drain may not be such a bad thing because brain drain is brain gain for the developed countries that have acquired the brain. However, the point still remains that for the gain to happen in a developed country, a drain had to have happened in a developing country which still makes the brain drain phenomenon a valuable research topic. Imam and Akinyemi (2015) expressed that key among the strategies to mitigate the effect of this brain drain is to support training and implement interventions that are country specific. Healthcare practitioners of Nigerian descent have tried unsuccessfully to transfer their skills and knowledge to their home country. However, this cannot work without government contribution. Participant BD00004 stated that,

> The government can also encourage medical professionals in the diaspora by setting up systems and frameworks to coordinate with doctors abroad to make sure that people can still come back home and be part of the healthcare system. Even though some private entities are doing something along that line, the government has to take a bigger role.

Participant BD00004 further indicated that,

> Now, for example, you know, in America, there is an association of Nigerian physicians in America called ANPA. And we have tried over the years to coordinate with Nigerian government to make sure that we can establish a process

> where doctors over here can go back to Nigeria and be able to impact the healthcare system as well. So, the Nigerian government must be given a priority and make sure that they devote some resources to connect those dots and make sure that we are allowed to come back and develop our own healthcare system and contribute as well.

Participant BD00001 also expressed that,

> Yeah, they are going back home. They have what we call in the United States, 501 (c)(3) and 503 (c) non-profit organization. So, they are going back home to their own community to do missions. I have a couple of girlfriends that go home like twice a year to do that. So that is really helpful. That is knowledge transfer. Now, and also, they are developing hospitals. I have a girlfriend that developed the ICU center for Lagos State Government. This was almost about 15 years ago, and they are still using that ICU today.

Each of the participants also felt there is a lot that healthcare practitioners in the diaspora can bring to the Nigerian healthcare sector. A few of the participants cited that they have tried to take the knowledge and skills gained from their work in the United States for yearly medical missions to Nigeria. However, some of the participants feel like the Nigerian government is not doing enough to engage Nigerian healthcare practitioners in the diaspora. There are several organizations in the United States that feature Nigerian healthcare practitioners practicing in the United States. The largest of the organizations is the Nigerian Physicians in the Americas (ANPA). In their research, Nwadiuko et al. (2016) expressed that of the participants polled in their research, some of the healthcare

practitioners expressed interest in reimmigration to Nigeria to practice medicine and basically pay it forward. Participant BD00004 conveyed that,

> Well, the knowledge gained here, and the experience can be very useful to Nigeria. The training, the sophistication, and everything we have learnt abroad, can be taken back to Nigeria and be very good value to Nigeria in teaching the doctors, medical students and also used to influence healthcare policy in Nigeria. Now, for example, you know, in in America, there is an association of Nigerian physicians is in America is called ANPA and we have tried over the years to coordinate with Nigerian government to make sure that we can establish a process where doctors over here can go back to Nigeria and be able to impact the healthcare system as well. For example, the government in Nigeria said they have to have a department for diaspora physicians within the Federal Ministry of Health before they can coordinate with organizations of Nigerian doctors abroad, to bring back the skills and knowledge to make sure that it can impact Nigerian citizens... So, the Nigerian government must give this priority and make sure that they devote some resources to connect those dots and make sure that we are allowed to come back and develop our own healthcare system and contribute as well.

Participant BD00005 expressed that,

> There are so many people who did not want to leave Nigeria. Such people can still come back home to practice, whenever adequate provision is made for them. First, do the right thing, increase the healthcare budgets, increase the fraction of

> the healthcare budget, put in place proper policies to make sure your hospitals are improved. This is the 21st century yet our hospitals (in Nigeria) were designed and still built in the manner of the colonial era. So, they need to bring these things up to date. Increase medical education. Health education increases more schools, increases the capacity of the schools, fund research, fund the schools, pay the professors well enough, fund research for people to do. Incentivize people to go into medical education, health care education, nursing, allied health all of that. Pay people well enough. Things will fall in place.

Participant BD00003 indicated that,

> There are many, many doctors who would jump at an opportunity to practice back home in conducive conditions. So, I travel very frequently back to Nigeria but there is no opportunity for me to practice in Nigeria, even though I am physically visiting there. It is just not a conducive environment to pass knowledge on. There is no environment for me to teach. The barriers are just astronomical, they are just too high.

Participant BD00001 stated that,

> I have another girlfriend who has a dialysis center at Ijebu Ode. She works in New Jersey, and she has a foundation. So, the knowledge gained by medical professionals in the diaspora are very viable for repairing the health care system in Nigeria. However, Nigeria being a very political country and segmented in terms of decision making makes it a little bit tough. The only thing I will say is, as they all are going back, or as we are all going back with knowledge, healthcare is

> pretty expensive. So, the government still needs to come in, or we still need to go back and get funding from somewhere else.

Participant BD00008 also said that,

> I have a friend, an infectious disease specialist, who goes back every year. He has this conference that he organizes back home in Nigeria, and he has a lot of international colleagues, you know, from the US, the United Kingdom, that speak at those conferences. He pays for them to go back to Nigeria, to give those lectures to train students and colleagues back home. Imagine if that person had even the slightest help from the government to say, hey, you know, instead of the government to step in and say rather than you pay for all these other people, you know, we will pay for them to come and train our students, you know, and donate their time to educate these people to get to the level of the Western world. So, people do not have to fly out of the country or die unnecessarily from infectious diseases and other ailments.

Sub-Theme 6: Shortage of Healthcare Practitioners in Nigeria

All 12 participants (100%) cited that at the time they were in Nigeria, there was already a shortage of healthcare personnel in Nigeria. Many of the participants have been here in the United States for an average of 10 years and the situation remains the same. Oladigbolu et al. (2018) assessed access to healthcare in Nigeria and pointed out that one of the healthcare access impediments is the shortage of resources specifically manpower, monetary resources, and materials. A few of the participants alluded to this in the interview responses. Participant BD00002 indicated that,

> Well, I think what it (brain drain) does is that it creates an imbalance in which you have quite a lot of experienced Nigerian doctors that could bring that knowledge to improve the health sector and quality of care in Nigeria.

Participant BD00005 expressed that,

> The health care sector in Nigeria is worsened as medical professionals leave the country. Because I mean, this is a place where you already have critical shortage, and people are leaving, and the people that remain home are not even practicing clinical medicine.

Participant BD00003 further stated that,

> It has been devastating. Brain drain has really devastated that healthcare system. First of all, personally, I do not think there are enough doctors in the country. This has therefore limited access to health care, especially among people who live outside the cities. For instance, when my father got sick with food poisoning, he had to drive about 60 miles to get to a hospital.

