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The Impact of Turnover and Turnover Intentions on Nigeria's Public Health Administration

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Walden University
2024

Abstract

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MPA, University of Lagos, 1998

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Dissertation Submitted in Partial Fulfillment

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Public Policy and Administration—General Specialization

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Abstract

High turnover creates a vicious cycle that affects employees with further shortages and turnover. This study explored the lived experiences and perceptions of a government employer and employees about turnover, turnover intentions, and the government's leadership effectiveness using Heidegger's phenomenological research methods. The theoretical frameworks that grounded the study were Herzberg's motivation-hygiene theory, public service motivation theory, and corporate social responsibility theory. The study questions focused on stakeholders' perceptions and lived experiences of the government's leadership effectiveness in addressing the impacts of high turnover, as well as the employees' consequent reactions to the government's leadership approach. Participant data were collected and analyzed using manual and software analyses and demonstrated poor motivations, negative employee reactions, and knowledge gaps. The purposive and snowball sampling methods were used in selecting participants in a semistructured personal interview. The results indicated that the hospital administrators were limited by the government and were consequently overwhelmed, lackadaisical, and unprepared to resolve the vicious turnover impacts ravaging the public health sector. Recommended remedies include advocating to the government about empathically accepting the realities of labor shortages in the health sector. Additionally, the government should prioritize the effectiveness and efficiency of health sector infrastructure, administration, and stable workforce maintenance. The implications for positive social change involve carrying out effective health sector reforms and comprehensive training of all stakeholders involved in the public health industry.

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Dedication

I believe in God and in Jesus the Christ as my Lord. I thank Him for strengthening me through this finish point. I dedicate this work to my darling wife, Rosemary Ngozi Uduma. She encouraged me during challenging times whenever I felt like giving up the project.

I am pleased to dedicate this work to my children, Ikennachukwu, Onyinyechi, Chinenyem, and Chinazam, for showing support and understanding in one way or the other through this journey that I embarked on it to prove to them that they should follow the path of knowledge/light.

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I thank my chair, Prof. James W. Beeks, and my mentor, Dr. Victoria B. Landu-adams, who, without knowing about my difficulties, supported and sharpened my work to this finish line.

I thank Walden University and a host of resource persons too many to list here who have shaped my academic skills in the opportunity of pursuing and continuing in positive social change.

All glory to God.

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I acknowledge all the 39 health care practitioners for their willingness and cooperation in allowing me to individually interview them. Your support remains evergreen in my memory. Thank you all for sharing your perceptions and lived experiences! Thank you all and all glory to God for the support, cooperation, and goodness enjoyed.

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Chapter 1: Introduction to the Study

The World Health Organization (WHO) reported in 2016 about a worldwide shortfall of 4.3 million health care workers. The medium-income countries (e.g., Nigeria and sub-Saharan Africa) are currently projected to be short 18 million workers by 2030, excluding the impacts of coronavirus, flood, climate change, and emerging/re-emerging infectious diseases (Liu et al., 2017; Nyaruaba et al., 2022; Suhr et al., 2022). The problem is worse for areas with poor health care infrastructure, high turnover trend, and exit intentions of health workers who may migrate to other countries searching for greener pastures.

Specifically, the high turnover trend in Nigeria has remained unreversed for over 3 decades despite the region's low 3% global workforce and high 25% global disease predicament (Dohlman et al., 2019). The agony derives from a continuously reduced workforce burdened with increasing health challenges. Dohlman et al. (2019) published that the unabated skilled labor migration from Africa to developed countries is as high as 70% and makes up one fifth of developed countries' health care workforce. Annually, government executives exacerbate it because budgets, turnover policy, and workers' welfare are poor despite the government's efforts for stability.

One way of grappling with the issue is to effect a positive change through budgeting and implementation. However, Nigeria's health care budget (about 4% of the national budget) is inadequate for significant improvement in its health care infrastructure and welfare (Shadare, 2022). That inadequacy in budgets promotes high turnover in favor of developed countries that have better infrastructure, health care budgets, and welfare.

Thus, employees immigrate to other countries to obtain better wages, an improved standard of living, and skill development (Ogaboh et al., 2020). The host countries prioritize health infrastructure and employee welfare, budgeting to attract such skilled immigrants. Nevertheless, the home country gains little or nothing and must bear with the remaining inadequate workforce replete with complaints about poor working conditions, work-life balance, capacity fulfillment, infrastructure, and burnout (Omonijo et al., 2015; Oruh et al., 2020).

Incidentally, government efforts have not mitigated the severe socioeconomic workforce problems and the consequences of the brain drain or high turnover of its health personnel. Additionally, the opinions of government (as a health care employer) and employees' conflict on the high turnover and exit intention trend. This conflict is perennial and entrenches the turnover and intention trend as a disadvantage in the sector. The negative consequences make it difficult for the few hands left to satisfy the population's preventive and curative health care needs.

In this study, I evaluated the research result to propose policy options for improving the Nigerian public health care sector in line with global best practices. The impact of high turnover, exit intentions, and the parties' conflicts were probed through the lived experiences of health care practitioners and the employer to reveal any hidden bases of perennial conflicts and stagnation in the sector. In this phenomenological study, I identified the remote burden of conflicts on the industry stakeholders and recommended a resolution framework based on the research outcomes.

Chapter 1 reveals the background of the problem, problem statement, purpose of the study, research questions, nature of the study, definitions of terms, theoretical frameworks, and significance of the study. It also states the scope, assumptions, and limitations of the study.

Background of the Study

Nigeria has abundant natural and human resources, federal health centers, university teaching hospitals, general hospitals, and private medical centers/hospitals designed to enhance citizens' health. However, Dohlman et al. (2019) and Ogaboh et al. (2020) have reported that Nigeria lost a considerable part of its highly skilled health care practitioners to the persisting high turnover trends. The remaining public health workers (through their union leaders) engage in constant disputes with their employer over poor remunerations and working conditions (Omonijo et al., 2015; Oruh et al., 2020). Those conflicts and turnover implications show low followership and confidence in the public health leadership. The union representatives' actions indicate that workers question the leadership effectiveness of their employer. Paradoxically, the government employer absolves itself of any failure in leadership or management of the persisting turnover and opines that the turnover trend is an export of excess labor despite the poor doctor/nurse-to-patient ratios. The conflicts cause vicious strike actions every year, with each party maintaining its viewpoint in a manner that requires probing deeper into the lived experiences of parties to determine the remote causes of conflicts and possible remedies to the problem.

Problem Statement

In Nigeria's health sector, the employees leave in favor of local industries and those abroad (Osibanjo et al., 2020) because of burnout, poor working conditions, work-life balance, capacity fulfillment, and infrastructure (Omonijo et al., 2015; Oruh et al., 2020). According to Omonijo et al., Oruh et al., and Osibanjo et al., the employer/government accepts turnover trends as the export of excess talents despite the negative consequences of inadequate personnel. These employer and employee positions represent complex lived experiences that may obstruct effectiveness and industrial growth in the health organization. The problem is constant conflicts and a high turnover trend between the government employer and its employees involving leadership effectiveness perceptions, experience, and the interpreting of government interventions on turnover and managerial relations (leadership) in the health sector (Otobo, 2016; Siyanbola & Gilman, 2017).

The conflicts in the industry about leadership effectiveness and turnover reduce health care delivery in Nigeria. There is little literature about stakeholders' lived experiences, perceptions, and the impact of the government's leadership redress on the problems of turnover and exit intentions in the industry. There is a need to know the experiences of employees and the employer in the prevailing trend of leadership impact, high turnover, and exit intention in the health sector. What are the perceptions and lived experiences of the professional employer and the Nigerian public health sector employees about the effects of government leadership on turnover and turnover intentions in the sector? What are the veracities of parties' positions in defense or complaint about the high

trend of turnover? These questions require phenomenological exploration to determine the realities of the phenomena (turnover, exit intentions, and leadership effectiveness) and their impacts on the public health care sector.

Purpose of the Study

This qualitative study was conducted to explore, understand, and discover current stakeholders' perceptions and the impact of turnover, exit intention, and leadership effectiveness, and how they impacted employees' and stakeholders' lives in the industry. There was a need to understand the association between an employer's leadership/managership and turnover impacts on employees to evolve ways to curb the problem's persistence. Therefore, I focused on the lived experiences of the employees and the employer to understand their experiences/perceptions of turnover/exit intentions and how leadership effectiveness influenced turnover and intention to stay (job satisfaction). That discovery of the current stakeholders' experience and adjusted perceptions was necessary for planning officers' interpretations, accurate forecasts, and predictions.

Research Questions

The objective of this study was to investigate what was causing the stakeholders' positions and their lived experiences of turnover and turnover intentions reality in the health care sector. The following questions were answered:

Research Question 1. What are the perceptions and lived experiences of the professional employer and the Nigerian public health employees about the effects of government leadership on turnover and turnover intentions in the sector?

Research Question 2. What are the impacts of the employees' perceptions and consequent actions on the employer's leadership effectiveness?

Theoretical Foundation

The corporate social responsibility (CSR) and motivation theories were used as frameworks in the study. Thus, the framework of this study was based on CSR, which states that an organization's obligation is not only legal, but also economic and ethical toward its members (Stewart et al., 2011), who (as employees) expect such fulfillment from the organization managers/leaders to be perceived/appraised as responsible leaders (Jamali et al., 2008). Thus, while Stewart et al. (2011) reported the tripartite responsibilities of organization leaders or employers, Jamali et al. (2008) propounded that organization leadership will not be perceived/appraised as ethical and responsible if the preceding tripartite leadership duties are not performed. Furthermore, the framework was based on the motivation-hygiene theory (MHT) of Herzberg et al. (1959), which states that employees who are propelled intrinsically (not for rewards or avoidance of punishment) are more satisfied on the job than those influenced extrinsically (to earn a bonus or avoid penalty). The employer's duties impact employee perceptions, stability (turnover), and satisfaction.

Similarly, public service motivation (PSM) is defined as an individual's attraction and commitment to the public good (Perry, 1996). The center of the motivation concept revolves around a person's drive to maximize public benefits in an organization. That was applied to explain the motivation dynamics between parties as they affect turnover trends and employee satisfaction. Generally, the frameworks facilitated specific analyses of

stakeholders' experiences/perceptions of the impact of turnover, intention, and leadership effectiveness. The contextual peculiarities of the African nature of public service helped to effectively apply theories and findings to interpret and respond to stakeholders' experiences/perceptions in the health sector. That resolved the problem and fulfilled the research purpose. Furthermore, the results provided scholarly insight and discovery for scholars and administrators to resolve participants' negative lived experiences of turnover, exit intentions, perceptions, and leadership effectiveness in the health sector.

Nature of the Study

I used Heidegger's phenomenological design to understand the lived experiences of the health care practitioners whom I scheduled for personal interviews, including medical doctors, nurses, laboratory scientists, radiographers, administrators, and public health professionals in Southern Nigeria. I used a sample size of 39 participants. The recruited population of interest that was interviewed was designed to accommodate a minimum of 15 interviewees, including five doctors, five nurses, one laboratory scientist, one radiographer, one administrator/employer, and two public health professionals. I increased the number of participants whom I interviewed to 39 to achieve the saturation requirements within the professional groups that I interviewed.

Heidegger's philosophy introduced above is better understood as a differentiation of Husserl's approach. Martin Heidegger was a student of Edmund Husserl, who created phenomenology as a philosophical research approach to intentionally access and describe (reduce) phenomena (consciousness) from those experiencing it through researcher bracketing or intentionality (Burkholder et al., 2016; Husserl, 1962; Welton, 1999).

Husserl recommended suspension (setting aside) of researcher biases, assumptions, and other related theories to understand the participant's lived experience of a phenomenon. He introduced *intentionality, reduction, bracketing, noesis, noema,* and *horizon*. Intentionality is a responsible consciousness of action. Bracketing or epoche is a term for researcher bias suspension. Noesis is the thinking means of the researcher as the subject or subjective interpreting of the object called noema. The horizon refers to a current prevailing experience of the research platform/process.

Conversely, Martin Heidegger introduced the concepts of hermeneutics (revisionary thinking) to vary Husserl's phenomenology with new terminologies, including *dasein, hermeneutic cycle, foresight/fore conception, spiral analysis,* and *multiple lenses* (Connelly & Clandinin, 1990; Dibley et al., 2020; Heidegger, 1996; Patton, 2020; Ravitch & Carl, 2016). According to Heidegger, it is impossible to bracket, suspend, or separate self/personal biases, assumptions, and related existing theories. That is because self and others are always there and involved in the world, which he termed *dasein,* meaning being there (Heidegger, 1996). Therefore, perception, understanding, and interpretation of phenomena constitute a continuous cycle of interaction termed *hermeneutics*.

The hermeneutic circle as a revisionary process describes the comprehension (understanding) process beginning from preconceived knowledge (foresight, fore conception, biases, or judgments) through interpretive understanding and revision. The revisionary result is a spiral (not circular or linear) analysis/understanding of how the parts relate to the whole of the data for continuous interpretation to a meaningful point.

Heidegger's hermeneutic phenomenology allows the use of multiple theoretical lenses. Hence, the design frameworks between employees and the government employer involved theoretical lenses including CSR, MHT, and PSM. Sequentially, the researcher's biases were written down or noted without suspending them through journaling in each data collection and analysis stage. The focus was on the lived experiences of doctors, nurses, laboratory scientists, radiographers, pharmacists, and representatives of the public health care employer in Nigeria. Their experiences were analyzed to understand the impacts of turnover and turnover intention on the employees and employer. It further helped to understand how the administrator's (employer's) leadership effectiveness shapes the lived experiences of the practitioners in the public health sector.

I used the personal interview process to collect data from participants through personal face-to-face interviews. Heidegger's phenomenological design facilitated adequate capture of the experiences of practitioners serving amidst the high trend of turnover and exit intention of health workers. I chose purposive and snowballing techniques to adequately meet the research design purpose and objectives, which were centered on profound lived experiences. Creswell and Creswell (2018) reported that the interview process design helps explore participants' lived experiences. The questions set the stage for studying the phenomena through Heidegger's hermeneutic phenomenological observation/study. The questions' qualitative nature was evident in investigating the respondents' lived experiences and perceptions of leadership effectiveness, turnover, and exit intentions.

I carried out an interview appointment with each respondent/participant. The organized recorded data were manually and digitally processed through transcription and synthesis, and through NVivo qualitative data analysis software. The interview data were recorded, stored, and analyzed. The member checking preceded data coding and was carried out in steps including recognizing, labeling, and tagging data for further analysis through descriptions, concepts, and themes (Babbie, 2017; Ravitch & Carl, 2016; Rubin & Rubin, 2012). The findings addressed the problem statement and provided information and understanding about the impacts of turnover, exit intentions, the root causes of conflicts, and leadership effectiveness in the health sector.

Definitions of Terms

Bracketing: Bracketing or *epoche* is a term describing the researcher's bias suspension in the research process (Patton, 2015). It is the researcher's effort to prevent researcher preconceptions or subjective views of the studied phenomena in the research process.

Brain drain: The deficit movement of professionals from one location to a better developed area (Goga, 2020). The brain resource becomes unavailable at the departure location but is active in the host environment. In this context, the term for the reverse of brain drain is *brain gain*.

Brain circulation: This is a process whereby skilled migrants in diaspora collaborate with their native countries to share knowledge, talents, and resources through online and offline contacts or visits without returning to their native countries

permanently (Ortiga et al., 2018; Zagade & Desai, 2017). The key point is on the repatriation of immigrants' output of resources and intellect to the native homeland.

Dasein: Literally means "being there" (Heidegger, 1996). Heidegger (1996) propounded assumptions that self and personal biases are always involved in the study of phenomena.

Foresight/fore conception: The acknowledgment of first initial biases/judgments in a hermeneutic phenomenological design (Heidegger, 1996). That includes the accommodation of biases and forethoughts prior to focusing on the phenomenon for a meaningful impression.

Hermeneutic cycle: A revisionary process of analyzing data to get to a better understanding of phenomena (Heidegger, 1996). It describes the process of understanding as a back-and-forth activity through forethought, meaning, and revision.

Horizon: The horizon is the current prevailing experience of the research platform or process (Burkholder et al., 2016; Husserl, 1962). According to Husserl (1962), the prevailing experience of interest is the horizon or platform.

Intentionality: This is a responsible consciousness of action in the research process, especially during data collection (Husserl, 1962). That is self-awareness of thought consciousness direction as a subject or object.

Leadership effectiveness: Refers to contextual predefined work outcomes in an organization (Madanchian et al., 2017) realized through influence. The leader and the follower agree on a target with conditions that permit evaluation or measurement of achieved results.

Multiple lenses: Refers to the permissibility of Heidegger's phenomenology to use more than one theoretical framework to study or analyze data/phenomena (Heidegger, 1996). That permits many perspectives and biases without suspending them but explicitly noting them for meaning and interpretation.

Noema: This is the object of thought, observation, consideration, or evaluation (Husserl, 1962). It is a point of subjective direction or process during intentionality.

Noesis: Noesis is the researcher's thinking means as the subject or subjective interpreting of the object called *noema* (Husserl, 1962). In contrast to noema, it is the object in the intentionality platform/process.

Phenomenology: A qualitative design approach applied to collect and study phenomena experienced by a participant (Husserl, 1962; Patton, 2015). Thus, it is a methodological study to gain broad or in-depth understanding of the meanings and nature of lived (everyday) experience of humans.

Public administration: An aspect of government efforts and a systematic study of art and science (Brownlow, 1956; De Graaf & Van der Wal, 2017) of managing, leading, organizing, staffing, budgeting, controlling, directing, planning, communicating, and coordinating work and policies in the state. That definition evolved to include work relating to government. It encompasses the functions of management. The administrative dimensions are included, namely, administration of resources, leadership, and the discretionary acts of management.

Public health: Zweigenthal et al. (2022) defined public health as a deliberate human effort to protect a people/community from disease, preserve healthy/safe living

conditions, and extend life. The focus is on the prevention and cure of disease and the maintenance and extension of life.

Reduction: This is the definitive conclusion or construction, or assignment of simple meaning to a complex phenomenon or event (Husserl, 1962). It is a philosophical interpretation of a complex phenomenon as the sum of its parts.

Spiral analysis: That is a term applied to describe the revisionary status and to distinguish it from being circular or linear in understanding how the parts and whole data interact (Dibley et al., 2020; Heidegger, 1996). The spiral meaning is distinguished from an analysis that is circular or linear in the revisionary understanding.

Suspension: This is the act of setting aside the researcher's biases, assumptions, and related theories to understand the lived experience of a phenomenon for a participant (Husserl, 1962; Patton, 2015). It refers to bracketing or epoche in a research process.

Turnover: Oruh et al. (2020) stated that turnover is the exit of an employee from an organization as initiated (or consented to) by that employee. Dismissals, terminations, and long service retirement are not considered as part of turnover.

Turnover intention: Turnover intention is a willful, conscious, reoccurring decision or process to leave a job soon (Ajayi & Olatunji, 2019; Memon et al., 2020). Thus, it is an employee's reoccurring desire or anticipation of turnover or the employee's voluntary plan to leave a job position. It does not cover long-term retirement planning.

Assumptions

I assumed that the participants would state their in-depth responses to interview questions truthfully in detail without being biased about their perceptions or experiences

of the phenomena in the public health care system in Nigeria. I assumed that the selection of sampling sites in Southern Nigeria was not biased towards other regions or populations and reflected a fair truth about Nigeria's health care in the area of study. Though I was not a participant and was skillful as a researcher, my personal experience of Nigerian public health care may have influenced the revisionary process of analysis and conclusions.

Scope and Delimitations

The focus was on the resolution of the social problems caused by turnover, exit intention, and leadership failure because of the perennial conflicts and vicious impacts on the parties, the public health sector, and the Nigerian populace. The populations included were high-level public health care manpower in Southern Nigeria. The populations excluded in the study included (a) the public health sector practitioners in the Northern region, (b) employees less than 2 years in service, (c) private health sector practitioners, and (d) nonemployees of the Nigerian public health sector. The interview questions most related to the PSM were few and did not gather adequate in-depth responses to generalize application beyond the Southern Nigeria. Conversely, the transferability of findings in similar conditions was expected to be high in Nigeria based on the phenomenological approach using Heidegger's revisionary hermeneutic cycle.

Limitations

Terrorist activities in Northern Nigeria threaten safety in data collection in the affected population areas and limit timely data collection from respondents in vulnerable areas/sites. Therefore, the design site was limited to the South population, where

terrorism threats are less frequent. The implication of the limitation will prevent specific generalization of data and findings beyond Southern Nigeria. In the South, getting practitioners as participants was complex because of political and confidential (nondisclosure agreements) reasons.

The generalizability of the study was limited because of the phenomenological approach that relies on the participants' lived experiences as subjective experiences. Interview questions asked did not capture all the shades of experience intensities because of the time limitations for an exhaustive follow-up in an in-depth data capture and syntheses. The vagaries of security/safety, energy, internet, labor union strikes, public office bureaucracy, and voice connectivity in Nigeria limited prompt data collection. Furthermore, the data capture of the feelings and experiences of junior (low-level) public health workers was not factored in the test of research questions. The study was focused on senior or high-level public health manpower because of the research purpose, designed for purposive sampling of participants who could communicate their experiences and perceptions adequately to fulfill the research questions required to resolve the research problem.

Significance of the Study

The study provided a scholarly report on participants' experiences and perceptions of turnover and turnover intentions within Nigeria's public health sector. The employees and the employer (the government appointee or director of a hospital or medical center) applied unsuitable policy and practice interventions on the prevailing experiences of turnover and leadership problems in the health sector (Ogaboh et al.,

2020; Omoleke & Taleat, 2017). Therefore, the study design was structured to reveal the peculiar contextual leadership motivation notions of PSM and recommended suitable interventions and a policy approach that will mitigate the problems to enhance positive social change.

The peculiar contextual outcome from the study balanced both the employer's and employees' appraisal/perceptions of ethical climate and leadership performance in the Nigerian public health sector. The knowledge of remote influences on stakeholders' experience and actions facilitated better understanding of stakeholders' experiences and behaviors. The results may be helpful to scholars and practitioners in education, human resource management, and policy reforms in their decisions and specialized practices that promote positive social changes.

Significance to Practice

The essence of research is the organization of knowledge. Khomsi et al. (2024) opined that such mobilized knowledge help policymakers to promptly handle the challenges of an organization and society. Thus, the difficulties that policymakers encounter in deciding about something that is unknown are resolved by research outcomes. In public health services, this research was set to identify critical issues, promote/recommend further inquiry, and highlight implications and consequences of findings. This study offers report resources, collaboration, and partnership to scholars, practitioners, and government institutions.

Significance to Theory

In this study, knowledge was advanced concerning the characteristics, behaviors, and impact responses of populations in the public health sector. That knowledge output could be applied in similar conditions to evolve or guide policy, research, and administration. The research had the potential of identifying patterns of behavior or social problems to test, confirm, or reject an idea, assumption, theory, or law. This study determined specific meanings, relevance, or contexts of applications of lived experiences and perceptions of participants. The contribution of the report outcome clarified and strengthened understandings of theoretical frameworks applied to resolve the social problems. Furthermore, the report outcomes answered the research questions and offered recommendations to resolve the social problems of turnover and turnover intentions in the Nigerian public health service.

Significance to Social Change

The scope of the study promoted phenomenological inquiry using Heidegger's hermeneutics. The potential implications involved promoting the approach to create a positive social change in theory and practice. Zagade and Desai (2017) reported a positive effort in harnessing immigrants' skills, talents, and resources by home countries for national development. The government is disposed to apply similar interventions to complement the recommendations in this report.

According to Zagade and Desai (2017), India used brain gain and circulation to channel immigrants' resources back home. The report provided complementary guidance for the government to implement similar interventions in addition to stabilizing the health

sector through reforms. The knowledge gained in public health research facilitated interpretations and recommendations to advance public interests, education, and interventions. Thus, the exploration of participants' perspectives and lived experiences on turnover and turnover intentions provided specific information, application, and recommendations to stakeholders for positive social change.

Summary and Transition

The high trend impact in the sector catalyzes social problems of unemployment, capacity underutilization, inadequate health care, and instability because of the low doctor-patient ratio (Okonofua et al., 2018). The prevailing high trend of turnover and exit intentions in Nigeria's public health sector is unabated and compounded by systemic corruption and poor leadership effectiveness. Paradoxically, the government employer prefers the high trend as an export of surplus labor despite employees' annual protests for burnout and inadequacies in training, funding, and welfare needs (Atoyebi, 2019).

Experts have reported that over 50% of the registered doctors are practicing abroad while the remaining half burn out at a ratio of 0.38 doctors per thousand patients in towns and cities and worse in rural areas at 1 doctor per 22,000 persons (Omeje, 2021; Oyadiran et al., 2020). The WHO recommendation of 1 doctor per 600 patients has continued to be an elusive best practice standard as the high trend has not been reversed for decades. Nurses emigrate at 5.8% annually, and thousands of public health professionals different from doctors and nurses are leaving the country for better bargains (Adesina, 2022; Besenyő & Kármán, 2022). The study outcome proffered solutions to bridge the gaps in the health care sector. Chapter 1 included details on the knowledge

foundation through the study background, research purpose, research questions, theoretical framework, nature of the study, problem statement, scope, delimitations, significance, definition of terms, limitations, and assumptions. In Chapter 2, I discuss the existing literature review about turnover and turnover intentions on Nigeria's public health administration.

Chapter 2: Literature Review

The literature review synthesized search results, theoretical dimensions, and concepts. The study examined the participants' experiences of turnover, turnover intentions, and leadership effectiveness in Nigeria's public health sector. In Chapter 2, I explore the literature on the topic, especially perception, exit, and effects/impact of phenomena in the health care sector. Thus, in the literature review, I synthesize the existing data to show the concept, history, and effects of turnover and turnover intentions in the Nigerian health care sector and the gap in studying the lived experience and perceptions of stakeholders in the health care organization.

Literature Search Strategy

Keywords and phrases used and combined in a library search for this literature review were *employee turnover*, *turnover intentions*, *managerial employment relations*, *qualitative research*, *public health*, *public administration*, *leadership effectiveness*, and *Nigeria*. Articles and books were retrieved from the public policy and administration section of the Walden University library using a Boolean search strategy. The majority of the articles used were sourced from peer-reviewed journals. A few books and website resources were combined with the peer-reviewed journals to provide relevant exhaustive study on the subject of turnover and turnover intentions impacts on Nigeria's public health administration. Further, a search was carried out through Google Scholar linked to Walden. The databases searched included Academic Search Complete, CINAHL Plus, APA PsycInfo, SocINDEX, and CINAHL Plus. The variables studied were turnover,

turnover intention, public service motivation, leadership effectiveness, perception of turnover, perception of turnover intention, and perception of leadership effectiveness.

Theoretical Foundation

This phenomenological study was grounded theoretically by CSR and motivation theories. Two outstanding scholar groups contributed to develop the CSR as a theory, namely, Stewart et al. (2011) and Jamali et al. (2008). Herzberg et al. (1959) propounded the motivation-hygiene theory (MHT), and Perry (1996) championed the emergence of the public service motivation (PSM) theory. The use of many theoretical frameworks to ground a phenomenological study is permissible in Heidegger's phenomenology because of Heidegger's concepts/interview approach of dasein, hermeneutics, foresight, spiral analysis, and multiple lenses in the study and analysis of data and phenomena (Heidegger, 1996).

Corporate Social Responsibility as a Public Health Policy/Program

The name and meaning of CSR commenced in 1992 as *business for social responsibility* (BSR) and stretched to socially responsible corporate policies (Shafritz et al., 2016). The arguments supporting CSR overwhelm all oppositions. CSR is about what responsibilities a business or organization should fulfill. Consequently, the responsibilities of the Nigeria-controlled public health sector should be to formulate, fulfill, and reform programs/policies that emanate from CSR as a responsible entity.

The concept centers on organizational accountability and obligations. CSR is about business or organizational internal and external stakeholder duties that are (a) legal by obeying laws and regulations; (b) philanthropic by giving back to society/community;

(c) economic by profit maximization; and (d) ethical through being fair, just, and avoiding questionable practices anytime in the organization life cycle (Carroll, 1979; Jamali et al., 2008; Shafritz et al., 2016; Stewart et al., 2011). These four prominent dimensions in the definition are for the contextual stakeholder groups, including patients, shareholders, employees, and community entities. Shafritz et al. (2016) emphasized that these component dimensions drive the entrenched legal, social, reputation, philanthropic, and economic values to the interrelated stakeholder groups including the employees, shareholders, consumers/patients, and community entities.

Conceptually, the emergence of large organizations creates social problems that require administrative remedies. Thus, the organization leaders/managers should responsibly resolve current and emerging social problems. The meaning is stretched to corporate social citizenship, where it further expands to emphasize responsiveness of action, activity, performance of outcomes, and results. CSR gives attention to the internal and external stakeholders stated above. Emphatically, the internal stakeholders consist of employees and their needs for work safety, skills, education, equity, and equality. The study focuses on employees' appraisal or perception of the organization's leaders regarding legal, economic, and ethical behaviors as an appraisal of leadership effectiveness.

Motivation as a Public Health Policy

Herzberg et al.'s (1959) MHT indicates that the best way to influence employees to perform is by prioritizing employee motivation intrinsically through their innate desires or nature for recognition, achievement, production, creativity, and committed

ownership prior to enhancing performance with external attractions of salary and outstanding physical gifts. Thus, there are two motivation factors that employers should prioritize in their applications, namely, intrinsic and extrinsic. Herzberg et al. did not indicate any singular factor or motivational practice that could simultaneously achieve both intrinsic and extrinsic motivations. The intrinsic conditions propel employees towards self-fulfillment rather than rewards or avoidance of punishment. Conversely, the extrinsic applications propel workers to earn a reward/bonus or avoid being penalized.

The intrinsic factors promote job satisfaction and drive motivation to perform tasks. The extrinsic induction that Herzberg termed "hygiene" factors is externally induced to reduce dissatisfaction and not motivate satisfaction. Hence, the employer's duty in the public health sector is to match better intrinsic and extrinsic ways to positively impact employee perceptions, stability, turnover, and satisfaction.

Similarly, Perry (1996) adduced the PSM as an attraction and commitment to the public good—that is, an individual's inclinations to promote public advantages. Thus, maximizing public benefits for the organization is the preoccupation of such a person/employee who is motivated by PSM.

In South Africa, the employer's application of motivation through variable work environment achieved different positive results on health workers where work environment experience included more conducive job design, sense of belonging in a team, effective leadership relationship, adequate remuneration package, competence reinforcement in trainings, and autonomous volition in areas of competence (Crafford et al., 2021). The results were desirably positive in promoting job satisfaction and

performance of tasks. Furthermore, health workers were better motivated through employees' statutory roles clarification, interprofessional collaborations, exposure to educational opportunities, and employee induction schedules (Crafford et al., 2023). The motivation applied by the employer was a mix of factors including employees' statutory roles understanding and acceptance as a source of motivation. Comparatively, the statutory outcomes of roles clarity, perceptions acceptance, and the impact of studied variables were different in outcomes during the study.

However, the PSM theory was helpful in explaining parties' motivation experiences. The theoretical frameworks functioned as a prism to analyze stakeholders' experiences and perceptions of studied variables. Moreover, the PSM theoretical interpretations were comparable with the Nigerian/African public health sector findings for peculiar scholarly insights. The CSR and motivation theories related to the study and explained participants' conflicting positions and behaviors. Hence, the research questions that were asked explored the causes of the stakeholders' positions, perceptions, lived experiences, and impacts of studied variables, including turnover, turnover intentions, and leadership effectiveness in Nigeria's public health sector.

Literature Review

This section presents the review of literature as it related to key variables and concepts. I address the historical impacts of turnover and turnover intentions on Nigeria's public health and contemporary management of the issues by other countries. Additionally, I discuss causes and effects and indicate possible suitable solutions peculiar to the Nigerian health sector or brain drain countries.

Turnover Resolution Measures

Several measures could be implemented to resolve turnover and its associated turnover intention issues. The United Kingdom is a major beneficiary of the turnover scourge of developing countries (Cometto et al., 2013). According to the authors, bilateral agreements in the past between the United Kingdom (as a beneficiary of turnover) and the victimized developing source countries witnessed a historical decline. That agreement could be optimized by developing countries through improved supervision/engagement of parties to stabilize the decline.

Walton-Roberts et al. (2017) identified poor employee remuneration as a cause of skilled brain drain/migration. The author identified commensurate increase of salary and welfare package as an effective measure to reverse brain drain incidences. The adequacy of remuneration in developing countries should be competitive with the remunerations in the developed countries to bridge the brain drain (turnover) gap. The bilateral engagement of a developed nation by developing countries should address the issue of wage disparity as an adverse push policy that promotes the migration of the skilled workforce. That will help to minimize turnover and turnover intention of professionals who are inclined to exit their job positions.

Logically, it may be difficult or impossible to reverse a certain level of skilled manpower exit if the migrants' professions, businesses, or citizenship decisions are entrenched in their host countries. However, such migrants' entrenchment/settlement could be exploited for the gain of the developing nations. That phenomenon was described as *brain circulation* by Zagade and Desai (2017). According to Zagade and

Desai, brain circulation is the process of exploiting the talents of immigrants to avail to their native homelands personal and corporate skills, capital, and resources.

Practically, the Chinese state engaged its diaspora citizens through concurrent and short-term engagements (Nair & Webster, 2012). These engagements connect the migrants and their native countries in a process that promotes specific and tangible demonstration of expertise and contribution of resources to the benefit of the developing home country. In academics, brain circulation advantages have been operational in China, Singapore, India, Malaysia, and Thailand (Ortiga et al., 2018; Paul & Long, 2016). Similar collaborations and contracts with immigrants in host countries could be used by developing nations to enhance research and development that will translate into higher productivity and reversal of brain drain/turnover.

Turnover as Brain Drain or Migration

Human movements out of Africa predate 300,000 years ago when needs for food, warmth, climate change, and safety motivated human migration during the ice age (Beyer et al., 2021). That established human movement as an age-old involuntary activity. The terms *turnover*, *brain drain*, and *migration* describing regional human movements are similar, though with distinctive differences. The term *migration* is the voluntary emigration (movement) of persons from one country or region to another, and *brain drain* is the movement of skilled professionals from one country/sector to a better developed country or area (Goga, 2020). This definition accommodates two types of migration, namely, internal and international migrations. The internal migration of a person is tied to residence or administrative change in a region, country, or geographical area. A sectorial

change from health to agriculture within Nigeria could be described as an internal migration. It may involve a change of address from a residence in Lagos, Nigeria to another location in Calabar, Nigeria.

Conversely, international migration is the transition of a person to a new residence or administration across a country's national boundary. An employee's movement from Nigeria's health sector to Europe or the United States in another administration is an example of international migration. Logically, the administration of an employee's services must change between countries to establish an international migration that is different from an incidental transfer of staff.

Thus, human movement across a boundary or boundaries is a migration event. The phenomenon becomes brain drain if such human migration is skilled. Similarly, turnover is deliberate employee exit from an organization (Oruh et al., 2020) irrespective of the employees' migration exits or brain drain movements. Nevertheless, according to Oruh et al. (2020), the actions of an organization in employees' terminations, dismissals, and retirements, which occur without the respective employee's voluntary initiation, do not fit in the descriptions of turnover.

Migration involves the movement of persons across national borders irrespective of little or no skill, whereas brain drain focuses on the specialized content of the workforce or persons being made unavailable in the less developed country or region. These immigrants are being attracted by benefits bordering on needs for infrastructure, remuneration, security, governance, and socioeconomic conditions that are nonexistent or scarce in their home countries (Grenier, 2015; Jenkins, 2016). For instance, the Royal

Society of Britain in the 1960s first used the term *brain drain* to describe the movement of scientists from the United Kingdom to the United States and Canada for better remuneration or academic experience (Hunter, 2013). Since then, the high turnover trend regarding brain drain of skilled human resources or general immigration has continued to stir debates, with immense losses from the developing to the developed nations.

Turnover and Turnover Intention

Satardien et al. (2019) and Okonofua et al. (2018) defined *turnover* as an employee's voluntary exit. The definition applied the term to only voluntary departure from an organization. Kim et al. (2017) described it as an individual membership movement from one social system to another. This definition framed the meaning of a movement to another organization without accommodation for any service unemployment before resumption in another firm. Osibanjo et al. (2020) described turnover as a brain drain when an employee is gainfully employed abroad in a more developed country. The term *brain drain* presupposes that the brain resource is underutilized, is lost, or should be better employed in the country of departure.

Similarly, Oruh et al. (2020) stated that turnover is an employee's exit from an organization as initiated or consented. Thus, employee turnover is a voluntary cross-border exit determined over a specified period. The authors do not include planned dismissal or downsizing in the meaning of turnover. Of course, marginal departure of health practitioners may be helpful to an organization to stay within optimal size. Experts have observed an increasing trend of voluntary exit in Nigeria's health sector that causes social problems in unemployment, capacity underutilization, inadequate health care, and

instability because of the low doctor-patient ratio (Okonofua et al., 2018). Turnover becomes consequential when a mass departure of professionals occurs in a short period, as prevailing in the Nigerian health sector. Furthermore, the consequential turnover adversity in Nigeria is described as *japa* (pronounced as jakpa) or *japa syndrome*, especially when it is abroad. Japa is a Yoruba word that means to run away for good.

Hudgins (2016) referred to turnover intention as an anticipated turnover or a plan to leave a job position. This definition of turnover intention does not capture timing or the meaningful long-term plan for retirement or change of career. Turnover intention is a willful, conscious, reoccurring decision or process to leave a job soon (Ajayi & Olatunji, 2019; Memon et al., 2020). The intention reference centers on being a voluntary and reoccurring process or decision. The decision or process timing is short term and cannot be long term or indefinite, even when the intention activity is peculiar to the employee. Nevertheless, the employee exit intention may be held as a thought process or plan or expressed verbally or through body language.

The health industry's turnover and intention outcomes favor other industries in Nigeria and abroad (Osibanjo et al., 2020). Consequently, the exit trend and its intention precursor affect the quality and quantity of health delivery in Nigeria. This study determined the remote behaviors and perceptions of employees about the high turnover trend and the government employer's leadership effectiveness.

Turnover and Turnover Intention Perceptions and Impacts

The perception of turnover and turnover intention is a self-perception, which reflects how health sector events/conditions shape the employee’s or employer’s attitudes

and emotions. The phrase is used to capture the meanings, interpretations, and adjusted prevailing behaviors of professionals (government officials and health care employees) in the health sector's high trend of turnover and turnover intention phenomena. In other words, it is not only about a party's opinions or perceptions, but it includes the lived experiences or impacts of the studied phenomena. It is about parties' (employees' and employer's) experiences of a phenomenon and how they perceive and interpret such consciousness or lived experiences of a phenomenon.

Causes of Turnover and Turnover Intention

Bello et al. (2020) reported that the causes of turnover may originate internally from the organizational policies or externally from the policies of other organizations or countries. Furthermore, Bello et al. attributed turnover causes to intrinsic motivational factors including stress, work-life balance, and workload. Thus, policies and conditions that are internal and external to the organization or country exert influence to attract or repel employees from job position. Hence, an organisation should intentionally design policies and conditions to project adequate employee welfare packages that promote carrier progression, job satisfaction, and stability.

Comprehensively, experts have broadly categorized the causes of turnover and turnover intention into pull or push factors (Bello et al., 2020; Okafor & Chimereze, 2020; Rabiu-Akewusola & Umukoro, 2022; Roth et al., 2022). The push factors are perceived adverse conditions that trigger employee exit intention and turnover. The pull factors are attractive conditions that promote employee job satisfaction.

Push Factors

These push factors include poor remuneration, inadequate educational opportunities, job dissatisfaction, insecurity, hostile political environment, burnout through understaffing, and preferential/unequal treatments between professionals.

Poor Remuneration. The minimum wage for federal civil servants in Nigeria was increased from N18,000 (equivalent to US $22) to N30,000.00 (about US $38) in 2019 (Sasu, 2022). According to Sasu, civil servants' minimum wage has not been reviewed to match the increased individual monthly cost of living that was 43,2000 naira (US $54) as at last 2020 report. Similarly, Sasu (2023) indicated the average monthly family cost of living (the poverty line) at 137,6000 naira. That trend implied that public health workers and minimum wage earners in the Nigerian public service are poorly remunerated below the poverty line. That is not the case in developed countries where employees earn higher remunerations with minimum wage above the poverty line. Furthermore, based on purchasing power parity, the inadequate remunerated employees are part of the 91 million Nigerians that live below the poverty line of $1.90 (Ejike, 2022; Okagba, 2019; Sasu, 2022). The inadequate wages will make the push factors effective for workers to exit their jobs to better remunerated positions in other regions or abroad.

Gaiduk et.al (2009) reported that workers search for better welfare packages if they perceive inadequate rewards of their services by their employers. Hence, poor remuneration has the tendency to push the workers away from their employment positions. Yuen et al. (2013) found that immigrants in Malaysia exited their home country jobs because of inadequate opportunities for self-development and promotion.

Thus, adequate skilled development or education avails the opportunity for career progression. Similarly, public health workers in Nigeria suffer inadequate study leave, disrupted education calendar because of incessant annual strikes, delayed progress to consultancy level or zenith of career progression as prevalent in developed countries (Omonijo et al., 2015; Oruh et al., 2020). Thus, adverse conditions prevalent in the public health sector in Nigeria promote high turnover in the sector. Furthermore, the authors identified job dissatisfaction, insecurity, burnout, and adverse preferential treatments as the bane of labor stability in Nigeria.

Insecurity. Nigeria is rated as a highly terrorized country that faces the scourge of infectious disease outbreaks and insecurity menaces from Boko haram, Fulani herdsmen, and the Islamic State's West Africa Province (ISWAP) terror groups that pose security/safety dangers to all health workers (Hussain et al., 2021; Olumade et al., 2020). These insecurities and poor handling of disease outbreaks encourage triggers for the exit/migration of public health workers to developed or safer countries abroad.

Job Dissatisfaction. Job dissatisfaction is an adverse condition that drives the employees away from employment. Conversely, the pull factors are attractive conditions that promote employee job satisfaction. Comparatively, the developed countries have better opportunities, technologies, and remunerations that facilitate the pull of migrants from the developing countries. These superlative advantages are major causes of brain drain in Nigeria and developing countries (Bara & Sapkota, 2015). The migrant's destination points have favorable social, economic, and political environments for robust productive activities including job security, job availability, attractive remuneration,

career development opportunities, performance/professional recognition, sociopolitical stability, conducive work environment, self-development support, superlative social security, and adequate retirement benefits.

The security of life, property, movements, and job positions are desirable benefits to employees and job seekers. Retirement benefits are useful savings and benefits towards the end of a carrier or job cycle including pensions, giving a reward for voluntary early retirement, and usage of medical facility after retirement. The provision of these benefits prevents or minimizes exit intentions and turnover. Their absence or inadequacy promotes a push influence on employees to look elsewhere for career fulfillment.

Inadequate Educational Opportunities. Educational developments are opportunities for self-fulfillment of employees. Every profession requires continuous update of best practices. Experts have established that the search for career development and self-fulfillment is an overriding factor for migration to other regions and positions (Ramoo et al., 2017; Sonzogno et al., 2022). Every profession requires continuous update of best practices with modern tools and best practices. Practically, the update on medical practices is essential for Nigerian doctors, nurses, and health workers to perform optimally with modern equipment and processes. The provision of study leaves and state-of-the-art tools will promote job stability. If such opportunities are adequate, staffers acquire better skills and occupation that minimizes job exits or dissatisfaction. Thus, educational subsidies or full sponsorship of relevant self-development programs will enhance job stability in key positions.

Hostile Political Environment. Experts have reported that the lack of personal safety and sociopolitical stability drive away workers towards regions where their safety and political stability will be guaranteed or perceived as stable (Roth et al., 2022; Sonzogno et al., 2022). That means that employees are prone to migrate if sociopolitical conditions threaten the safety of staffers or if environmental conditions are not favorable as a push factor. Nigeria is witnessing frequent acts of insecurity from terrorists including Boko haram and Fulani herdsmen, and that will push health workers away from their job positions to developed countries where these dangers are mitigated or compensated for employees.

Burnout Through Understaffing. The direct consequence of understaffing in the public sector is burnout of the remaining inadequate staff. Reduced workforce predisposes workers to stress because of overload of work pressure. That stressful poor ratio of a public health worker to a patient promotes turnover and exit intention. Consequently, the vicious cycle pushes skilled workers out of the health sector.

Preferential/Unequal Treatments of Health Care Professionals. The Nigerian leaders/health sector managers are grappling with rivalry between doctors and other skilled health workers. The Nigerian health care policy permits dominance of medical doctors over other health professionals and their associations including nurses, pharmacists, physiotherapists, and radiographers (Alubo & Hunduh, 2017; Mohammed et al., 2022). These discriminated professionals are organized as Joint Health Sectors Unions (JOHESU) and conflict over equality disputes on allowances, salaries, and consultancy statuses. That implies that doctors' statuses, allowances, and salaries are

superior to that of JOHESU, and medical doctors lead the health sector in a discriminatory leadership process/qualification. Consequently, teamwork harmony and coordination will not be optimally efficient in a discriminatory practice. The prevalence of such unequal treatment and valuation predisposes the members of JOHESU to migrate to the developed countries for better recognition and fulfillment.

Pull Factors

Bara and Sapkota (2015) have stated that the developed countries have better remunerations, technologies, and opportunities that influence migrations from the developing countries. These pull factors include job security, job availability, attractive remuneration, career development opportunities, performance/professional recognition, sociopolitical stability, conducive work environment, self-development support, superlative social security, and adequate retirement benefits.

Job Security and Job Stability. Job security is the assurance of employment for a reasonable and foreseeable future. Conversely, job insecurity is the perception of imminent threat of the cessation of employment anytime soon (Mutambudzi et al., 2022). Mutambudzi et al. (2022) established that social safety nets (welfare programs) constitute a factor of job security and quality of life after retirement. Social safety nets (e.g., health insurance, working hours, educational grants, allowances, pensions, and retirement benefits) are better practiced by developed countries than the developing countries. According to Mutambudzi et al., employees in the UK enjoy better than their US counterparts in health/social welfare protection benefits beyond the employment life cycle. That means that there are varying benefits that apply after retirement that are not

based on any income-generation. Job security and job stability differ when focused on job position and the employee. The critical thought about the stability of a job is tied to the employee that is not planning to exit to increase the trend of turnover, brain drain, or migration. Better job security in developed countries facilitates job stability and acts as a pulling attraction on employees in the less developed areas to migrate to a preferred environment.

Attractive Remuneration. Better comparative remunerations in other sector/region engender a pulling attraction on the employees in less remunerated regions. Roth et al. (2022) reported that higher remuneration asserts employee recognition, valuation, and attraction of workers. For instance, nurses or doctors from developing countries that earn about twenty times less than their counterparts in the developed countries will perceive better professional valuation and appreciation as a pull to migrate to the developed country offering better remuneration/recognition.

Career Development Opportunities. Naturally, employees want to grow in their skills and profession and are attracted to the environments where growth opportunities are prevalent or enabled (Ramoo et al., 2017; Sonzogno et al., 2022). Thus, health care professionals will prefer to practice in an environment where there are opportunities for further education, skills, and career progression with modern equipment. These opportunities abound in developed countries and function as attraction points for health workers domiciled in developing countries where these opportunities are inadequate or nonexistent.

Performance/Professional Recognition. Mohammed et al. (2022) reported the prevalence of teamwork conflicts among public health professionals with poor managerial coordination of the services of medical doctors, nurses, pharmacists, radiographers, and physiotherapists. That implies that emerging roles of contributing professionals in patient care are not harmonized for proper recognition and acceptance by all stakeholders involved in patient services. That is worsened by government policy of preferential value/status treatment and rivalry created by the selective leadership dominance of medical doctors over all public health professionals. The government's leadership and welfare roles as an employer are poorly competing with the welfare/leadership roles of developing countries. Hence, workers are prone to migrate towards better health care recognition of workers and performance of the Western world.

Sociopolitical Stability. Roth et al. (2022) reported that the pull factors are conducive to job security and sociopolitical stability required to retain workers in their employments. That prevents or minimizes hostile elements, policies, and practices that forestalls the commencement of turnover/migration trend. Thus, employees' satisfaction is enhanced. Furthermore, employees focus on excelling on their career for better patient care that benefits all stakeholders. The absence of significant pull factors has predisposed public health workers to high turnover/migration trend.

Conducive Work Environment. Adequate standard welfare and workplace safety conditions have many advantages including minimized hazards, job stability, increased productivity, and labor-management harmony. Consequently, Bara and Sapkota

(2015) emphasized that lack of adequate pull factors in Nigeria is responsible for increased brain drain, migration, or high turnover trend.

Self-Development Support. According to Ramoo et al. and Sonzogno et al., career development and self-fulfillment is a factor of turnover/migration from developing to developed countries. It affords better usage of modern tools and best practices. Western countries have relevant educational programs that promote self-development and training of employees. These support programs and policies could help reverse the high turnover trend in the developing countries.

Superlative Social Security and Retirement Benefits. Welfare programs influence job security during and after retirement (Mutambudzi et al., 2022). That includes fair working hours, allowances, health insurance, educational grants, and pensions. Mutambudzi et al. reported that the UK and the US promote adequate health and social security benefits. These benefits are competitively poor in developing countries when compared with programs in the Western world. To promote job stability in the developing countries, policy makers and executives should acceptably improve best practices in social security to mitigate high turnover trend.

Leadership and Leadership Effectiveness in the Health Sector

Northouse (2016) defined leadership as influencing a person, persons, or groups to achieve a common goal or interest (Northouse, 2016, p. 6). That ability is expressed in the process of influence or symbolism involving the source of influence as the leader on the loyal receiver of influence as the follower. Thus, it is a process in which a person exerts influence (not force) on others to fulfill a joint objective more cohesively than

coherently. The central point here is the exertion of influence on a person or group. Northouse indicated that the ability may be innate (naturally endowed) or acquired. This viewpoint focuses on the natural residential traits of the leader over the follower.

Contextually, organizational leadership is the Management's prompt ability to engage, decide, and implement what is mutually acceptable to stakeholders (Reiche et al., 2017). This definition has introduced mutual agreement and outcome specificity to the notion of influence as a context of leadership in an organization. That is a situation where leadership influence promotes mutual goals fulfillment as the basis of effectiveness. Specifically, that context means the Nigerian public health sector leadership should achieve mutual public health goals between the employer and the employees to prove sectorial leadership effectiveness.

Northouse reported that experts described leadership as a style, ability, behavior, skill, responsibility, process, experience, characteristic, management function, the position of authority, or influence on a relationship. According to Northouse, the majority have noted that leadership is an influence-driven work process. Thus, there is difficulty among scholars to arrive at one definition or viewpoint in addition to debates about its effectiveness and differences in processes between leadership and management.

Comparatively, leadership is about the use of formal and informal influence without any form of mandatory force or payment for yielding to influence, while organizational management is the transactional application of formal directions and control of human, material, and other work-associated resources to achieve organizational goals (Reiche et al., 2017; Wajdi, 2017). Thus, employees mandatorily carry out a

manager's task/directive for remuneration and for fear of sanctions against nonperformance of tasks. However, under leadership influence, employees fulfill duties freely based on their relationship with the manager without fear of the mandatory consequences of failure.

There are effectiveness dimensions of leadership in domestic (within a country) and global leadership. Domestic leadership effectiveness refers to specific leadership outcomes and context, including the culture, leadership approach, or leadership style of a leader in his/her home state or domiciled country (Madanchian et al., 2017; Reiche et al., 2017). The targeted organizational outcome is agreed upon between leaders and followers. Global leadership refers to cross border work-related influences of a range of internal and external contexts involving national cultures with significant task and relationship complexities (Reiche et al., 2017). Global nature involves cross border contexts of culture and the nature of work. Osland et al. (2020) reported divergent views (cross cultural, comparative, expatriation, and global management focus) on global leadership effectiveness. The connecting reference summary to the divergence is the leader's ability to influence multiple cross-border task-related demands. In all dimensions, the implication of both leadership and management skills are necessary for effectiveness in managing people according to proper human values, motivation, environmental conditions, and optimal execution of work visions/strategy.

The Nigerian Economy and Its Health Care Industry

Nigeria is an independent democratic state that is naturally endowed with immense untapped commercial quantities of natural minerals, human resources, and a

large regional (African) economy that is rated second after South Africa (Imam & Akinyemi, 2015; Okunola et al., 2019). The possession of a sound brain economy and natural resources are sufficient to enrich citizens in Nigeria. However, it is rated poor despite its extraordinary endowments, including natural arable agricultural land, and ranking as the largest oil exporter in Africa (Suberu et al., 2015). The comparison of Nigeria's potential and fulfillment paints a sordid picture of maladministration that has negatively affected governance and public administration of all sectors, including the health sector. Moyosore (2015) reported that corruption compounds the economic hardship of Nigerians since an average person earns less than 1 US dollar per day. The health sector has lost skilled workers because of turnover, turnover intention, socioeconomic hardship, and government mismanagement.

The Nigerian health sector consists of public and private organizations but is controlled by government ministries regarding statutory requirements, supervision, and licensing. Individual persons/entities can own health centers in line with statutory requirements. These private establishments promote competitively higher service cost affordable to middle and higher-income earners. Hence, the members of the public throng the public health centers and create excess demand, which the inadequate public workforce fail to satisfy because of burnout and inadequacies in training, directions, policies, funding, and welfare supports (Adeloye et al., 2017). That implies that the Management of public hospitals/health centers owned by the state and federal governments is riddled with maladministration and neglect.

Public health workers' unions regularly embark on strikes (annually) to protest their neglect and other welfare issues including little or no payment of remunerations, inadequate service equipment/infrastructure, and poor working conditions (Omonijo et al., 2015; Oruh et al., 2020). These adverse conditions push health care professionals to seek jobs in other sectors or abroad, thereby viciously increasing the deplorable conditions that promote turnover and turnover intentions.

Experts have opined that the Nigerian public health system lacks adequate policy formulation, updates, safety, inclusive leadership, and consultations (Ogaboh et al., 2020; Omoleke & Taleat, 2017). These opinions reflect the workers' union demands and the basis of unresolved strike actions in which the government employer barely promises resolution before the following strike action. Paradoxically, the government denies any maladministration or labor shortage and encourages turnover trends to indicate excess resources despite empirical data supporting the shortage of public health workers (Atoyebi, 2019). The remote causes and reasons why each party insists on being right, in its opinion, to the health sector's detriment will be determined during this investigation.

The public health sector is bedeviled with systematic corruption. According to Onwujekwe et al. (2020) corruption shows up as bribery, absenteeism, and unofficial payment-related inducements for preferential attention in the sector. Absenteeism becomes painful when patients suffer or die because of the absence of practitioners, and patients suffer when corrupt officials administer substandard drugs and medical equipment.

Transparency International indicated that Nigeria ranked worse continuously, scoring 146 out of 198 in 2019, 149 out of 180 in 2020, and 154 out of 180 in 2021 (Transparency International, 2019; Transparency International, 2020; Transparency International, 2021). Akinola et al. (2022) reported that citizens have little or no trust in government and a high perception of systemic corruption. These alerts should influence the Nigerian public officials to reverse these negative perceptions, especially in the health sector, to stabilize the turnover trend. The veracity of these rankings promotes the negative perception of a more corrupt state, and the Nigerian leaders appear incapable or too overwhelmed to arrest or curb the menace.

All sectors in Nigeria (including the health sector) have defied applied remedies but have not practically considered the ethnic underpinnings of corruption (Arowolo, 2020). That suggests ethnic decentralization or governance restructuring to effectively handle ethnicity's natural content in Nigeria's public administration practice. Otherwise, the endemic corruption implication continues to compound the degenerated health care conditions and hasten a push of committed, honest practitioners towards leaving the sector for the western world, where ethnicity and corruption rankings are applied minimally.

The public health care policy supports out-of-pocket expenses from patients, which are unaffordable or expensive to most Nigerians based on the less than $1 earnings per person per day (Idoko, 2021; Oladigbolu et al., 2018). Thus, adequate health care access and delivery are hindered because of the poverty of most patients who cannot afford the high out-of-pocket expenses in public centers and the costlier bills of private

hospitals. This funding of public health institutions and the economic poverty condition compound the burden on citizens since the government is not sufficiently increasing funding to mitigate the poverty conditions of most citizens.

Public Health Administration in Nigeria

Experts have defined public health as an organized human effort to prevent disease, extend life span, and preserve human living benefits (Zweigenthal et al., 2022). The high points of this definition include disease prevention and cure, health maintenance, and life extension. The consequence of failure to prevent disease or promote standard health conditions for society is what makes it public health. Jain et al. (2022) emphasized that all infrastructure contributes to public health. That is in terms of connecting with human welfare for physical, social, or overall wellbeing. Thus, every public health activity or infrastructure aims to enhance the human benefits that make up public health.

Public health administration is in layers of meaning. In one part, it refers to the academic realm and curriculum content of public administration education. Another part refers to the practical delivery of scholar-practitioners within the industries. Furthermore, it refers to government efforts at managing, leading, organizing, staffing, budgeting, controlling, directing, planning, communicating, and coordinating work and policies of the government. The preceding is the focus of analysis, especially about how the government employer administers public health through its public health workforce. The definition covers administrative dimensions, including the discretionary acts of

Management, leadership, and administration of resources and policies in the health sector.

Public Health Administration and Policy in Nigeria

This section focuses on the concept of public health administration and how the leadership manages its public health services through the implementation of health policies and legal options. The structural forms of public health administration are stated for better understanding of health administration in the sector and the employer's role in policy reform, implementation, and leadership effectiveness. Coincidentally, the government functions as the employer and leader of all employees in the public health sector.

Public Health Administration

Experts stated that public health involves orderly human effort to avoid disease, maintain healthy living, and prolong life (Zweigenthal et al., 2022). The emphases are on disease prevention, cure, management, and extension of life. Every infrastructure improves public health (Jain et al., 2022). That is in terms of understanding that every infrastructural resource promotes human overall welfare physically, economically, and socially. Thus, public health activities or infrastructures enhance human benefits that make up public health.

The public (health) administration has references. It mainly refers to government efforts at managing, leading, organizing, staffing, budgeting, controlling, directing, planning, communicating, and coordinating work and policies of the government (Brownlow, 1956; De Graaf & Van der Wal, 2017). The references include the academic

realm and curriculum content of public administration education and the practical delivery of scholar-practitioners within the industries. The authors' definition covered the discretionary acts of Management, leadership, and administration of policies and resources in the health sector.

The preceding is the focus of analysis, especially about how the government employer administers public health through its public health workforce. The executive arms of government carry out the public health administration in Nigeria under the supervision of the federal and state ministers appointed by the Executives. Theoretically, Nigeria's health administration operates under a legal policy framework discussed below.

Nigeria's Health Policy

Nigeria's Federal Ministry of Health revised Nigeria's current national health policy in 2016 to address citizens' health concerns, including the need for a significant decrease in maternal mortality, the spread of human immunodeficiency virus, malaria, and under five mortalities. Other legal frameworks are designed to achieve universal health coverage (Adenipekun, 2022; Federal Ministry of Health, 2016). That revision reflected the universal health coverage and combined the need for effective governance, justice, and equity as a basis for easy health care access. Thus, the current Nigerian national health policy reflects the health strategy of the NEPAD–New Partnership for Africa's Development, NEEDS–New Economic Empowerment and Development Strategy, and the MDG–Millennium Developmental Goals. On paper, the national policy is laudable but utopian, substandard, and deficient in community input (Abubakar & Gobir, 2018). These current health policy services are carried out in private and public

facilities described as primary health care (PHC), secondary health care (SHC), and tertiary health care (THC) facilities in all federation states.

The PHC is the main emphasis of social, mental, and physical health care focused on the people rather than on disease. It involves services that are preventive and rehabilitative. The SHC is about specialized patient care on referral from the PHC. It includes general inpatients' and outpatients' services from community health services, general medicine, surgery, gynecology, obstetrics, and pediatrics. The THC consists of specialized services, including diagnostic laboratories, blood banks, physiotherapy, and rehabilitation. These specialized skills are delivered at teaching hospitals or highly equipped private facilities caring for specific diseases (e.g., orthopedic, neuropsychiatric, cardiovascular) and patients. The state and federal health ministries/agencies oversee all health care tiers established to rehabilitate (protect) patients and promote, prevent, and restore health.

Other Background Issues in Nigeria's Public Health Sector

The government's efforts of managing (controlling) the health care resources and institutions are ineffective and steeped in poor leadership, corruption, inadequate health care funding, insecurity, and high turnover (high personnel exit) (Olumade et al., 2020). A high proportion of the human resources are continuously drifting to other countries. These public health workers leaving their employment for jobs in another sector, or another country induce vicious problems for those remaining, including high turnover, brain drain, excess workload, and further decreases of the poor doctor to patient ratio. That turnover trend induces middle to upper income citizens to continue medical tourism

abroad (Orekoya & Oduyoye, 2018). In the vicious cycle, it is sequential for those that have not left their job positions to contemplate an exit to western countries for socioeconomic welfare/benefits.

The endemic corruption pervades all sectors, including the public health industry, and employees have emigrated for an advantage to care for their families (Moyosore, 2015). Human capacity development is low (Joshua et al., 2014) and compounded by coronavirus impacts. The unabated negative impacts of turnover are worsened by coronavirus incidence through direct restriction of trade links that connect Africa to Asia, Europe, and the US.

According to Welde et al. (2022), a quarter of the identified 2.1 million diaspora immigrants are Nigerians who indirectly promoted their state's gross domestic products (GDP). That was an indirect positive effect of a high turnover trend that promoted the economy. However, the tax benefits of the bulkier part of the diaspora earnings directly belong to the host countries, apart from the nonfinancial values and contributions of the immigrants missed by the home state. Additionally, Nwosa (2021) reported that the coronavirus disease (COVID-19) effects reduced diaspora remittances and foreign direct investments, which labor stability would have minimized. That coronavirus impact became an eye-opener that the benefit of the physical presence of the health professionals is more valuable in labor stability than the diaspora remittances which cannot buy the specialized diaspora skills.

The high turnover trend promotes depletion of health care practitioners/services in Nigeria and enhances health advantages in the western countries. The WHO indicated

that Africa shares 64% of total world health care shortages (Olutayo, 2017) and ranks 187 among 191 world health care systems (Abubakar et al., 2018). That indicated the gravity of skilled professionals' scarcity in the health sector. The WHO's low assessment was based on five conditions, namely, overall population health, health disparities, health care responsiveness, overall accessibility, and financial sponsorship. Experts corroborated the trending malaise in Nigeria and reported that Nigeria's unemployment rate of 33% is the second highest rate after Namibia on the global list of unemployment rates (National Bureau of Statistics, 2021; Olurounbi, 2021). The preceding figure indicated an upward scourge of 27% from the second quarter of 2020 and a marginal increase from 4.1% in the second quarter of 2022 to 4.2% in the 2023 second quarter period (National Bureau of Statistics, 2023). However, these progressions indicated undesirable unemployment conditions in addition to the high turnover trend.

Ogbu (2019) reported that the US accommodates more than two million Nigerians, 20,000 doctors, and 10,000 academics reluctant to return. That creates a shortage of health workers in Nigeria. The current turnover or turnover intention trend is alarming because over 80% of Nigeria's qualified medical doctors plan to work abroad for better welfare packages (Omeje, 2021). That indicates that most doctors do not wish to grow their careers in the Nigerian health sector.

Rubagumaya et al. (2016) reported that there are 17,000 immigrant practitioners from Africa that are licensed and practice under the US American Medical Association. That turnover/migration statistics indicate that high turnover pervades all of Africa and shows more impact on the health care services because of a similar mode of practice,

training, and curriculum between western countries and Nigeria. Nigerian doctors are inclined to complete online and offline courses, and practical training abroad (Imam & Akinyemi, 2015). That indicates that Nigerian medical doctors crave job positions and qualifications from abroad. Saudi Arabia, Emirates, and Oman source 80% of their skilled workforce from Nigeria (Omeje, 2021). These professionals migrate to developed countries without returning to continue practice except at retirement (if they wish to return) when their services are less needed. Immigrants became transformed with better living conditions and remunerations that are not accessible in Nigeria.

Omeje (2021) reported that the Medical and Dental Council of Nigeria (MDCN) accounts for about 72,000 registered doctors with a potential annual entry of 4,000, but over 50% of the registered doctors are practicing abroad. Thus, the opportunity to strengthen health service resources is limited and elusive. The remaining half remains inadequate to cater to Nigeria's growing population of about 200 million persons because current statistics indicate a ratio of 0.38 doctors per 1000 patients against the WHO recommendation of 1 doctor per 600 patients and SHW (skilled health worker) ratio of 4.45 per 1000 (Omeje, 2021; Oyadiran et al., 2020; WHO, 2016). The figure indicates that the availability of a doctor for patient consultation is rare and could be zero in some communities. Experts argue that the 0.38 doctors per thousand patients are average in towns and cities but not in rural areas where 22,000 persons compete to consult one doctor (Omeje, 2021). Based on that ratio, the need for a doctor will get worse if there is an epidemic, pandemic, or emergency in towns and rural areas. Despite the brain drain and turnover intention trend, standard medical infrastructure and labor stability have

eluded the health sector because the ruling class (government) has not sufficiently attended to it.

The debates on the increased migration of public health professionals (mostly doctors and nurses) have dominated the international health policy discussion since the 1990s (Adesina, 2022). Adesina (2022) monitored the migration and unemployment trend from 2013 to 2020 and reported that the unemployment rate and annual change respectively became worse from 3.70% unemployment rate, stable at -0.04% annual change to a high trend of 9.01% unemployment rate with 0.48% annual change propensity. The increase in unemployment trend corroborates increase in migration trend since 2013.

In absolute figures, the author reported that current nurses' migration from Nigeria is at an annual rate of 7000 from 2021 and depletes its current register of 125,000 nurses at about 6% rate. Thousands of other public health professionals are leaving the country in pursuit of better welfare bargains (Besenyő & Kármán, 2022). Though this study focused on doctors and nurses, it accommodated other public health professionals to study their lived experiences of turnover, exit intention, and leadership effectiveness in line with the research design.

The government committed to African Union 2001 Abuja Summit to annually execute health services/infrastructural spending at 15% or more of the total budget but failed every year by achieving about 4% of the total budget (Abang, 2019; Omeje, 2021). That buttresses the assertion that the ruling class does not show sufficient attention to building the health sector to reverse the negative consequences of high turnover and

intention trends. Nevertheless, the government believes it is at its best performance despite missing the benchmark targets.

Furthermore, the health sector is a victim of systemic corruption that is apparent in the country. Arewa (2019) opined that the corruption/plunder going on in Nigeria is worsening the state of the health sector and citizens' poverty, education, and nonmedical sectors. That makes the work of practitioners more challenging than it should be. The corruption of processes and insensitive leadership make human and material resources management difficult and induces intolerant employees to emigrate abroad (Moyosore, 2015). Thus, health care workers have exited the health sector and created challenging vacancies to fill. Consequently, the vicious cycle of the high turnover scourge continues to cause excessive health care emigration to other developed countries.

Summary and Conclusions

The summary of Chapter 2 center on the review of existing relevant data, theories, concepts, and themes that are essential to understand and interpret the dynamics of the phenomena required to fulfill the research design. Contextually, CSR is about the employer's responsibilities to its internal and external stakeholder that are described as: (a) legal–obeying laws and regulations, (b) philanthropic–giving back to society/community, and (c) economic–profit maximization, and (d) ethical–fair, just, and avoiding questionable practices anytime (Carroll, 1979; Jamali et al., 2008; Shafritz et al., 2016; Stewart et al., 2011). Shafritz et al. (2016) stated that these responsibility virtues drive legal, social, reputation, economic, and philanthropic attributes that connect with the employees, shareholders, consumers/patients, and the community stakeholders. As a

concept, the employer creates social problems that need remedies which the leaders/managers should resolve. The internal stakeholders refer to the employees and their needs of work safety, skills, education, and equity/equality.

Herzberg et al. (1959) MHT postulates that the best way to influence an employee to be productive is to prioritize his/her motivation intrinsically through his/her innate desires for achievement, recognition, creativity, and ownership. Thus, these innate influences override external attractions of salary or an outstanding physical gift. They further promote job satisfaction and task performance. The Herzberg extrinsic (called hygiene) factors are induced externally to reduce dissatisfaction. It does not motivate satisfaction. Consequently, the employer should match intrinsic and extrinsic options to positively influence employee experience, perceptions, satisfaction, and labor stability.

Similarly, PSM as an attraction and commitment to the public good will be helpful to explain parties' motivation experiences (Perry, 1996) to mitigate leadership effectiveness and employee satisfaction issues. The theoretical frameworks help to analyze and compare stakeholders' data within and outside Nigerian. In Chapter 3, l discuss the role of the researcher, research design/rationale, methodology, interview approach, the population and sample logic, plans for data collection, coding, data storage, protection, destruction, and analysis/procedures.

The background of the problem found in the literature review hinged on the theoretical and conceptual frameworks that could interpret the government's leadership effects on employees' turnover, exit intention, and the perception of leadership effectiveness. The Heidegger's phenomenology was identified as an excellent approach

to study, understand, and interpret lived experience data of participants for a credible method and report. The gap in the existing literature will be filled through this research design to understand collected information about impacts of studied phenomena on participants and the health sector.

Chapter 3: Research Method

This qualitative phenomenological study examined turnover impact on experiences and perceptions of the public health care employer and employees in Nigeria and probed the impact of leadership effectiveness on the high turnover trend. The study outcome may help in proposing a solution to mitigate high turnover and its precedent intention predicament. Chapter 3 indicates the study's methodology, research design, population and sample size, data collection and analysis, and plan for data storage, protection, and destruction.

Research Design and Rationale

I evaluated the qualitative approach options for this study and decided on Heidegger's phenomenological design (Heidegger, 1996). I applied this qualitative design and skillfully examined turnover, turnover intention, and leadership effectiveness observed in the lived experiences of the study population. A phenomenological study is best structured through a semistructured and open-ended interview guide (Seidman, 2019). As highlighted above, the nature of lived experience influenced respondents to express their thoughts, experiences, feelings, and historical accounts, which facilitated relevant interpretations and meanings of data. Patton (2020) emphasized the concentration of full attention on an interviewee's words. It helps the researcher to carry out in-depth interviews with minimal bias or within the disclosed assumptions in the study.

The research design availed answers to the questions bordering on the perceptions and lived experience impacts of turnover, turnover intentions, and government leadership

of its employees. Furthermore, it addressed the role of the employees' perceptions and impact of leadership effectiveness of the employer. I describe the key concepts and phenomena:

- The phenomena of interest included turnover (voluntary exit of position or sector), job satisfaction (willingness to stay in a position), turnover intention, and leadership effectiveness. Turnover intention refers to the search for alternative posts or misbehaviors against job commitment.
- The concepts explored included motivation/PSM, CSR, turnover, exit intentions, job satisfaction, and leadership effectiveness.
- The recurring patterns noted were turnover and signs of exit or job displeasure. The conflicting ideas were the notion by the government employer that the high turnover trend represents labor surplus and the view of employees that the ravaging turnover trend means destitute/ineffective leadership and poor working conditions.
- The topics for developing questions included turnover, exit intentions, job satisfaction, and leadership effectiveness.
- The keywords and phrases that formed the basis of my questions were *turnovers*, *exit intentions*, *job satisfaction*, and *leadership effectiveness*.

The need to access rich lived experience data in an in-depth interview warranted using Heidegger's phenomenological qualitative approach over a quantitative method. I applied Heidegger's phenomenological approach to facilitate rich in-depth information required to understand the trend of high turnover and exit intentions. According to

Heidegger (1996), knowledge is a revisionary process that synthesizes as perception, understanding, interpretation, experience, or decision. Hence, I have applied Heidegger's interpretive concepts to contextually understand the participants' experiences and perceptions of the studied phenomena within the Nigerian public health sector.

Gerring (2017) asserted that using numbers, statistical figures, and extensive sampling to explain a phenomenon befits a quantitative method and that a phenomenological approach is appropriate to unravel hidden knowledge about the studied phenomena. Thus, the preference of a qualitative design over a quantitative method is because of the focus on lived experiences of participants. Furthermore, Gerring supported a small data set sampling as befitting a qualitative study that uses words and easily understood language to make sensible observations. However, the adequacy of data collection of samples was determined through data saturation when information began to be repetitive in the collected data.

Role of the Researcher

Burkholder et al. (2016) stated that the role of a phenomenological researcher involves being skillful to gather and synthesize participants' perceptions and lived experiences of a phenomenon or phenomena. The essence of that skillful exercise centers on the avoidance of bias during data collection and analysis. As a researcher, I avoided asking leading questions and follow-up questions designed to influence the participant to say or imply what they did not want to communicate or express. I consciously avoided being personally reactive or judgmental of the participant's expression in addition to the commitment of confidentially keeping the participant's data. I intentionally noted my bias

without suspending them as stated in the assumptions through journaling in each data collection and analysis stage. Thus, I applied Heidegger's hermeneutics (revisionary thinking) concepts that upheld multiple lenses, dasein, revision, foresight/fore conception, hermeneutic cycle, and spiral analysis.

Birt et al. (2016) highlighted the use of member checking as a participant validation exercise that will enhance the credibility of a report when participants review their interview statements for any corrections prior to the researcher's scholarly analysis and usage. Thus, I carried out member checking of interview data/recordings to ensure the credibility of data for the analysis and report. I asked simple, unbiased questions that clearly related to the study. I consciously noted my personal subjective experiences and perceptions during the research process and focused on the participants' experiences with fore conceptions of the theoretical concepts (as multiple lenses) and my knowledge of the social problem in the industry. Thus, I noted my reflections, ideas, and personal beliefs as disclosed in the assumptions.

Methodology

Participant Selection Logic

The selection of participants for the sample population was restricted to any federal health center or teaching hospital in Southern Nigeria cities including Lagos, Enugu, Abakaliki, Ibadan, Benin, Abeokuta, and Port Harcourt. The designed interview population included a minimum of 15 participants, including five nurses, five doctors, one radiographer, one administrator/employer, one laboratory scientist, and two public health professionals. Rudestam and Newton (2015) reported that a small data set in a

phenomenological study could facilitate meaningful analysis and credible reports. This phenomenological study was focused on the lived experiences of public health care workers in Nigeria. Furthermore, Burkholder et al. (2016) established that a phenomenological study centered on adequate, in-depth data on participants' experiences/perceptions could occur with a sample size range of five to 15 participants. According to the authors, a phenomenological study does not require an extensive dataset to establish credibility, transferability, and dependability.