Participant BD00008 indicated that,

> The amount of brain drain is mind boggling. Because every time I see patients, they come in and they are like, "Where are you from? I am sure you are from Nigeria" and when I confirm they always comment that Nigeria has good doctors, "you guys trained good doctors". Such comments make me happy and sad. Sad because all these good Nigerian doctors are here providing care for people in the United States while Nigerians do not have the access to this kind of care.

Participant BD00004 declared that,

> It is really very sad, because the ratio of doctors to the citizens in Nigeria is well below WHO recommendations? There are at least close to 40,000, if not more, doctors of Nigerian descent here in the United States. You can imagine what that would have done to the Nigerian health sector if they were back home in Nigeria.

Participant BD00005 conveyed that,

> Um, so it obviously has worsened, especially in terms of manpower capacity. There are not enough medical practitioners in Nigeria, and so the few available ones are overworked. And now they even become doubly overworked because their colleagues are leaving the country.

Theme 3: Reality of Knowledge Gap

Since the participants were trained and/or worked as a healthcare practitioner in Nigeria before migrating to the United States, I was interested in obtaining lived experiences of the notable differences that the participants observed during their training/work as healthcare practitioners in the United States versus their experience in Nigeria. Based on the emergent themes obtained from the transcripts, the following sub-themes were identified, alongside supporting excerpts.

Sub-Theme 1: Nigeria Training versus American Training

Each of the 12 participants felt their education in Nigeria was great until they moved to the United States and realized that they had a huge knowledge and skills gap. Participant BD00005 explained their own encounter with the knowledge gap by using an adage to buttress the point of knowledge and skills gap from their Nigerian training to the one acquired in the United States by saying that,

> Nigerian doctors will come and beat their chest feeling they are the best. Of course, a one-eyed man is a king in the village of the blind, but when he steps outside, he would then realize that he is half blind.

Participant BD00010 also indicated that,

> When I look back over the years, I realized the fact that there are so many things that we saw in Nigeria, that we heard about, in theory, but could never really make a diagnosis because the tools we needed there were not available. We are here and the equipment we need are readily made available. It is sad and disheartening when you compare and see that these are things that should be available in Nigeria, people should want to read it to have ready access to health care, emergency health care.

Out of the 12 participants, eight of them (66.7%) mentioned that the power distance discussed earlier (Theme 2, Sub-theme 2) made it difficult for them to get better working condition in Nigeria. Some of their senior colleagues spoke to them in a demeaning manner and some of them even aided and abetted them in making a migration decision. Some of the participants expressed that the treatment they got from their senior colleagues was the catalyst for their migration to the United States. Awire and Okumagba (2020) stated that many of the students' survey felt the healthcare education they got in Nigeria was subpar and the treatment some of residents got at the hands of their senior consultants was so disheartening they had to relocate. Participant BD00002 declared that,

> The plastic surgeon who was the head of the team, had mentioned to us that it will be an excellent idea if we had some further training out of the country. So, we can

> get the full breadth of medicine because of the other deficits in what we will learn, and what is out there, because he did his studies in the United Kingdom. So, he felt that it was much of a disservice for us to just stop our training, and do everything in Nigeria, that it is best for us to be able to travel and get the full breadth of the medical field. So, you know, that kind of impacted my mind.

Participant BD00006 also stated unequivocally that,

> In the final year of med school, I had a very clear vision. I told myself, no, this is not the place. If I am going to practice medicine, it cannot be in Nigeria.

Participant BD00003 further stated that,

> I was studying for a test. And I was I was, you know, I had procrastinated; I was a little behind on the amount of studying I should have done. And I was in the library studying when the power went out. And, typically, you know, the University at that time, when the power goes out, you know, you wait a few minutes, maybe go outside, get some fresh air. And, you know, they might turn on the generators. But I just realized that the generators were not coming on. And I waited and waited and waited, and the generators did not come on, and I had to go get a kerosene lantern. And I studied with kerosene lanterns. And that was one of the moments where I said, if I have the opportunity to get out of the country and go practice medicine in a place where I can get constant electricity, I will definitely go practice there.

Out of the 12 participants, 100% of the participants explained that they were able to collaborate with their attendings and senior colleagues which was otherwise

impossible in Nigeria. While there is a high-power distance in Nigeria, the United States power distance index is lower in comparison to Nigeria. According to the new research by Hofstede Insights (2020), using Hofstede's cultural dimension theory on cross-cultural communication. There one that fits within the confines of this research is the power distance index. Oruh and Dibia (2020) also articulated that the power distance index measures the inequality of power between members of society who are on the lower rung of the proverbial ladder and the upper echelon of society. The power distance is higher in Nigeria than the United States. Where the United States has a power distance index of 40, Nigeria's power index is twice that of the United States at 80.

There is a hierarchical way of life in Nigeria where everyone has their place and there is inequality between teachers and students, employer and employees, even religious leaders, and parishioners. In Nigeria, the high-power distance makes it difficult for students and teachers to collaborate on the teaching protocol. Teachers in medical and nursing schools in Nigeria are prone to having a high-power distance and therefore makes it difficult for students to ask questions for fear of retribution and verbal assault from their teachers. Many of the participants expressed appreciation for the collaborative practice and the low power distance they saw when they got to the United States. Participant BD00002 stated that,

> Well, in Nigeria, you do not realize that you do have a gap in knowledge until you leave and go elsewhere. Because the cohort of people you deal with, basically operates under that same gap in knowledge. But when you travel out, then you realize that you really did have that gap in knowledge. Because you get to

> experience quite a couple of things that you were not prepared to envisage, because you never dealt with them. You never saw them; you never handle them. And, and, you know, the medical practice was a little broader in the US than what you were used to in Nigeria.

Participant DB00006 further indicated that,

> And the power distance affected me so badly, that in my first year of residency, I got a very bad evaluation by my attending. He told me point blank, that I never challenge, argue, or question his diagnosis. For instance, he will say, "Oh, yeah, I think this patient has got lupus", and I would just swallow it and agree without questions. And I think it is because a lot of Nigerian doctors have been so plagued by that power distance working for consultants back home where you never question them. Here, it is collaborative and helped sharpen my medical skills.

Out of the 12 participants, 50% of the participants also compared their training in Nigeria to what they experienced in the United States. In Nigeria, some of the participants indicated that they were not forced to choose a specialization. However, when they came to the United States, they had to do a specialization in order to be able to practice medicine in the United States. Participant BD00002 stated that,

> The Nigerian medical system is set up in such a way that after medical school, you could actually essentially work as a general practitioner, without undergoing a residency training, over here is not the same. Over here, everybody will have to pretty much on the go residency and get into a specialization.