Moreover, saturation incidence is a guide to determine adequate sample size (Marshall & Rossman, 2016; Saumure & Given, 2008). During the data collection stage, I increased the sample size beyond the planned minimum of 15 participants to reach saturation within a professional group (e.g., doctors, nurses, medical laboratory scientists [MLSs], administrators, radiographers, and pharmacists) as sample saturation did not occur at a sample size of 15. Marshall and Rossman (2016) and Saumure and Given (2008) indicated that saturation has been established when further analysis does not lead to new information and all studied phenomena have been explained by previous samples.

Sample

Rudestam and Newton (2015) emphasized the need to identify a suitable sample selection by selecting sampling techniques that will answer the research questions. Logically, that matching requirement should further align with the study's purpose/objectives. I applied purposive and snowballing techniques in the study's sampling plan. The purposive sampling technique is subjective or selective and represents the most appropriate technique for a qualitative researcher to study a particular

population that is involved with the phenomena studied (Aparasu & Bentley, 2019). Hence, I used the purposive sampling technique because it was the most suitable technique for me as a qualitative researcher to hermeneutically focus on the phenomena of interest experienced by the specific public health population. Thus, the enumerated sample of health care professionals were in the center of the research problem and had lived experiences of the turnover, turnover intention, and leadership effectiveness impacts.

The enumerated population of participants included 13 doctors, 10 nurses, four radiographers, six laboratory scientists, two pharmacists, and four public administrators/employers. The techniques helped to ensure access to the richness in specific data on the studied phenomena. The snowball sampling technique is a nonprobability sampling technique whereby available participants recommend other similar participants for data capture/interview (Aparasu & Bentley, 2019). I solicited suitable recommendations for participants in Southern Nigeria from initial interview recruits. Thus, I applied the purposive and snowballing techniques to focus the sampling plan on the sampled public health care professionals in any federal medical center or hospital in Southern Nigeria cities in Abakaliki, Enugu, Ibadan, Port Harcourt, Benin, Abeokuta, and Lagos.

However, I strictly followed the planned sampling of a minimum of 15 participants whose qualification criteria for participation included (a) current observed engagement identity as an employee (or an employer/administrator) who is directly involved/working in the Southern part of Nigeria's public health establishments; (b) 2

years minimum working experience in the public health sector; and (c) skilled qualification as a doctor, nurse, medical laboratory scientist, radiographer, administrator, or professional in Nigeria's public health sector. Any unqualified intending participant was excluded from the sampling plan. The recruited qualified professionals contributed rich texts required in the study from their lived experiences and knowledge of leadership effectiveness, high turnover impact, and exit intention phenomena.

Instrumentation (Data Collection Tools)

Experts have stated methodological guidance on fulfilling interview and the research questions through subsidiary probing of the interview questions in a phenomenological approach (Fagerlund et al., 2019; Laureate Education, 2017). Thus, the research questions formed the main themes, which the investigative subquestions that I asked the participants fulfilled. Furthermore, a researcher should be a neutral agent asking exact, open-ended, one-at-time questions (Lindig et al., 2020; Turner, 2010). I was intentional in asking exact, open-ended questions during the face-to-face interview sessions. These learning resources facilitated my research skills' fulfillment of Heidegger's approach in the selection of a data collection instrument for the interviewee.

Patton (2015) stated that a model's essence as a method is its feasibility and not replication. That applies to methods of interview that could be employed in credible participant consent and data capture. Experts reported the use of the email interviewing model alone or with other qualitative approaches (e.g., telephone and face-to-face) during participants' informed consent and data capture (Meho, 2006; Rubin & Rubin, 2012; Webber-Ritchey et al., 2021). The approach is phenomenological and suitable for

Heidegger's hermeneutical cycle analysis of participants' lived experiences and descriptions of events, situations, and personal involvement in the subject matter. Therefore, the data collection instruments and authorizations (as shown in Appendices A, B, C, D, E) were adopted based on the learning resources and the research questions. As indicated, the written interview questions for all participants (Appendix A) were classified into Appendix B for an employee participant and Appendix C for an employer participant.

Using a qualitative phenomenological design, I fulfilled the data collection process through a phenomenological qualitative interview. The design questions (Appendix A) set the stage for collecting interview data and studying the phenomena through Heidegger's phenomenological interview approach. I applied a semistructured and open-ended face-to-face interview approach/instrument and accessed data from 39 participants (13 doctors, 10 nurses, six medical laboratory scientists, four radiographers, two pharmacists, and four administrators/employers) in federal public hospitals/medical centers located in Southern Nigeria.

Procedures for Recruitment, Participation, and Data Collection

I followed the steps itemized below:

1. *Population sites identification*. The research sites used for the collection of data were hospitals/medical centers in Southern Nigeria, including Federal Medical Center, Ebute-Metta, Lagos, National Orthopedic Hospital, Yaba, Lagos, and Federal Neuropsychiatric Hospital, Yaba, Lagos.

2. *Participant identification and recruitment.* This was carried out to satisfy inclusion and exclusion criteria. I carried out the identification process by checking on hospital and work relationships of a prospective participant before recruitment. The coronavirus safety preferences were given to every participant to choose a face-to-face personal interview on the site or virtual personal interview through Zoom, Skype, Duo, WhatsApp, Snapchat, or voice calls.
3. *Participant submission of signed consent forms*. I executed the consent forms before commencement of the interview. The consent forms addressed confidentiality and anonymity issues to protect participants from loss of privacy, psychological distress, economic loss, and loss of professional reputation.
4. *Interview appointment.* This involved fixing a meeting date and choosing whether the interview would be virtual or physically conducted face to face.
5. *The interview event.* This involved conducting the interview as planned with the participant through recorded online/virtual or offline/physical media. I executed one successful interview with each respondent/participant. The voice interview data were audio recorded and stored for analysis.
6. *Recorded data transcription*. The recorded interview questions and responses were transcribed using Microsoft Office's transcription tool and manual transcription/editing to ensure correct audio transcription.

7. *Member checking*. This involved participants' verification or clarification of the audio-recorded data and transcript match for accuracy to avoid bias and to promote trustworthiness. The respective participants were given 7 days to verify and clarify that the words in the transcript exactly matched the recorded data before the commencement of analysis.

The interview recruitment flyers used in the online and offline recruitments were as shown on Appendix D. The interview criteria were included or attached to the online and offline recruitment methods. I respectively interviewed the participants physically one after the other using face-to-face interview sessions. Each interviewee was given the audio-recorded interview data and the audio transcript to clarify and verify the audio and transcript data within 7 days before I used the collected data for analysis and reporting. I completed basic doctoral courses for conducting basic, health, and general research programs, as shown on Appendix E. I obtained Institutional Review Board (IRB) approvals from Walden University's IRB and Nigerian local authorities' IRBs prior to the data collection process, with IRB approval numbers (a) 05-30-23-0625086 from Walden University; (b) 22-075 from the Nigerian Institute of Medical Research; (c) 48-23 from National Orthopedic Hospital; (d) 23-21 from Federal Medical Centre, Ebute-Metta; and (d) 2023-001-07-097 from Federal Neuropsychiatric Hospital, Yaba. Participants were recruited through online and offline flyers, phoning, emailing, social media targeting, and physical contacts at the sampling centers/hospitals.

The recorded data were transcribed, organized, and synthesized manually and through NVivo qualitative data analysis software. As in the learning resources, the

member checking process preceded data coding, which included recognizing, labeling, and tagging data for further analysis through descriptions, concepts, and themes (Babbie, 2017; Ravitch & Carl, 2016; Rubin & Rubin, 2012). The process was designed to change as more data emerged deductively or inductively for the final analysis and report. Saldana (2021) encouraged multiple recoding/coding to answer the research approach and design purpose. That process helped maximize the applied approach that focused on the essence of Heidegger's revisionary process of hermeneutic cycle interpretation. I applied open and axial coding of the interview data with notes in the preliminary steps. Open coding identified critical concepts within the interview texts, and axial coding pointed to the central code related to other codes. Thus, I coded the interview texts and notes based on answers to the interview questions, phrasal descriptions, and concepts related to the studied phenomena. The interview line texts and Excel coding were collated for analysis and report.

The participant's consent was procured for storage, protection, and destruction of the applicable interview data to protect participants from any misuse of participants' data. A participant's permission for guided usage was documented. Thus, participants voluntarily signed and executed the informed consent agreement forms prior to commencement of data collection.

Data Analysis Plan

This stage captured my analytical skill as a scholar who can report research findings accurately for credibility and dependability. Creswell and Creswell (2018) recommended the manual or automatic inclusion and transcription of all field notes.

Manual methods were laborious, affordable, and facilitated a rich essence of the Heidegger's phenomenology or hermeneutic cycle.

Comparatively, the NVivo computer software simplified procedures though at a high price. However, quality inclusion, organization, and transcription were achieved with my dexterity and judgment. My judgment (as a researcher) is crucial in focusing pertinent thoughts (dwelling) on the data to transcribe and code the participants' data for interpretation/meaning in the analysis process. I used NVivo computerized software and the manual coding in a complimentary manner. The NVivo software was better in prompt sorting, coding, and thematic transposition of raw recorded/transcribed data while the manual method was good for meaning assignment in the Heidegger's revisionary process (Heidegger, 1996) and hermeneutic cycle interpretation. The manual method was useful in deciding resolution for discrepant cases and specific data connection to research questions.

Kiger and Varpio (2020) stated that the concept of thematic analysis involves searching the dataset to identify, analyze, and report the most frequent patterns as themes. Thus, themes and patterns helped gain insights in understanding the direction of the participants' experiences. In this phenomenological study, thematic analyses were suitable during coding and analysis to make meanings of data through sorting of common themes and their linkages to a category. Thus, Kiger and Varpio (2020) noted six steps in the thematic coding process as follows: (1) data familiarization, (2) generation of initial/first codes, (3) theme search, (4) theme review, (5) naming and definition of themes, and (6) reporting. The authors commented on the process steps, that data

familiarization require knowledge acquaintance with the content and nature of the transcribed data before proceeding to the second step of generating first perceived codes, and to subsequent successive steps towards reporting. As highlighted in the sections above, the manual coding was combined with NVivo computerized software to maximize prompt organization and the rich essence of lived experience understanding in Heidegger's revisionary cycle.

I hermeneutically carried out the exercise of interpretations to avoid prejudice and I sequentially filed and saved the collected data in online and offline storage media including memory discs and cloud storage. Seidman (2019) encourages inductive reduction or summary collation of data codes/ideas in a qualitative method rather than deductive derivation of the codes/themes. Seidman (2019) referred to skillful use of specific observations and patterns in a sample to develop a new conclusion or theory in the inductive process. Thus, I observed the data themes and patterns and gained insights for clear dependable conclusions in the research analysis and report.

Issues of Trustworthiness

Burkholder et al. (2016) reported that researcher subjectivity is allowed in a qualitative study through a process that is verifiable for analyses and conclusions. The focus is on the verifiable processes which form issues of trustworthiness for the veracity of a report. Trustworthiness criteria include credibility, dependability, transferability, and confirmability (Butcher, 2022; Lincoln & Guba, 1985). Thus, according to Lincoln and Guba, Burkholder et al., and Butcher, trustworthiness is the criteria for a verifiable

process of data collection, analysis, conclusion, and report. I discuss these trustworthiness criteria and how I fulfilled them below.

Credibility in qualitative research is the equivalent of internal validity in quantitative studies that requires the collected data content and research questions to match design objectives (Burkholder et al., 2016). In the data collection plan, I included strategies of saturation, reflexivity, member checking, prolonged contact with participants and triangulation. Thus, in line with the learning resources (Marshall & Rossman, 2016; Rudestam & Newton, 2015; Saumure & Given, 2008), I detected the adequacy of sample size and concluded it to be acceptable when repetitive information in the collected data were observed during and after the 15th participant's data and within the professional groups of doctors, nurses, administrators, pharmacists, radiographers, and medical laboratory scientists (MLS). I fulfilled credibility through close participants' engagement and member checking of transcripts. Furthermore, I used multiple theoretical perspectives as guided in Heidegger's revisionary process (Heidegger, 1996) as a procedure for examining conclusions and forming triangulation of vantage points, reflexivity, and member checks.

Transferability is a qualitative term corresponding to external validity in quantitative research, which is a generalization level of report about a research population (Burkholder et al., 2016). Though generalization is not the focus of a qualitative study, it suffices to make meaningful descriptions for reasonable application of transferability in equivalent populations. I deployed semi and open interview structure to facilitate rich lived experience or thick descriptions of the research setting, phenomena, interviews,

field notes, documents, and participants' quotes. The study assumptions add to the thick descriptions to enable readers suitably apply the study findings.

Dependability is a qualitative term equivalent to reliability in a quantitative study and centers its meaning on the consistency of getting the same result from the same data collection instruments (Burkholder et al., 2016). I used audit trail and triangulation incidence to achieve dependability in the study by keeping reflective field notes, memos, and journals to guide on dependability in the usage of data collection instruments.

Confirmability is a qualitative term describing an aspect of trustworthiness whereby instruments used in a detailed research process is available for independent experts' analysis and confirmation (Burkholder et al., 2016). That expert confirmation center on instruments including procedures, field notes, reflective journals, and available memos. I took notes during and after the data collection process prior to analysis. I applied Heidegger's hermeneutics in the revisionary confirmations of participants' data and gained better insights of participants' responses. I noted the body language signs and sounds with insightful meanings of participants' perceptions and lived experiences. I asked repetitive interview questions that involved body language/signs for a participant's voluntary response or clarifications.

Ethical Procedures

The IRB process for approval by Walden's Ethics Committee commenced and was consummated with an approval number 05-30-23-0625086 after fulfilling the IRB requirements for approval. This study stipulated that a participant's consent form be executed before data collection. The participants were free to withdraw their voluntary

participation in the study at any point in time. The interviews were reported anonymously, and a code/number was matched to each participant for confidentiality.

Confidentiality Conditions

The rule of confidentiality was respected and followed in data collection. A participant has the right to a confidential identity during and after the data collection process. The participant's right was protected by dating and anonymously coding the audio recordings. Data were backed up in Microsoft's One Drive cloud storage and Dropbox cloud storage facilities. Creswell and Creswell (2018) stated that the storage of analyzed respondents' data may be held for a reasonable period. Consequently, participants' data may be stored and destroyed after 5 years to forestall inappropriate usage and usage without respondent's consent. All participants were informed that future usage or sharing of a participant's dataset with another researcher in the future will not involve another round of obtaining informed consent because the dataset will contain no identifiers. That information and related participant's rights are included in the consent forms that was signed by every participant in the study.

Summary

In Chapter 3, I stated the plans and fulfillment for this study methodology. Heidegger's phenomenological design approach is suitable for collecting and analyzing the participants' lived experience data. Thus, I applied purposive and snowball sampling techniques to recruit health care practitioners to a saturation point for a meaningful and credible sample size. I carried out member checking process by allowing the interviewed participants to review and validate the correctness of the collected data to ensure the

credibility of the data analyzed for reporting. The analyzed data were safely stored before its detraction (in 5 years) to protect participants' confidentiality.

In summary, I described the fulfilled research design methodology, including the explored key concepts and phenomena, sample size, population characteristics, data collection method/plans, data analysis procedure, recruitment, researcher role, trustworthiness issues, ethical/confidentiality considerations, type of data storage plan, protection, and destruction. In Chapter 4, I discuss the study results, participants' demographics, data collection, analysis, and trustworthiness issues.

Chapter 4: Results

Introduction

The purpose of this study was to explore and understand the lived experiences, perceptions, and leadership effectiveness impacts on the employer and the employees within the Nigerian federal public health care system. The impacts of turnover and how it related with the employer leadership effectiveness perception of the employees needed proper understanding to fathom ways of mitigating the turnover problems and resolving the leadership effectiveness issues. I focused on participants' lived experiences and perceptions to understand how leadership effectiveness perceptions influenced the impacts of turnover and turnover intention of employees. The following questions were answered:

1. What are the perceptions and lived experiences of the professional employer and the Nigerian public health employees about the effects of government leadership on turnover and turnover intentions in the sector?
2. What are the impacts of the employees' perceptions and consequent actions on the employer's leadership effectiveness?

The organization of this chapter includes a descriptive explanation of the data collection process, the analysis, and the study's trustworthiness. The second part of this chapter states the data organization, while in the third part, the discussion centers on emergent theme formation and coding. The fourth section of Chapter 4 provides details of the trustworthiness incorporated in the study and a summary of the chapter.

Research Setting

Initially, there were delays in getting participants from the hospitals' authorities visited for data collection because the authorities took time to satisfy their internal processes and checks before granting access to collect data. I obtained signed informed consent from each participant prior to carrying out the interviews as a voluntary face-to-face personal interview. Participants gave dates and times that were convenient to them in the face-to-face interview. The interview data collection commenced on August 4, 2023, at National Orthopedic Hospital, Igbobi, and ended on August 31, 2023, at Federal Medical Centre, Ebuta-Metta, Lagos State, Nigeria. The participants' data from Federal Neuropsychiatric Hospital were collected within the same period of August 2023.

During the commencement of an interview session, I explained the purpose of the study, the participant's protections, and the content of the signed informed consent form detailed in the consent form for an employee and the consent form for an employer. I answered all questions asked by a participant prior to and during the interview session. The clarifications were carried out to guarantee a participant's protection, understanding and voluntariness in the interview sessions.

The interview session durations with participants ranged from 11–72.08 minutes, with an average duration of 35.08 minutes and few outliers beyond the planned 45 minutes because of extended answers from such participants. I stored the interview process data on my computer and remotely in Microsoft's One Drive and Dropbox cloud services, including participants' audio recordings, transcripts, and scanned consent form copies. I noted the date and time of the interview sessions and linked an identity code to

every participant for the protection of participants' privacy, identity, and academic/analytical reference purposes. After every interview session, I sent the audio record and its transcript to the participant for member checking validation and feedback. The validation process was a credibility approach designed to achieve correct transcription of words and signs emanating from the interview audio data. The interview data analyses commenced after checking feedback from participants.

Participants' Demographics

I used the purposive and snowballing sampling techniques to optimize the fulfillment of the research design, including answering the research questions. The purposive method is a subjective technique designed to focus on a traceable, observable, and peculiar population involved with the phenomena being studied (Aparasu & Bentley, 2019; Bakkalbasioglu, 2020). Those specific population characteristics of the federal public health workers matched the research design required to directly give answers to the research questions while fulfilling the study purpose and objectives.

In Aparasu and Bentley (2019), the snowball sampling method is a nonprobable approach to sampling whereby a participant may recommend another similar participant for data collection. The difficulty in promptly getting an adequate number of participants to satisfy expected saturation conditions in the sampling was mitigated through snowball sampling measures. In interview fulfillment planning, snowball sampling mitigates adverse consequences of disappointments from the purposively scheduled interview sessions (Audemard, 2020). Thus, eight participants purposively recruited and

interviewed recommended other participants who had similar population characteristics. That helped mitigate the interview schedule disappointments.

The study centered on the population with high-level manpower and 2 years minimum experience. The selected population participants were proficient in expressing/communicating their lived experiences and perceptions. The focus on these skilled and experienced population characteristics helped to answer the research questions and resolved the research problem.

Specifically, when approval was received from the hospital authorities, I interviewed six professional groups, including 13 doctors, four radiographers, 10 nurses, two pharmacists, six laboratory scientists, and four federal public hospital administrators. The approval process included disclosures of informed consent content, inclusion criteria, and the recruitment flyer in Appendix D. Demographically, the inclusion criteria were fulfilled before recruitment through physical observation of work identity conditions in the hospital's beats for the participants and through the local authority IRB guidance. The learning resources recommended a range of five to 15 participants in a phenomenological study (Burkholder et al., 2016), which may be increased to achieve saturation as a guide for sample size adequacy (Marshall & Rossman, 2016; Saumure & Given, 2008). Hence, the sample size was increased to achieve saturation in all the six professional groups reflected in the participants' demographics in Table 1. As indicated, Table 1 shows participants' identity code, gender, hospital/medical center, professional group/specialty, job experience, and interview duration.

Table 1

Participants' Demographic Summary

Participant's identity	Gender	Hospital/medical center	Professional group/specialty	Job experience	Interview duration (minutes)
PD0001	Male	National Orthopedic Hospital Igbobi, Lagos	Administrator	> 2	10.03
PD0002	Female	National Orthopedic Hospital Igbobi, Lagos	Medical laboratory scientist	> 2	35.21
PD0003	Female	National Orthopedic Hospital Igbobi, Lagos	Medical laboratory scientist	> 2	15.34
PD0004	Male	National Orthopedic Hospital Igbobi, Lagos	Medical laboratory scientist	> 2	46.33
PD0005	Female	Federal Medical Center, Ebute-Metta	Registered nurse	18	29.38
PD0006	Female	Federal Medical Center, Ebute-Metta	Registered nurse	> 2	22.36
PD0007	Male	Federal Medical Center, Ebute-Metta	Registered nurse	18	17.53
PD0008	Female	Federal Medical Center, Ebute-Metta	Registered nurse	> 2	20.14
PD0009	Female	Federal Medical Center, Ebute-Metta	Registered nurse	18	31.31
PD0010	Male	National Orthopedic Hospital Igbobi, Lagos	Radiographer	30	10.53
PD0011	Male	National Orthopedic Hospital Igbobi, Lagos	Radiographer	> 2	33.43
PD0012	Male	National Orthopedic Hospital Igbobi, Lagos	Doctor	12	37.42
PD0013	Female	National Orthopedic Hospital Igbobi, Lagos	Registered nurse	16	18.10
PD0014	Female	National Orthopedic Hospital Igbobi, Lagos	Registered nurse	17	32.52
PD0015	Female	National Orthopedic Hospital Igbobi, Lagos	Registered nurse	18	31.52
PD0016	Female	National Orthopedic Hospital Igbobi, Lagos	Registered nurse	> 2	29.22
PD0017	Female	National Orthopedic Hospital Igbobi, Lagos	Registered nurse	9	47.46
PD0018	Male	National Orthopedic Hospital Igbobi, Lagos	Doctor	3	60.31
PD0019	Male	Federal Medical Center, Ebute-Metta	Medical laboratory scientist	13	23.39
PD0020	Female	Federal Medical Center, Ebute-Metta	Medical laboratory scientist	18	38.49
PD0021	Female	Federal Medical Center, Ebute-Metta	Medical laboratory scientist	18	40.03
PD0022	Male	Federal Medical Center, Ebute-Metta	Radiographer	15	72.08
PD0023	Male	Federal Medical Center, Ebute-Metta	Radiographer	35	30.06
PD0024	Male	National Orthopedic Hospital Igbobi, Lagos	Doctor	5	72.00
PD0025	Male	Federal Medical Center, Ebute-Metta	Doctor	12	40.04
PD0026	Male	Federal Neuropsychiatric Hospital, Yaba	Administrator	31	51.48
PD0027	Male	Federal Neuropsychiatric Hospital, Yaba	Doctor	8	27.20
PD0028	Female	Federal Neuropsychiatric Hospital, Yaba	Administrator	23	22.14
PD0029	Male	National Orthopedic Hospital Igbobi, Lagos	Doctor	> 4	50.12
PD0030	Female	Federal Neuropsychiatric Hospital, Yaba	Doctor	12	37.34
PD0031	Male	Federal Neuropsychiatric Hospital, Yaba	Administrator	> 2	9.26
PD0032	Female	Federal Neuropsychiatric Hospital, Yaba	Doctor	4	43.23
PD0033	Male	Federal Neuropsychiatric Hospital, Yaba	Doctor	35	45.52
PD0034	Male	Federal Neuropsychiatric Hospital, Yaba	Doctor	> 2	33.59
PD0035	Male	Federal Neuropsychiatric Hospital, Yaba	Pharmacist	> 2	50.19
PD0036	Female	Federal Neuropsychiatric Hospital, Yaba		10	23.57
PD0037	Male	Federal Neuropsychiatric Hospital, Yaba		23	49.39
PD0038	Female	Federal Medical Center, Ebute-Metta		> 2	30.30
PD0039	Female	Federal Medical Center, Ebute-Metta		> 2	50.56
		Total Interview Time			1,368.12
		Average Interview Time			35.08

The distribution of the professional groups interviewed and their aggregate gender representation are shown in Table 2 and include health administrators, medical doctors, nurses, medical laboratory scientists, radiographers, and pharmacists. The focus of this study was the lived experience and perceptions of the professional group members and

not gender issues, which does not alter the positions and relationships between parties (employer and employees).

Table 2

Distribution of the Professional Groups

Professional groups:	Administrator/employer	Doctors	Nurses	Medical laboratory scientists	Radiographers	Pharmacists	Males	Females	Total
Number of participants	4	13	10	6	4	2	20	19	
Total									39

Selection of Participants

Thirty-nine participants were selected and interviewed to achieve saturation for the study using the purposive and snowball sampling techniques. The inclusion criteria that I used included the following:

- Observed job engagement identity of the participant in the federal hospital/medical center located in Southern Nigeria
- A minimum of 2 years job experience
- Observed skilled practice as a doctor, medical laboratory scientist, nurse, administrator, radiographer, or a federal health care professional. The vulnerable persons who met the inclusion criteria and were willing to participate were given equal opportunity to participate and be protected within a minimal risk.

Interview of Participants

The participants chose to complete a face-to-face personal interview at a time convenient to their schedule within the hospital setting. As shown in Table 1, the interview sessions ranged from 10 minutes to 90 minutes, with an average interview time of 35.08 minutes. I developed a combination of 14 semistructured and open-ended questions designed for a deep probe into the perceptions and lived experiences of participants. The participants freely responded to questions and profoundly expressed themselves. According to Seidman (2019), the guide for phenomenological research should be semistructured and open ended to promote a rich expression of the participant's thoughts, feelings, and historical memories that enhances relevant data interpretations and meanings.

Furthermore, Patton (2020) highlighted the need to focus full attention on words used by the participant during the interview session. Thus, I asked semistructured and open-ended questions while concentrating on participants' words and body language. I probed a participant's answers and body language to get a better instant understanding of the participant's answers. The questions that I asked were neither leading nor designed to manipulate the participant. I took notes on the participant's body language expressions and its role in the responses to questions.

Data Organization

I stored participants' data in a secured personal computer, Microsoft's OneDrive facility, and Dropbox cloud environments to mitigate any imminent loss impact and data vulnerability to unauthorized usage from my end. The extent of data protection involved

a two-step security layer that included a password and authenticator requirements for access. Authenticators require different conditions, including passwords, code generations to a preregistered phone number, and code generations to a preregistered email or device. The interview session audios and transcripts bear individually assigned labels/codes to achieve better filing system, access, and masked protection of participants' identity during data processing and reporting. The transcripts were checked by the participants prior to data analysis/reporting to strengthen data validity and credibility.

Data Collection

The Walden University IRB approved the data collection; the IRB approval number is 05-30-23-0625086. The local authorities gave approvals for data collection as described below:

- The Nigerian Institute of Medical Research approval number is 22-075 and covers data collection interests within Nigeria.
- The National Orthopedic Hospital approval is 48-23, covering data collections in its hospital units and locations.
- The Federal Medical Centre, Ebute-Metta gave approval for data collection with approval number 23-21, restricted to its hospital units.
- The Federal Neuropsychiatric Hospital, Yaba's approval number is 2023-001-07-097 and covers all its hospital units and locations.

I carried out online and offline recruitment of participants through physical contacts at the hospitals/medical centers, by email, by phone, and by using the interview

recruitment flyer (Appendix D). The collection of participants' data took about 4 weeks and ended on August 31, 2023. During the period, participants' data were collected in hospitals/medical center sites at the National Orthopedic Hospital, Igbobi; Federal Medical Center, Ebuta-Metta; and Federal Neuropsychiatric Hospital, Yaba, Lagos State, Nigeria.

I selected 39 participants through purposive and snowballing sampling techniques. The participants were contacted physically at the hospitals. Every participant was assured of the contents of the signed informed consent form prior to the commencement of every interview session. At the interview session commencement, the participants were given further opportunities to ask questions about the research, and all questions asked were answered in line with the participants' protection in the informed consent agreement. Participants expressed themselves freely in English with few local words and Nigerian Pidgin English, which were noted in the verbatim transcription of the interview audio.

Data Collection Steps

The data collection steps are stated below:

1. *Sites identification*. The sampling sites I used for collection of data were (a) the Federal Medical Center, Ebute-Metta; (b) the National Orthopedic Hospital, Yaba; and (c) the Federal Neuropsychiatric Hospital, Yaba, Lagos.
2. *Identification and recruitment of interviewees.* I confirmed a valid work relationship of a prospective participant in a federal hospital site before recruitment to satisfy inclusion conditions. Every participant had options to

choose a virtual interview (e.g., Zoom, Duo, Skype, WhatsApp, voice calls, and Snapchat) or a face-to-face personal interview at the hospital site. The options factored preferences because of coronavirus disease safety measures. A negative work relationship status in a chosen hospital site satisfied the exclusion requirement for such applicants.

3. *Submission of the signed consent form by the prospective recruit*. The consent forms were executed prior to the commencement of an interview session. The participant's protection was addressed in the signed consent forms, including matters of confidentiality, anonymity, psychological distress, reputation, privacy, and economic loss.
4. *Scheduling of an interview session*. That involved factoring in the participant's convenience. The date and time were fixed to conduct a face-to-face personal interview.
5. *The interview appointment*. This was the planned interview schedule. I carried out one successful interview session with each participant. The interview session was audio recorded and securely stored for analysis.
6. *Transcription of the audio record*. The interview audio of every participant was transcribed using Microsoft's office transcription tool. Manual transcription/editing was applied to ensure proper verbatim transcription.
7. *Members' checks*. I sent the audio and its transcript to the participant for verification or clarification of the data for accuracy. That helped to avoid bias and promoted trustworthiness. The participants were given 7 days to verify

and clarify the data as an exact representation of the interview event before I commenced analyses/reporting.

Data Analysis

Kiger and Varpio (2020) stated that frequent patterns in participants' responses should be considered as themes in thematic analysis. According to Kiger and Varpio (2020), thematic analysis is a qualitative method that identified patterns in the dataset for meaningful analysis. I familiarized with the data and generated first codes that helped to form themes for analyses. Thus, I used thematic analysis to summarily describe the data and link the data by common themes. The themes fit into different categories. The thematic coding process and analysis involved six steps:

1. *Data familiarization*. In this step, I broadly searched, filtered, and sorted bits and clusters of words/phrases for understanding. The first step of data analysis required a deep dive into the collected data.
2. *Generation of initial first- and second-cycle codes*. In this step, I laboriously grasped and recorded the first and second representations of answers as initial codes. I carried out the first and second cycle coding which involved descriptive, content, and memo/notes coding: (a) I captured the participant's answers to questions in an excel sheet; (b) I focused on the content of the answers to extract codes (words, phrases or sentences) relevant to the research questions, prior to the formulation of themes; (c) I took notes as memos of inspiring observations. The second cycle coding involved coding the content codes into patterns across the participants and focusing on the research

questions. Thus, the interview questions served the research design purpose by generating answers for the research questions. I combined manual sorting/coding with the digital process using NVivo software.

3. *Themes search*. This stage involved inductive coding and assignment of themes and categories that relate in one way or the other.
4. *Themes review*. Themes review involved a revisionary way of repeating the above process for status confirmation, change of linkage preparation, or induction of cumulative pattern impact.
5. *Themes descriptions and linkage*. In this stage, I concluded on assignment of descriptions, themes, and their linkages.
6. *Report production/documentation of themes, subthemes, and categories*.

The sampling plan was to sample 15 health care professionals at data saturation point. The professionals interviewed included doctors, employer administrators, nurses, medical laboratory scientists, radiographers, and pharmacists. Saumure and Given (2008) recommended repetitiveness of information for saturation consideration of an adequate sample size. However, the opportune order and process of availability of recruits and interviewing of the recruited professional groups did not generate new information for saturation considerations until the 39th participant's interview session.

Coding

I examined the data of the two distinct populations (employer and the employees) studied and extracted descriptive words, phrases, sentences, and meanings that aligned with the research questions and purpose. Saldana (2021) pointed out coding as an

important procedural activity that requires bits sorting and organization. The codes were further sorted based on meanings that were different, similar, and linked. The employer and the employees' data had similar, different, and linked codes in the themes and categories. Hence, the exercise was repetitive in listening to the audios, reading the transcripts, and comparing understandings with digital outputs from the NVivo software. I inserted line numbers in the transcripts through the Microsoft word layout format for easy line reference of codes, notes, and their subsequent processing/revision. I experienced the Heidegger's hermeneutics of revisionary thinking and spiral understanding of data during the coding process.

During the second cycle coding, I processed the codes and derived patterns from the representations of the first cycle coding. According to Saldana (2021), pattern coding are labels that identify similar codes into a group that he described as "meta-code" (p.367). The metacode is a category representation of similar code characteristics that are linked together. The studied phenomena impact the employer and the employees. The research questions are focused to extract these impacts and how the employees relate with sectorial administration and motivations. Thus, the responses provided answers to the two research questions in a way that is meaningful and revealing. In Table 3, I summarized the coded transcripts of the two population groups in the study (the employer and the employees) into themes, categories, subcategories, and excerpts of participants' words as on the transcripts.

The specific themes that emerged from the coding of the two groups of participants' data included

- poor employees’ motivations
- negative employees' impacts and reactions
- knowledge gaps

Table 3

Participants Summative Coding Table

Codes	Categories	Subcategories	Participant ID	Excerpts	Themes
Employer lethargy, Ineffective replacement policy, Employment embargo, Ineffective government policy, Problematic leadership, Limited employer duty	Poor employees' motivation	Inadequate motivation, Labor shortages, burnout, and nonreplacement of exited staffers	PD0001	in terms of coping, I don't think we are coping…it's not always that quick to get approval to employ replacement when people leave.	Poor employees' motivations
		Poor overall leadership effectiveness	PD0009	the workload is so much because…the female surgical ward, the ward is 24-, 25-bedroom and we will be only two on duty because we don't have enough.	
		Employer and employees overwhelmed with work pressures	PD0032	services are not put in place to ease out stress, to ease, um, the burden of care or workload	
Frequent strikes, Turnover intentions, Reduced service delivery, Aggression transfers, Employer apathy, Disconnection, Distrust	Negative employees' impacts and reactions	Complaints and feelings of discouragements (being unmotivated), Turnover intentions and turnover as a vicious cycle, Poor health service delivery, Sympathy for the employer's failures (Stockholm/Attachment syndrome), Employees' frequent strike rituals and despondency	PD0001	But I must tell you that it has actually severely affected the hospital services. It has also impacted on the existing, the permanent staff who are still here, and have to do more work than they would have	Negative employees' impacts and reactions
Discriminations and rivalries, Reasons for not migrating or exiting jobs, Persistent turnover intentions	Knowledge gaps	Aggression transfer to patients, patients' relatives, and society	PD0026	this time around the rate of exits of health worker is quite on the increase. Prominent among those that have left are nurses, doctors, then even health administrators are not left out of it…They are also leaving. Ehm, one, understand why they're leaving. Everybody wants, um, better prospect for tomorrow	Knowledge gaps
		Ineffective and inefficient federal health administration and policies, Reasons why Nigerian public health professionals are not migrating abroad or exiting their jobs, Reasons why turnover intentions persist	PD0001	But I must tell you that it has actually severely affected the hospital services. It has also impacted on the existing, the permanent staff who are still here, and have to do more work than they would have	
			PD0012	I'm at a particular age, which I don't think I'll start hurrying to another foreign land	
			PD0010	the country leadership, they are the one responsible for japa syndrome…They care less about them, so that's the major reason why people are running away	

The codes that emerged from the employer's transcripts included leadership ineffectiveness, union strikes, inadequate remuneration, impacts of turnover, impacts of intention, poor motivations, little or no recreation, and work-life balance, inadequate training, employees rivalries, doctors dominance, job evaluation, CSR, uninformed production focus/process, wrong priority of producing health care graduates over citizens' need and staff welfare, callous, insensitive, or apathetic to health care professionals' burnout, little or no training. The employees' transcripts coding gave the following codes: poor motivations, inadequate staffing, burnout of employees because of over work, inadequate staffing/replacement of exited staffers, poor work-life balance, ineffective employment policy, frequent strikes actions by employees, poor work conditions/environments, poor remuneration, inadequate remunerations compared to inputs and prevailing economic/inflationary trend, economic hardship, medical hardship, distrust of employer by employees (because the employer always breached agreements), disconnection and apathy between the employee and the employer, and interprofessional conflicts. The emergent codes were meaningfully organized as in Table 3 to answer the research questions and achieve the design purpose.

As in Table 3, the impacts of the studied phenomena on the employer and the employees persisted. All employees complained of burnout, poor motivations, turnover intentions, and inadequate training experiences. However, three participants (Participants PD0002, PD0006, and PD0016) were distinct from other participants as outliers in indicating little or no turnover intention.

Trustworthiness of the Study

Credibility

In the learning resources, Burkholder et al. (2016) reported that trustworthiness or credibility threats in a scholarly report include: (a) little reflection of the participants' lived experiences, (b) scanty data collection, (c) biased interpretation of the report, (d) preempting participants' responses in a way that does not represent their views and experiences, and (e) formulating preconceived ideas that are not in the collected data. In ensuring research trustworthiness and credibility, I took steps and avoided these threats by collecting adequate data samples at saturation point where information in the data became repetitive. Furthermore, the collected data were triangulated through member checking (participants' own data validation/clarification) of the collected participants' transcripts and audios to ensure originality of participants' perceptions and experiences. Thus, the data I used in the analysis and reporting was the member-checked data which reflected participants' experiences and views.

In mitigating any bias possibility, I applied the established Heidegger principle of noting preconceived knowledge as a foresight/fore conception before commencing interview/data collection. In the Heidegger's phenomenology, I applied the multiple theoretical lenses' approach (Heidegger, 1996) in examining conclusions, triangulations, reflexivity, and member checks. The participants' responses were studied, compared, and analyzed to answer the research questions and fulfill the research objectives/purposes. The 39th participant indicated data saturation and revealed themes, categories, and subcategories from the collected interview data. Seidman (2019) asserted that interviews

should be concluded within a set period to meaningfully compare and relate participants' experiences. Thus, the data collection process commenced on August 4, 2023, and ended on August 31, 2023. The participants were comfortable and willingly expressed their perceptions and feelings on the questions that I asked.

Transferability

Transferability is the extent of a qualitative research result application (transfer) to other contexts/settings that involve different participants (Korstjen & Moser, 2018). The focus is on the possibility of applying the research results to another similar situation and subject that has different participants. The goal is not focused on generalization but meaningful analysis in fulfillment of the research questions. That implies that the considered transferable data should be adequately meaningful and rich in quality to suit application in another similar environment. In ensuring the achievement of transferability, I carried out diligent collection of rich and valuable data to a saturation point using personal face-to-face interview which generated thick and valuable descriptions of participants' experiences. The participants' data were coded and analyzed manually and digitally using NVivo software. During the coding and analysis process, themes were identified with corresponding categories and subcategories.

Transferability is an issue of subjective determination of the reader/audience when the consideration/judgement to apply a research result to another similar condition arises (Korstjen & Moser, 2018; Patton, 2015). However, the knowledge available from this study is a guide to readers/researchers in deciding about transferability and developing conclusions related to similar subjects.

Dependability

Dependability is a consistency equivalent of reliability in a quantitative study, and it is focused on consistently arriving at the same result using the same data (Burkholder et al., 2016). The emphasis is on research instruments and the consistency of results it could generate. Burkholder et al. explained that the process is a strategy and a descriptive disclosure of: (a) how data were collected, (b) how categories were derived from codes/data, (c) how any inputs from field notes, memos (reflective journals) are applied in the report, and (d) accessibility of reflective data for independent analysis. Thus, a clear process steps in an audit trail that gives consistent meaningful results is dependable. I relied on the interview instruments, derivation of codes categories and themes, field notes, memos, reflexive journaling, audit trails, and member checks triangulations to achieve dependability of the report.

Furthermore, Haven et al. (2020) asserted that the essence of dependability is the meaningful fulfillment of the protocols that are set in the research design. In that light, the participants were asked the same minimum number of questions as stated and guided on the approved research proposal and IRB process documents. Though participants' interview dates and hospital locations were different, the mode of interview carried out for all participants was the same face-to-face personal interview and based on the content of signed informed consent forms. The participants used the same individual confidential process to check and validate the applicable audio file and transcript. I used the interview questions to generate participants' responses that helped to answer the research questions which aligned with the research design protocols.

Confirmability

Confirmability is a qualitative criterion in which the research procedures, methods, analysis, and report's conclusions could be independently verified by experts to arrive at equivalent results (Burkholder et al., 2016; Butcher, 2022; Lincoln & Guba, 1985). That presupposes that the independent expert analysis is based on the same data. Thus, the confirmability quality of research conclusions is based on the use of the participants' data that are involved in the detailed research process and not on a researcher's personal opinions and analysis. Burkholder et al. (2016) stated that confirmability audit shares the same principle and instruments with dependability audit whereby instruments (including the questionnaire, transcript, audio, field notes, and memos/reflection journals) are available to be checked by experts in the detailed research process. I applied the Heidegger's revisionary method of analysis in checking through participants' data for better reflexive insights of participants perceptions and lived experiences. I noted body language display signs and sounds in my reflective notes during the data collection and coding process.

Study Results

The purpose of this study was to explore the current lived experiences and perceptions of the participants, and how the employees' and stakeholders' lives are impacted by turnover, turnover intentions, and the employer's leadership effectiveness. Furthermore, I purposed in the study to understand the conflicting relationship between the employer's leadership/managership and the employees' turnover impacts reactions to determine the problem resolution options. Hence, the interview questions were designed

to get participants' responses that helped to answer the research questions and fulfill the study purposes.

During the interview (data collection) process completion, all participants checked and validated the interview audio and the transcribed files as representing their experiences and perceptions on the subjects covered during the interviews. The coding and analysis process commenced after the member checking process. I carried out manual coding of transcripts and digital processing of transcripts through NVivo digital software with the aim of answering the research questions and assessing the application of the theoretical and conceptual frameworks in the study. The manual process helped me to apply the Heidegger's concepts of revisionary thinking, multiple theoretical lenses evaluation, and spiral analysis of participants' experiences/perceptions. I looked out for codes, patterns, and themes that are aligned with the theoretical framework and the research questions. The coding process helped to identify codes, themes, and knowledge gaps relevant in answering the research questions as indicated in Table 4, and in Figures 1, 2, 3, and 4 below:

Table 4

Summary of Themes and Subthemes

Themes	Subthemes
(RQ1) Poor employees' motivations	• Inadequate motivations • Labor shortages, burnout, and nonreplacement of exited staffers • Poor overall leadership effectiveness • Aggression transfer to patients, patients' relatives, and society
(RQ2) Negative employees' impacts and reactions	• Complaints and feelings of discouragements (being unmotivated) • Employees' frequent strike rituals and despondency • High turnover intentions and turnover as a vicious cycle • Poor health service delivery • Sympathy for the employer's failures (Stockholm or attachment syndrome)
Knowledge gaps	• Ineffective and inefficient federal health administration and policies • Reasons why Nigerian public health professionals are not migrating abroad or exiting their jobs • Reasons why turnover intentions persist

Figure 1

Summary of Findings

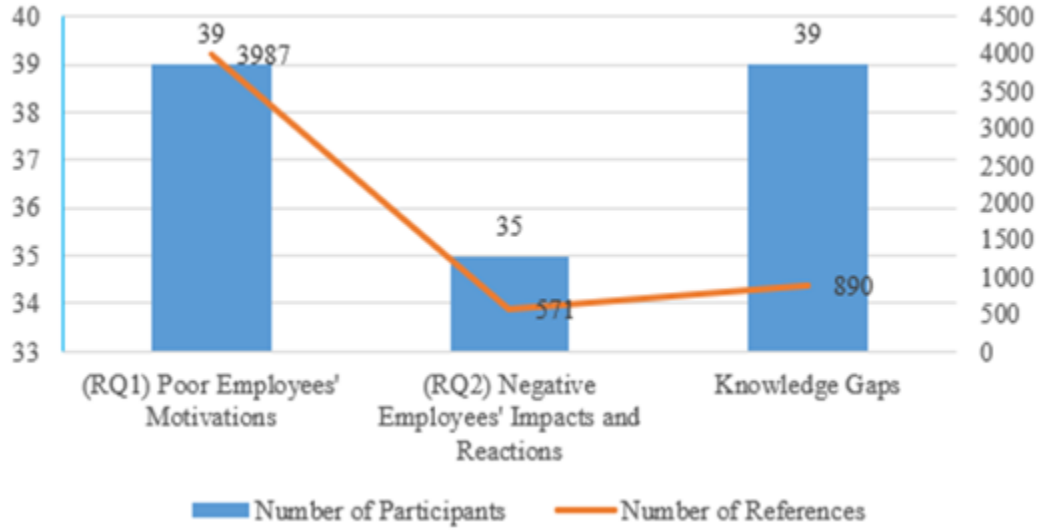


Figure 2

Summary of Answers to Research Question 1

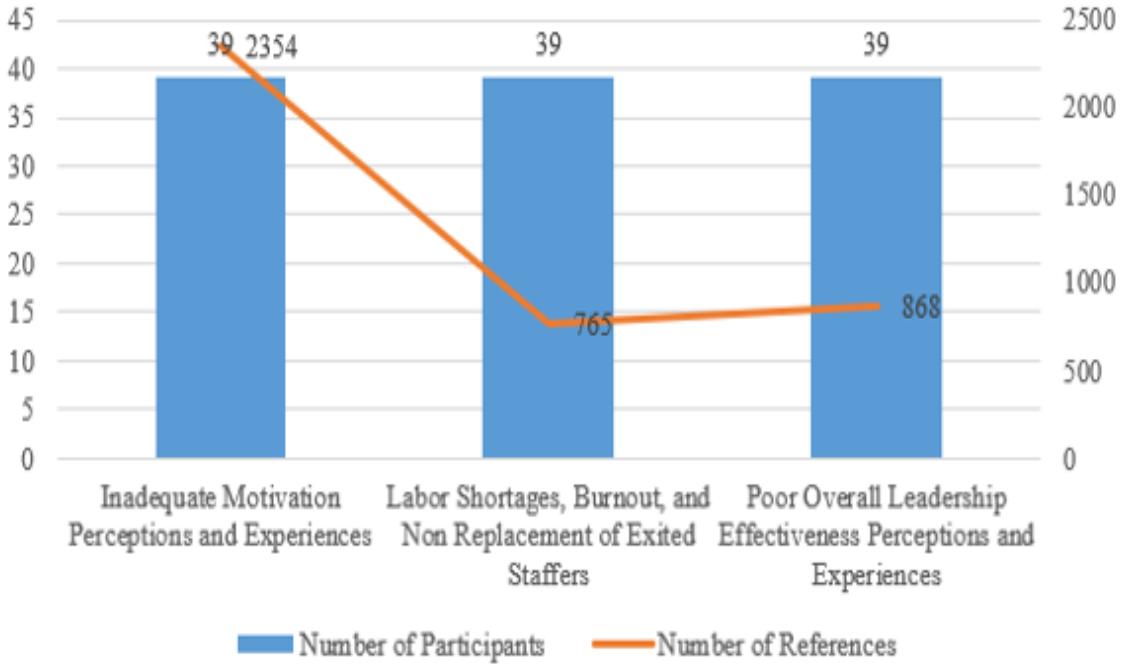


Figure 3

Summary of Answers to Research Question 2

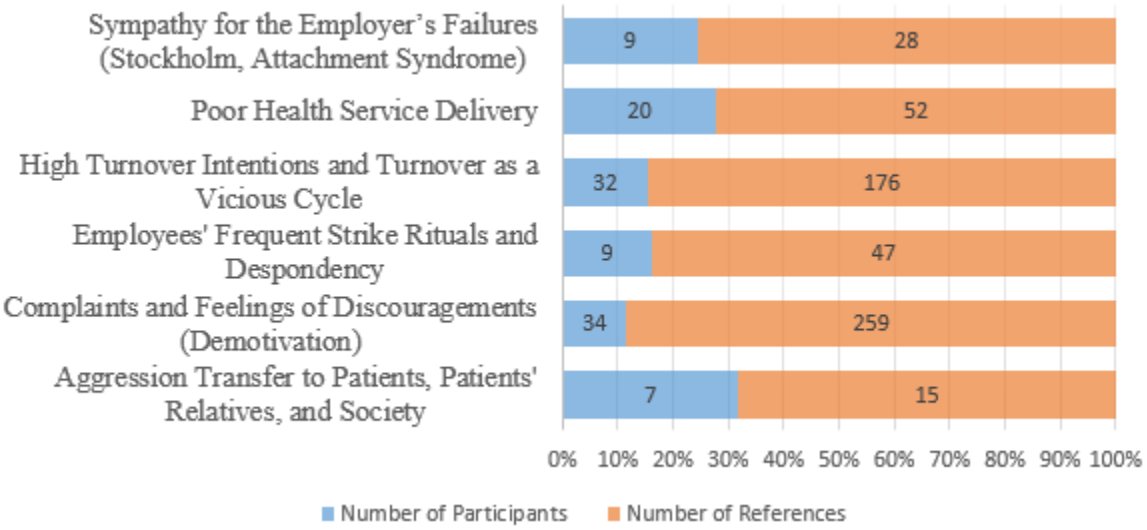
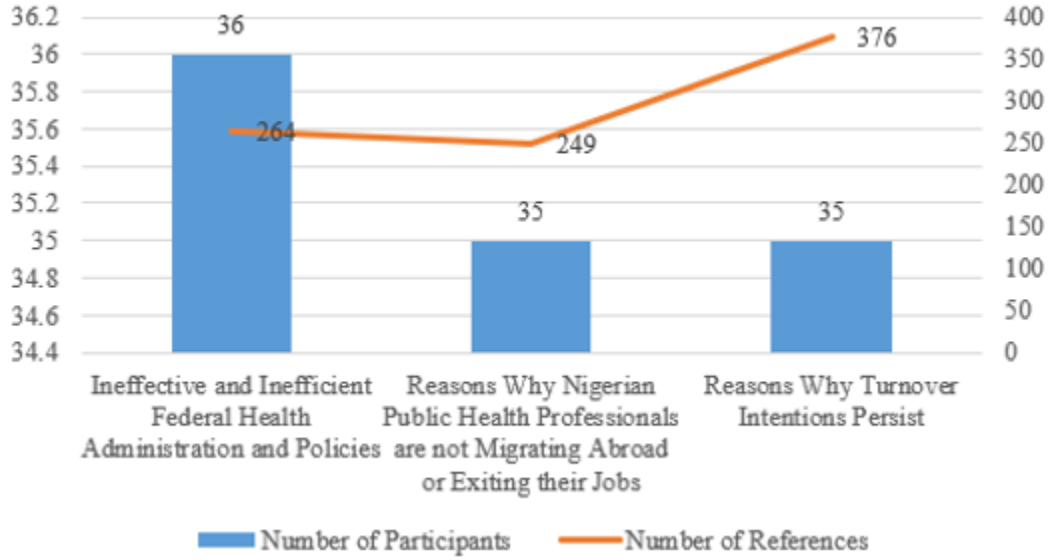


Figure 4

Summary of Knowledge Gaps



Research Question 1 (Theme 1): Poor Employees' Motivations

I asked 17 questions to the participants (employer and employees). The nature of a participant's responses warranted further probing questions for clarity on the

participant's responses on the interview subject. I asked 13 open-ended questions to the employees centered on extracting the lived experiences and perceptions of employees on the impact of turnover and turnover intentions on Nigeria's public health administration. I asked four questions to the employer participants on the research subject focused on the employer's coping experiences amidst increased turnover trend, CSR impact on leadership and work administration, leadership effectiveness, and staff training experiences supervised within the last 5 years. All participants were interviewed officially (after each hospital's IRB approval) within the hospital sites/offices. The following three sub-themes emerged: (a) inadequate motivations; (b) labor shortages, breakdown from burnouts, and nonreplacement of exited staffers; and (c) poor overall leadership effectiveness.

Subtheme 1: Inadequate Motivations

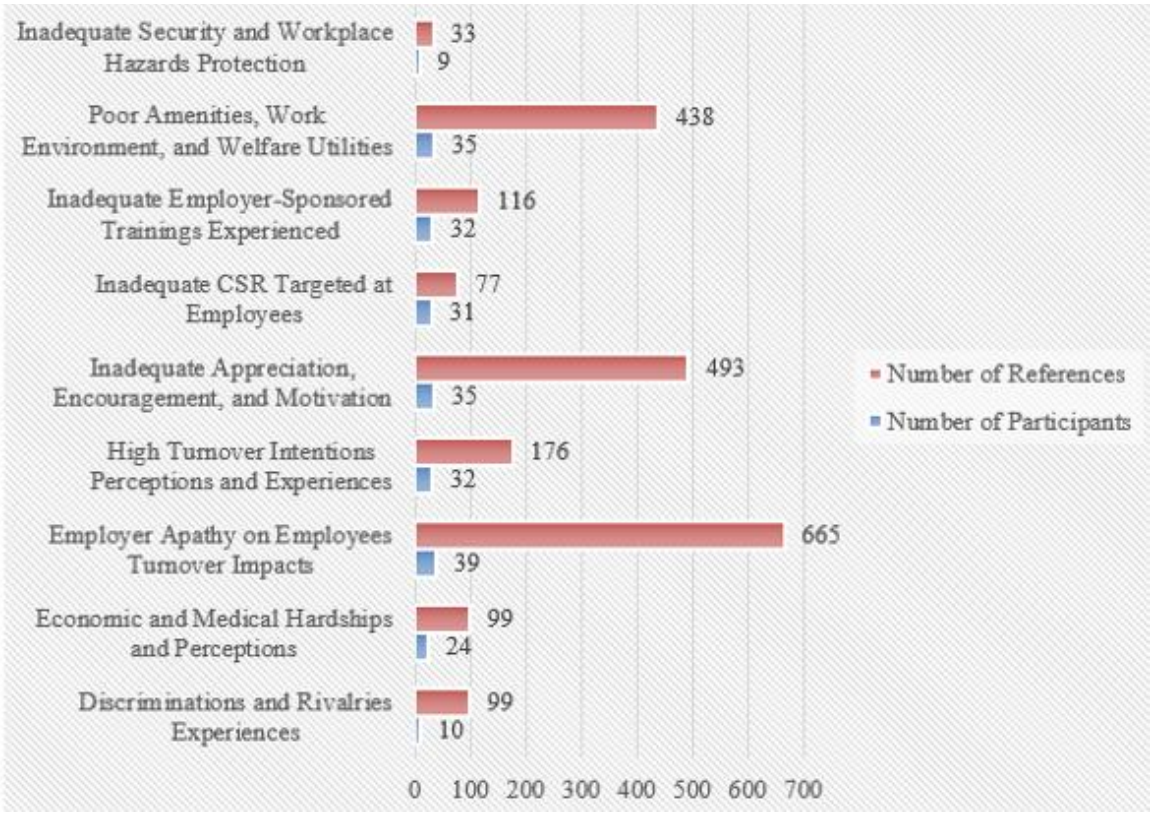
Herzberg et al. (1959) propounded that an organization's best method of optimizing an employee's productivity is by prioritizing on that employee's innate motivations. The innate motivations refer to the intrinsic needs of an employee including recognition, self-development, creativity, and drives for achievement. Similarly, in reference to public organizations, Perry (1996) reported that PSM is an employee's attraction and commitment to public interest. Thus, organizations should look out for employees whose passions and interests are expressed to promote the overall public good and not personal pursuits that hinder or conflict with public interests.

The experiences and perceptions of employee participants indicated the quality and magnitude of motivations provided by the employer and enjoyed by the employees.

All 39 participants (100%) cited inadequate employee motivation references (see Figure 5) in terms of discriminations, rivalries, hardships, employer apathy, inadequate appreciation, little or no motivation, little or no CSR benefit, high turnover intention feelings, poor work- and family-life balances because of extended work hours, poor work conditions/environments, retrogressive work experiences, and inadequate training experiences.

Figure 5

Inadequate Motivations



Discriminations and Rivalries. Ten employee participants in Figure 5 (25.64% of all participants or 28.57% of employee participants) narrated their experiences of

discriminations. Participant PD0002 complained of being discriminated as a medical laboratory scientist in favor of doctors:

> Do I have any experience? The only, the only challenge I have with. Then you know in my department here, and I won't really say it's my employer [medical director]. I think it's from the ministry because you know here, no matter your level of education; they still bring the doctors to come and head.

Similarly, Participant PD0022 complained of doctors' dominance of administration:

> if it comes to admin, administering this environment, we can do it as well. But you are being, you are being disenfranchised. You are being prevented from getting to that capacity. And because somebody knows that, okay, it's only its profession that can get there. So they believe that other ones are worthless, are second citizen on the premises.

In another turn, Participant PD0035 lamented about earnings disparity:

> Disparity and what I mean, that, I've told you that as a body, we have like a national association within the country. You see yourself, somebody of the same level with you work in another hospital earning better than you …The same federal hospitals … Different remuneration, virtue of the input the administration, the management of the institution is getting together to their level.

The complaints of discrimination from professional groups reflected rivalry among professional groups and between the employees and the employer. Thus,

Participant PD0002 blamed the federal ministry of health (the employer) for the development of discrimination/rivalry:

> Then you know in my department here, and I won't really say it's my employer [medical director]. I think it's from the ministry because you know here, no matter your level of education; they still bring the doctors to come and head … They still bring the doctors in to come and head. You can see when you came in, you asked for the HOD, I directed you to the Secretary to the HOD's office. The HOD is a medical doctor … Yes, that is just one of the discouragements that I personally I'm experiencing in the department, in the environment where I work. Then you've noticed that in the hospital set-up, there's no committee that is being raised, any committee formed must be headed by a medical doctor. That mentality is there.

These complaints of discriminations and rivalries are about doctors' dominance of professional groups in administrations and earnings as signs of poor motivation.

Economic and Medical Hardships. Twenty-four employee participants in Figure 5 (61.54% of all participants or 68.57% of employee participants) stated their economic and medical hardships. Participant PD0009 complained of economic hardships: "The money we are getting is not enough. Even if you are getting enough where it seems you are getting enough, the workload is much, that is just the challenge." Similarly, Participant PD0014 complained of economic hardship: "when I get my money. And at the end of the day, I look at the expenses I am going to make with my local, with my

local, it doesn't meet the needs …" There were worse complaints that involved economic and medical grievances by Participants PD0016 and PD0019.

Participant PD0016 complained of economic and medical hardships:

> If you are sick and you go to the hospital, the stress of moving about brings, add more sickness to you than improving, number 1. You go for submitting your name after authorization, after you go through, you'll be waiting, you, and you're dying. You will work from here to there; they didn't have facility there. You go to the next hospital, maybe the next hospital, the money to take you there, and who to support you there is not there. All these things are not improving our welfare.

In the same pain, Participant PD0019 complained of medical and economic hardships:

> The salary doesn't motivate. Everybody works just to live … Then also on the, uh, medical care. It's very poor … The National Health Insurance Scheme deducted; they deduct certain amount of money from our salaries on monthly basis … There are some you'll be responsible for and there are some costs the health insurance will be responsible for, which is very, very unfair … It discourages us … the salary does not cater for what I needed to cater for. It's not enough to cater for what I needed to pick up for

Oruh et al. (2020) noted that excess workload and poor employee welfare promoted employee turnover. These participants' expressions are indications that their complaints may lead to increased turnover reality if no remedy is applied to improve the workers welfare.

Employer Apathy on Employees Turnover Impacts. Thirty-nine (100.00%) participants that included employer responses (see Figure 5) expressed employer apathy over turnover impacts. Thus, all 35 (100%) employee participants in Figure 5 felt that the employer is apathetic about the turnover impact reality of shortage of labor. Participant PD0038 expressed the employer's apathy about the health sector:

> I don't want to use apathy, but the negligence of um, [Sigh of pity] ... negligence paid to the health care system is just alarming sometimes…I'm sure you heard that there was a recent strike … So, it seems like things just happened or it comes, oh, there's a strike. Oh, what do they want? Okay, let's promise them this. Then they go back to work and then the same old cycle repeats and they're back to the joint table they gave after a few months that this same thing we're talking about 2 years ago, we're still doing talking about it now, but government said they didn't notice ... it might be responsible for a lot of demotivation.

In the same plight, Participant PD0039 bemoaned the employer apathy through the nonreplacement of exited professionals and excess workload:

> Well, for us it has not been easy. In my own department alone, um, about three doctors have left this year and none of them have been replaced … So we are already like that, wired to just work, work, work like a machine, work, work, work, and forget about your own self…So you would've expected that, um, the, the in a place where the patients are coming to see the doctors, the doctors should be treated well. So the doctors, we just see ourselves as, um, like we're just

> animals, just working. And then as long as we're making money for the, this thing, our welfare is really not paramount.

In another participant's complaint, Participant PD0004 expressed discouragement because of the employer apathy:

> Yes, the, where I'll say that I'm discouraged is in the fact that as the, the exit of professionals is going on. Ordinarily, it is not a civil service arrangement. One would have expected my employers to quickly arrange for replacement of such persons that are exiting so that there won't be that gap in terms of the absence of these persons because it's creating extra stress on the system and it's not coming as quickly as it should. If it were to be in private establishment the, the response would have been quicker. It's a bit discouraging because it looks like my employers are not really in tune with the happenings.

Additionally, Participant PD0034 was displeased that the employer could not keep to agreements between it and the employees' trade union. Hence, Participant PD0034 complained of no equipment, strikes, and government's unfaithfulness:

> Strikes, strikes. I mean, no equipment. The strikes, I mean the, the, the, eheh, the, they agree with the government of something. And they're not fulfilling that promise. I mean maybe the association, the union have agreed and it's all publicized, sign memorandum of understanding. And there's no understanding after that, that one too is really, it puts, it puts me off … Then third thing is being able to replace these people because what makes people now go again is because

> the work is now getting enormous for the few that are in the system. So, they leave too, making it more enormous for people that are in the system.

Besenyő & Kármán (2022) noted that Nigeria is compounding the unemployment and turnover problems by neglecting the welfare of its most skilled workforce. The complaints of these skilled health care professionals give credence to the authors' assertion. Thus, that expression of employer insensitivity by participants should be a nudge to the employer to take steps to be sensitive to employees' genuine needs.

High Turnover Intentions. Thirty-two employee participants in Figure 5 experienced high turnover intentions (82.05% of all participants or 91.43% of employee participants) from their responses against three employee participants (7.69% of all participants or 8.57% of employee participants) that indicated no turnover intentions experiences. Participant PD0002 exhibited no turnover intentions experience: "the way, the lifestyle lived there, I'm not comfortable, I can't live such lifestyle. That is just it. Age is not on my side." Participant PD0002 was not willing to work in another organization in Nigeria or abroad if given better desirable service conditions. When I asked, "Why would you reject?", Participant PD0002 answered: "Contentment."

Analogously, Participant PD0006 preferred current job than exiting: "I will stay where I am. Why? Because there is this saying that the devil you know is better than the one you don't know." Likewise, Participant PD0016 showed no experience of turnover intentions:

> Mhmhm, before I go into anything, there's a way I discuss with my maker, and he has a sign for me. Until I see the sign before I can decide to leave for anything. If

> not, if not, before I even enter here, I was even planning to, but I tell God, if it's your will for me to go out, let me not get federal appointment. If it's not your will let me get federal appointment. At the dying minute of leaving, this job came.

However, 32 employee participants indicated high turnover intentions for job positions that are within or outside Nigeria. For instance, Participant PD0020 explained the willingness to exit: "Of, of course. I will, with a better pay, better. See it's not even because of better pay alone, just better services, better working condition." Similarly, Participant PD0019 expressed high turnover intention with reasons:

> I'll willingly go because I know in Chevron I'll have other, I'll, I'll have access to other employees' uh, uh, allowances and benefits. I'll have access to better health care. My children will probably go to better schools.

Incidentally, all the employer participants (100%) were aware of the prevalence of high employees' intentions to leave. The employer Participant PD0001 described the high intention as a prevalent issue:

> That intention is always there because I think in some sectors, you'll find out that almost everybody has packed his bag, they're just waiting to check it into the boot. So unless the situation changes a bit in the country, we will probably continue to have this challenge.

Contextually, the employer Participant PD0026 observed that the hospital administrators as employers are involved in the high exit intentions in addition to the employees:

> Um … this time around the rate of exits of health worker is quite on the increase. Prominent among those that have left are nurses, doctors, then even health

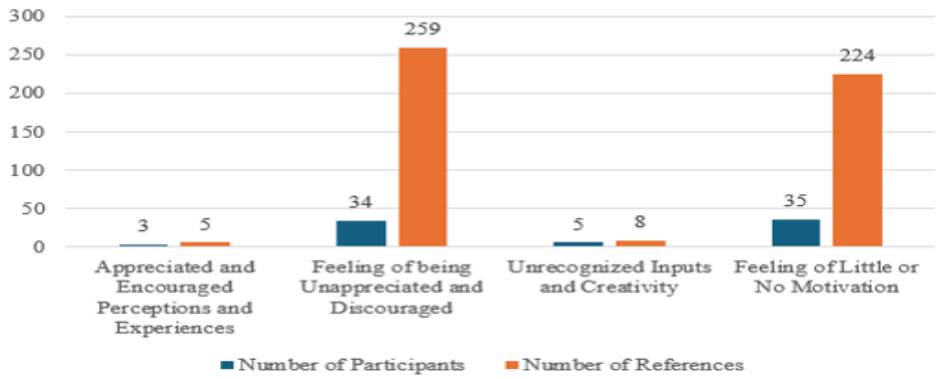
> administrators are not left out of it … They are also leaving. Ehm, one, understand why they're leaving. Everybody wants, um, better prospect for tomorrow.

In another employer experience, Participant PD0028 remarked about the entrenched turnover trend: "Migration, so to speak and turnover, I can say is now a routine thing in public service in Nigeria because people look at the environment and think of something that can benefit them in the future." Emphatically, the employer Participant PD0031 corroborated the high staff departures: "Work as an employer, what we do basically, is that virtually almost every week we get application for withdrawal of service." The cumulative experiences of the employer participants implied that it is not only employees that are leaving their jobs for abroad offers but employers are abdicating their positions in search of greener pastures abroad.

Inadequate Appreciation, Encouragement, and Motivation. There were four distinct categories (see Figure 6) of employee participants that expressed satisfaction or complained of being inadequately appreciated, encouraged, and motivated by the employer as discussed below.

Figure 6

Inadequate Appreciation, Encouragement, and Motivation



Feeling of Appreciation. Three employee participants in Figure 6 (7.69% of all participants or 8.57% of employee participants) felt appreciated and encouraged in their responses. Participant PD0006 stated that, "I can't remember anywhere at any point in time where I was discouraged. Really, it's not. I can't remember a situation where I know I felt discouraged." Participant PD0034 expressed that, "I feel, I feel so, I feel definitely it could get better, but I feel comfortable with what I, I mean what I'm doing and what I'm earning. Yeah." Likewise, Participant PD0039: "Appreciating, that's the word. Somebody's appreciating us. So it makes us feel like, okay, in a government hospital, it is not a private hospital. In a government hospital…It looks like we're not complaining much, but the workload."

Feeling of Little Motivation. Eighteen employee participants in Figure 6 (46.15% of all participants or 51.43% of employee participants) felt little motivation from the employer. Participant PD0013 indicated inadequate motivation: "So, there is much to be desired when it comes to motivation. That's long and short of the story." Similarly, Participant PD0027 narrated experience of inadequate motivation:

> Very poor [laugh]. Not in Nigeria. Do, do, I'm sure you are aware that national association of resident doctors just came back from a strike, not too long ago. And majority of it is about, um, apart from the patient and infrastructure, there's also the, the concept of appreciation, reward, um, giving necessary dues and stipends as at when due. So, my experience is very poor. And, and to be very honest, that's the major bone of contention why the japa thing has to just keep continuing for now. Because when you don't reward me and I'm at work more than 40 hours in a week, and some other person is somewhere up there because he's a politician, is receiving so much and so much definitely it's skewed. So, the reward system is extremely poor … The federal government and, and their motivating me is not part of their work. [laugh] Their work, the way they see themselves is, or the way it appears, employer-employee, do your job and collect your salary. There's no, there is nothing like, okay, um, there's this extra thing or we are feeling your effect or something. So, motivation is not there. There's no extra perk.

In the same breath, Participant PD0037 stated that: "Um, in the last, uh, couple of, um, years Uh, I've not been really and satisfactorily motivated."

Feeling of No Motivation. Seventeen employee participants (43.59% of all participants or 48.57% of employee participants in Figure 6) felt no motivation. Participant PD0039 explained the absence of motivation feeling: "Like I said, if you are waiting for somebody to, uh, appreciate you, you'll probably not do this job…No motivation at all. There's no motivation." Evidently, Participant PD0007 insisted on no motivation experience: "the motivation is zero…there is no motivation from anywhere.

We hardly go for…trainings, for seminars that will impact our knowledge or whatever. If we have to go, you will have to sponsor yourself most of the time."

Heavyheartedly, Participant PD0009 recounted a traumatic experience of feeling unmotivated:

> I've worked for 17 years. I've worked here for 17 years. There's no time I experienced motivation. Apart from doing this one they give us, sometimes, half bag of rice. That was the highest I've gotten…Nothing. They've not given us anything. Nothing. I've not received. If any other person has received, unless like arrears, promotion arrears, hazard allowance that is earning, COVID 19 allowance, apart from that there's nothing like motivation…The example is that the money I receive as salary does not encourage me. Do you know that if they pay the salary, that day my BP will be very high. That day, immediately I see alert, my blood pressure will go kpim!

Similarly, Participant PD0010 painted a sordid picture summary of no motivation experience: "No motivation. Nothing. Just like you are working in a slave camp. No motivation. Nothing." In the same breath, Participant PD0019 narrated grim experience of no motivation:

> Or I mean something else coming outside your salary. But in Nigerian context, you are just to your salary and that's what, there is nothing like motivation … The salary doesn't motivate. Everybody works just to live … There are so many ways by which we have been discouraged or by which I have been discouraged personally. But then since we don't have a choice, Nigeria is not a country where

> you lose a job and get another one so quick. And we have families to take care of. So, we keep managing, we're not being motivated to, to get more skills.

Feelings of Being Unappreciated and Discouraged. In terms of being unappreciated and discouraged, 34 employee participants (87.18% of all participants or 97.14% of employee participants in Figure 6) felt that the employer did not appreciate them in any way. Participant PD0032 felt unappreciated: "Well, the fact that I'm not appreciated enough. That's one. Two, the fact that, um, services are not put in place to ease out stress, to ease, um, the burden of care or workload." In utter displeasure, Participant PD0033 asserted: "Hmm. Currently I feel we are not being appreciated." Likewise, Participant PD0039 felt unappreciated: "I personally don't feel appreciated."

Similarly, Participant PD0020 experienced inadequate appreciation because of perceived training rights' denials: "I personally, I don't feel I'm being appreciated as I ought to because for me, that's all. Seminars I want to go for and I'm not allowed to go." In the same boat, Participant PD0012 revealed feelings of discouragement and displeasures:

> I'll say one of the ways they discouraged me, number 1, like I said, sometimes very difficult to get anything. Apply for anything, something new and something like that. Severally, the equipment you need, sometimes just for a lot of time, are not available. A lot of times we need to do something private. Sometimes, you bring our private tools to do our work in the hospital. Because you don't want to lose the skill that you have acquired.

Inadequate CSR Targeted at Employees. Stewart et al. (2011) and Jamali et al. (2008) posited that the fiduciary and moral duties of an organization is to be accountable, transparent, and honest to its stakeholders in a legal, economic, philanthropic, and ethical nature through acceptable means including CSR. Among the stakeholders, the employee stakeholders have a participatory obligation to appraise the organization's performance on its fiduciary and moral duties. Furthermore, the authors reported that the organization's CSR have internal and external dimensions and that the internal dimension should be prioritized on promoting employees' human rights, working conditions, workplace security, equitable/equal opportunity, labor rights, development of skills and education. Thus, the employees will not appraise/perceive the organization leadership as effective if it failed the leadership effectiveness tests in legal, economic, and ethical obligations.

All four employer participants (10.26% of all participants or 100.00% of employer participants) indicated that the employer carries out community-focused CSR and employee-focused CSR. Participant PD0031 narrated a community-based CSR:

> Now when you talk of corporate social responsibility, that have come with different angles. Okay. What my responsibility to the community in terms of mental health. Part of what you have done today now is, there is what we call community education, social awareness, okay, and we have various platform. I just finished a board meeting now for the hospital. We do it once in a month. Today we talk about men's mental health. It's an opportunity. It's part of our social responsibility to be able to tell the public, populace about what to do about their

> mental health. Creating awareness, teaching them what to do and educating them. So, we do this for regular basis through community outreach, through social media and through uh, webinars.

Furthermore, Participant PD0031 narrated an employee-based CSR program: "Yes. Maintaining the health of our employee is very, very important. For example, every year now, we do general medical checkup for every staff." Participant PD0038 (among four employee participants) corroborated the employee-focused CSR: "Well, Okay. So they offer us yearly, um, medical checks…Yes, I have, from the last how many years now? Maybe 3 years." Whereas four employee participants (10.26% of all participants or 11.43% of employee participants) acknowledged enjoying an employee-focused CSR, 31 employee participants (79.49% of all participants or 88.57% of employee participants in Figure 5) indicated no benefits of any employee-focused CSR.

Thus, all employee participants were not fully aware of the employer's employee-focused CSR described by the employer Participant PD0031. For instance, Participant PD0007 revealed no benefits of employer's CSR targeted at employees: "No, at all. I don't have any experience of such." Participant PD0012 clarified on no personal benefit of hospital's CSR: "Well, I'm not aware of any corporate social responsibility towards me as an individual, but I do know that where I work do that for the society." Likewise, Participant PD0019: "I don't think there is anything like social responsibility the organization is doing from that. I've never benefited from any." Participant PD0030 emphasized that: "There is none sir. Well, in my own wards … In my own experience,

there is none. Like I could tell you, in my own rights and my own views, there is none. Rights … There is none sir."