Participant BD00004 expressed that,

> And then of course here, technological advancement is huge, you know, in Ohio, the healthcare system is better funded. So, you tend to practice things. Professionally, it is closer to what you know, closer to what you have read or where you need to do. Again, funding is the main difference back home in Nigeria, the healthcare system is not well funded, postgraduate specialization training is not mandatory. Here, you just, you know, you can, after basic medical training, you have to specialize in a particular area, and get more training. So that is, that is the basic difference.

Participant BD00004 further expressed that,

> Unlike Nigeria, where you can, you know, after your basic medical training, you can go into general medical practice. Over here, you are pretty much made to choose a specialty where you have to specialize. So, you are forced into a particular specialty, either internal medicine, pediatric surgery, whichever one, but the system here encourages people to specialize in a particular area, so you do not keep practicing everything. There is a focus which is good.

Out of the 12 participants, 16.7% stated what they thoroughly enjoyed about migrating to the United States and working in an American Hospital was the fact that they could get mentoring advice from a senior colleague. Some of the participants also stated that through their working in a hospital in the United States and having someone to mentor them, they were able to take many classes and seminars to strengthen their skills and knowledge. Participant BD00011 expressed that,

> It is the best kind of training. Not just in terms of equipment, right? But in terms of mentorship, right. So as an intern here, you are with an Attending all the time. And that is a very critical point, because the attending here is accountable for the patient. But back to Nigeria, the attending physician may see the patient maybe once a week, there is no repercussion ever, he is going to get paid every week, whether he sees a patient or not. But here, the attending has to see a patient every single day and are held accountable.

Participant BD00003 in their response stated that the mentorship is so lacking in Nigeria that colleagues still in Nigeria introduce them to new doctors who just want to be mentored on how they will leave Nigeria.

> The barriers are just astronomical; they are just too high. And, you know, even when I have had opportunities or conversations with people with medical students in Nigeria, where someone has introduced me to someone to mentor them, 100% of them want mentorship, on how to leave Nigeria. So, the only opportunity to mentor people is to mentor them to leave, there is no one who wants mentorship to stay or to be a better doctor in Nigeria.

Participant BD00003 further stated that,

> And I remember my experience as a first-year resident, just the attention they paid on your welfare. You lived on campus in the hospital, there is a 28-floor tower that has one- and two-bedroom apartments, where the residents live in, you pay a very small amount for rent, your utilities are included and they give you money to purchase your stethoscope, you get money to purchase your books, you get free

> food in the cafeteria after 4pm. There was just a lot of really huge investment in the welfare of doctors. Um, I remember when I was a resident, you got a discount, because it was a Henry Ford Hospital, you got a discount if you purchased a Ford, Lincoln, or Mercury car. So, my first car in the US was through the Ford Motor Company, you know, you got a discount for that. So, it just, it was just the welfare of, of a doctor was just everything, they took care of everything. I did not have to worry about anything. So, 100% of my time, I focused on my medical education and being a better doctor.

Out of the 12 participants, 83.3% of the participants complimented the ability to gain access to good equipment that made doing their job easy. There was also the ability to work in a conducive environment that made it easier to do their job. Participant BD00006 expressed that,

> You do not know that you are not prepared until you get here. Because you, you thought your education was really good in Nigeria. You thought you were really strong. And then you will come here to the United States, and you will see an EKG for the first time. You have never held an EKG your entire years of training and practice in Nigeria. So, there is a learning curve, where you now have to retrain yourself, okay. You have to retrain yourself because your knowledge is so bad.

Participant BD00005 also stated that,

> Here, there's accreditation, there is training, there is certifications, and there are checks and balances. So, your hospital is not just working unethically. You look

> at the infrastructure, you look at the equipment, you look at innovation, all of that I think are completely missing in the Nigerian system. But here the people, processes and system are working."

Participant BD00008 also indicated that,

> working in healthcare in the US obviously has its own challenges, but at the same time, it is very rewarding, extremely rewarding, because what you have to practice your trade is very available, you know, you have all the equipment you need, and you have the staff support needed. And tertiary care is available any which way you look at it. And even in the rural areas there is access to healthcare. Because even in those rural areas, they have ambulances, and they have medivacs that can air lift people out and stuff.

The healthcare practitioners in the United States actually respect their patients. In Nigeria, the system is so frustrating that the healthcare practitioners are frustrated. The people getting treated too are frustrated because there is just systematic chaos all around. Participant BD00005 expressed that,

> In the winter, this guy just wanted a warm bed and some warm food, period. Everybody knew it when he walked in the hospital and he said, I just pooped some blood. And you know what, that is what you write down and you do not discharge somebody who said they just pooped some blood without overnighting them and doing necessary tests. So, everybody knew. Because when we said, okay, you need to drink a gallon of GoLYTELY, because we are preparing you for colonoscopy, he was like hell, no, I am not drinking that. I am hungry! We

gave him food; he crossed his legs and watched TV. Even though people abuse the healthcare system, overwhelmingly it saves lives.

Summary

There were three major themes that emerged as a result of this study. Most of the participants expressed the dire need for an overhaul of the Nigerian healthcare sector in order for it to get better. Each of the themes that were identified also yielded sub-themes that emerged during data analysis. Each theme was discussed in its entirety with excerpts from the participant to back up the themes that emerged during data analysis.

The emergent themes from the research demonstrated the extent to which brain drain was eating into the core of the Nigerian healthcare sector and even Nigeria as a whole. Brain drain from Nigeria to the United States was relatable by all of the participants as they were all able to associate the concept with the flow of discourse during the session. The results from data analysis showed that the government has a huge role to play in fixing the brain drain issue in Nigeria and its effect on the Nigerian healthcare sector. Chapter 5 of this study includes the interpretation of the findings, the limitations, implication for social change and recommendation for action and further research.

Chapter 5: Discussion, Conclusion, and Recommendation

Introduction

The purpose of this heuristic phenomenological study was to examine medical brain drain in Nigeria and probe the lack of public policy within the healthcare sector. In addition, this study proposed public policy options that could help revitalize the Nigerian healthcare sector. Due to the burgeoning number of healthcare practitioners leaving Nigeria, the role of the Nigerian government was explored to determine the factors that contribute to people leaving Nigeria.

The research questions that guided the research were, "what are the reasons for healthcare practitioners leaving Nigeria and what are the impact of those decisions on the Nigerian healthcare sector?" The simple answer to the research questions is that Nigerians are leaving Nigeria due to the cited push factors. This has in turn caused medical brain drain in Nigeria. Medical brain drain is at the moment playing a significant role in the underdevelopment of Nigeria as a whole and specifically the healthcare sector. It should be stated that every industry in Nigeria is impacted by brain drain, but it seems that the Nigerian healthcare sector is the most impacted as it crosses all socioeconomic areas within the country, and this is due to the fact that the healthcare sector is responsible for the health of the nation. Nwogbe and Haliso (2020) argued that currently Nigeria has a poor healthcare policy implementation. The lackadaisical nature of the Nigerian government has also aided in Nigeria not being able to meet the United Nations Millennium Development Goals (MDG). There were eight MDG goals that were initially signed with 189 UN member states in 2000. These goals were meant to be achieved by

2015. While not all the goals were completely health related, each of the eight goals had an element of healthcare attached to it. The eight goals were very important specifically for developing countries to eradicate a lot of deficiencies in the developing countries. In research from Oleribe and Taylor-Robinson (2016), the eight-goal initiative was designed to eliminate hunger and poverty, encourage gender equality, decrease child mortality, develop maternal health initiatives, battle viruses such as HIV/AIDS and parasite that causes malaria, preserve environmental sustainability, and start a global development partnership.

Oleribe & Taylor-Robinson maintains that Nigeria as of 2015 has not met the goals because there is still a high infant mortality rate, high HIV/AIDS rate, and malaria and other diseases are still very prevalent. Many of these health-related goals cannot be achieved because another level of burden placed on Nigeria is the fact that the healthcare practitioners that can help with attaining those goals have left Nigeria due to brain drain.

Adepoju (2018) stated that as of 2018, 12 doctors are lost each week to developed countries. In a report cited in the study, over $4.6 billion is spent by African countries in training doctors. These doctors then leave Africa to go to greener pastures to practice medicine. The participants perception with regards to the issue of brain drain specifically in the healthcare sector are (a) challenges of living in Nigeria, (b) lack of government support, (c) the reality of their knowledge gap.

Brain drain as a phenomenon has destabilized the Nigerian economy, of which the healthcare sector is included. In the United States, the most educated immigrants are from the African continent. Statistics show that 39% of these immigrants have bachelor's

degrees or higher in comparison to the 31% of the American born population (Chand, 2019). Pull factors have drawn many Nigerians to the United States so that they can get better wages, sharpen their healthcare knowledge and skills using new technology, and settle in a secured environment where they can flourish. Some of the participants cited the push factors that pushed them out of Nigeria were the quality of the education they received while undergoing their healthcare education, lack of policies/rules/regulations, the corruption that is within the government, and the poor overall infrastructure (bad roads, outdated healthcare facilities etc.). Chapter 5 shows the interpretations of the findings, and the findings are linked to the theoretical framework and the literature review that was previously discussed. Furthermore, the limitations, implication of the study, interpretation of the findings, and further research recommendation on brain drain in Nigeria are all discussed in Chapter 5.

Interpretation of the Findings Vis-à-vis the Literature Review and the Theoretical Framework

Theme 1: Challenges of Living in Nigeria

The current literature shows that Nigeria's healthcare system has failed woefully. Ogaboh et al. (2020) pointed out that push factors out of Nigeria include the inadequate facilities, infrastructure, and funding. Doctors are consistently striking because of all the aforementioned issues plaguing the Nigerian healthcare system. Omoleke and Taleat (2017) asserted that the federal government is always in breach of their contract with the workers and hence the reason the workers are constantly striking. This in turn puts the health of the population at risk, and there is no one to take care of the patients. As one of

the participants stated, there was a labor strike when they had just graduated as a new medical doctor, and they were left to their own devices to care for the patient's medical need. There were no supervisors (attending) on duty to guide them and to make sure they were doing the right thing.

Poor remuneration was a major sub-theme for this research. The push factor of poor remuneration is one of the most often-cited reason why many healthcare practitioners migrate to the United States. Some of the participants mentioned that they lacked motivation because they were poorly paid. Participant BD00007 was unequivocal on their experience with trying to manage their finances and also be afforded the ability to live comfortably on their wages. Participant BD00007 worked in a private hospital, which normally pays more than government and university run hospitals. Participant BD00007 remembered a specific experience about her car:

> My friends, we still used to make fun because I had one little, tiny Mitsubishi. So, it is a two-door car. And then I used to live on the island. No, sorry, I used to live on the mainland. So, when I am coming to work on the 3rd mainland, I will be praying. There is lots of smoke that will be coming out of the car. I will say, hey, God, just get this car across this bridge today. I will be like, oh, my goodness, you know, I can. And that was a car my parents actually bought for me, can you imagine how many years after graduation, I still could not even buy a tire not to talk of a car. So here is a small little car. My parents bought for me; I could not even maintain it properly. I just thought, wow, this is I mean, this is just, it is almost like you are forced to think outside the box, because this is not going to

> work. You know, I could hardly buy food stuff for the month, I could hardly maintain a car that was now bought for me by my parents. I mean, it was just, it was quite depressing.

Omoleke and Taleat (2017) expressed that healthcare practitioners are not on par with their counterparts in other parts of the world when it comes to being adequately remunerated. The poor remuneration makes life grim for many participants, and they end up looking for ways to leave Nigeria like the participants of my study.

High power distance has long been a problem in many societies, and Nigeria is not exempt especially with a Power Distance Index of 80 (Hofstede Insights, 2020). Some of the participants mentioned that the high-power distance between them and their senior colleagues was a deterrent to learning. According to Oruh and Dibia (2020), the high-power distance in Nigeria makes it impossible for employers to be questioned by their subordinates. This has in turn created a relationship that is similar to that of a Master and servant. In a country with a high level of stress, the master-servant relationship between employers and employees has created a hostile work environment that increases the stress levels of the employees.

Another factor that contributes to migration of Nigerian healthcare practitioners is the decrepit Nigerian healthcare infrastructure. Botezat and Ramos (2020) expressed that the rich infrastructure in developed countries is what pulls healthcare practitioners from under-developed to developed countries.

All the participants in the study had experienced brain drain as they have all migrated from Nigeria to the United States for various push-pull factors. During the

interview, participants were asked if they knew what brain drain was, and they all unequivocally stated they understood the term and phenomenon and that they were all participants of the brain drain phenomenon.

Some of the participants expressed discomfort as being part of the brain drain phenomenon because it was not their intention to create a vacuum in the Nigerian healthcare sector. However, the lack of healthcare policies, poor economic conditions, subpar training, stunted career growth, and insecurity were cited as reasons for migrating to a country that was able to fulfil all the deficiencies they encountered in Nigeria. As discussed in the result section of Chapter 4, some of the participants expressed that there have been dire consequences of brain drain, especially within the healthcare sector.