Consequently, the employer's score card from the 31 employee participants (88.57%, Figure 5) indicated a negative reaction from the sample that there were little (11.43% from four employee participants) CSR impacts in terms of supporting employees' human rights, workplace security, labor rights, working conditions, equitable/equal opportunity, development of skills, and training. It is a clarion call for the employer to rise to the occasion with effective interventions worthy of the employees' favorable appraisal in employee-targeted CSR and leadership effectiveness.

Inadequate Employer-Sponsored Trainings. The employer responses indicated that the training of employees is not extended to all employees but to selected staffers (see Figure 5) because of cost implications. Employer Participant PD0028 explained the reasons for selective employee training:

> Yes. Sometimes because of the financial know-how. Sometimes the employer might not have enough money due to maybe subvention from above is not enough for training capacity. You'll not be able to train people who are willing to be trained. Then you can resort to local training, which is not more. They, they sometimes they don't show interest in getting that, uh, training locally. Because when you go for outside your territory training, you get more advantage, because you'll be exposed to a lot of things, plus the paid thing that will enter your *per diem*, that will enter your pocket. You'll have something in return that can encourage you to, you know do that something.

Furthermore, Participant PD0026 clarified on the employer's permissible trainings:

> Um, then, there are doctors or nurses who also want to go off on study leave. What we've basically done is: ensure that if you are doing any study leave, uh, it has to be in, it has to be local content one, and you can go to any of our universities to pick up, ehm, any degree program or master's degree program. But if it has to be that you want to go abroad, um, in recent time, the board, uh, did not approve of such…but if you look at somebody going abroad or going pick up a program at university, we'll not be able to afford that. So we still pay salaries…No, we don't even, we laid embargo on going abroad. Because when you go abroad, you are leaving a seat. You are leaving a seat, but your number is still, you as a number is still subsisting. So if you say how many staff we have in this place, you say 10, but one of them have gone, has gone abroad. So that one is, is, uh, is, is a disservice, it is a disservice to the system … So, uh, so we have an embargo on you applying for study leave, ehm, abroad.

Whereas three employer participants (7.69% of all participants or 75.00% of employer participants) indicated that the employer carries out regular annual trainings, two employer participants (5.13% of all participants or 50.00% of employer participants) responded that the employer's selective training is focused on public service rules (the Code). According to Participant PD0026, "The one that, that's within my role is to explain the public service rule." Participant PD0028 corroborated it with a reason that

employees “have different backgrounds and orientation, but what we know that helps us in public service is what we call public service rules.”

However, 32 employee participants in Figure 5 (82.05% of all participants or 91.43% of employee participants) complained of inadequate employer-sponsored trainings in the last 5 years and majority of the employee participants did not experience any employer-sponsored trainings. Twenty-one employee participants (53.85% of all participants or 60.00% of employee participants) experienced no trainings in the last 5 years. Nine employee participants (23.08% of all participants or 25.71% of employee participants) experienced one training program in the last 5 years. Two employee participants (5.13% of all participants or 5.71% of employee participants) experienced two employer-sponsored trainings in the last 5 years and only three employee participants (7.69% of all participants or 8.57% of employee participants) experienced a minimum of three trainings in the last 5 years.

Among the 21 participants with no recent employer-sponsored training experience, Participant PD0002 complained: “Okay, you know that is part of the, our employer’s, the problem we are facing is that they don't send us for course, training. All in the name of no fund.” Participant PD0003 revealed that: “They don’t approve them o! The did not approve, except the one I sponsor myself. They don’t send me on training except the one I do myself.”

Cheerlessly, Participant PD0007 affirmed no employer-sponsored training exposure within the last 5 years: “We hardly go for, for, for trainings, for seminars that will impact our knowledge or whatever. If we have to go, you will have to sponsor

yourself most of the time … None o … Remember ke? I did not go." Likewise Participant PD0030: "We were not sponsored by employer in last 5 years. Yes sir … No sir. You can ask them when you get upstairs."

Poor Amenities, Work Environment, and Welfare Utilities. All 35 (100%) employee participants in Figure 5 narrated experiences about poor amenities, inadequate remunerations, and poor work conditions. Twenty-nine employee participants (74.36% of all participants or 82.86% of employee participants) complained of inadequate earnings, payment delays, and no extra work allowances (called overtime). Participant PD0033, a consultant, complained of inadequate earnings:

> After I've already talked about that; remuneration is discouraging unless you are a patriot. If I want to compare my own salary with my peers, yes, it's nothing to write home about if I change my own salary to pound sterling. For example, it is more or less what maybe the doctor starting newly in the, in the UK would take. Meanwhile, I'm at the peak of my own career here. I'm a consultant. And to, to, to everybody, Oh, the consultant is the peak. In fact, they are the highest paid in the country.

Participant PD0014 complained of no extra work allowance: "you come by 4:00 in the evening, you're supposed to close by 8:00 in the morning. You see yourself closing by 10 in the morning. Who pays the extra hours? ... There's nothing like payment for overtime … No overtime." Differently, Participant PD0002 complained that "They started this June, 2 months ago, so they are just owing them 5 months which has never

happened since I joined this service, for the past going to 25 years, it has never happened. They must owe backlog."

> Similarly, Participant PD0035 lamented about rights denial and payment delays: I must tell you that the consideration I've been, I got my, the rank I'm now, an assistant director, I got it 2 years ago. The package meant, meant promotional arrears, meant for that has not been given to me up to today … We were promoted and uptil now, I've not gotten the promotion arrears meant … The new level started every January of every year. I was promoted around, I was promoted around July. Then it, it took them up to November before they started implementing the salary. But the arrears accrued from January to that November before of last year 2021 has not been given to us … The increment, I've, I've, no, they've started giving me the new salary. But my salary did, that promotion was, take effect from January of the year, years I started. You get it. And they started implementing by November. Telling you now from January to October, that increment that should be having given to you, that's reflection of that increment has not been implemented.

Twenty-three employee participants (58.97% of all participants and 65.71% of employee participants) complained about inadequate work environment, amenities, and welfare utilities. Participant PD0036 lamented about poor work ambience and furniture:

> The major thing I would say I'm not enjoying presently is the, my work ambience, the condition of where I work … What d'you, yes! We are not able to do one-on-one counselling because what we have presently is just physically an open hall.

> The chairs are not conducive. Like this morning now I broke my hand … So, the chairs are not conducive. The other day I was, I spent my personal money to repair the fan and everything. So, that, if the environment is conducive, the office space, good furniture, conducive AC and everything, I would leave.

Similarly, Participant PD0033 complained about lack of optimal supply of office/work equipment:

> You want to measure the height. The stadiometer is not, is not there, you know, and those little, little things, I mean, furniture … You want to write; you want to type a letter. They're telling you there's no paper. I mean those are discouraging. Those are, can make you become disenchanted with the system. That even a paper. How can there be no paper or you want to print? They tell you there is no ink to print, to print.

Despondently, Participant PD0024 talked about frustrating experiences of erratic electricity and bad roads: "you are plying the road, the roads are bad and be like, is every day that I have to be doing this? ... frustrations or the electricity supply is almost erratic." In the same plight, Participant PD0012 recounted times of disappointing experiences about nonavailability of basic work amenities: "things like power, provision of basic amenities, electricity, water. A lot of times, we are in the theatre, everybody is available to do a particular surgery, for instance now, and then there's no power. Or when there's no water."

Participant PD0019 decried experiences of being exposed to hazardous work environment without protections:

> For example, at least there are some facilities that you need to protect yourself as a health care provider. Provider like a PPE. Nobody cares. So, you just keep working as long as the work is get done. I'm a histopathologist scientist. So, I work in the histopathology lab where I'm exposed to xylene, where I'm exposed to formalin where I'm exposed to alcohol, and where I'm exposed to some other reagents that some of them are actually carcinogenic, but then I'm not being protected … Yes. I don't have anything to protect myself … There are masks that we use. Okay. When, whenever you are getting, whenever you find yourself around all these chemicals like xylene, formalin, and co. There are special mask you use to protect yourself, especially to protect your respiratory system from being infected or being affected by this chemical. But there's nothing like that.

Similarly, Participant PD0011 lamented about exposure to hazards and inadequate hazard allowance:

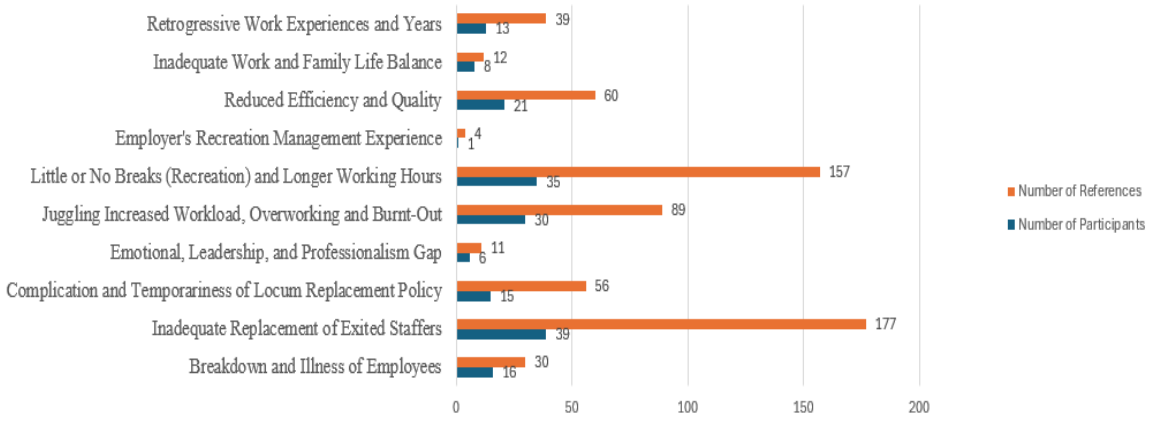
> The feeling. The experience. Okay, there is no care. Because part of the care and what we supposed to enjoy is this hazard allowances as hospital workers. You can imagine over the years they give you 5000 naira as hazard allowance for … For a month. When you face those crowd that come with different ailments, and also try to protect yourself from those ailments, not to contact those things, you know. And those of us working with radiation. The hazard, the radiation hazard, it's 5000 Naira a month and 56,000 a year. Can it take care, God forbid, can it take care of the effect of radiation problem when it eventually comes?

Subtheme 2: Labor Shortages, Breakdown From Burnouts, and Nonreplacement of Exited Staffers

All 39 participants (100%) complained of excess workloads (see Figure 7) which implied labor shortages in carrying out daily tasks; 16 of the 39 participants complained of breakdown/illness incidences. The employer's excess assumption test was carried out to determine the adequacy of health workers in the public health service (see Figures 7 and 8) in addition to further participants' complaints about inadequate replacement of exited staffers, little or no break (recreation) in a long work period, reduced efficiency/quality, and retrogressive work routine.

Figure 7

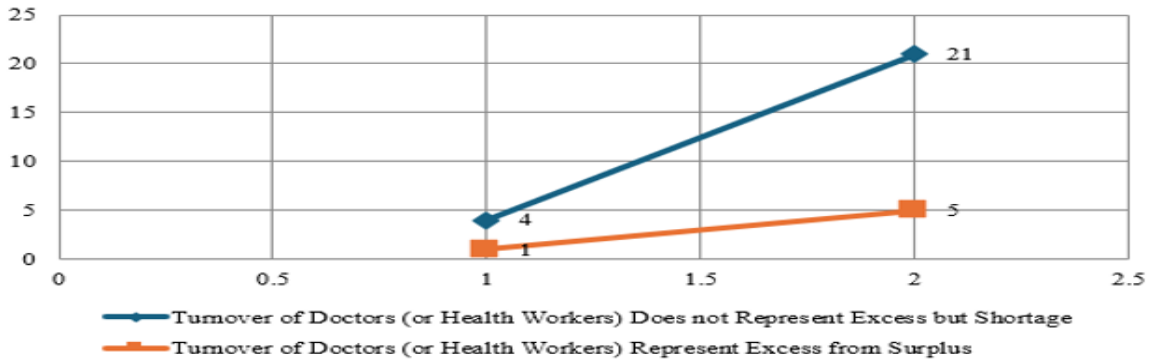
Labor Shortage Impacts



The Employer's Excess Assumption Test. The responses from all 39 participants in Figure 7 indicated dire shortages of labor, excess workloads, and burnouts.

Figure 8

Employer's Excess Assumption Test Results



Furthermore, five participants at the peak of their careers (three employee participants/consultant doctors, one employer participant/consultant doctor, and one employer participant/director) resolved the excess doctors/health workers' assumption test (see Figure 8) by indicating their perceptions and experiences.

All the four consultant doctors (participants) indicated no excess health professionals but shortage of doctors/health workers in the health sector. Employee Participant PD0012 affirmed: "I don't know where they get their statistics from. But I can say that it is definitely wrong." In the same experience, an employer participant insisted: "I don't agree with that, see there's no excess doctor o [laugh]. We don't have medical doctors o, that's why we are recruiting. As we are recruiting, they are leaving."

Thus, WHO best practice standard recommendation of 1 doctor to 600 patients is not satisfied in the Nigerian public health sector as experienced by the consultant doctor participants. Omeje (2021) reported that access to health care in Nigeria is below optimal requirement in the cities and gets worse in rural areas where thousands of persons

compete to access a doctor. These conditions persist and will worsen if the employer's interventions fail to succeed in reversing the turnover trend.

Breakdown and Illness of Employees Because of Excess Workload From Turnover Impacts. Sixteen employees of the 39 participants (41.03% of all participants and 45.71% of employee participants, Figure 7) that complained of excess work pressure cited stress-related issues of breakdown, illness, and fatigues. Oruh and Dibia (2020) and Oruh et al. (2020) stated that excess workloads, burnout, and labor exploitations are common push factor stressors responsible for turnover and turnover intentions. The implication of participants' perceptions and experiences of excess workload, breakdown, illness, or burnout is the persistence of complaints, turnover, and exit intentions.

Consequently, Participant PD0009 stated that:

> it has not been easy for us in the nursing unit. And the workload is so much because, I want to use myself as an example when we are in the female surgical ward, the ward is 24, 25 bedroom and we will be only two on duty because we don't have enough. They will employ somebody this, this month, within 4 months they travel. So, we that couldn't travel, it becomes an issue. Because you work and work and get so exhausted … The workload is much, that is just the challenge. Nobody is happy about it. No body.

Likewise, Participant PD0011 expressed that the workload burden is compounded with no replacement of exited staff:

> People keep on leaving. No replacement. How will you be motivated? And they, if they are in the service where, maybe your colleagues, as colleagues we are

> about, say, 20 and people are leaving, no replacement and get you out to maybe eight or six, then, is there any, are there any motivations there? ... The discouragement is on, people leaving, and the workload is getting more than before.

Furthermore, Participant PD0016 stated that the volume of work was overwhelming with attendant extended hours of work:

> The, the workload is too much I had to ask for permission of one of them to join me and I make sure I finish the dressing. I closed around 7:00 PM before I was transferred to this my present ward. And the present ward now, with all that we do observe, and there was a time they brought a student to me on observation and the student cannot go alone. I had to take the parents' number and called them and where they are coming from is very far. Something I'll close 4, I stayed till 9:00 PM before the mother came.

Similarly, Participant PD0034 responded that "Individually, on my own personal level, the effects on everybody's increased workload because if you have like 10 people working and three or four have left, you still have to continue the same volume of work. Even more work"

Poignantly, Participant PD0009 expressed painful health conditions occasioned by excess work pressures: "So, the work, like me now, I'm having serious waist pain. I cannot bend down as I'm telling you I can't bend down." Participant PD0009 continued the painful expression,

> Yes, I take drug every day. I can't bend down as you see me here. I work. Anything that will make me to come down like this I avoid it. Majority of us are like this, especially nurses. We are, we are not many because everybody wants greener pasture. That is just the truth. The money we are getting is not enough. Even if you are getting enough, we are not getting, since you are not getting enough. The workload is much, that is just the challenge. Nobody is happy about it. No body. In fact, let me tell you, everybody wants to go.

Likewise, Participant PD0030 confessed that the workload impacts "At increased stress to us and no additional benefits." Participant PD0030 emphasized the health challenges experienced:

> Yes. Official sick off, officially given a sick off from the clinic because of ill health. So it's a lot of, a lot of challenges, okay, a lot of challenges. And there's a limit to the adjustments we can make as humans. Yes.

In the same dilemma, Participant PD0034 complained that "currently I, I use a back support…when you sit for too long, you know, it could affect."

The 39 (100%) participants' responses in Figure 7 point at the excess workload and burnout that are caused by the high turnover trend as not acceptable and proper in the health care industry. All the 35 employee participants yearned for remedies from the employer to remove the stressful excess workload and mitigate the high turnover trend, employee health breakdowns, and turnover intentions. Yalma and Asuzu (2020) reported that participants in their study exited their jobs or country because of excess workloads,

stress, and poor working conditions. However, the employer appeared overwhelmed and unable to ameliorate the predicaments of the employees.

Consequently, an employer Participant PD0026 expressed the employer's incapacitation:

> We try to collapse the wards together and ensure that, um, where we have, um, different we have, we ensure that the number of people that will cover those complexes are now put together instead of separating them. Um, so that the available number can be utilized for that purpose. I won't deny the fact that we also apply for recruitment or personnel. Uh, but I can tell you in the past 2 years as we're recruiting, they're leaving … So, we recruit every year. Um, just this last year, we recruited over 30 nurses. Uh, upper last year also, we recruited over 30 nurses, um, about 20 doctors, 20 doctors. But what happen is that after they start for 1 year, second year, they're gone. So you see number, you see that, we see that as we make effort to recruit, to solve the problem, but the problem persists.

Thus, the employer as an organization accepted its failure to sufficiently resolve the turnover-induced labor shortage problems.

Inadequate Replacement of Exited Staffers. The replacement of exited staffers is the employer's responsibility. All four employer participants (see Figure 9) complained of being overwhelmed and limited to carry out that function amidst the high trend of turnover. Participant PD0001 complained that "it's been a challenge the last few years. But in terms of coping, I don't think we are coping."

Figure 9

Ineffective and Inefficient Federal Health Administration and Policies

Furthermore, Participant PD0001 bemoaned the employer's limitation that:

> it's also challenging to do that because you know we, as an administration, we are centrally regulated from the federal ministry. So it's not always that quick to get approval to employ replacement when people leave. Well, bye and large, we've survived in having more of locum staff to replace them. So we are able to get those locums quickly, ehm, to replace and at least offers some support in various units where those staff have left. But I must tell you that it has actually severely affected the hospital services. It has also impacted on the existing, the permanent staff who are still here, and have to do more work than they would have.

The employer Participant PD0026 expressed the employer's bewilderment in resolving the turnover problems: "So you see number, you see that, we see that as we make effort to recruit, to solve the problem, but the problem persists." In the same vein, employer Participant PD0028 expressed the employer's incapacitation:

> we ask for replacement from the federal government, they will not give that approval at that particular time … The only thing, we have challenges is the number of people that are working at that same time … If the federal government will do same by helping us to replace those people that exit service, it'll go a long way to help the system … So, when the federal government is not allowing that we do within our reach to help ourselves out. We also try to pick people we call locum staff. Experts from somewhere, you know, who want to work. You know, with us, we call them locum staff.

Similarly, employer Participant PD0031 expressed the employer's handicap in resolving the turnover issue which the employer described as a stressful task: "We don't have medical doctors o, that's why we are recruiting. As we are recruiting, they are leaving … It's stressful but we are coping."

Thus, the task of replacing the turnover-induced vacancies is complicated and beyond the hospital administrators who represent the employer. All 39 participants complained of inadequate replacement of exited employees which the employer's replacement policy (called locum) could not resolve.

Consequently, Participant PD0015 illustrated locum's weakness:

> Yes. Are they not trained nurses? ... They don't. They don't stay. Because. OK, let me just give you an instance. You employ 10 nurses this month, maybe within 2 months, you employ 10 nurses. Within that 2 months, 15 left. Are you not still having deficits? ... Yes, so that is the problem, and they are not even trying to match it. Because if ten leaves, ten enter, it will still be balanced.

In another dimension, Participant PD0033 clarified the locum problem:

> Like see, um, I can tell you that I, the number of nurses that have left the system in this establishment will be going to the hundreds … They have been replaced. But here is the problem. If hundred people leave a system. And you bring in 30 or 40 … They have not been replaced! There's a gap … Those 40? I can tell you they themselves, the majority of them, like I always tell people that they're just here to shore up their bank accounts and they leave too.

Astonishingly, Participant PD0034 expressed a surprise on why the employer is inefficient and ineffective in filling the vacancies: "But why? We have enough doctors still in this country, large number still out there. Who actually waiting to come in to do this, I mean this, this work." Thus, it is a paradox that specialist applicants as health workers abound in Nigeria, but the employer is not able to employ and retain them to stabilize its workforce.

Little or No Break (Recreation) and Longer Working Hours. All 35 employee participants in Figure 7 (100.00% of employee participants and 89.74% of all participants) narrated experiences of little or no recreation or break during office hours. Participant PD0007 shared a frequent experience pattern that excluded recreation or break schedules:

> For recreation, the only, there's no time for recreation. But when you want to eat you can go and eat. It can be 30 minutes, you're back to your work. Eh eh. There is no specific time, although we are supposed to have an hour break, maybe for eating or however, but most of the time we don't observe it. If the ward is busy,

> you can even carry your food and go home. So, but ideally, it's meant to be an hour, but most of the time it's not observed.

Participant PD0011 had similar experience of little or no recreation during work period: "Recreation. Recreation is, I can say exactly at zero level. Exactly these days, there's no, no time for me to go for break." Participant PD0016 revealed a work experience devoid of official recreation or break times: "See in this place, we don't go on break. Sometimes you bring your food, and it is when you will go home, you will remember that you have not eaten the food." Participant PD0021 indicated that: "Huh? We don't go on break here. We don't have specific time on break. So we don't have time for break."

Nevertheless, employer Participant PD0026 stated that the employer made recreation facilities and breaks available to employees but could not compel its utilization. Employer Participant PD0026 stated that "we make it available. Yeah, at this level, it's not in our job role." Furthermore, the employer Participant PD0026 clarified on the availability of recreational facilities and employees' nonutilization:

> We are aware of the challenges, and so we ensure that, um, we look towards that. We have all, we have a, we have a gym. We have health, uh, we have a long tennis court where we expect that they would make use of all these things. But you know, most of our staff, they, they, people are more, [Sigh to emphasis point] it's just when you look at the, the fraction of people that use these facilities, it's just gonna be a little lower, you know. But I will assume that, uh, whatever sensitization we've done in the area of health, they'll go home and do whatever

> they need to do about it … Some of them use it. But, you know, a lot of people have excused why they're not using it. They want to go home. They cannot remove their clothes during office hour, you know, but there are provision for all this. I play long tennis. I go to our gym; we have a gym … We encourage. You understand. And insurance, it's available.

Reduced Efficiency and Quality. Twenty-one employee participants in Figure 7 (60.00% of employee participants and 53.85% of all participants) reported about reduced work efficiency/quality in their work experience. Participant PD0024 recounted an experience that the service efficiency gap created cannot be filled except with the replacement of exited employees:

> Yeah, well in all fairness, as much as possible. We try in our best capacity to give the best to the patients, even in the face of this shortage of manpower … No, well, well, what I would say is, um, we are coping, but there's still, it, it, it's telling on us. Let me put it that way. We are trying to fill the gap, but in as much it's still not there yet because, um, in all fairness, you can't fill the gap except you have a replacement for those that have left. So, so in a way, even, even though in as much as possible, we are trying to give the best to the patients, we still know that we are not giving the full, uh, how do I put it? We're not giving it 100%, and I, I'm trying to be realistic … Yes. Yes. So, so, um, for example, some patients will complain that when they, they are, they see their doctors, they'll say probably doctor didn't hear them out. And they didn't have that time, that robust time to have discussion.

The impact of labor shortages negatively affected patient services/efficiency and subjected the fewer staff to longer working hours with little or no break.

Retrogressive Work Experiences and Years. Thirteen employee participants (37.14% of employee participants and 33.33% of all participants, see Figure 7) complained of retrogressive work experiences and the retrogressive quality of service years. Participant PD0010 complained: “I’m doing basic professional job. I should have 10, 20 younger ones that I will supervise. So, who's going to supervise me?” Participant PD0015 lamented about retrogressive work experiences:

> at our level which is supposed to be supervisory, we find ourselves doing all these jobs like that the, the, the junior ones are supposed to do because we don't have. We have more of the senior ones available now. They are the ones that are on ground, senior ones. So, that is it. It’s really paining,

Participant PD0018 expressed disenchantment at retrogressive years and experiences which Participant PD0018 claimed that the employer administrators did not suffer such retrogression as employees:

> Certainly, theirs might be, might have been better because Nigeria keeps deteriorating. So, it means 2015 is better than 2016. Likewise, 2022 is better than 2023. That's how Nigeria is. So, so most times they have, they have it better.

According to Participant PD0025, the patient and the professionals have suffered reduced benefits:

> And like 2, 3 years ago, the complainant then was, um, the, uh, deficiency, deficiencies in the number of professionals. Now that the, the majority of people

> are even leaving, I mean the; more professionals are leaving and the patients still, the, the, the load of patients may be increasing. So you understand how overwhelming it could be. So, um, how do we cope? Yes, we do what we can do. [laugh] You understand? So, what it means is that, uh, the effectiveness, you can't get, you can't get it hundred percent. So, what it means is that you have to, as a psychiatrist, for instance, I need to, if I run a clinic, I may need to spend like 30, 45 minutes with a patient. So, but with this load, so that luxury, it's not, uh, affordable. So instead of saying, I want to spend 30, 45 minutes, maybe I need to, I can just call down the time I spend with the patient to like maybe 10, 15 minutes … The patient don't get up to what they're supposed to get. So, everybody's affected, the professionals are affected, the patients are affected.

Participant PD0027 narrated a retrogressive coping experience:

> sometimes it has to mean that a senior staff would've to be doing the work of a junior staff all in the name of coping. So as I rise in the level, there are some things I might not be expected to do, but because there are, if more junior cadre staff have left, then you have to step in because someone has to do that role. So, we try to cope that way too. And definitely that has led to some other, um, health impact and psychological impact, but we, we have no choice to work as to move.

Furthermore, Participant PD0037 narrated a painful frequent retrogressive experience occasioned by sudden staff exits:

> Yeah. The way it impacts on me directly is the fact that, um, um, over time the, we've had instances, particularly the last rotation before now. That's penultimate

> rotation. Uh, where I had two residents working with me, two senior registrars. And just me going to the rotation, uh, a week apart, the two of them resigned and I had to run through the whole gamut of the clinical work, administrative work, I mean, name it all by myself until the point when the management just gave me, uh, made a stopgap measure to post someone down to me to help me through that, uh, patch. So it can be very, uh, impactful in term, negatively, if I may say…In the last, uh, 2 years? It, it's a regular occurrence…say every 2, every 2 and a half months? Yes.

The continuous effects of acute labor shortage and longer working hours became a discouragement to employees and altered the experiences of line managers and their seniors. Hence, the retrogressive work experience involved the seniors doing the work of juniors as a persistent undesirable schedule. Thus, retrogressive work burdens were not only overbearing as excess workloads but were push factors on professionals to contemplate exiting the system, which further compounded the excess workload problem.

Subtheme 3: Poor Overall Leadership Effectiveness

All 39 participants recounted different experiences (see Figures 10, 11, and 12) about employer's insensitivity, breaches, conflicts in leadership/administration experiences, misapplications of political/administrative powers, pesky relationships between supervisors and subordinates, poor service delivery, and patients' transferred aggression for failures of the employer. All four employer participants (100%) gave responses that strengthened or alluded to a system rut tolerance, employer breaches, and confirmation of conflicts in leadership and administration despite the employer's claim of a leadership

effectiveness model. The claims of operational effective and efficient leadership effectiveness by the employer were diminished by the employee participants' majority denials of such prevailing operational benefits.

Figure 10

Poor Overall Leadership Effectiveness

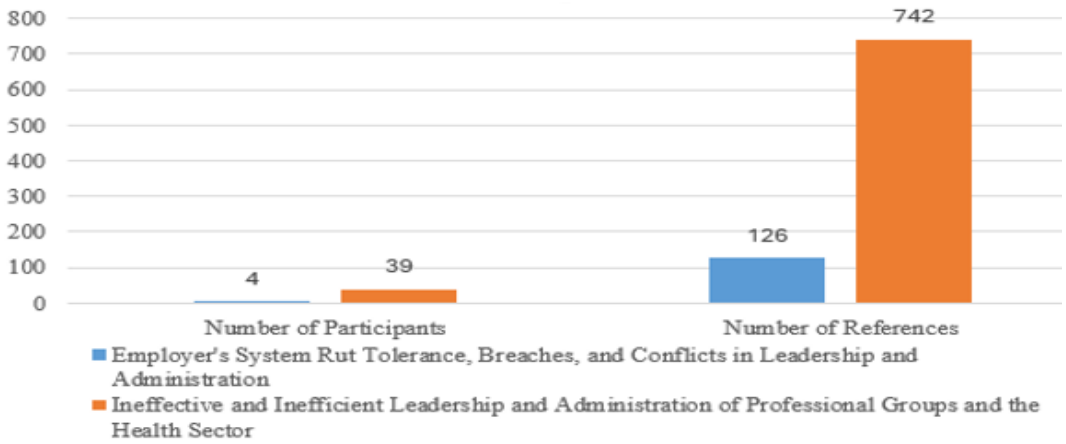
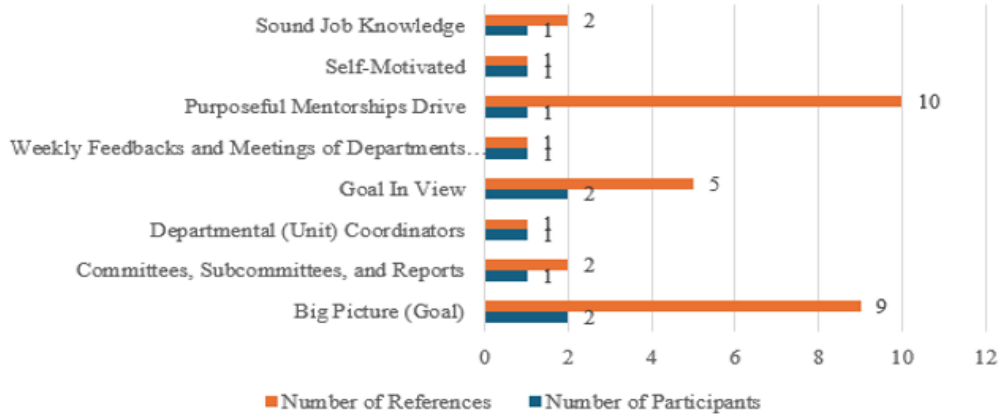


Figure 11

Employer's Leadership Effectiveness Model



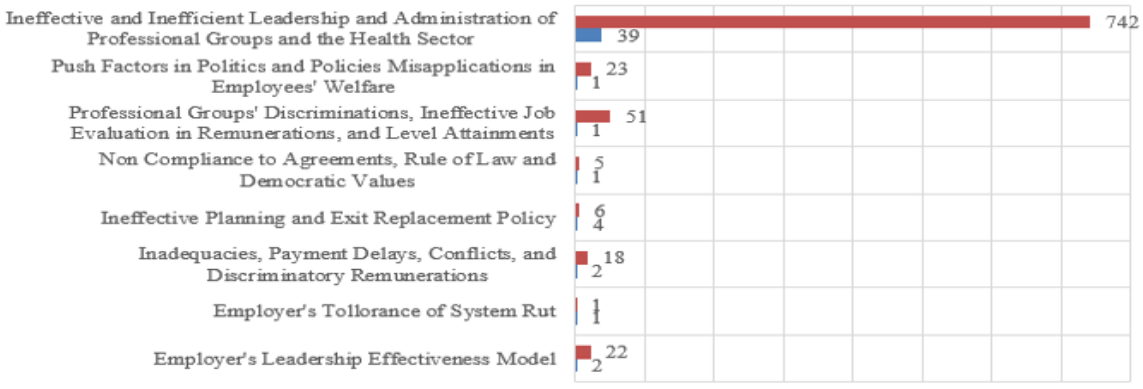
Employer's System Rut Tolerance, Breaches, and Conflicts in Leadership and Administration. The employer has an effectiveness model (see Figure 11) comprised of (a) a goal as the big picture, (b) purposeful mentorships drive, (c) self-

motivation, and (d) sound job knowledge. The employer Participant PD0026 explained the steps of the effectiveness model:

> From, from my own perspective, the best thing as a leader … is for you to have a big picture in mind … And as a leader, you are supposed to influence people to work and give their best to work … so you yourself must be well, well motivated and well, well driven so to be able to do that…So, the first thing is your inner drive in your inner ability to see the big picture and know that this is the big picture you're going to confront and be resolute, you know … It is also important for you to know your onions as a leader. Uh, because there will always be in a public sector like these people love to claim right. Uh, even when they know their right infringe on the right of others. So, um, you must be abreast of what you know, and know your onions and be able to drive it.

Figure 12

Employer's System Rut Tolerance, Breaches, and Conflicts



The employer Participant PD0031 expanded the model's clarification focused on the uses of effective committees and supervision of departments:

> Effectiveness, we achieve this through various means. Number 1, most of the important assignment, I have committee for them so that the workload does not rest on me alone. So, I have subcommittees, the subcommittee taking care of the environment, the subcommittee taking care of patient feeding. The subcommittee taking care of medication. The subcommittee taking care of the laboratory. So, all this make them to be active participants in running the system. So, everybody has a role. All they just need to do is to give me reports on monthly basis on what they do or what they do, or what they did not do or what they need to do. These are some of the things you get done … Secondly, secondly, apart from working through sub committees, I also have some head of departments who coordinate various units … And department for me, they also give me feedback through regular meetings. The hospital also has a top management committee that meets once a week every Wednesday where we discuss all the affairs of the hospital and put things in place or work related for the hospital. So, these are some of the ways we make sure that people are effective … In the discharge of their duty. So, the HOD head of department has responsibility. The committees and their chairman also have their responsibility. So, it makes the job seamless and easy.

However, the employer participants and the employee participants narrated different experiences that were unaligned with the generic purpose/goal descriptions of the employer's effectiveness model. For instance, Participant PD0026 frankly revealed that the employer experienced helplessness in health service system and tolerated the system rut limiting the "resolute" goal/reform of the effectiveness model:

> So, but the truth of the matter is the system, we, we cannot have it still because the larger society is not having it. We are microcosm of the bigger society. So nothing theoretically, didactically, or anything empirically, we'll keep having it in paper, but in practical terms, we're not ready for that change.

The employer Participant PD0026 expressed frankness in the employer's ineffectiveness in filling the vacancies: "but I can tell you in the past 2 years as we're recruiting, they're leaving." Participant PD0026 expressed a variance between theory and practice because of weak or no political will to do what is right: "let me just be sincere with you. The public service is … well defined … But in practice, we may have problem because all we needed is just a political will to do the right thing."

Furthermore, the employer Participant PD0026 recounted experiences of inadequacies, conflicts, payment delays, and discriminatory remunerations in the public health sector:

> It's not adequate, for instance … when you say, okay, this is doctor, this is nurse, this is the psychology, psychologist, are there mutual respect among this team? Is it that the doctor will see, the nurse will see the doctor as the only one that is the beneficiary of the whole system? For instance, I've told them job evaluation is bad in the public service, especially in the health sector … Yes. For instance, you said the doctor should earn more than the nurse … There are parameters for doing that … Yes. All jobs should be evaluated … Every man should man his own profession … But in this case, the doctors are manning their [other colleague's professions that are not doctors] own unit … Which is where things will not work

> … Yes. This is where we have a lot of problem. If you want to put that doctor in a, to head, put him in an office different from the office where the, the, the, the, the laboratorist is … How can, how can a junior doctor be earning more than somebody who has spent 25 years in service? You, you, you get what I'm saying?

Similarly, employer Participant PD0028 spoke about inadequate remunerations administered to the employees and recommended remunerations improvement to beneficially reverse the turnover trend:

> Well, I will suggest that uh, governments, governments should look into the aspect of, uh, improving the remuneration of, uh, workers, because there are most people, most people are not intending to japa, so to speak in quote. Eh, some people want to stay in their father land and then do their best, you know, and help, uh, the society. But, uh, when you talk about the take home package that cannot take care of you and your family, you might start thinking otherwise. But then if there will be a change or improvement on that aspect, it'll go a long way to sustain what we have here. People will relax more.

Whereas the employer Participant PD0026 admitted that the employee's legitimate right to freedom of movement cannot be stopped, but the employer's duty "is to make our own economy much better and make the work environment much more attractive to the extent that those going abroad will not see anything to go there." Participant PD0026 emphasized a solution, that "it's more of the environment. It's more of the politics in the system, it's more of the rule of law that are working in, it's more of the democratization of the system. Yeah." The responses of the employer participants

indicated a reality of employer's lethargy, apathy, or helpless subordination to another power/interest that is averse to public interest.