Chand (2018) expressed that there is already a limited pool of experienced candidates in the workforce and to lose the talent to developed countries is unconscionable. As if that is not scary enough, according to Jenkin (2016), by the year 2035, there will be a huge shortage of healthcare workers to the tune of 12.9 million. Currently there is a global shortage of 7.2 million healthcare workers. Jenkins further pointed out that the future global shortage will be mainly from Sub-Saharan Africa. Ogaboh et al. (2020) also confirmed that there are a lot of quality medical practitioners from Sub-Saharan Africa where Nigeria is located and those will be lost in the predicted healthcare shortage. Ogaboh et al. further expressed that a wide range of health and education misfortunes are prevalent in developing nations such as Nigeria. This is shown by the number of Nigerian doctors that have migrated and currently live and practice abroad.

The Nigerian healthcare system is also described in such a way that it does not bode well for the users of the healthcare system. Oladigbolu et al. (2018) argued that for many Nigerians, the inability to pay high out-of-pocket expenses for healthcare has shown how bad the healthcare system in Nigeria is. According to Idoko (2021), many Nigerians live on less than $1 a day and live below the poverty level. Participant BD00005 summed up the Nigerian healthcare system by stating that

> this system is completely inadequate, it is set up to fail, it is not set up to save lives. It is set up to fail, the entire thing is a sham, bring anybody I will, we will break it down, we will analyze it, the personnel we do not have. We do not have enough personnel, the personnel that we have, the training is not optimal. We do not have equipment, we do not have people to manage the equipment, the few people who know about it, I can ask about it do not have the capacity to manage it. And you do not have infrastructure.

In order to find the genesis of the problem surrounding brain drain in Nigeria, the participant research started with their Nigerian college experience. Nzokurum and Agala (2019) expressed that an educational institution such as the medical school is established to ensure effective learning and teaching. The first theme that emerged from the study was the college experience of the participant. The participants discussed the quality of the education they received, the quality of their college professors, the fact that their learning was more theory than clinical practice, and the lack of amenities needed to teach them to function well in their jobs.

In terms of the quality of education that was received, the participants indicated that their education was good but did mention that while the quality of the education was great, the ability to learn with new technology was often lacking because the educational facilities were simply not outfitted with the new technology that was available to their counterparts in developed countries. Owolabi et al. (2020) also asserted that Africa as a whole and specifically Nigeria are still stuck with outdated teaching methods even though developed countries have progressed in several areas and areas, including teaching anatomy and career development.

This finding about their quality of education and the quality of the instructions received supported the push-pull theory that people will migrate when there is an improved opportunity for them. The participants felt that what pulled them to the United States was the fact that they were in a challenging environment and in their opinion, things were not getting better and there was little more that Nigerian could provide to them in terms of learning.

Also, the learning environment in Nigeria seems to lean more towards classroom learning versus hands-on experience. Abdu-Aguye et al. (2019) expressed that participants in their study stated that there was a huge gap in the knowledge acquired in school because much of the real-world experience they encountered was not part of the classroom curriculum and thereby made it easy to put into practice what has been taught to them in theory.

Lack of amenities and equipment rounded off the participants' experience in college. Uzomba et al. (2021) identified one of the factors that hinder the quality of care

as insufficient equipment and lack of basic amenities such as water and electricity. This also translated to the learning environment as some of the healthcare practitioners stated they never saw some basic standard equipment such as an X-Ray or MRI machine until they migrated to the United States.

Theme 2: Lack of Government Support

The second emergent theme that evolved as a result of this research was the participants view of the Nigerian government. The participants felt that the Nigerian government does not play a constructive role in the Nigerian healthcare system. The participants stated that there was lack of funding, lack of policies, the overall Nigerian economy, the overhaul of the current Nigerian healthcare system and a liaison between the Nigerian government and the healthcare practitioners in the diaspora.

The underfunding by the government also does not only happen in the healthcare sector but also under the education sector. Awire and Okumgba (2020) expressed that there has been severe challenges in the education sector due to insufficient funding, poor planning, and loss of values. This unintentionally contributes to the poor healthcare sector as the education of the healthcare practitioners is affected by poor planning and underfunding the education sector. Awire and Okumgba further articulated that there is a definite correlation between the underfunded education system and brain drain which in turn causes brain drain in the healthcare sector. Ogaboh et al. (2020) indicated that funding and good infrastructure are part of the pull factors that pulled Nigerian healthcare practitioners to developed countries.

Unemployment which is another push factor that promoted brain drain was cited by some of the participants as a reason for migration. Rufai et al. (2019) in their study expressed that policies that delve into labor practices in Nigeria may potentially help reduce brain drain in Nigeria. Rufai et al. further stated that developing countries such as Nigeria are often plagued with brain drain of workers within the health and technology sector due to pull factors such as better employment conditions and training opportunities that would otherwise not have been afforded to them if they remained in Nigeria.

Various push-pull factors as proposed by both Ravenstein (1889), and Lee (1966) led to an aggregate of factors which led to all the participants migrating to the United States. The participants cited everything from unemployment to quest for more as the reason for them migrating. The government has also been lackadaisical in their approach to overhauling the healthcare sector in Nigeria. Omoleke and Taleat (2017) pointed out that the gross underfunding is a serious social cankerworm devouring the fabrics of the Nigerian health institutions. As a result of the lean budgetary allocation to the health sector, the Nigerian health system is below the WHO's Standard of 15% of the total budget.

The participants unanimously agreed that the government needed to play a bigger role in revitalizing the Nigerian healthcare sector. In research from Ajide and Ridwan (2018), they found that the government paid a little more attention to education than they did to healthcare. Currently, the government has not really put much energy in improving all the sectors in Nigeria with Rufai et al. (2019), stating that the drive to rectify the deficiencies in the different sectors need to be strengthened.

Apart from revamping the country as a whole, the participants felt that the government lacked accountability. Corruption and poor policies seemed widespread in Nigeria and the healthcare sector is no exception. Onwujekwe et al. (2020) expressed that the reason for corruption within the healthcare system is not even understood currently but seems to be a by-product of the corruption that is prevalent in the whole of Nigeria.