The employee Participant PD0034 bemoaned the fact that employees' unions "agree with the government of something. And they're not fulfilling that promise." Participant PD0034 decried the employer's breaches, that: "the association, the union have agreed and it's all publicized, sign memorandum of understanding. And there's no understanding after that, that one too is really, it puts, it puts me off." Likewise, Participant PD0038 recounted that the employer does not keep agreements: 'Okay, let's promise them this. Then they go back to work and then the same old cycle repeats and they're back to the joint table".

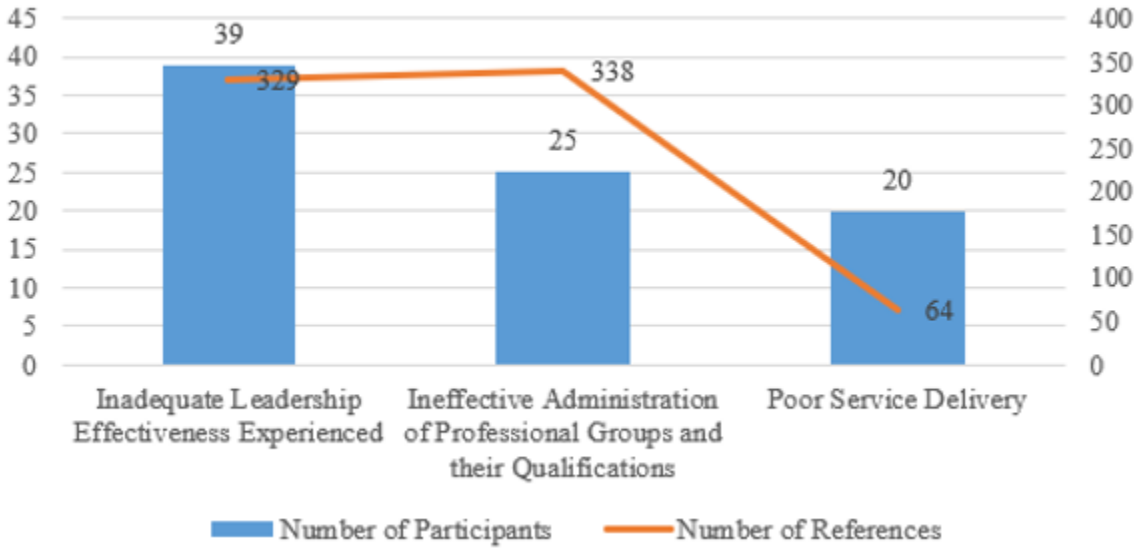
Similarly, the perception of Participant PD0010 was that the employer does not keep promises: "Promise. None granted. Promise. Promise." In the same experience, the employee Participant PD0009 affirmatively expressed doubts that the employer could respond positively and keep agreements in the future: "Government will not change. They won't change. Provided it's Nigerian government, they won't change." These participants' expressions of perceived employer's breaches and inefficiency (see Figures 12 and 13) substantiated Akinola et al. (2022) report that citizens doubt government's integrity to rid the system of maladministration and corruption. Thus, participants' complaints represented professionals' exiguous trust in the government's leadership.

Ineffective and Inefficient Leadership and Administration of Professional Groups and the Health Sector. Ogaboh et al. (2020) opined that Nigeria's health sector was ineffective in leadership, policy formulation, staff trainings, and safety. Despite the

government's denials of any maladministration, the employee participants responded to corroborate evidence of employer's maladministration and leadership failures. All 39 participants shared different experiences on the leadership effectiveness of the employer (see Figure 11).

Figure 13

Ineffective and Inefficient Leadership and Administration of Professional Groups



Participants shared experiences and perceptions about the administration of professional groups within the Nigerian health sector. Three groups of responses occurred, including those in affirmation of enjoying the leadership effectiveness of the employer, those that did not enjoy it, and those that scored the employer's leadership effectiveness as being inadequate. Whereas 14 employee participants did not enjoy any leadership effectiveness, 12 employee participants enjoyed it, six employee participants criticized but commended the employer's leadership, and nine respondents indicated that the employer's leadership effectiveness was inadequate as discussed in the next sections.

Figure 14

Responses to Leadership Effectiveness Enjoyment Question

Inadequate Leadership Effectiveness Experienced. In the light of complaints about the excess workload, reduced labor, and turnover-induced stress, I asked the employee participants how they are enjoying the leadership effectiveness of the employer (see Figure 14). Twenty-three participants (58.97% of all participants or 65.71% of employee participants that included 14 and nine participants) experienced little or no leadership enjoyment. Twelve employee participants (34.29% of employee participants and 30.77% of all participants) responded affirmatively that they enjoyed the leadership effectiveness of the employer and 50% of the 12 employee participants (17.14% of employee participants and 15.39% of all participants) commended the employer activities for reasons and experiences that included (a) not restricting their promotions; (b) listening to them; (c) provision of lights, charging spots, and tea breaks; (d) constructing befitting buildings ; (e)conducting training programs; (f) relating with employees; (g) being

visionary and empathizing; (h) introduction of documentation/records automation; (g) being trusted and not micromanaged; and (h) seamless operations.

Participant PD0032 commended the employer for being accessible: "We get the opportunity to talk with him one-on-one. He gives us that room and um, I would say he really plays his role as a leader and as a senior." Likewise, Participant PD0038 commended the employer for provision of lights, charging spots, and tea breaks: "There's usually lights … so you can charge your phone, you can charge your laptops … there's no reason for me to be looking for paper … earlier this year, we started having like tea breaks at work."

Similarly, Participant PD0006 commended the employer for training programs enjoyed: "In, my immediate employer motivates us through training, training and retraining. For instance, we went for, in the last 6 months, virtually everybody in this hospital have gone for one training or the other …" Categorically, Participant PD0036 commended the employer for listening to them: "There's nobody that will not enjoy your leader listening to you … taking advice from you. That's a good one … wherever you hide, there are people that have your back. I'm enjoying those ones about them."

Nine employee participants (25.71% of employee participants and 23.08% of all participants in Figure 14) responded that the leadership effectiveness delivered by the employer was inadequate. Participant PD0004 shared a motivation amidst the inadequate leadership effectiveness:

> Well, the motivation, this time around, I may say as somebody at the management level, the motivation is coming from the fact that my own supervisors are now

> appreciative of the fact that I am elastic enough to accommodate the challenges that are coming and, you know, not micromanaging me is an indication of the trust they have in my ability to handle, handle the challenges that are coming. It's motivating to me because it means they appreciate my experience and my output that's why they are, they can sleep easy, when we do the tasks. So I'm happy about that.

Similarly, Participant PD0002 commended the employer for consistent promotions despite the inadequate leadership effectiveness: “The only thing I will say, I get my promotion as at when due. At least, since I came in here, I've never been restricted for my promotion at the expected time.” In the same breath, Participant PD0003 commended the employer for constructing befitting buildings: “We didn’t enjoy anything. But at least we have been given a befitting building unlike before the environment is, you know when you are coming you always get angry that you are even coming to the set-up.” Briskly, Participant PD0024 indicated that the employer was visionary and empathizing amidst the inadequate leadership effectiveness: “Yes … he's a visionary person … he tries to create this connection between his employee and himself … trying to empathize with them. And trying to make them see that I see your feeling. I can feel what you're going through …”

In response to the question on how the leadership effectiveness of the employer was enjoyed, 14 employees (40.00% of employee participants and 35.90% of all participants in Figure 14) shared experiences/perceptions that they did not enjoy the

leadership effectiveness of the employer. Participant PD0007 asserted that no form of leadership effectiveness was enjoyed:

> I don't. I don't think there's, there's any, any enjoyment in this, in this leadership of a thing we are experiencing now. I don't think there's any, there's nothing to enjoy. Had it been I don't love what I'm doing, I don't think I'll be coming to work [laughs].

In that line, Participant PD0018 narrated a perception and an experience to indicate that leadership effectiveness was not functioning:

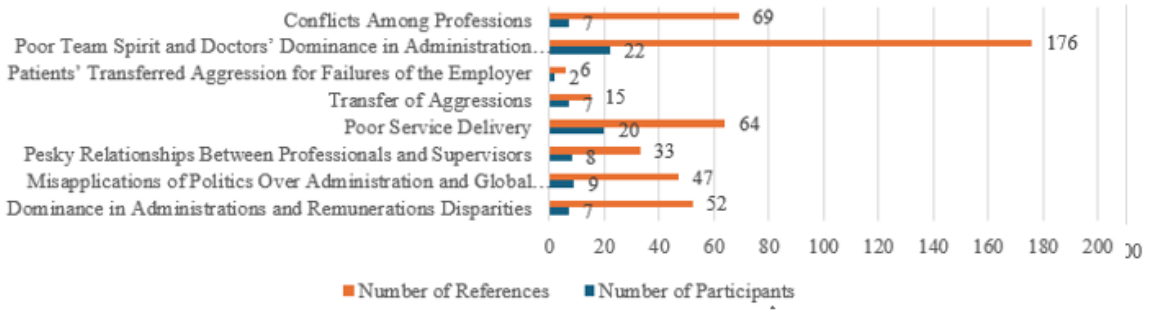
> we are in a system where people do things the way they want to. They form cabals. They're lackadaisical about things, the system does not check once somebody becomes the oga … sometimes you make complaints of certain things and as if it's falling on deaf ears … we've been complaining that we have, not too much, we have just mechanical ventilator, we have about two functioning in the ICU. The rest are not functioning ... let's bring in more mechanical ventilators. And we've lost patients that needed mechanical ventilators, but we don't have any to put them on. And you tell management these things and they say oh, imagine. The feedback you should get is to walk into the ICU few days or few weeks or few months down the line and see good functional mechanical ventilators ... Do you know the funny thing? By the time a minister is coming here, you find all those things … You just find things that you've not seen, that you've been fighting for them to bring. You just see it there … Yes, even in the theatre … But when it

dies down, everybody returns to status quo. So, what you hear is, we'll look into it, we'll attend to it.

In the same vein, Participant PD0019 indicated no enjoyment of leadership effectiveness: "Well in Nigeria context, yeah. Leaders are just after the work till they get done … They're not after your personal wellbeing. They're not after anything that has to do with you personally … I don't enjoy anything." Briefly, Participant PD0012 expressed feelings about no enjoyment of leadership effectiveness: "I am not enjoying them at all." Similarly, Participant PD0013 indicated no enjoyment of leadership effectiveness: "I say we are not feeling their, we are not, to the best of my knowledge, they need to ehm, do more … Apart from receiving the salary that they are giving; I don't know what they are doing." Likewise, Participant PD0014 indicated no enjoyment of any leadership effectiveness: "Honestly speaking, it is not, is not something I'm, I am not. It's subjective. I am not enjoying it, not enjoying it."

Figure 15

Poor Administration and Service Delivery Impacts

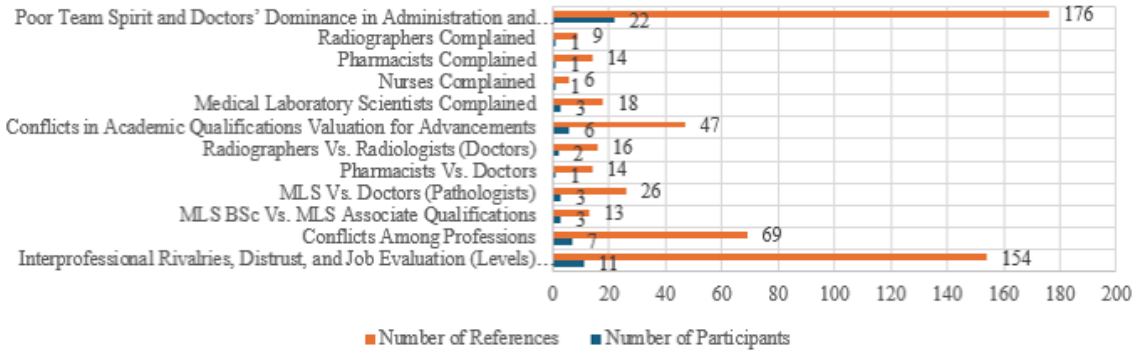


Ineffective Administration of Professional Groups and Their Qualifications. Twenty-two employee participants (62.86% of employee participants and 56.41% of all participants) experienced complaints (see Figures 15 and 16) that included conflicts in

academic qualifications valuations for advancements, doctors' dominance in administration and remunerations, interprofessional distrust and poor team spirit, job evaluation (levels) discrimination and rivalry, and pesky relationships between professionals (line managers) and supervisors.

Figure 16

Ineffective Administration of Professional Groups and Their Qualifications



Conflicts in Academic Qualifications Valuation for Advancements. Six employee participants in Figure 16 (17.14% of employee participants and 15.39% of all participants including nurses, radiographers, pharmacists, and medical laboratory scientists) experienced conflicts in the valuation of their academic qualifications for carrier advancement. Participant PD0021 narrated an experience of dichotomy and discrimination on the job:

> we came with associate … When if you did not also add your this thing, they'll not promote you to this level … If you don't add your master's degree, yes. They'll not promote you to an assistant director. That was actually what affected some … Because yes, they don't, they, they, they see association, associates as different from BSc. They have dichotomy in that. They say yes, you know, ministry of

> health, they, they don't even regard associate as a measurement of education as equivalent to BSc … It's the same job description … It's even the associate, it's even the, that the council that is giving that associate that are also giving these people an autonomy to work as medical lab scientist. But you know, at times this is actually the problem, I'm with AMLSCN. I went to do my fellows; I brought my fellow certificate. They said no, I went to do my master's. And even when I was applying for my master's, it was a, it was a tug of war …

Conflicts Among Professions. Seven employee participants in Figure 15 (20.00% of employee participants and 17.95% of all participants) complained of discrimination affecting their career progression and administrative functions. Specifically, medical laboratory scientists shared intra-professional conflicts on qualification issues with HND, Associates, and BSc degree qualifications. Participant PD0003 narrated the experienced disparities and discriminations:

> this categorization of staff like we that went to the school of medical laboratory science institute before the program is being turned to degree, you understand. So, there's a disparity and including people that have HND and BSc, there's a disparity. Meanwhile, those people are just, that started from the university, when they come, it's we that are on the ground that will still train them, train these people. But at the end of the day, they are always after the paper certification which is no skill. Because most of us that have gone to school of medical laboratory sciences, we are the one on ground in order to train the incoming one that graduated from the university and at the end of the day when the time now

> come there is a bar that we can reach because we have gone to school of medical laboratory, likewise nurses. You understand? Not only scientists. Nurses, radiographers.

Medical laboratory scientists experienced conflicts with pathologist doctors as revealed by Participant PD0020:

> But they believe that the pathologist that does not have so much brain in my unit knows it better than me … Well, that is what they feel and they will attend to the pathologist rather than attend to me … Okay. Then, if you give a professional advice, then the pathologist gives a professional advice … They seem to take, okay, I don't know if this is because they all sit together, because they have a common um, practice.

Participant PD0022, a radiographer, shared a discriminatory experience with an example as a solution:

> There's a politics in medical sector … That, okay, if it, if it comes to admin, administering this environment, we can do it as well. But you are being, you are being disenfranchised. You are being prevented from getting to that capacity. And because somebody knows that, okay, it's only its profession that can get there. So they believe that other ones are worthless, are second citizen on the premises … We have, we have made enough noise to federal government about this. Even president Tinubu! … Through my union. I'm a union leader … That if, if at all, we are going to have them because of course they're part of us in the health profession, we're going to have them. It should not be only one. Like, you know,

> we in the past, we used to have minister of health and minister of state for health. There should be one of the other head professionals among the two … Either pharmacist as the head, doctor as a minister of state. Or doctor as head or radiographer as the minister of health. Like that. If it goes round, then this discrimination will definitely be removed … the director general of the World Health Organization is not a doctor, just to tell you that the best practice is not the best in Nigeria … All we are saying is let there be egalitarian.

In addition to radiographers, nurses, and medical laboratory scientists, pharmacists are, similarly, complaining about experiencing discrimination and rights denials/frustrations. Participant PD0035 shared similar experiences of discrimination and denial of dues:

> Let me start from qualification. I'm a consultant, a qualified, certified, uh, west, member of West African Postgraduate College of Pharmacists. And that prescription called for becoming a, a, a consultant. When you qualify for it, you become a consultant in your field. Since 2022, 2018, I mean, the federal government have given us a letter of, or a letter that we will be appointed as a consultant in the institution. But the medical directors, the federal medical directors in the, in the nation stopped that. Pharmacists cannot get to consultant level. Pharmacists cannot be paid specialist allowance. And this has been holding since 2018 up to date … With, with their own concept, because the medical, the, uh, minister of health comes from their own jurisdiction, even when the head of service have given out orders that it should be implemented. We saw that they

> met as a member of a, as a group of, uh, uh, medical directors, and agreed that they don't see a reason why pharmacists should be paid, be given any specialist allowance. They don't see reason why pharmacists should be called consultants … We have been on it, we have been on it. This is, this is what government have given to us as early as 2007 accredited, certified … The minister of health stood on it and … Yes. The minister, the minister of health has not given them, the medical directors; they are saying that the minister of health has not given them a go-ahead nod.

These discriminations, rivalries, and conflicts became more impactful because of the turnover-induced labor shortage, excess workload, and stress which accentuate the problem in a vicious cycle to perpetuate the exit intentions and turnover.

Poor Team Spirit and Doctors' Dominance in Administration and Remunerations. Twenty-two employee participants in Figures 15 and 16 (62.86% of employee participants and 56.41% of all participants) complained of poor teamwork amidst the turnover-induced excess workload and doctors' dominance. The doctors' dominance of administration was at the center of pesky relationships and interprofessional groups' disharmony. Alubo and Hunduh (2017) and Mohammed et al. (2022) reported that the Nigerian health sector promoted medical doctors' dominance and interprofessional rivalries with pharmacists, nurses, radiographers, laboratory scientists, and physiotherapists. That implied a discriminatory leadership process and poor teamwork with colleagues. Participant PD0035 corroborated that disharmony and neglect by medical doctors who dominated administration:

> I must tell you that the, the job we do is like a teamwork deal, most projected to some profession when, when a profession become domineering over others … It makes you feel that maybe your own profession should not have been in existence … Good? I work as a health care team. Thus, I'll give you an instance of where I made a clinical presentation. I had made a slide to project pharmaceutical care practice within my ambit of practice. And because I was not, because those in charge felt that they would give me less opportunity to express my own feelings, I felt it was not good enough. They don't want me to sell myself. And they had their own profession being given enough time.

Participant PD0022 shared analogous experiences about doctors' dominance of administration and disenfranchisement of other medical groups:

> if it, if it comes to admin, administering this environment, we can do it as well. But you are being, you are being disenfranchised. You are being prevented from getting to that capacity. And because somebody knows that, okay, it's only its profession that can get there. So they believe that other ones are worthless, are second citizen on the premises.

Similarly, Participant PD0021 narrated an experience of poor team collaboration and discrimination:

> See, they have been fighting on that. They've been on it. They've been on it for a long time. That's what I'm telling you now, I'm telling you that we don't enjoy it. I don't think that there are other people in this profession that ask about this, that they'll tell you that they're enjoying this. Doctors have infiltrated all over the

> places. Do you know that they're the ones, when you talk about ICT, they're heading ICT? When you talk about this other one, they're heading this other one. When you talk about this other one, they're heading this other one. We've been on fights. We have been on fights. On daily basis, on daily basis.

Participant PD0018 narrated disharmonious experience between resident doctors and a colleague (chief medical director):

> Should, should inform the ministry of health that, oh, we are having shortage of like five doctors or six doctors. Let me give you one good example that comes to mind. They cancelled what we call bench fee because sometimes our training entails we go to other hospitals to train also. In Igbobi, we don't have general surgery, we don't have [Pause a moment] … In Igbobi, we don't have general surgery and we don't have some other stuff like that. Do you understand the point? So you have to go to place like LUTH or LASUTH where they have surgeons and neurosurgeons to acquire some skills and training that would better equip you to be the holistic doctor the system wants you to be. We apply to LUTH, to LASUTH, and we told them that they've cancelled bench fee. The CMD then told us then that we must pay the bench fee, even give, gave us letters that show that we must pay the bench fee. And the bench fee was how much? Twenty-five thousand, it was, it was not, it was cheap. But the association of resident doctors have agreed with federal government that that fee should no longer be paid. Because we are going there not just to learn but to also render service … Do you know what? We now went to our president, the ARD president,

> the national ARD president and told him. The man called the, the, the, the CMD out. And guess what he said? He now told the government that they have enough residents, they don't need us again…They don't have enough residents. The residents are crying. And somebody because he wants to say Okay, these people, they think they'll go and report me and go, scot-free, I will declare to the government that I have enough residents.

The team experience between nurses and doctors was an issue. Participant PD0009 complained of doctors' dominance in remuneration, politics, and administration:

> They don't, they don't, because I want to tell you this. If, if you have worked as a nurse for 12 years. A medical student that is entering for the first time, your salary and that, that person's salary is the same … The cheating is too much … I have a degree in nursing. I'm a BSc holder … I entered with eh you know, nursing, we entered with the general nursing, nursing and midwifery council, RN, RN, that is how we entered. Initially, majority did not do BSc nursing. But upon your years of experience, when those students enter, their salary and their own is the same ... The thing is, the payment is from the top. It is not FMC that is paying us … We, we don't work in the same pace. … They have come this morning to do ward round, they have gone. The work is, mainly we are the people doing the job.

Participant PD0004 bemoaned the experience of interprofessional politics and rivalry plaguing the Nigerian medical professions:

> Well, times when you look at maybe a challenge and it is difficult to handle because of the level of steps you have to go to be able to sort it out; is in the, and

> another thing is the factor that is a bit ubiquitous, which is interprofessional politics and rivalry. It is ehm; it's really not a good one. In the sense that it makes it difficult for, for one to be, how do I put it ... Things are not done in, in a very transparent, eh, manna when it is, it's, a, it's a situation that is playing between professional groups. In short, I must tell you that that's the kind of discrimination, it may, you know, be existing in different places. It may not be so serious where I am in this institution. But it is, it's all over and the fact that one is here does not limit one to this place here. OK, there are colleagues in other places. You have to interact with people in terms of knowledge and information. But it's a bit limiting in the sense that you meet a dead end when you are going outside your professional, ehm, walls of your profession to access information. Because there is a kind of discrimination and secrecy between the individual profession and that has robbed off on something that is close to my heart and that is medical research. So in this country, medical research is suffering because of that interprofessional rivalry and discrimination.

According to Participant PD0002, it was not a pleasant experience because medical doctors dominated all departments and were head of all committees:

> Do I have any experience? The only, the only challenge I have with. Then you know in my department here, and I won't really say it's my employer [medical director]. I think it's from the ministry because you know here, no matter your level of education; they still bring the doctors to come and head … They still bring the doctors in to come and head. You can see when you came in, you asked

> for the HOD, I directed you to the Secretary to the HOD's office. The HOD is a medical doctor … Yes, that is just one of the discouragements that I personally I'm experiencing in the department, in the environment where I work. Then you've noticed that in the hospital set-up, there's no committee that is being raised, any committee formed must be headed by a medical doctor. That mentality is there.

Pesky Relationships Between Professionals and Supervisors. Mohammed et al. (2022) reported that there was a lack of adequate teamwork among health professionals in Nigeria. This poor colleagueship cooperation extended to frictions between supervisors and subordinates in the course of duties. Eight employee participants in Figure 15 (22.86% of all participants or 20.51% of employee participants) complained of pesky relationships with superiors.

Emotionally, Participant PD0014 complained of strained relationship with superiors/leaders which involved shouting at subordinate in a way perceived as excessive or disorderly:

> OK ... our leadership ... if you have done something, maybe there is something that doesn't need to be, doesn't warrant, you know, kind of shouting. Or maybe, you know, somebody will just call you and something you can just say, OK, this is done like this or this is not done like this, the, the way they take things as if … I understand the, this is inappropriate way of discipline, this, not, it wasn't even anything to discipline, it was just saying, for instance, let me give an example. There was, we are now using computer. We are on the EMR, Electronic medical

> record, that's what we use now … So, a day after a very stressful night, for 16 hours, I was called to the office and said that, ok, ehmm, why did you change this, the thing is like 2 minutes delay on ward round. I now ask, this 2-minute delay, is it my fault? Is it not computer? It is, why is, on the other hand, computer has recorded it I input, and computer reads, it depends. Come and check. Because of this, they made a mountain … Just something that wasn't real … Because it wasn't a caution. It's not a caution because it's not a fault. It's not a fault. No, no, no. So, I I'm just telling you many, many things that have occurred that make somebody to feel like leaving the job one day.

Furthermore, Participant PD0014 complained about the strained relationship with a superior, and its negative patient's care implications:

> The manpower is not there, the manpower is not there. The people that are still managing to do and they don't want to *japa*, maybe they have not *japa*, they, they may still *japa*, but they're still there. You are not managing them well to be able to, at least, even if you are, they will go, they will do that we work with the whole of their hearts to be able to, you know, to achieve their aim. Our aim is to care for the clients and for them to have a good delivery, good service. If you are already discouraged somebody, that person will not have that spirit. You will just be angry while you're doing your job. The person you're angry with is the one paying, he's paying for the service … I have many things that have happened that made me to not be interested in this job. It's still based on our leaders, really ... there was a time that our, our, our official letters were being held.

In the same breath, Participant PD0016 complained of leader's fault-finding behavior and use of discourteous words:

> First semester, no go back for the exam, 2nd Semester, no go back going for hospital final practical, from there they said go back to service area. You didn't know book. So go back … Setting, they will look for things you have done wrong. Things they don't look for, things that you do right, and nobody knew. Do you know that I stayed till that time? ... Because of the cost price of transportation. And you are given out, nothing is coming in. Rather, they will be looking for faults. She's, she's this, she's that, she don't do this, she don't do right. She don't do it. And everybody's intelligence is not the same.

Similarly, Participant PD0017 complained of leader's culture of blame and lack of encouragement for any diligence:

> Yeah, especially when I was, when I, when I was running bi duty. Presently I'm running permanent morning. Or when I was running bi duty, 16 hours on a patient, you might be two nurses on 24 patients from 4:00 PM to 8:00 AM the following morning. After I've done this, I've done this. I've done just to ensure just, you know. I dot my Is and I cross my Ts, and my superior come, and the first thing is not even well done. The first thing is OK, oh you didn't do this, you didn't do this. Culture of blame. No. Pull, pull. Pull them down syndrome. You are just looking for the loopholes … What of the one I've done. I'm not a machine. I've done to the O, OK why is this so? Why is this sheet here? Why is this? You know, minute things that you can overlook or just say, OK, well, you've done

well. You've done well, but next time you'll try, then there, there, there is a way we correct that is. How do I put it now? Or you can correct to pull down and you can correct to encourage.

Mournfully, Participant PD0020 cried emotionally remembering an experience of pain, broken moral, and discrimination by doctor-superiors:

When I joined service, I felt they cheated me on coming and I tried to talk with it, but the person who was in charge [crying/anguish sound] broke my morale … Really, really broke my morale. It was just that I was at a point, what if I had had my way there? ... But when I came in, it was like the person treated it like a personal property thing that he was meant he had the prerogative to put you wherever he feels like … Because even when people were now bringing the latest placement and all of that, he refused. He said they're not interested in it. So he was speaking like a boss. Well he was the one they placed as the boss.

Cheerlessly, Participant PD0029 felt overstressed, overworked, and emotionally trampled upon by superiors perceived as being insensitive and unappreciative of services rendered:

... during a call and we had a whole lot of patients that were trooping in, trauma cases, accident victims, they were trooping in. I was the only resident on call then. I did my best and did as much as I could to take care of the patients. Then ... the following day ... while checking on the patients with the entire team. I had some senior colleagues that were just shouting and raising their voices at an overworked resident. One of my worst moments is also during one of these postings that you

> would've to be on 24-hour calls for 7 days and you'll be expected to resume 8:00 AM the following week to go about in normal activity … You will come back and resume 8:00 AM the following morning to work up to 4 for the next week, and resume 24-hours call again the following week … I've actually felt like quitting my job over and over again. Because I was overstressed, overworked, and the scenarios where senior colleagues don't even show gratitude despite the fact that you've been working a lot.

Empathetically, Participant PD0032 complained of colleague doctors not valuing their lives and supervisors that are apathetic to juniors even when the juniors complain being ill:

> generally, we are not appreciated at all. And that's simply because ... we doctors, we don't really value our lives compared to other professions within the health care system. In the sense that you could have a doctor probably having a particular complaint and you have the senior colleague insisting that, well, there's nothing I can do about that, just have to do your work … So, it's peculiar to the junior ones and what we hear in return is we've all been there. We've all gone through that. Yes, we get that a lot … I was really depressed. I tried. In fact, I, I would go for rounds and my senior colleagues would be, I don't want that fighting doctor in my unit. I don't want this; I don't want that. And I've not even started the unit. And they're saying all sorts of things about you.

Likewise, Participant PD0036 complained of overbearing task from a superior:

> I think the last time I can think of getting tired of my job was when we have to see like almost 300 patients in the day and we have few hands and the work was really, really stressful. And one other time that my boss gave me an assignment and it was glaring that this assignment can't be done because there are guidelines to follow. And he kept on saying that I should make it happen when it's glaring it did not meet with the guideline. And it was on my case and everything. I think those are the times I, I had to notice.

Herzberg et al. (1959) recommended performance reflections and the training of superiors/supervisors on the effective use of motivators and hygiene factors. According to Herzberg et al., motivators referred to (a) the achievement of quality performance, (b) the recognition for the achievement as feedback, and (c) the work content as it essentially relates with those carrying it out. The hygiene factors included (a) work supervision, (b) service conditions, (c) remunerations, (d) interpersonal relationships, (e) organization policies, (f) administrative best practices, (g) employee benefits, and (h) job stability as a function of security. Herzberg et al. emphasized the importance of training as an avenue to appropriately identify and apply the motivators and hygiene factors. Herzberg et al. stated that "These reflections apply to supervisors on any level, from the foreman over a group of machinists to a company president dealing with his department heads" (p. 136). Thus, the jobs of leaders and supervisors of all cadre in the public service basically require regular skills acquisition and retraining on prevailing best practices for optimizing the relationships and skills of subordinates and the work goals. That will help mitigate work problems, administrative issues, and pesky relationships.

Misapplications of Politics Over Administration and Global Best Practices (GBP). Ogaboh et al. (2020) reported that the poor leadership and maladministration of the public health sector impacted its policy effectiveness and leadership process. That implied that ineffectiveness in governance and the problem mitigation process failed and facilitated misgovernance and poor leadership effectiveness. Thus, the political system tolerated the downturn of health care policies/reforms and interventions away from GBP. Nine employee participants in Figure 15 (25.71% of employee participants and 23.08% of all participants) referred to this sociopolitical decay in the cause of sharing experiences and perceptions in the health sector.

Apparently, Participant PD0009 believed that doctors are politically favored by the employer/government, hence they get whatever they agitated for to a better degree than nurses: "Yes. Apart from this thing you're doing now, go around, ask whatever they ask, give them time they'll just give it to them. They'll never give us." Explicitly, Participant PD0010 quipped and shared a perception that past political leadership had spoilt the remuneration system with respect to the salary structures: "[laughs] … From the inception of President Obasanjo, he has spoilt everything. All the remuneration has been bastardized. Even the salary structure, if you can see as you are talking today, the resident doctors just resume 3 days ago."

Likewise, Participant PD0011 lamented the negligence and self-centered roles of the political leadership of Nigeria and the lack of a maintenance culture in the health care sector:

> The japa syndrome. To be sincere the cause of the problem, our leaders, political leaders, in particular, to be precise, they are the cause of all these things. Because though we say, all these things we are not enjoying, in the health sector. They go out there and see them at foreign countries, out of the country. Even when they fall sick, they go there. Even common headache, they go they go there. When they have a fall, like even sprain, sprain ankle that they can manage in any, even general hospital not to talk of orthopedic hospital, that they can go there. You won't find them here. It's either Germany, Britain, or whatever…Eher They fly them out for medical treatment when we have all the teaching hospitals, specialist hospitals here in Nigeria. And the doctors here, the doctors, the radiographers, the pharmacists, laboratory scientists, that are also travelling out there ... So, the whole thing is just from our leaders … The political leaders, self-centred.

Similarly, Participant PD0012 decried the lethargy and arm-twisting approach of the political leadership in handling of striking union workers and the management of labor shortage:

> ... that strike shouldn't have come again because first time they went on strike, it was because they said, you know this is a new government, you know that kind of thing, please give us some time, we'll look into it. They set a particular time, and nobody looked into it at that particular time ... that clearly shows that you are not appreciating the people that are working for you. And so, those categories of doctors that went on strike that time now, if you ask them now, before you say Jack Robinson, they'll leave. Before the flew they are not being appreciated …

> There are many doctors that can come into the system. But, somehow, somehow somebody in government just put so many impediments on the way, that you cannot replace those people easily. So, and then of course, government was like the other time trying to pass a parliament through the rep ... I'm also aware that now, before it used to be very, very easy for other category of medicals, especially the nurses to migrate, but I'm also aware now that government has somehow gotten WHO and other organization to hotlist Nigeria as a country that people abroad should not be taken ... the government is asked why didn't you give them enough incentives to stay in your country?

In another turn, Participant PD0013 bemoaned the profligate spending of the political leaders while workers languish in squalor:

> The discouragement is ... the issue of not having enough hands ... federal government, not cutting cost of governance ... and we are still having 70 billion prov, for our legislators and 40 billion for them. So, it's so discouraging, yeah … Forty billion for their bullet proof cars. So, when you look at cost of governance and the way they are. The other day, they were sending prayers to, to their this people, and an ordinary a federal government worker that will come in the morning to. Sometimes, you don't even have time to have your meal, and is there languishing, and you are sending prayers. How many hours have they worked? That they're, this 10th, 10th Senate that they commenced. They've gone on break o. Yes, and they've sent two, two million, at least, I learnt, allegedly … It was reported ... It's discouraging and disillusion, appalling and disillusioning.

In a different dimension, Participant PD0018 criticized a perceived political manipulation of the system by a medical director in pursuit of selfish interests that are against public good as expressed in the laws guiding residency training of doctors:

> They cancelled what we call bench fee because sometimes our training entails we go to other hospitals to train also. In Igbobi, we don't have general surgery, we don't have [Pause a moment] … In Igbobi, we don't have general surgery and we don't have some other stuff like that ... So you have to go to place like LUTH or LASUTH where they have surgeons and neurosurgeons to acquire some skills and training that would better equip you to be the holistic doctor the system wants you to be. We apply to LUTH, to LASUTH, and we told them that they've cancelled bench fee. The CMD then told us then that we must pay the bench fee, even give, gave us letters that show that we must pay the bench fee. And the bench fee was how much? Twenty-five thousand, it was, it was not, it was cheap. But the association of resident doctors have agreed with federal government that that fee should no longer be paid. Because we are going there not just to learn but to also render service.

Participant PD0018 continued and decried the perceived political manipulation of resident doctors for personal ego and selfish goals against public interest of the resident doctors:

> We now went to our president, the ARD president, the national ARD president and told him. The man called the, the, the, the CMD out. And guess what he said? He now told the government that they have enough residents, they don't need us

> again … They don't have enough residents. The residents are crying. And somebody because he wants to say Okay, these people, they think they'll go and report me and go, scot-free, I will declare to the government that I have enough residents … we are in a system where people do things the way they want to. They form cabals. They're lackadaisical about things, the system does not check once somebody becomes the oga, is an emperor, forgetting that power is transient.

In another point, Participant PD0021 alluded to a perceived favoritism in judgement that was politically rendered to a member:

> Because they're all doctors. They want to take over … They're all political. And since that guy came in again, since they brought him back, because they have brought him back. Since they brought him back, he has never mentioned anything. He has never done anything. He's just on his own to work and go. So such a person, do you think that he has not been discouraged?

Emphatically, Participant PD0022 affirmed that "there's politics in medical sector …" Participant PD0022 expatiated the political conflicts between doctors and other health care professionals and clarified perceived concepts:

> These things we can do, but because of, uh, medical sector politics … Hmm. There's a politics in medical sector that, okay. We call it professionism. Professionism … One profession is the most important. And that's what's the head of so many people in society that when you're talking about hospital, you're talking about doctors … You say a physician … There are people we call doctors because, you know, there are so many doctors at the hospital … But the

physicians are the good we are, they're regarded as the most important. So, the most important, now they're keeping it, that only these people. So, and the politicians giving them that edge. That's why before now ... in the hospitals, administrators were in charge … And largely you see … even distributions of things in the hospital. But around 1984 in Nigeria … There was uproar having seen that they're trying to be high handed. So other health professionals, doctors, nurses, pharmacies, and other radiographers, they said, okay, let's have the core people handling, uh, heading hospital, core head professionals.

Furthermore, Participant PD0022 expatiated concepts and how other professional groups were disenfranchised politically:

So, the first people that came out and said, okay, let's go and lead are the physicians and they got there they sat there and disenfranchised the other health professionals … It's history. It's recorded. It's not, uh, I'm not cooking it … In as far as Nigeria is concerned … Now, so, you now have a situation whereby ministry of health can only be headed by doctors alone, these physicians alone. It's not done anywhere. Even in America, it's not done like that ... if it comes to admin, administering this environment, we can do it as well. But you are being, you are being disenfranchised. You are being prevented from getting to that capacity. And because somebody knows that, okay, it's only its profession that can get there. So they believe that other ones are worthless, are second citizen on the premises … in the past, we used to have minister of health and minister of state for health. There should be one of the other head professionals among the

> two. Either pharmacist as the head, doctor as a minister of state. Or doctor as head or radiographer as the minister of health. Like that. If it goes round, then this discrimination will definitely be removed.