Currently the policies and regulations within the healthcare sector are weak and almost non-existent and therefore has allowed brain drain within that sector to go on for a long time. Some of the participants stated that they are willing to work with the government, but they do not think the Nigerian government realizes there is a brain drain problem. The Minister of Labor and Employment, Dr. Chris Ngige certainly does not think Nigeria has a brain drain problem. Atoyebi (2019) explained that Dr. Ngige claims there are enough doctors in Nigeria and that directly contrasts what Dr. France Faduyile expressed as the president of the Nigerian Medical Association. According to Adegoke (2019), Dr. Ngige purports that the reason doctors are leaving Nigeria is because they are a desired product that is surplus in Nigeria and that is why there is medical brain drain. However, according to the Nigerian Medical Association which is the body that documents the population of doctors in the country, there are only about 40,000 doctors in the country who have the lofty job of caring for its over 200 million citizens. In the end, the participants feel it is a battle they cannot win even if some of them said they were willing to provide their medical training and services to Nigeria for free. However, they do not think the government is willing to cooperate and allows healthcare practitioners a chance to give back.

Through the participant's responses, it was found that because of the current state of the healthcare system, some of the constituents embraced a traditional and/or holistic approach to compliment the current healthcare set up that is available to them. The healthcare practitioners are not themselves practicing holistic medicine but finessed the way of understanding what some of their patients believe there is a cultural component to their healthcare. Typically, many patients self-medicate and use traditional means for their ailment and some of the healthcare practitioners stated that they had to incorporate that into their patient care in order to get patients to use their services due to lack of health education. Li et al. (2020) pointed out that the most common diagnosis for typical illness such as malaria is self-medication and self-diagnosis by the patients simply because many of them cannot afford to go see a general practitioner.

Due to the poor healthcare system in Nigeria, there are some ailments that could otherwise be treated and prevent unnecessary death. The preventable deaths of patients was a sour point amongst the participants. Some of the participants expressed dismay at the abysmal healthcare infrastructure and how it contributes to the otherwise preventable deaths of patients. Medical error in the Nigerian healthcare system is high. The medical error which sometimes results in death is very prevalent in the Nigerian healthcare system. In research conducted by Yalma and Asuzu (2020), the participants in their study stated that they were pushed out of the country due to factors such as being overworked, underpaid, stressed and the working environment not being conducive. It is easy for medical error to occur when the healthcare worker rate per 1,000 patients still does not meet the WHO standard.

Theme 3: Reality of Knowledge Gap

The third emergent theme was the knowledge gap of the healthcare practitioners after they migrated to the United States. In the research by Abdu-Aguye et al. (2019), even on the educational level in Nigeria, there is already a disparity between the knowledge taught in class versus real world application. Participants in their research stated that the correlation between a particular medication as a resolution to a medical condition was not even covered in their curriculum. The deficiency was not realized until they got into the real world to practice their hands-on experience. That issue also translated to how some of the healthcare practitioners that were interviewed during this research felt.

Abdu-Aguye et al. analyzed that the knowledge gap between Nigerian graduates and their counterparts in other parts of the world was a huge problem. Some of the participants expressed that while the training received was good according to Nigerian standards, it was not until they moved to the United States that they realized their knowledge and skills gap was huge. This was also highlighted when dealing with senior colleagues who have trained abroad that they needed to sharpen their skills.

The healthcare practitioners were able to see the difference in their lived experience as healthcare practitioners in Nigeria through their migration to the United States. The practitioners were able to discuss how their experience in the United States showed collaboration with their senior colleagues over the power distance they experienced in Nigeria. They also were able to determine that there was a huge knowledge and skills gap between the experience they gained in Nigeria versus their

experience in the United States. While in Nigeria the doctors generally are a Jack of all trades, they came to the United States and went into a specialized experience. Some of the participants also conveyed that they were able to get more training and mentorship from their work in the United States versus when they were in Nigeria, and this helped them refine their medical skills in the United States. Finally, some of the participants stated that they had never even used some of the diagnostic tools that makes practicing medicine in the United States easy for them. The availability of good equipment, infrastructure and healthcare access for many Americans were the pull factors that encouraged their migration to the United States.

Limitations of the Study

The most glaring limitation was the sample size. Currently there are a lot of Nigerians in other parts of the world that were not part of this study. The study consisted of a sample of Nigerians in the United States. While the call for participants was to include participants from all over the United States, only a selected few agreed to participate. This heuristic phenomenological study was limited to 12 participants from the original 10 that was initially suggested during the research proposal process. However, to achieve data saturation 2 more participants were added to make sure that everything that could be gained from the research was accomplished. There were also more doctors in the study than nurses and other healthcare practitioners.

Another limitation was the exclusion of other African countries in the study. Brain drain is a phenomenon that affects the African continent, so in order to get a rich view of the phenomenon, it would have been great to get the perspective of other

immigrants from other African countries. The inclusion criteria of just Nigerians limited the scope of the findings.

A third limitation for studying African healthcare practitioners is the fact that whenever a generalized study is being conducted, African healthcare practitioners are labeled as African Americans. So, unless a purposeful sampling is conducted, in some cases, brain drain study from different countries can be quite limiting.

Researcher's Experience of the Brain Drain Phenomenon

This heuristic phenomenology study included the experience of the researcher as they are "present throughout the process and, while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge" (Moustakas, 1990, p. 9). As the researcher, I knew firsthand the state of healthcare in Nigeria because I lived in Nigeria as a child. I recall being a 9-year-old whose appendix almost ruptured and I almost died because there was no money readily available to make an immediate payment. It was not because the money was not available, the money was just not with us at the hospital. I recall my mother rushing her driver to her store to go bring some money back to pay so that they could commence with the surgery. Countless people have died simply because they did not have the resources to pay, or the doctor was not readily available to take care of the patients. A friend died in front of the hospital because a doctor was not available to treat her while having an asthma attack.

I did not fall within the inclusion criteria that tackled this study. I was not born in Nigeria. I did not study a health-related degree in Nigeria, I did not graduate college nor

practice in the healthcare industry in Nigeria. Somehow, I found myself affected by the brain drain of healthcare practitioners when my middle son started having seizures and almost died on a trip to Nigeria in 2015. I could not find a pediatric neurologist in the whole of Lagos, a state with an estimated population of 15 million people. While on the search for a doctor my son got seriously ill and there was no cover for the ear probe. The examination table was covered in tarp that was dingy and dirty. This event prompted me to leave Nigeria and come back to the United States where the doctors were readily available and easier to reach.

While in Nigeria, I met a few healthcare practitioners that were not working in the medical field because the jobs were hard to come by and when you did get the job, you were unacceptably underpaid, the working conditions are not conducive and many of them are waiting for their turn to leave the country.

From my experience, there are a few recommendations that should be considered when dealing with medical brain drain in Nigeria.

Recommendation for Future Research

The research on brain drain is very important as more and more people are waiting on their turn to migrate out of their home country and migrate to developed countries. It is important to study the relationship between migration and the role of the government in the home country (Atte, 2020). It is also important to study why people are migrating and what the government can do to make them stay. While it is a herculean task; it is one that must be taken seriously as medical brain drain is on the rise and its impact of healthcare sector.

The first issue at hand is that unfortunately Nigeria does not have healthcare related policies in place that will help build the healthcare sector. The first recommendation would be to develop good healthcare policies and with close attention being paid to the healthcare sector. The research showed that brain drain was not only happening in the healthcare sector but in different sectors within Nigeria. It will be important for the Nigerian government to do a study within each sector to find out what is lacking and what can be done to retain human capital in Nigeria. Nigeria should also work on mutual agreements with countries they are losing the most talents to. Cometto (2013) stated that when the United Kingdom realized that majority of their doctors were foreign doctors, they implemented a bilateral agreement with developing countries, and they saw a decline. Such an agreement will help formulate brain gain and brain circulation strategies.

The healthcare curriculum especially for the medical schools in Nigeria is also lacking. The education curriculum needs to be revamping to be on par with the 21st century. Some of the participants interviewed expressed that they did not realize how large their knowledge gap was until they moved to the United States. Some expressed having never seen a diagnostic tool such as an MRI or CAT machines prior to moving to the United States. In that same vein, it begs the question on how patients were diagnosed with serious illnesses that can only be diagnosed using MRI's and CAT machines. Some of the participants stated that they left Nigeria simply because Nigeria had nothing else to teach them due to inadequate amenities and the mediocre curriculum. So there needs to

be an overhaul in the educational sector too in order for the healthcare professionals to be on equal footing with their counterparts in developed countries.

Another recommendation for the Nigerian government would be to study wage rates in different developed countries and to see how their healthcare practitioners can be on par with their colleagues in developed countries. The government must recognize that the reason why people are leaving is because of the wide wage disparity between Nigerian healthcare practitioners and their counterparts in the United States or the United Kingdom.

It is also recommended that the Nigerian government implement brain gain and brain circulation strategies. Brain gain strategies may include a data collection tool for Nigerians in the diaspora. Nigeria does not have a proper data collection tool that shows how many people are actually outside of the country. The tool used for data collection is very vital as it helps the Nigerian government determine subject matter experts in different subject areas (such as healthcare). Currently many hospitals in Nigeria lack healthcare specialists as specializations are not a core component of their curriculum and there is a dire need for specialists that can come in from their current country of residence to teach new techniques to the healthcare practitioners still in Nigeria. Brain gain is very essential in revitalizing a lot of sectors in Nigeria and specifically the healthcare sector. The tool that will be utilized for data collection would be a starting point for the Nigerian government to develop policies that will help them create an exchange program between Nigeria and the current home country of the subject matter experts. Many if not all of the

participants expressed interest in helping with the revitalization of the healthcare sector but constantly see the Nigerian government as the roadblock.

Another avenue will be to develop brain circulation strategies that will have the government working very closely with Nigerians in the diaspora. Brain circulation will involve the government creating a program that employs Nigerians in the diaspora for a period of time (about 1 months to a year). During that time, this person from the diaspora will come in and teach their specialty to people that wish to possess their skill set. Brain circulation can help bridge the gap between Nigerians in the diaspora and the Nigerian government and it may help the Nigerian government view external policies that can be adapted to cater to Nigeria as a whole.

A final recommendation will be for a quasi-experimental method research to be conducted to delve deeper into the brain drain issue surrounding several African countries. A quasi-experimental allows for the observation of the bigger problem surrounding the brain drain phenomenon. While quasi-research does not allow randomization, the nuances of the methodology will allow this study to explore other African countries that are also experiencing the same issue. A retrospective study can be conducted which will compare participants that have migrated and the ones that are in the country. In this study, the skill sets, knowledge gap and other variables will be measured to "force" the government to look inward and change their course. There are many entities that include African Nations such as the Economic Community of West African States (ECOWAS), African Union (AU), etc. and this will probably be a gateway to present the issue and for the nations to find a collective solution to the problem.

Implication for Social Change

The implication for social change will include the ability for the Nigerian government's buy-in into reassessing the current infrastructure that includes healthcare practitioner retention strategies and healthcare policies. Lawal and Aluko (2016) stated that the Nigerian foreign policy is also quite lacking. The current set up of the country can make it an arduous task to create a foreign policy that will create an exchange program with developed countries like the United States and the United Kingdom. However social change can occur in Nigeria if the healthcare infrastructure is structured and understood by both the healthcare practitioners and the policymakers in order to put in place proper healthcare policies that address the current healthcare issues in the country and one that can help retain healthcare practitioners in the country.

Currently, the government and the healthcare practitioners are not in agreement that there is a problem with the healthcare sector. The current Minister of Labor, Chris Ngige, a medical doctor by profession, does not believe there is shortage of healthcare professionals in the country. There should be an honest conversation about the issue at hand and that issue is brain drain. Developing countries such as Nigeria are consistently losing human capacity, and this is happening all over the world. Egbejule (2019) expressed that the Nigerian government has spent a lot of money training healthcare practitioners to the tune of $21,000 to $51,000 over the years. Yet the government does not seem to understand that losing these healthcare practitioners to other countries is a loss of their resources, and a loss on their return on investment. Onwujekwe et al. (2020) also stated that due to the widespread corruption in Nigeria, it will be productive to have

a working session where evidence is presented to stakeholders within the government that there is indeed an issue of brain drain in Nigeria and it has a profound effect on the Nigerian healthcare sector

Conclusion

The perceptions and thoughts of 12 Nigerian healthcare practitioners that migrated to the United States due to push-pull factors are included in Chapters 4 and 5 of this research. The participants were healthcare practitioners (Nurses and Medical Doctors) who were born, obtained their degree and practiced in Nigeria and have subsequently migrated to the United States. The research questions that guided the research was, "what are the reasons for healthcare practitioners leaving Nigeria and what are the impact of those decisions on the Nigerian healthcare sector?" As a result of data collection from the participants, three themes emerged from the interview responses: challenges of living in Nigeria, lack of government support and the reality of their knowledge gap.