Explicitly, Participant PD0022 explained a perceived politics of denial from past government administrations to date and requested for fairness:

> Obasanjo in his last administration made this man, the minister of health, Eyitayo Lambo. You can go and check it, Eyitayo Lambo. And I tell you now, the director general of the World Health Organization is not a doctor, just to tell you that the best practice is not the best in Nigeria … All we are saying is let there be egalitarian … So you will never see them complain of discrimination … Because they're the one at the helms of affairs … If they go there to ask for money ... they only bring all those other things so that you think that they are in love of the country ... People don't get what they're supposed to get from job … They can't do laboratory work. They can't do radiographer's work.

It was obvious that the misapplications of the political process in the health sector as recounted by employee participants have not helped but worsened the policies and laws directed towards mitigating the negative turnover impacts and the failure of leadership. Thus, employer Participant PD0026 stated that there was no political will to do right things in the service: "let me just be sincere with you. The public service is … well defined … But in practice, we may have problem because all we needed is just a political will to do the right thing." That corroborated the employee participants' complaints about the abuse of politics and Ogaboh et al. (2020) report that poor

leadership, policy ineffectiveness, and maladministration persisted in the public health sector.

Poor Service Delivery. The consequence of turnover-induced labor shortage and excess workload caused poor service delivery. Twenty employee participants in Figure 15 (57.14% of employee participants and 51.28% of all participants) complained of poor service delivery because of the turnover-induced excess workload and labor shortages. Participant PD0014 explained the poor service delivery implications of excess workloads on the reduced workforce:

> On the workload … it's pathetic that our people are leaving. It's actually pathetic based on the workload and there is no employment … The workload is much and the people are not giving effective treatments to the, to this, to the clients, the main target population that will get the treatment ... aside from the workload, it's affecting the delivery system to the clients … Our aim is to care for the clients and for them to have a good delivery, good service. If you are already discouraged somebody, that person will not have that spirit. You will just be angry while you're doing your job. The person you're angry with is the one paying, he's paying for the service.

Similarly, Participant PD0037 stated that "no matter how much one tries, of course, it'll … it'll affect some, you know, the quality of, um, services. Particularly those who will come at the latter, uh, parts of the clinic." Likewise, Participant PD0035 explained that as qualified pharmacists "are leaving the country, then the medication can be into the hands of insecured ones. The tendency of giving quality medicine will be

affected … The tendency of administering quality medication will be affected." In another turn, Participant PD0017 stated that "an angry hungry nurse will be an angry nurse. There will be transfer of aggression. And patient … will suffer it." The patients' sufferings are consequent upon poor service delivery from poor leadership/administration.

Research Question 2 (Theme 2): Negative Employees' Impacts and Reactions

All 35 employee participants (100.00% of employee participants and 89.74% of all participants) showed perceptions and actions that reinforced the negative consequences indicated in Figure 3. These consequential impacts included embarking on strikes, high (91.43%) turnover intentions, aggression transfers to patients/society, poor service delivery, sympathy for the employer's failures, complaining helplessly.

Subtheme 1: Complaints and Feelings of Discouragements (Being Unmotivated)

Thirty-four employee participants in Figure 3 (97.14% of employee participants or 87.18% of all participants) felt regularly discouraged and unmotivated by the employer in the course of duty. Participant PD0033 felt discouraged because of labor shortage and excess workload:

> Like I said, inadequate replacement of personnel that has, that has left. You know, it leads to more pressure on the remaining people in the system. And that one, you know, it brings up its own added pressure. Pressure of work, pressure, your own physical health is being challenged also because you are working, stretching yourself to the limits. Your own mental health is being challenged also … And it's

> discouraging. So, this issue of people leaving the system and then not able to bring in other personnel, that's replacement … Quitting job is an everyday thing.

Conversely, Participant PD0023 felt discouraged with the value of remuneration compared to that of the politicians: "I would say very poor compared to the politicians who are taking off money every now and then for not doing much work" In another experience, Participant PD0023 felt deprived from carrying out a cherished service:

> I can do ultrasound; I can do MRI. I can do CT. FMC Ebute-Meta has regulated or has kind of limited us to normal x-rays. Uh, at least to ionizing radiations, which is the x-ray, and the rest. And they are depriving us of doing ultrasonography, most of us have been qualified, we've done the PG program … Yes, because I have love for ultrasonography and oncology. That's what brought me to radiography.

In another instance, Participant PD0029 loathed an experience of call duty without resting prior to another duty:

> One of my worst moments is also during one of these postings that you would've to be on 24-hour calls for 7 days and you'll be expected to resume 8:00 AM the following week to go about in normal activity … You will come back and resume 8:00 AM the following morning to work up to 4 for the next week, and resume 24-hours call again the following week … So in those postings, I've actually felt like quitting my job over and over again. Because I was overstressed, overworked, and the scenarios where senior colleagues don't even show gratitude despite the fact that you've been working a lot … it feels like you're always at

> work and even when you go, they keep calling you about things that you might have even sorted out. I personally don't believe anybody should call you after 4:00 if you are not on call … a doctor is supposed to rest after a 24-hour call.

Subtheme 2: Turnover Intentions and Turnover as a Vicious Cycle

Omonijo et al. (2015) and Oruh et al. (2020) reported that the unbalanced treatments of the professional groups, employee burnouts, insecurity, and job dissatisfaction are debilitating problems in Nigeria's health services. These negative conditions are worsened by the prevailing high turnover and turnover intentions trend. The inability of the employer to reverse the high trend of turnover promoted the vicious cycle of the studied phenomena. Thus, 32 employee participants in Figure 3 (91.43% of employee participants and 82.05% of all participants) indicated high turnover drives amidst the prevailing economic/medical hardships, labor shortages, excess workloads, and high turnover impacts. Participants PD0039 responded that "Nobody wants to stay. Even the older ones are leaving now … Yes, I would still want to leave … it is not just about the health sector … not just about, oh, I'm a doc. It's about the, um, the economy, society … security."

Likewise, Participant PD0036 complained of inadequate work environment and was inclined to leave: "I mentioned earlier that I don't really, I'm, I'm not really cool with my work environment. That's the only reason I will accept to leave." Frankly, Participant PD0032 indicated a plan to exit: "I'm working towards leaving, but as of the time I'm going to leave, I don't think I'm ready to disclose that. But definitely every doctor

wishes." Similarly, Participant PD0030 revealed exit plan, that "It is on my mind. And I know that any moment from now, I'll be gone."

Swiftly, Participant PD0004 indicated readiness to switch organizations within or outside the country: "So, if I have an opportunity of leaving here or leaving this institution or going anywhere where I'm paid enough to look back and say I'm taking care of my responsibilities, I will take it." In the same situation, Participant PD0009 expressed readiness to exit job for abroad offers:

> I don't want anything Nigeria. I want outside … Yes, because that side, they pay per hour. If you worked 1 hour, you know how much you are making. Here, I'll start night duty by 5, sometimes 9:00 AM, I've not, 5 pm. By 9:00 AM I have not finished handing over and the salary remains the same. Sometimes you do this night shift twice in a month … If I see the opportunity, I'll go.

A reputable consultant surgeon (Participant PD0012) was positive in the high turnover test and showed readiness to switch job positions in preference for better working condition offer abroad:

> I will, I will, I will take that question, maybe in stages. Like I mentioned before, I'm just 2 years before retirement now. Are you getting me. So, whether I like it or not, in 2 years' time the government my employer will ask me to leave whether I'm serious or not. Today, there's even another mistake that we are making. I don't know why they do that, where you throw away your good staff, just because you're 60 years old. Meanwhile, all the politicians that are doing it, all of them are going to 70, some are 80 years old. Again, in the face of people actually leaving

> the system and creating a deficiency. That to me, I don't know what kind of thinking is behind that. So, I'm going to use that to, to answer your question. So, if somebody has offered me an appointment at this level outside this or this, I will take it because in 2 years' time, they're going to drive me away, anyway.

Incidentally, the high turnover intention drives of these employees warn of eventual turnover outcome. Osibanjo et al. (2020) stated that Nigerian health workers are in high demand because of attractive working conditions and better social amenities. According to employer Participant PD0026, a better competitive economy and working conditions will help to reverse the high turnover trend. Hence, Participant PD0026 as an employer would want "to make our own economy much better and make the work environment much more attractive to the extent that those going abroad will not see anything to go there." The vicious nature of the high turnover and intention experiences are obviously an emergency for the employer to promptly resolve in other to retain these trained professional health workers that are inclined to leave.

Subtheme 3: Poor Health Service Delivery

There are 20 employee participants in Figures 3 and 13 (57.14% of employee participants or 51.28% of all participants) that shared experiences of inadequate health service delivery. On the employee coping technique at work, Participant PD0018 shared a compounded workload experience of patients upsurge and reduced productivity:

> Yes, but the problem is because our health care, primary health care facility is actually not functioning. Because for the patients we see they're supposed to be treated at the level of the primary or the secondary care facility. So there's a huge

burden on the tertiary health care facility. So patients that have headaches that should have been sorted out at the level of the primary health care. OK, if it can't be sorted out, you go to the second, secondary health care. You find everybody *ab initio* emptying themselves into the tertiary facility.

Furthermore, Participant PD0018 stressed the workload burden on the tertiary health care institutions that promoted poor service delivery:

So there is more burden, much more workload, reduced productivity. And I will tell you the reasons why there's reduced productivity … As the clinic runs you get tired. I've not stood up, as in standing up to take my time off with me to get myself and come back to sit and see patient. As I keep seeing patients, my attention span drops, my ability to pay attention to close details drops. So you find patients coming for things that would have been sorted out while they were seeing me … For example, I forgot to ask you to do this test, you should have done this test for surgery next week. But the patient was seeing me at the time when I was at my, at my lowest. I didn't request for that. I forgot requesting for that. So, by the time the patient comes in and I say, Oh, no, you can't, you can't, you can't have your surgery done. The fault is not the patient's fault.

Similarly, Participant PD0006 indicated a reduced productivity when excess workload burden was on the reduced number of staff:

Ok, the employee turnover and turnover intention has greatly impacted on the level of care we give to patients. Like I said, when you're supposed to have four

> patients to a nurse, and you are having 10-12 patients. You understand that the nurse will not be able to put in all, ehm, that's needed in the care of patients.

Furthermore, Participant PD0025 narrated about reduced patient's quality engagement and poor stakeholder's welfare because of increased turnover impacts:

> the effectiveness, you can't get, you can't get it hundred percent. So, what it means is that you have to, as a psychiatrist, for instance, I need to, if I run a clinic, I may need to spend like 30, 45 minutes with a patient. So, but with this load, so that luxury, it's not, uh, affordable. So instead of saying, I want to spend 30, 45 minutes, maybe I need to, I can just call down the time I spend with the patient to like maybe 10, 15 minutes … The patient don't get up to what they're supposed to get. So, everybody's affected, the professionals are affected, the patients are affected.

In the same predicament, Participant PD0014 indicated that "The workload is much, and the people are not giving effective treatments … it's affecting the delivery system to the clients … You will just be angry while you're doing your job." Pertinently, Participant PD0012 noted that "The patient is at the brunt of everything. They are the ones that suffer for it." According to Participant PD0025 "The patient don't get up to what they're supposed to get … everybody's affected, the professionals are affected, the patients are affected." Hence, the poor service delivery affected all stakeholders.

Subtheme 4: Sympathy for the Employer's Failures (Stockholm/Attachment Syndrome)

There were conflicting experiences of participants who complained of employer's apathy, neglect, discouragements, and lack of appreciation, but defended or commended the employer for being caring, visionary, and empathic. That demonstration of sympathy or commendation for the employer connotes a condition that could be described as attachment or Stockholm syndrome (Shaughnessy et al., 2023). Thus, the reference to attachment or Stockholm syndrome in this discussion is limited to a situation whereby a victim is expressing sympathetic defense, bonding or love for a trauma giver. Nine employee participants in Figures 3 and 17 (25.71% of employee participants and 23.08% of all participants) indicated a sympathetic bonding with the employer despite complaints of excess workload, labor shortages, little or no motivation, appreciation, encouragement, and empathy. For instance, the Participant PD0008 felt discouraged and lowly appreciated by the employer:

> Well, ehm, to, to be honest, employees' appreciation from the employer has been very low when you compare the private sector to the public sector … So, I don't think there is appreciation in the public sector … There was a time when one of those our facility had issues, got spoilt. You know, if it was your own thing, you could just fix it on your own. But the fixing, it took a lot of time. So you have to send patient back even yourself, the job that you love to do, you come to work and just sit idle. You're not used to it. So, it's discouraging.

However, Participant PD0008 commended the employer for a seamless work: “I work in a unit where we need some technology and I can say in this hospital, my employer has done so well by providing us what we need. So, our work is always seamless.”

In another instance, Participant PD0024 complained gloomily affirmed the lack of appreciation from the employer:

> The federal ministry of health, our employer … the appreciation for me is not there. Is not there. It's not there. To, to, to bring that to perspective … I know that you should be aware of the recent, uh, ma uh, strike action by the Nigerian Association of Resident Doctors … So … this thing is still boiled down to the appreciation that you just asked about … That was the reason why the strike was on. So, because we felt that we are doing a lot more than what they, our employer, the way they're appreciating us. And we know our colleagues in other spheres … Maybe this is the number of hours I spend at work, and with this, there's time for uh, uh, maybe some break off, vacation that comes with some other packages. And it'll now be like, what am I doing here?

Surprisingly, Participant PD0024 glowingly defended the employer as being visionary, empathic, interactive, and encouraging:

> Well, the leadership of my employer? Well, I will take it. I, I think I'll bring down, down home. Home in the sense that I'll be looking at it from the perspective of the direct leadership, talking about the medical directors and the. So I, I will say as much as possible, Um, as I said earlier, our employer that is home now … Yes, of this hospital is someone that, uh, he, he's a visionary person.

> So, and then also he's someone that we see that as much as possible, he tries to create this connection between his employee and himself. So, so from there, even though the system at large and society … Yes. Even though they're not doing so much as we would have been appreciated, but because of the effects that he has on his staffs, trying to empathize with them. And trying to make them see that I see your feeling. I can feel what you're going through, because that is still giving some of us that hope and that, uh, respite that things probably will be better and also still encourages some people to still stay behind.

Subtheme 5: Employees' Frequent Strike Rituals and Despondency

Nine employee participants (25.71% of employee participants and 23.08% of all participants in Figure 3) feel despondent and complained of neglect. Participant PD0038 narrated experiences of despondency and fruitless strike rituals:

> there's a strike. Oh what do they want? Okay, let's promise them this. Then they go back to work and then the same old cycle repeats and they're back to the joint table they gave after a few months that this same thing we're talking about 2 years ago, we're still doing talking about it now, but government said they didn't notice … I think it might be responsible for a lot of demotivation … It's very discouraging … you feel like … you are not so important. So really why bend backward? ... why break yourself because you're trying to, you know, make what … Anybody that is not frustrated with where the country is going now is not, is probably just joking. I think I felt that way during the last resident doctors' strike … it wasn't like we were speaking out of place or not, um, saying the right things,

> but, but just not heard. And nobody really cared. And just reading, generally just reading comments of people around whoever of society and just feel like nobody really, um, really appreciates the efforts you actually put in as a medical personnel.

Similarly, Participant PD0034 relived the frequent strike experiences and frustrations:

> Strikes, strikes. I mean, no equipment. The strikes, I mean the, the, the, eheh, the, they agree with the government of something. And they're not fulfilling that promise … the association, the union have agreed and it's all publicized, sign memorandum of understanding. And there's no understanding after that, that one too is really, it puts, it puts me off … It happens a lot. In a year, resident doctors may go on strike like 4, 5 times … In one single year. Yeah, I mean, I mean, I'm sure. That, my friend that I said came, left again. He, he counted one strike once, and they did seven strikes in a year. He was counting, because he was showing it to me. He was outside the country for a long time, he was counting. Me, I don't know the reason he was counting. He was counting and counted I think six or seven that same year … So if doctors go like 3 or 4 times, they may go like another 3, 4 times … A lot. A lot. A lot. Because it disrupts everything.

Subtheme 6: Aggression Transfer to Patients, Patients' Relatives, and Society

Five employee participants (14.29% of employee participants and 12.82% of all participants, see Figure 3) explained the bases for aggression transfers to patients, patients' relatives, and society. Participant PD0017 stated that "an angry hungry nurse

will be an angry nurse. There will be transfer of aggression. And patient … suffer it." Likewise, Participant PD0021 explained the aggression transfers of team members: "If you're not somebody that is prayerful … you won't be able to work … most times they are antagonistic to some patients, they are antagonistic to people, to relatives … because of what they see around them."

In an instant, Participant PD0014 complained of provocations that stir aggressions to patients amidst labor shortage burden:

> The manpower is not there, the manpower is not there. The people that are still managing to do and they don't want to *japa*, maybe they have not *japa*, they, they may still *japa*, but they're still there. You are not managing them well to be able to, at least, even if you are, they will go, they will do that we work with the whole of their hearts to be able to, you know, to achieve their aim. Our aim is to care for the clients and for them to have a good delivery, good service. If you are already discouraged somebody, that person will not have that spirit. You will just be angry while you're doing your job. The person you're angry with is the one paying, he's paying for the service.

Conversely, Participant PD0038 blamed society for not seeing "most medical workers as humans. It's just, they see you as a doctor, they see you as a nurse, you know. They expect you to always be in that capacity at any point in time." Paradoxically, Participant PD0038 continued to blame society (instead of the employer) for not helping health workers: "I feel that society is not, uh, helping … when the health sector is

agitated with these same issues, you readily hear somebody say … is it only money, multiple pay? Like is there, is there always money, money, money."

Theme 3: Knowledge Gaps

All 39 participants shared experiences in filling the knowledge gaps. The 39 participants included the employer participants and the employee participants. Participants' experiences and perceptions provided information about the effectiveness and efficiency of public health policies and administration, reasons why Nigerian public health professionals are not migrating abroad or exiting their jobs, and the reasons why turnover intentions persist.

Subtheme 1: Ineffective and Inefficient Federal Health Administration and Policies

Thirty-five participants (see Figure 9) indicated that health administration and policies executed in the sector are ineffective and inefficient. The 35 participants included 31 employee participants (88.57% of employee participants and 79.49% of all participants) and four employer participants (100.00% of employer participants and 10.26% of all participants). The details of inputs from these participants are discussed below.

Dire Shortage of Public Health Care Professionals in Nigeria's Public Health Sector. All 39 participants (100%) complained of inadequate staffing (see Figure 7) with negative impacts of excess work pressure and stress. Thirty-one employee participants (88.57% of employee participants or 79.49% of all participants in Figure 9) indicated the nature of labor shortage as being dire or an emergency that needs an urgent effective employer intervention. Dohlman et al. (2019) reported that sub-Saharan Africa shared

25% global disease problems and an inadequate 3% global workforce. That condition has worsened with the unabated high turnover and exit intention trend. Ipinnimo et al. (2023) reported that the acute shortage of health care workers that was prevalent in sub-Saharan Africa (including Nigeria) is now less than 2% global workforce and grappling with 25% of world disease conditions. Participant PD0021 revealed the dire impact of the labor shortage experience:

> We have a challenge. Shortage of staff. We have a challenge because they don't employ, we are few on the bench. And those, those, those of us that are, they don't employ. We are actually being worked out, like in hematology, I know about two people that have gone. Chemistry, they other people have gone. That's outside the country … [laugh] Few hands, and they are complaining serious. The workload is getting too much on them. And as I'm telling you now, we also have about three of them. Four, in hematology that are about to leave. And if four of them leave, I think we'll have only two people.

I asked Participant PD0022 to share experience of job enjoyment and the following response of Participant PD0022 indicated dire shortage of labor:

> how can I enjoy such, when, for instance, um, we know that there is a rate that when you have this number of people working, you must have this number of people working with them. For instance … WHO standard. When you have one radiologist … You have at least four radiographers working with that radiologist … Yes. Now what? You keep on increasing radiologist without increasing radiographers … you now have 9 radiologists, 9 radiographers.

Similarly, Participant PD0023 independently gave clear details that revealed the prevailing excess workload and labor shortages of public health professionals:

> We doubled up our efforts. That is also wearing us out because we have now been overworked because of these people that are leaving are not being replaced. We've been without, um, interns for months now and you can see even my chiefs are coming to work and work, even do calls. Okay. In the time past, there were second, third of calls … If you see us working now, we are short-staffed. The number of persons in this department do not equate to the work or the output of what we get from here compared to other units … The standard here uh, is a certain number of radiographers that should be available to do a certain amount of work per day. WHO and other policies stipulated by our board and also our association. But we are short-staffed … In 24 hours, for any of our imaging modalities, it's expected that three radiographers man a modality in 24 hours. Three, minimum in a day. So, like now we have x-ray … Now for example, x-ray machine is being operated, we have a room for x-ray suspect. It is expected that three persons work on each in 24 hours, 8, 8 hours a day. So if we have one room, second room, third room, and about fourth room. It means, in counting, I should have three radiographers in 24 hours manning x-ray room. I should have three manning ultrasounds. I should have three manning um, mammography room. I should have three manning, you know, the CT room. But in this case, we are not even upto. We are basically, about nine radiographers here and we have CT, we

have x-ray, we have mammo, we have the ICU physical unit. We have the A and E. We have the theatre radiography.

Participant PD0023 continued to explain about the acute labor shortage and excess workload burden:

You can see that my colleague did call yesterday had to stay back to go to the theatre, work till 12 noon before going home. And x-ray is nobody's friend. We're not, uh, advised, it's standard, we shouldn't spend too much time in radiation producing area. So, there's a benchmark of how much exposure one should be to radiation. Because we're not able to measure it. They're invisible. They are causing stochastic and nonstochastic effects to people.

Participant PD0030, a consultant doctor, bemoaned the acute labor shortage and excess workload in exasperation and despondency:

Over work! Will make you lose interest. You'll be on your feet from morning till evening you'll close … Well it is difficult. So that is where the problem is for we in this environment. It is difficult for you to, to, to uh, to combine the medical director and federal ministry of health because if you go to him and you say you are overworked, you want manpower, he will tell you that his employers are not giving him a, do you understand … That is what he'll tell you. So that is his own superior … is not allowing him to make the progress.

Furthermore, Participant PD0030 continued to recount the prevalent dire shortage of public health professionals amidst poor working/safety conditions:

> So we have to separate the two … Eheh, or he'll say that the federal government has not, there's no waiver. Even if the ministry of, of health is aware that you are short of staff, they will tell you that the federal government is not giving approval for employment. So, it is quite, it's quite funny. Alright, that the people that see the workload cannot do anything about it … It's very, it's a paradox. It's, they are aware. They're aware doctors are leaving every day. They're aware nurses have gone. This year alone, I'm sure more than 100 of them have also left. But imagine 100 have left, they've not refilled. They've not replaced them. That is wrong … we expect them to say we are dying under the weight of work. Right? Urgently do something about it … In a day in this facility, sometimes we see, we have to register almost 30 new patients. And that is a lot for a facility. Amongst that 30, apart from that 30, there are other old patients who are, this is just my own section here, returning for care, emergency breaking things. And in the midst of it, your safety, if I get injured, that's another thing I did not tell you, we did not talk about. If I get injured in the course of work, there is no compensation.

Underlying Interprofessional Conflicts, Discriminations, and Doctors' Dominance. There were 11 participants (see Figure 9) including 10 employee participants (28.57% of employee participants or 25.64% of all participants) and one employer participant (25.00% of employer participants or 2.56% of all participants) that complained about the underlying interprofessional conflicts, payment disparities, and career advancement discrimination. Mohammed et al. (2022) reported that the Nigerian health care employer encourage doctors' dominance and the ravaging interprofessional

imbalances, acrimony, and rivalry in the health care sector. The opportunity of investigating the turnover impacts in the sector has revealed a continuation of the longtime problems of disparity, discriminations, rivalries, and nonstandard payments in the public health sector.

Incidentally, Participant PD0002, a medical laboratory scientist, felt discouraged and grimly talked about doctors' dominance mentality as an interprofessional conflicts: "They still bring the doctors in to come and head … Yes, that is just one of the discouragements that I personally I'm experiencing in the department … any committee formed must be headed by a medical doctor. That mentality is there." Likewise, Participant PD0035, a pharmacist, was perturbed and complained of payment/promotion disparity in favor of medical doctors: "I'm talking about those in administration setting not being consistent in making everybody professionals to be, to get a particular level … You as a pharmacist, the person is a doctor. Then he, the doctors enjoy better levels."

In corroborating the interprofessional problems, Participant PD0026, an employer participant, admitted the negative impact of these conflicts, interprofessional distrust, and discriminatory remunerations in the public health sector:

> It's not adequate, for instance … when you say, okay, this is doctor, this is nurse, this is the psychology, psychologist, are there mutual respect among this team? Is it that the doctor will see, the nurse will see the doctor as the only one that is the beneficiary of the whole system? For instance, I've told them job evaluation is bad in the public service, especially in the health sector … For instance, you said the doctor should earn more than the nurse … There are parameters for doing that …

> All jobs should be evaluated … Every man should man his own profession … But in this case, the doctors are manning their [other colleague's professions that are not doctors] own unit … Which is where things will not work.

Furthermore, Participant PD0026 continued in the admission of conflicts, faulty job evaluations, disparity, and discriminations:

> This is where we have a lot of problem. If you want to put that doctor in a, to head, put him in an office different from the office where the, the, the, the, the laboratorist is … But there will be a place of convergence … But why would there be a place of convergence? By virtue of experience … How can, how can a junior doctor be earning more than somebody who has spent 25 years in service? You, you, you get what I'm saying? ... nobody wants to stay in an environment where they are not really given recognition.

The impacts of these problems on employees have become magnified by the prevalence of the turnover-induced labor shortages and excess workloads to the extent that employees talk about them while answering turnover-related questions. That was evident in all the participants' perceptions and observed lived experiences. Thus, the problems reinforced the turnover impacts and viciously compounded it.

Employer's and Employees' Reactions to Excess Professionals Assumption. Omeje (2021) reported that over 50% of Nigeria's registered doctors (about 72,000) practiced abroad. That implied that less than half of Nigeria's doctors were insufficiently available for the public and private sector patient services. That ratio, 0.38 doctors per 1000 patients, is far below the WHO standard of 1 doctor to 600 patients (Oyadiran et al.,

2020). Five participants (consultant doctors and an administrator, see Figure 8) stated their experiences and resolved the employer's excess health professional's assumption. Four consultant doctors disagreed that there are excess doctors in the health sector. The employer Participant PD0026 promoted the sentiment that there are excess health professionals in Nigeria but could not show any valid evidence to support an excess assumption of health workers in Nigeria.

Conversely, Participant PD0012 described the employer's excess assumption, that: "it is definitely wrong" and not supported by any evidence or valid statistics that alluded to an excess of any health professionals in the Nigeria's health sector. Similarly, the employer Participant PD0031 debunked the excess assumption and insisted in his experience as an employer that: "there's no excess doctor o [laugh]. We don't have medical doctors o, that's why we are recruiting. As we are recruiting, they are leaving." Nevertheless, all 39 participants in Figure 7, including Participant PD0026, agreed that there was persistent labor shortages of doctors, nurses, and health care professionals in the public health sector.

Employer Overwhelmed, Limited, Inactive, and Uncommitted. All four employer participants in Figure 9 (100%) had experiences that were overwhelming. The four employer participants indicated being limited by the federal ministry of health in carrying out their responsibilities. Thus, the limitation of the hospital administrator-employers gave rise to the lethargic experience of all categories of the employer.

The fact that Participant PD0001 was incapacitated and could not cope in effectively carrying out staffing functions was evident in the employer's response: "But

in terms of coping, I don't think we are coping." The employer Participant PD0001 indicated a restraining experience: "as an administration, we are centrally regulated from the federal ministry. So it's not always that quick to get approval to employ replacement when people leave." The result of the ineffectiveness of Participant PD0001 was indicated that: "it has actually severely affected the hospital services. It has also impacted on the existing, the permanent staff who are still here, and have to do more work than they would have."

Similarly, Participant PD0026 was perplexed and overwhelmed in resolving the high turnover trend impact of labor shortage and stated that "as we make effort to recruit, to solve the problem, but the problem persist." The employer Participant PD0028 indicated a handicap from federal authorities:

> we ask for replacement from the federal government, they will not give that approval at that particular time … The only thing, we have challenges is the number of people that are working at that same time … If the federal government will do same by helping us to replace those people that exit service, it'll go a long way to help the system.

Participant PD0031 indicated an experience of being stressed and limited: "We don't have medical doctors o, that's why we are recruiting. As we are recruiting, they are leaving … It's stressful but we are coping." Despite the introduction of a temporary staff replacement policy called locum, the employer was not able to carry out one of the functions of management/administration which is staffing. Thus, the incapacitation of all the employer participants in resolving the labor shortage problem was evident.

Oruh et al. (2020) reported that employees' job tasks are overwhelming and pressured through managerial actions of the supervisors who want to achieve certain work goals using their subordinates. The 39 participants interviewed complained of stressful excess workload because of the inadequate replacement of the exited employees. Therefore, Participant PD0009 alluded to the overwhelming workload that complicated tasks for professionals:

> ... it has not been easy for us in the nursing unit. And the workload is so much because, I want to use myself as an example when we are in the female surgical ward, the ward is 24, 25 bedroom and we will be only two on duty because we don't have enough. They will employ somebody this, this month, within 4 months they travel. So, we that couldn't travel, it becomes an issue. Because you work and work and get so exhausted … The workload is much ... Nobody is happy ...

Likewise, Participant PD0011 corroborated the workload burden that,

> People keep on leaving. No replacement. How will you be motivated? ... we are about, say, 20 and people are leaving, no replacement and get you out to maybe eight or six, then, is there any, are there any motivations there? ... The discouragement is on, people leaving, and the workload is getting more ...

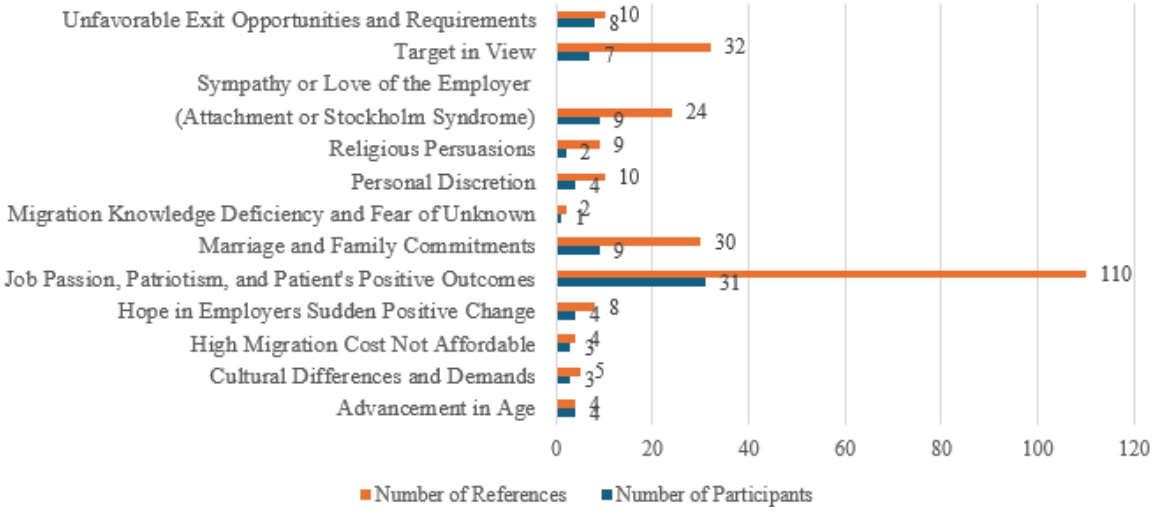
In the same line, Participant PD0032 felt unappreciated that "services are not put in place to ease out stress, to ease, um, the burden of care or workload." Similarly, Participant PD0016 complained about high workload and extended closing time:

> The, the workload is too much I had to ask for permission of one of them to join me and I make sure I finish the dressing. I closed around 7:00 PM before I was

transferred to this my present ward. And the present ward now, with all that we do observe, and there was a time they brought a student to me on observation and the student cannot go alone. I had to take the parents' number and called them and where they are coming from is very far. Something I'll close 4, I stayed till 9:00 PM before the mother came.

Figure 17

Reasons Why Nigerian Public Health Professionals Are Not Migrating Abroad or Exiting Their Jobs



Subtheme 2: Reasons Why Nigerian Public Health Professionals Are Not Migrating Abroad or Exiting Their Jobs

The adverse intrinsic (inadequate motivational push factors) and alluring extrinsic (pull factors) conditions from abroad that promote turnover and turnover intentions are rife in the workplace and on employees including excess workload, poor remunerations, stress, poor welfare conditions, and lucrative offers from abroad. However, 35 employee participants (100.00% of employee participants or 89.74% of all participants in Figure

17) shared their experiences and disclosed the reasons they did not exit their jobs or migrate out of the country despite the vicious impacts of turnover and turnover intentions. These reasons included: (a) advancement in age; (b) attachment or Stockholm syndrome; (c) cultural differences and demands; (d) high migration cost not affordable; (e) hope in employer's sudden positive change; (f) job passion, patriotism, and patient's positive outcomes; (g) marriage and family commitments; (h) migration knowledge deficiency and fear of the unknown; (i) personal discretion; (j) religious persuasions; (k) target in view; and (l) unfavorable exit opportunities and requirements. The reasons adduced and discussed below clarified the retention of job positions because of different compelling limitations and conditions that had kept them glued to the public health sector in Nigeria despite the search for better working conditions.

Advancement in Age. Four employee participants (11.43% of employee participants or 10.26% of all participants in Figure 17) disclosed that advanced age consideration affected their decision to stay on their jobs within the country. Participant PD0002 did not want to migrate because "Age is not on my side … at this stage of my life, I don't think I can go there, to go and do all these menial jobs." Participant PD0004 did not want to seek job positions abroad on the consideration that "as you can see, I am not that young anymore." Participant PD0012 explained that "right now, I'll say I'm at a particular age, which I don't think I'll start hurrying to another foreign land to go and start all over again." Participant PD0035 explained that his consideration for age is to be self-employed: "I consider my age and time already put in … My age is one of the things that I believe that even if, what's next is for me to even plan to, how to work for myself."

Thus, advancement in age is a deciding factor for not leaving job positions or migrating abroad.

Cultural Differences and Demands. Three (8.57% of employee participants or 7.69% of all participants in Figure 17) employee participants explained that they delayed migrating abroad because of incompatible cultures. Participant PD0002 indicated that the inability to adapt to lifestyle changes abroad is a hindrance to migration, and stated that "the way, the lifestyle lived there, I'm not comfortable, I can't live such lifestyle." Participant PD0021 stressed the factors of cultural differences as a delay in exiting local jobs for foreign engagements:

> I was just looking at it because I've seen most people that are outside there, when, they don't behave well. I felt that let me just nurture my children here to an extent. Because when you forfeit the character and the value … Yes value, when you put it in them, if they move outside, it'll still be there. Yes. But if they, if I should move out like that, I don't think I, I don't have that mind. I wanted to put a lot of things, behavior, even our culture, imbibe it in them before they can actually travel.

In the same vein, Participant PD0023 shared that cultural difference between regions was a deciding factor for delaying job exit for abroad: "I have a family and I think it's the best to give them that African cultural touch ... when they get to a level where they can understand wrong and good before I can move them out of this country.

High Migration Cost Not Affordable. There were 3 (8.57% of employee participants or 7.69% of all participants in Figure 17) employee participants that

disclosed that their nonmigration was because of unaffordable high cost implications. Participant PD0018 explained that the intention to migrate was delayed because of the cost implications: "you want to go write the exam, 5.7 million. You have your grandmother, your age mother there that needs something. You have your wife, you have a brother … this money … it's difficult for you to bring them together." Participant PD0035 stated that financial costs are impeding the desire to exit the country for self-employment: "So … if I have what it takes for me to even be out of the country, to work for myself, not to be employed, to be thinking of pay or employed job."

Hope in Employer's Sudden Positive Change. Four participants (10.26% of all participants or 11.43% of employee participants in Figure 17) hoped in the sudden successful outcome of government's future interventions. Participant PD0037 believed in the employer's sudden positive change despite the employer's failures in mitigating the turnover impacts of excess workloads and acute labor shortage. Participant PD0037 affirmed that: "some of us still believe that, uh, the government can turn it around … some of us see the goods in the society and we just still feel that beacon of hope can still materialize someday." Participant PD0022 concurred to that belief and planned to evangelize nonbelievers: "my belief is that if people like us remain in the system. If, uh, we are able to convince like one out of 10 our number is increasing …" However, Participant PD0025 had set an undisclosed future exit period from that belief when it will be time to leave the country: "I still believe maybe something will happen in that line, but the truth of the matter, if it doesn't happen, then I'll have to go."