Emotions were raw from the participants ranging from dismay at the Nigerian healthcare sector to the role of the government in the decrepit Nigeria that currently exists. There was an interesting observation with the participants with reference to their year of graduation. The year of graduation of the participants ranged from 1983 to 2014 and each participant had almost similar responses to their college experience. They claim their college experience was great but then upon migrating to the United States realized they had a huge knowledge and skill gap in comparison to their American counterparts. Another observation was how quickly the migration happened. One participant

specifically left Nigeria a year after graduation and for one participant it took sixteen years before the migration happened. One of the participants had only been in the United States for three years and this particular participant was the lone participant that chose another career path upon migration. When interviewed, participant BD00012 stated that after going through medical school in Nigeria, he migrated to the United States and decided to change his focus to the business side of healthcare. So, participant BD00012 currently does not practice medicine in the United States but is still working in the healthcare field.

The task of coordinating and compiling data for this heuristic phenomenological study was not an easy feat. The findings from the participants and literature review all suggest that there is a huge problem with brain drain in Nigeria as a whole but special attention needed to be paid to the healthcare sector as it affects the healthcare delivery to the population. The general consensus amongst all the participants is that the Nigerian government needs to participate in brain circulation in order to lessen the effect of brain drain in Nigeria. The participants cited many reasons why a complete brain gain may not be a realistic approach until the Nigerian government accepts that there is a brain drain problem. Darkwa (2018) pointed out that professionals that have migrated bring resources to the country for its development. These resources range from financial capital in terms of remittances to the country to human capital but most of the participants feel that this brain circulation will only happen with the joint relationship between Nigerians in the diaspora and the Nigerian government. As one of the participants stated, when the Nigerian government is ready, they (the participants) will be ready to pay it forward.

I was extremely grateful to all the participants that were willing to tell their story without inhibition and with confidence. The participants were assured that their real names will not be utilized during this study and as such each participant's identity was protected. I am appreciative of the trust they had in me to tell their lived experience as healthcare practitioners that migrated to the United States and therefore experienced brain drain firsthand.

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Appendix A: Interview Protocol

Purpose Statement: The purpose of this qualitative heuristic phenomenological study is to analyze the role of the government in fostering a good relationship between the Nigerians in the healthcare field located in the Diaspora and the Nigerian government or even the private sector with the help of the Nigerian government. Also, this study will aim to add literature to the field of public policy and administration by providing a study that explores the lived experiences of Nigerian medical personnel that were born in Nigeria and moved to another developed country to practice in the medical field due to Nigeria's failing government.

Date of Interview: _____

Time: _____

Venue: _____

Questions:

1. Describe your college experience in Nigeria and explain how it prepared you for the healthcare field Nigeria?
2. What was your experience as a healthcare practitioners living in Nigeria?
3. In your own words, describe the Nigerian healthcare system to someone that does not understand it.
4. In your working experience in Nigeria, what was the government's role in the country's healthcare system? Especially at it relates to policies and regulations.
5. Can you describe the pivotal moment you decided to move to the United States to further your healthcare career and why?
6. Describe your experience working in the healthcare field in United States and explain the difference between your experience working in the United States versus your experience in Nigeria?

7. In your experience, do you think the government plays a big role in the healthcare sector in the United States in comparison to the Nigerian government?
8. Are you familiar with the term brain drain? What is your brain drain story? What factor does brain drain play in the current Nigerian healthcare system? And what part do you think the Nigerian government has played in emergence of brain drain in Nigeria?
9. In your experience, do you believe that your acquired knowledge from the United States can be used train healthcare practitioners in Nigeria. What do you think the Nigerian government can do to foster a relationship between Nigerian healthcare practitioners in the diaspora and the players in the healthcare sector in Nigeria that can affect change?

Appendix B: Protecting Human Research Participants Completion Certificate

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Oluwakemi Osigbesan** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 09/03/2010

Certification Number: 504454

CITI PROGRAM

Completion Date 31-Aug-2020
Expiration Date N/A
Record ID 38166447

This is to certify that:

Oluwakemi Osigbesan

Has completed the following CITI Program course:

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Student's (Curriculum Group)
Doctoral Student Researchers (Course Learner Group)
1 - Basic Course (Stage)

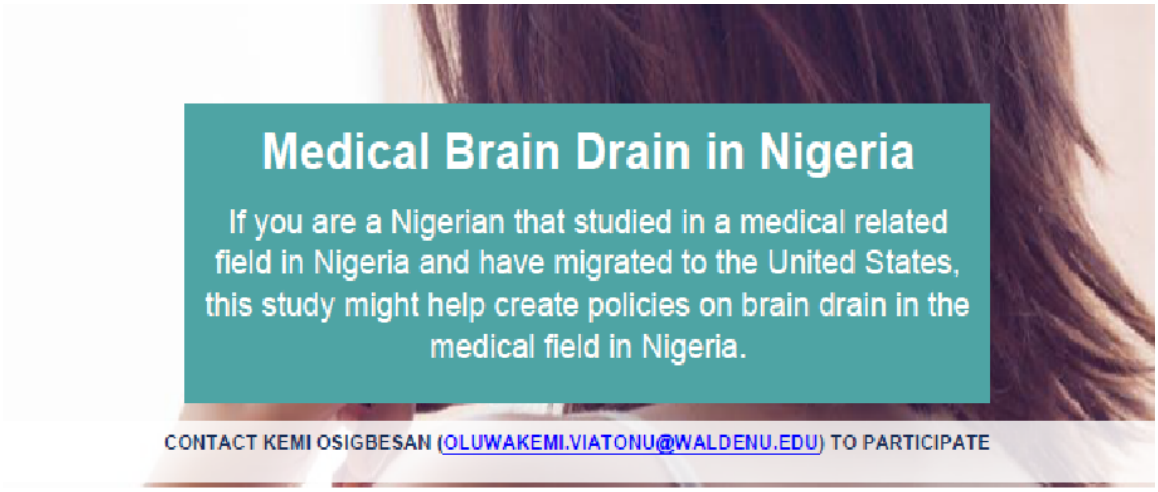
Under requirements set by:

Walden University

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w28ce1f52-00f3-4632-8c5b-1684673798fe-38166447

Appendix C: Recruitment Flyer



You are invited to participate in a research study that involves medical brain drain in Nigeria and its effect on the Nigerian healthcare sector. For this research, you are invited to describe your experiences being in the healthcare field in Nigeria and what prompted you to move to the United States.

Location

- This will be a virtual interview that will be conducted using zoom.

Are you eligible?

- Male or Female born in Nigeria
- Graduated with a healthcare related degree
- Practiced in the healthcare field in Nigeria
- Migrated to Nigeria and currently practicing or retired from the healthcare field.

If meet these requirements, please provide your contact information by clicking on the link below:

https://fhh7xtt5y40.typeform.com/to/Vqv6PQDV