Job Passion, Patriotism, and Patient's Positive Outcomes. Notably, 31 employee participants (88.57% of employee participants or 79.49% of all participants in Figure 17) did not migrate or exit their job positions because of their job passions, patriotism, and the positive outcomes from patients. Participant PD0010 shared an experience of job passion that was driven by patriotism to fulfill professional calling on citizens:

> You see, I'm feeling to leave at any day, at any time, because the job is, but the only thing that let me stay is because it's professional calling … Yes. So not all of us can leave. If, if everybody, qualified people leave, who is going to take care of our citizen? So definitely some people have to stay, whatever the risk, of anything … That's why we're staying.

Similarly, Participant PD0013 stated that "I have told you that I am a passionate nurse. I love what I'm doing. I love what I am doing. That's why I'm still here." Participant PD0016 affirmed that: "It's my father's life, land and I need to serve my people rather, money is not my priority too much. It's important, but the well-being of my people is more a priority to me. That is what kept me." Participant PD0016 emphasized being patriotic in valuing and caring for citizens:

> I didn't even think of it because as they are going there, I don't know what they are going for. Most of them that are gone, they say they achieved something anyway, but me, I'm not a beggar…God is sustaining me … So, why should I, my person is dying, I will leave him and go somewhere? ... So I value my people out there.

Marriage and Family Commitments. Ten employee participants (28.57% of employee participants or 25.64% of all participants in Figure 17) stayed on their jobs in preference to migration abroad because of their marriage and family commitments. Participant PD0020 emphasized that family priority forestalled relocating abroad for greener pasture:

> Like I said, I've been on this job for like 18 years. And I've been married for like 15 years. That 18 years. My husband does not have the same vision of *japa* [laugh] and I don't want to just leave like that … Family is my number 1.

Participant PD0019 explained the family commitments that forestalled any migration abroad:

> Well, in Nigeria or in this our society. When you work and earn salary, the salary is not meant for only you. As I'm speaking, my salary is meant for more than 10 people. Myself and my immediate family as in my nuclear family … My dependents. So, my salary is meant for 10 people. So, you can't just joke with the lives, of the lives of 10 people unnecessary. So, you have to think twice before you quit the job. So not until you get something, because there is no way your expenses will come down. Expenses will always go up. So, if you don't get anything that equates what you are getting now or something more, then the desire to leave the job, is, will not be there.

Similarly, Participant PD0017 revealed that:

> I'm not a single, I'm a married woman, I have responsibilities, I have aged parents that I have to see, I have to take care of, I have siblings, I have children. So,

> number 1, I have to stay on the job to meet my needs. There is no amount of money that my husband can give that can meet all the needs…

Migration Knowledge Deficiency and Fear of Unknown. One employee Participant PD0037 (2.86% of employee participants or 2.56% of all participants in Figure 17) indicated that senior colleagues in his social circle had considered migrating but abandoned the plan because of ignorance of the processes involved in migration and for fear of the unknown future at the migration destination. Participant PD0037 revealed that:

> It's not been realized. Now, and my, and my fear is when I speak with some of my senior colleagues whom I thought are settled in the country and they're not looking elsewhere, I'm so alarmed. Some of us, or some of them rather, had fallen into a state called learn helplessness. They actually want to japa but they don't know how to initiate where to start, where they will fit in. The fear of the unknown is what is keeping them, and I'm talking reality … They're, they're like, they're like, the tiger in the cave. They can't get up. They are trapped.

The implication of this portends high alarm on the helplessness of senior employees losing hope in resolving their problems directly with the employer or indirectly through their unions.

Personal Discretion. Four participants (10.26% of all participants or 11.43% of employees in Figure 17) gave personal reasons for not migrating abroad. Participant PD0033 indicated a personal discretion that everybody cannot migrate and said that:

> All of us cannot go, I always say this, all of us cannot go abroad if all of us go abroad. I always ask this question, will you take all your family members abroad with you? The answer is no. Perhaps, you can take your nuclear family. Will you take every person connected with you? The answer is no. So when my friends call me over there, ah, I'm sending so and so person to you, please help me see. You know, I've always laughed. What of if me too have gone, who will you now be calling. So not everybody … Not everybody will go. Some will still stay behind no matter what … Because I've not seen any overwhelming reason for me to go. That's the truth. I've not, yeah. Even monetary wise. Yes. Like I said, yeah, I know that yes, money is there, but I always also console myself.

Similarly, Participant PD0038 showed no interest of relocating abroad for personal reasons:

> Okay, so why have I continued to work in F M C? I feel like, I don't know, do, is there another job somewhere else? I don't know. Why am I stayed back when every other person seems to be leaving? I think that's the question? Well, it could be personal reasons for me. I'm just not probably interested at the moment in relocating.

Religious Persuasions. Two participants (5.71% of employee participants and 5.13% of all participants in Figure 17) had religious reasons why they did not consider migrating abroad. Participant PD0016 revealed that religious persuasion affected job passion and patriotism:

> Mhmhm, before I go into anything, there's a way I discuss with my maker, and he has a sign for me. Until I see the sign before I can decide to leave for anything. If not, if not, before I even enter here, I was even planning to, but I tell God, if it's your will for me to go out, let me not get federal appointment. If it's not your will let me get federal appointment. At the dying minute of leaving, this job came … Because I feel it's the will of God for me and nothing that happened affect me, with all my heart. So, I do it with joy, with all my heart … I don't think God will say that … If he will say that, I will have the zeal of japa syndrome in me, yes.

Participant PD0022 emphasized that the experience of patriotism was driven by religiosity:

> Alright. Um, it's difficult coping at this, uh, time because it's, uh, taking toll and taxing the little available and beyond their limits. And people fall sick, uh, frequently than normal … And of course, because of, uh, the spirit of patriotism. Some people are still hell bent on staying back in the country. Now those ones that are patriotic and they want to stay back, if the trend continues, their health might be affected. And in the long run, we may not even have anybody to handle this again … See, it is deep religious belief that it's fueling patriotism. Patriotism is not standing alone … Wait, my own patriotism is a product of religiosity. So it's not, they're not separate. One is a product of the other.

Sympathy or Love for the Employer (Attachment or Stockholm Syndrome). All participants attested to grave conditions of the employee in terms of the employee burdens of excess workload and labor shortage that are caused by the employer's

inability to replace the turnover-induced exit of staffers. Nine employee participants (25.71% of employee participants and 23.08% of all participants in Figure 17) praised the employer for being, visionary, empathic, and caring. All employees complained of the employer's failures that included the employer's apathy, discouragements, neglect, and little or no appreciation.

However, these expression of sympathy or commendation for the employer suggested a sympathetic bonding or love for a perceived trauma giver that is described as attachment or Stockholm syndrome (Shaughnessy et al., 2023). Thus, Stockholm syndrome is a situation whereby a victim is bonded or attached with an oppressor and sympathizes or defends the oppressor's actions. Nine employee participants in Figure 17 complained about the employer and at another instance commended the employer as though there were no significant complaints. Participant PD0008 indicated an experience of discouragement and low appreciation by the employer: "to be honest, employees' appreciation from the employer has been very low when you compare the private sector to the public sector … So, I don't think there is appreciation in the public sector … So, it's discouraging." Conversely, Participant PD0008 praised the employer for a seamless work: "I work in a unit where we need some technology and I can say in this hospital, my employer has done so well by providing us what we need. So, our work is always seamless."

Similarly, Participant PD0024 complained that: "The Federal Ministry of Health, our employer … the appreciation for me is not there. Is not there. It's not there." However, Participant PD0024 defended the employer as being empathic, interactive,

visionary, and encouraging: “our employer … he's a visionary person … he tries to create this connection between his employee and himself … he has on his staffs, trying to empathize with them. And trying to make them see that I see your feeling.” Perhaps, employee participants use their personal cordial relationships/attachments to a hospital administrator or officer to alternately appraise their experiences with the employer in terms of complaint against the federal ministry of health or commendation of the medical director at the hospital.

Target in View. Seven participants (20.00% of employee participants and 17.95% of all participants in Figure 17) had goals inhibiting leaving their jobs for abroad offers. Participant PD0018 revealed the intention to complete a residency program prior to relocating abroad: “So, your exams are very expensive and all of that. So, a lot of doctors are at the verge of going. For me, I'm still here because I want to finish my program.” Participant PD0024 affirmed a targeted plan of becoming a consultant prior to any migration decision:

> Just like I said at the point in time that all of us we have, there as, we have our aspirations and goals … As I am, I'm a, I'm in training. There is orthopedic residency training. Currently I'm a senior registrar. Usually, as I said earlier, it usually starts as a registrar. And now I'm a senior registrar looking in few years time, I’ll be a consultant. So I think it’s my goals that has kept me going. I have a vision to achieve.

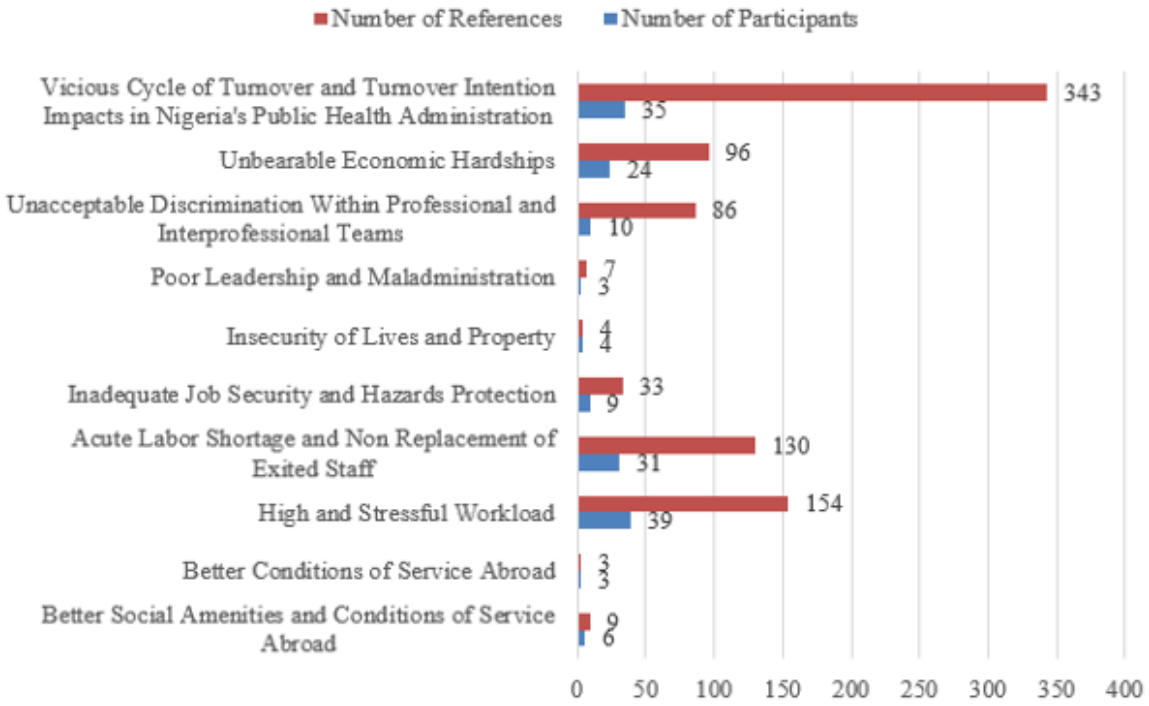
Participant PD0023 revealed that migration was not an option until the targeted goals are significantly achieved:

> You know, um, one thing I believe is like to, I'm a pacemaker. I'm a change agent and I love to be part of what corrects a bad thing. I love improvement. I have a commitment to put in my quota to lift the practices of radiography in this hospital from where it was where I met it to a better Eldorado. And until I get to that appreciable length and where my strength cannot carry me again, I think I'm still fine here.

Unfavorable Exit Opportunities and Requirements. Seven employee participants (20.00% of employee participants and 17.95% of all participants in Figure 17) had exit opportunities and requirements that were not favorable. Participant PD0020 revealed that there were no desirable foreign offers: “I have not yet gotten a job. Another job in this same profession that will give me that flexibility. Flexibility, flexibility. So I'm still here.” Participant PD0023 wanted to reach certain undisclosed level in civil service before any exit: “I need to get to the next level of my life in civil service, to a rank that I'll now retire or I can still get any other thing and leave here.” Participant PD0017 said: “I don't think of leaving the job until I get a better one.” Similarly, Participant PD0015 revealed that: “Why I have not left is because I've not. I've I have not. I have not had the, the opportunity. I'm still waiting for the opportunity. One day it might come.”

Figure 18

Reasons Why Turnover Intentions Persist



Subtheme 3: Reasons Why Turnover Intentions Persist

The participants provided responses that helped to capture records of factors of turnover intentions. Thirty-two participants (82.05% of all participants or 91.43% of employee participants, see Figures 3, 5, 7 and 18) gave reasons based on their perceptions and experiences why turnover intentions persisted. The reasons included: (a) better social amenities and conditions of service abroad, (b) insecurity of lives and property, (c) poor leadership and maladministration, (d) unacceptable discrimination within professional and interprofessional teams, (e) unbearable economic hardships, (f) viciousness of the cycle of turnover and turnover intention impacts in Nigeria's public health

administration, (g) high and stressful workload, (h) acute labor shortage and nonreplacement of exited staff, and (i) inadequate job security and hazards protection.

Better Social Amenities and Conditions of Service Abroad. Bara and Sapkota (2015) reported that inadequate welfare/safety conditions increased turnover and turnover intentions. These packages refer to minimized workplace hazards, adequate remuneration, and medical benefits. Mutambudzi et al. (2022) included health insurance, fair working hours, educational grants, and pensions as benefits enjoyed in UK and US. However, employee participants complained that these benefits are scarce or inadequate in the health sector.

Six employee participants (17.14% of employee participants and 15.39% of all participants in Figure 18) complained of poor social amenities and poor service conditions. Participant PD0010 stated that the employer "care less about them, so that's the major reason why people are running away." Participant PD0010 added that the employer did not compete favorably with the developed countries in the provision of "necessity of life, food, accommodation, peace of mind. So that's why majority of people who are leaving." Participant PD0022 bemoaned the lack of adequate social amenities as found abroad: "Okay, now, uh, you have uh, you have no good road. You have no proper transport. Uh, and enough model system of transport for people to transport themselves. And you do not have, uh, accommodation for staff."

Participant PD0034 asserted that the turnover rate will shoot higher until citizens do something about the country to improve quality of life:

> I said, people leave for different reasons and that's why the major reason may be remuneration or easier life or quality of life. I mean electricity, transportation, things are easier. Definitely. And that's why, that's why people, the turnover rate will still be higher until we do something about our own country and able to improve the level of quality of life. Reduce the poverty. Reduce the security, basically.

Participant PD0027 shared the citizens responsibility sentiment that "There's a lot of fractions and problems to be solved over time. When we get ourselves, things will be fine." Participant PD0011 disclosed that the employer did not provide adequate health protections against hazards in the work environment, and illustrated with an insufficient hazard allowance claim:

> For a month. When you face those crowd that come with different ailments, and also try to protect yourself from those ailments, not to contact those things, you know. And those of us working with radiation. The hazard, the radiation hazard, it's 5000 Naira a month and 56,000 a year. Can it take care, God forbid, can it take care of the effect of radiation problem when it eventually comes?

Insecurity of Lives and Property. Hussain et al. (2021) and Olumade et al. (2020) reported Nigeria's grueling disease outbreak vulnerability and terror predicament from Fulani herdsmen, Boko haram, and the Islamic State's West Africa Province (ISWAP). Terrorists harass, maim, kill, and kidnap victims regularly in cities and villages despite the operations of government forces. Similarly, Roth et al. (2022) and Sonzogno et al. (2022) reported that sociopolitical stability and inadequate personal safety promote

turnover intentions and migration to safer environments. Four participants in Figure 18 including three employee participants (7.69% of all participants or 8.57% of employee participants) and one employer participant (25.00% of employer participant) shared their perceptions/experiences on insecurity of lives and property. Participant PD0034 pointed out that insecurity problems transcended beyond the health sector as a major problem:

> That's even not within the public health alone. The security level in this country. That is enough to threaten, if somebody hears the episode of kidnaps, he'll like to actually leave. That is enough to a member of a family. The trauma is enough to actually. So that's one area we need to look into critically which is outside the public health, I mean the, the, what do you call it the, the security.

In furtherance, Participant PD0027 emphasized that the insecurity of lives and property was part of the problem fueling turnover and turnover intentions:

> I'm talking of presently, I'm in Lagos, right? And, and the level of insecurity where you compare it, it's not as much as compared to the Northeast. So, there are states in Nigeria that don't have my professional, um, subspecialty, they don't have them at all. Do you understand? But there are more in some other states because of the security; not that they don't have mental illness there. Do you understand? So, the security is also something that, um, is also part of the whole issue. Then when you now look at the remuneration and you want the better life for your family and your children. So when you see that it's not balancing and everything, you know.

Poor Leadership and Maladministration. Ogaboh et al. (2020) reported that there was persistent maladministration of the Nigerian health sector in terms of leadership, staff trainings, and policy effectiveness. Three employee participants (7.69% of all participants or 8.57% of employee participants in Figure 18) corroborated the maladministration in the sector. Participant PD0019 alluded to poor leadership effectiveness in a response: "Well in Nigeria context, yeah. Leaders are just after the work till they get done … They're not after your personal wellbeing. They're not after anything that has to do with you personally … I don't enjoy anything." Furthermore, Participant PD0012 indicated poor leadership effectiveness: "I am not enjoying them at all." Similarly, Participant PD0014 indicated no enjoyment of any leadership effectiveness: "Honestly speaking, it is not, is not something I'm, I am not. It's subjective. I am not enjoying it, not enjoying it.

However, Participant PD0034 pointed out that poor leadership was a collective resolve:

> Quality of leadership actually even in the health industry still come out from all of us, people that head the industry or any part of Nigeria. They're a part of us, and as for quality of life, it's not as if we don't know what to do ... we try and enlighten and then educate. We know what to do, not that you don't know what to do.

Thus, it is the citizens that will raise the bar to induce effective resolutions of leadership and maladministration problems. Hence, Participant PD0022 resolved that: "We have

found ourselves in the quagmire, and the, the best way to do is to keep keeping on until we're able to get to the end of the tunnel. And the dawn is, uh, is here."

Unacceptable Discrimination Within Professional and Interprofessional Teams. Mohammed et al. (2022) asserted that the continuous malaise of poor teamwork and different remuneration scales among health professionals hampered services and patient care in the health sector. However, government's preferential values and remuneration systems poorly competed with offerings abroad and worsened the trend of turnover, turnover intentions, and workers' harmony. Ten participants (25.64% of all participants or 28.57% of employee participants in Figure 18) lamented the unabated discriminatory practices in the health sector. Participant PD0020 described discrimination within professional and interprofessional teams as a reason to migrate abroad:

> Truth of the matter is they'll continue to japa. People will continue to japa until we bring job satisfaction. See like I tell some people at times when you see some other health professionals, *japaying*, it's not all because of money and all of that. Some of them are *japaying* for sanity's sake. When they are working in a place where they feel a certain profession is suppressing them, suppressing them, suppressing them and they know they have opportunities out there where they can flourish as their own professionals. They want to go there. So until we're able to align everything together, it may be a little bit difficult

Unbearable Economic Hardships. Roth et al. (2022) reported that high and attractive work compensation promoted turnover and turnover intentions. Employees complained of economic hardships which their remunerations could not ameliorate. Sasu

(2022) reported poor minimum wage increase from N18,000 (about $22) to N30,000.00 (about $37) in 2019. Despite the low wage review, it is still an issue to review or execute it according to current economic realities. The economic reality of an average individual's monthly cost of living in Nigeria is above 43,200 naira and the average monthly family living cost as the poverty line have exceeded 137,600 naira (Ejike, 2022; Okagba, 2019; Sasu, 2023). That implied hardship for staffers especially the minimum wage earners that feel the least respite when they go to the general goods market.

That experience predisposes the workers to migrate abroad or nurse the intention in an effort to solve their economic problems. Twenty-four participants (68.57% of employee participants and 61.54% of all participants in Figures 5 and 18) bemoaned the hardship they suffered in the service. Participant PD0027 asserted that "Everybody has their different reasons for leaving, but maybe 50% will be monetary to be able to add a better life …" According to Participant PD0013, "I cannot see any, salaries are paid, but that salary is not taking us home now with what is, yes, I want to be frank with you." Participant PD0029 indicated willingness to migrate and that "The only reason why I think so is because I've not found the clear-cut route or adequate finance to leave."

Vicious Cycle of Turnover and Turnover Intention Impacts in Nigeria's Public Health Administration. The vicious nature of turnover and turnover intentions exacerbated the acute labor shortage with overbearing tasks, inadequate job security, and any hazards protection. Omonijo et al. (2015) and Oruh et al. (2020) identified burnout, insecurity, job dissatisfaction, and preferential treatments of the professional groups as the cause of ruin in the health sector. That ruin is aggravated by the ravaging dire labor

shortage. The reduced workforce that was not refilled had become more stressful on the few workers available. Consequently, these professionals meditated high turnover intentions and are disposed to further vicious impacts including job dissatisfaction, turnover, breakdowns, and frustrating union strikes.

Whereas all 39 (100%) participants (see Figure 18) complained about the vicious impacts of turnover and turnover intentions, 32 employee participants (91.43% of employee participants and 82.05% of all participants in Figures 3 and 5) showed high turnover intentions in the prevailing economic/medical hardships, reduced workforce, and excessive tasks. Participants PD0039 responded that "Nobody wants to stay. Even the older ones are leaving now … Yes, I would still want to leave … it is not just about the health sector … not just about, oh, I'm a doc. It's about the, um, the economy, society … security."

Participant PD0036 complained about an inadequate work environment that induced exit feelings: "I mentioned earlier that I don't really, I'm, I'm not really cool with my work environment. That's the only reason I will accept to leave." Participant PD0032 frankly indicated a plan to exit: "I'm working towards leaving, but as of the time I'm going to leave, I don't think I'm ready to disclose that. But definitely every doctor wishes." Participant PD0030 revealed exit plan, that "It is on my mind. And I know that any moment from now, I'll be gone."

These high turnover intentions of employees pointed to an eventual turnover outcome. The Nigerian health workers are highly lured by foreign organizations with attractive working conditions and better social amenities (Osibanjo et al., 2020). These

alluring foreign conditions are accessible to the Nigerian health workers. The availability of equivalent competitive economy and working conditions within Nigeria by employees will help reverse the high turnover trend. Hence, Participant PD0026 as an employer would want "to make our own economy much better and make the work environment much more attractive to the extent that those going abroad will not see anything to go there." The vicious nature of the high turnover and intention experiences are obvious emergency for the employer to promptly resolve in other to retain these trained professional health workers that are inclined to leave.

High and Stressful Workload. Oruh et al. (2020) reported that turnover and turnover intentions are promoted by employee burnout and excess workloads. The high and stressful workload was a palpable experience of all employees that I interviewed. The participants' experiences and perceptions extended to complaints of breakdowns or illnesses which were explained by them as stress related. Thus, the impacts of labor shortages have extensive implications beyond excess workload. All 35 (100%) employee participants and four (100%) employer participants (see Figures 7 and 18) attested about high, stressful, and vicious work pressures. Participant PD0009, for instance, lamented:

> it has not been easy for us in the nursing unit. And the workload is so much because, I want to use myself as an example when we are in the female surgical ward, the ward is 24, 25 bedroom and we will be only two on duty because we don't have enough. They will employ somebody this, this month, within 4 months they travel. So, we that couldn't travel, it becomes an issue. Because you work

> and work and get so exhausted…The workload is much, that is just the challenge. Nobody is happy about it. No body.

Participant PD0011 complained that,

> People keep on leaving. No replacement. How will you be motivated? And they, if they are in the service where, maybe your colleagues, as colleagues we are about, say, 20 and people are leaving, no replacement and get you out to maybe eight or six, then, is there any, are there any motivations there? ... The discouragement is on, people leaving, and the workload is getting more than before.

Furthermore, Participant PD0016 expressed that the workload burden involved longer working hours:

> The, the workload is too much I had to ask for permission of one of them to join me and I make sure I finish the dressing. I closed around 7:00 PM before I was transferred to this my present ward. And the present ward now, with all that we do observe, and there was a time they brought a student to me on observation and the student cannot go alone. I had to take the parents' number and called them and where they are coming from is very far. Something I'll close 4, I stayed till 9:00 PM before the mother came.

Participant PD0034 explained the work pressure that "Individually, on my own personal level, the effects on everybody's increased workload because if you have like 10 people working and three or four have left, you still have to continue the same volume of work. Even more work"

Furthermore, Participant PD0009 bemoaned painful health conditions: “So, the work, like me now, I’m having serious waist pain. I cannot bend down as I'm telling you I can't bend down.” Participant PD0009 lamented the painful work pressure:

> Yes, I take drug every day. I can't bend down as you see me here. I work. Anything that will make me to come down like this I avoid it. Majority of us are like this, especially nurses. We are, we are not many because everybody wants greener pasture. That is just the truth. The money we are getting is not enough. Even if you are getting enough, we are not getting, since you are not getting enough. The workload is much, that is just the challenge. Nobody is happy about it. No body. In fact, let me tell you, everybody wants to go.

Participant PD0030 narrated that the workload impacts “At increased stress to us and no additional benefits.” Participant PD0030 emphasized the health challenges experienced:

> Yes. Official sick off, officially given a sick off from the clinic because of ill health. So it's a lot of, a lot of challenges, okay, a lot of challenges. And there’s a limit to the adjustments we can make as humans. Yes.

Participant PD0034 pointed at the back body part and complained about an undesirable back condition caused by extensive workhours: “currently I, I use a back support…when you sit for too long, you know, it could affect.”

In Figures 7 and 18, all the 39 participants’ (100%) experiences of excess workload and burnout were an overwhelming and intolerable impacts in the service. Yalma and Asuzu (2020) found that the participants that they investigated migrated to another country because of poor work conditions and stressful workloads. The scenario is

repeatable based on the prevalence of similar conditions especially as there was no sign of relief for all the 35 employee participants that yearned for remedies from the employer. The employer appeared overwhelmed and unable to ameliorate the predicaments of the employees. For instance, an employer Participant PD0026 expressed the employer's incapacitation:

> We try to collapse the wards together and ensure that, um, where we have, um, different we have, we ensure that the number of people that will cover those complexes are now put together instead of separating them. Um, so that the available number can be utilized for that purpose. I won't deny the fact that we also apply for recruitment or personnel. Uh, but I can tell you in the past 2 years as we're recruiting, they're leaving … So, we recruit every year. Um, just this last year, we recruited over 30 nurses. Uh, upper last year also, we recruited over 30 nurses, um, about 20 doctors, 20 doctors. But what happen is that after they start for 1 year, second year, they're gone. So you see number, you see that, we see that as we make effort to recruit, to solve the problem, but the problem persists.

These complaints by employees related to poor work conditions as a factor of turnover and turnover intentions and reflected similar conditions reported by Yalma and Asuzu (2020). The reference included exiting jobs or country because of poor work conditions, stress, and excess workloads. The employer (as an organization) accepted that it failed to resolve the turnover-induced manpower shortage. Consequently, the turnover and turnover intention trend persisted and inclined for the worse through the high and stressful work conditions.

Acute Labor Shortage and Nonreplacement of Exited Staff. All 39 participants (100%) in Figures 7 and 18 agreed that acute labor shortage persisted with consequential burnout and breakdowns in the public health sector. Thirty-one employee participants (88.57% of employee participants or 79.49% of all participants in Figure 9) emphasized the severe labor shortage as a factor of inefficiency and ineffectiveness of the health care administration. Dohlman et al. (2019) reported that 25% global disease burden is ravaging the sub-Saharan Africa (including Nigeria) with a dwindling workforce. The impact of the increasing vicious high turnover and turnover intention trend is set to complicate the disease problems if no effective interventions are applied. Ipinnimo et al. (2023) asserted that the severe shortage of health care professionals in sub-Saharan Africa has dwindled from 3% to less than 2% global workforce and is worse grappling with the 25% of global disease conditions. Participant PD0021 lamented the adverse labor shortage impacts on employees:

> We have a challenge. Shortage of staff. We have a challenge because they don't employ, we are few on the bench. And those, those, those of us that are, they don't employ. We are actually being worked out, like in hematology, I know about two people that have gone. Chemistry, they other people have gone. That's outside the country … [laugh] Few hands, and they are complaining serious. The workload is getting too much on them. And as I'm telling you now, we also have about three of them, four in hematology that are about to leave. And if four of them leave, I think we'll have only two people.

Participant PD0022 indicated that job enjoyment was elusive because of the dire labor shortage:

> how can I enjoy such, when, for instance, um, we know that there is a rate that when you have this number of people working, you must have this number of people working with them. For instance … WHO standard. When you have one radiologist …You have at least four radiographers working with that radiologist … Yes. Now what? You keep on increasing radiologist without increasing radiographers … you now have nine radiologists, nine radiographers.

In the same instance, Participant PD0023 bemoaned the acute labor shortage and gave details of increased work pressures from the modalities/machines involved in the work schedules:

> We doubled up our efforts. That is also wearing us out because we have now been overworked because of these people that are leaving are not being replaced. We've been without, um, interns for months now and you can see even my chiefs are coming to work and work, even do calls. Okay. In the time past, there were second, third of calls … If you see us working now, we are short-staffed. The number of persons in this department do not equate to the work or the output of what we get from here compared to other units … The standard here uh, is a certain number of radiographers that should be available to do a certain amount of work per day. WHO and other policies stipulated by our board and also our association. But we are short-staffed … In 24 hours, for any of our imaging modalities, it's expected that three radiographers man a modality in 24 hours.

> Three, minimum in a day. So, like now we have x-ray … Now for example, x-ray machine is being operated, we have a room for x-ray suspect. It is expected that three persons work on each in 24 hours, 8, 8 hours a day. So if we have one room, second room, third room, and about fourth room. It means, in counting, I should have three radiographers in 24 hours manning x-ray room. I should have three manning ultrasound. I should have three manning um, mammography room. I should have three manning, you know, the CT room. But in this case, we are not even upto. We are basically, about nine radiographers here and we have CT, we have x-ray, we have mammo, we have the ICU physical unit. We have the A and E. We have the theatre radiography.

Furthermore, Participant PD0023 explained about the adverse implications of acute labor shortage and excess workload burden:

> You can see that my colleague did call yesterday had to stay back to go to the theatre, work till 12 noon before going home. And x-ray is nobody's friend. We're not, uh, advised, it's standard, we shouldn't spend too much time in radiation producing area. So, there's a benchmark of how much exposure one should be to radiation. Because we're not able to measure it. They're invisible. They are causing stochastic and nonstochastic effects to people.

Participant PD0030 (a consultant doctor) lamented the severe shortage of manpower with increased work volume; Participant PD0030 became exasperated and despondent:

Over work! Will make you lose interest. You'll be on your feet from morning till evening you'll close … Well it is difficult. So that is where the problem is for we in this environment. It is difficult for you to, to, to uh, to combine the medical director and federal ministry of health because if you go to him and you say you are overworked, you want manpower, he will tell you that his employers are not giving him a, do you understand … That is what he'll tell you. So that is his own superior … is not allowing him to make the progress. So we have to separate the two … Eheh, or he'll say that the federal government has not, there's no waiver. Even if the ministry of, of health is aware that you are short of staff, they will tell you that the federal government is not giving approval for employment. So, it is quite, it's quite funny. Alright, that the people that see the workload cannot do anything about it … It's very, it's a paradox. It's, they are aware. They're aware doctors are leaving every day. They aware nurses have gone. This year alone, I'm sure more than 100 of them have also left. But imagine 100 have left, they've not refilled. They've not replaced them. That is wrong … we expect them to say we are dying under the weight of work. Right? Urgently do something about it…In a day in this facility, sometimes we see, we have to register almost 30 new patients. And that is a lot for a facility. Amongst that 30, apart from that 30, there are other old patients who are, this is just my own section here, returning for care, emergency breaking things. And in the midst of it, your safety, if I get injured, that's another thing I did not tell you, we did not talk about. If I get injured in the course of work, there is no compensation.

Inadequate Job Security and Hazards Protection. Mutambudzi et al. (2022) reported that job security was determined by social safety nets including health insurance, educational grants, normal working hours, and pensions. These welfare programs prepare and improve the quality of life during the employment life cycle and after retirement. Mutambudzi et al. identified that the UK employees enjoyed better than the US job holders in welfare protection benefits during and after retirement. The benefits that accrued after retirement imply that it is not tied to any performance by a retiree. The notions of job stability and peace of mind during and after retirement are strong pulling forces for employees in developing countries (including Nigeria) to contemplate a job exit and migrate to a preferred foreign country. Nine participants (23.08% of all participants or 25.71% of employee participants in Figures 5 and 18) complained about hazardous work environment and harsh security of jobs in addition to poor welfare.

Participant PD0020 showed readiness to leave a job position for an offer of better working conditions: “Of, of course. I will, with a better pay, better. See, it's not even because of better pay alone, just better services, better working condition.” Participant PD0019 indicated high exit intentions with similar priority on better working conditions:

> I’ll willingly go because I know in Chevron I'll have other, I'll, I'll have access to other employees’ uh, uh, allowances and benefits. I'll have access to better health care. My children will probably go to better schools.

Participant PD0020 further described rivalries and dichotomies within interprofessional teams as an added reason to exit job position for abroad:

> Truth of the matter is they'll continue to japa. People will continue to japa until we bring job satisfaction. See like I tell some people at times when you see some other health professionals, *japaying*, it's not all because of money and all of that. Some of them are *japaying* for sanity's sake. When they are working in a place where they feel a certain profession is suppressing them, suppressing them, suppressing them and they know they have opportunities out there where they can flourish as their own professionals. They want to go there. So until we're able to align everything together, it may be a little bit difficult.

Bara and Sapkota (2015) reported that unsafe work conditions increased tendencies for exit contemplations and turnovers. That included anything that is hazardous or debilitating physically or emotionally. Mutambudzi et al. (2022) referred to programs and processes that protect the employees including fair/protective remunerations, medical benefits, health insurance, healthy working hours, and minimized workplace hazards. However, nine employee participants complained that these benefits are inadequately provided by the employer in some instances or absent in the health sector.

Participant PD0019 decried being exposed unprotected to a work environment that was hazardous:

> For example, at least there are some facilities that you need to protect yourself as a health care provider. Provider like a PPE. Nobody cares. So, you just keep working as long as the work is get done. I'm a histopathologist scientist. So, I work in the histopathology lab where I'm exposed to xylene, where I'm exposed to

> formalin where I'm exposed to alcohol, and where I'm exposed to some other reagents that some of them are actually carcinogenic, but then I'm not being protected … Yes. I don't have anything to protect myself … There are masks that we use. Okay. When, whenever you are getting, whenever you find yourself around all these chemicals like xylene, formalin, and co. There are special masks you use to protect yourself, especially to protect your respiratory system from being infected or being affected by this chemical. But there's nothing like that.

Participant PD0011 lamented that the employer failed to provide adequate health protections against hazards in the workplace, and stated details of meager hazard allowance:

> The feeling. The experience. Okay, there is no care. Because part of the care and what we supposed to enjoy is this hazard allowances as hospital workers. You can imagine over the years they give you 5000 naira as hazard allowance for … For a month. When you face those crowds that come with different ailments, and also try to protect yourself from those ailments, not to contact those things, you know. And those of us working with radiation. The hazard, the radiation hazard, it's 5000 Naira a month and 56,000 a year. Can it take care, God forbid, can it take care of the effect of radiation problem when it eventually comes?

Participant PD0009 narrated an experience that was reminiscent of own (participant's) trauma trigger:

> I've worked for 17 years. I've worked here for 17 years. There's no time I experienced motivation. Apart from doing this one they give us, sometimes, half

> bag of rice. That was the highest I've gotten … Nothing. They've not given us anything. Nothing. I've not received. If any other person has received, unless like arrears, promotion arrears, hazard allowance that is earning, COVID 19 allowance, apart from that there's nothing like motivation … The example is that the money I receive as salary does not encourage me. Do you know that if they pay the salary, that day my BP will be very high. That day, immediately I see alert, my blood pressure will go kpim.

According to Mutambudzi et al., these employee complaints presented sufficient experiences of discomfort that promote turnover and turnover intention. Thus, employees will contemplate the exit of their jobs when adverse conditions prevailed beyond their tolerable limits. That will further complicate the turnover and turnover intentions maladies except the employer commences an efficient/effective intervention.

Summary

In this analysis, three main themes emerged and yielded sub-themes and categories. The themes included poor overall perceptions and lived experiences of the employer, negative impacts of the employees' perceptions and consequent actions on the employer's leadership effectiveness, and knowledge gaps reality. The first theme yielded sub-themes: (a) poor overall leadership effectiveness perceptions and experiences; (b) labor shortages, burnout, and nonreplacement of exited staffers; and (c) inadequate motivation perceptions and experiences. The second theme's sub-themes included (a) aggression transfer to patients, patients' relatives, and society; (b) complaints and feelings of discouragements (being unmotivated); (c) employees' frequent strike rituals and

despondency; (d) high turnover intentions and turnover as vicious cycle factors; (e) poor health service delivery; and (f) sympathy for the employer's failures (Stockholm or attachment syndrome). The third theme yielded the following sub-themes: (a) ineffective and inefficient federal health administration and policies; (b) reasons why Nigerian public health professionals are not migrating abroad or exiting their jobs; and (c) reasons why turnover intentions persist. Participants expressed their perceptions and experiences of being overwhelmed, burned out, and helpless under the impacts of turnover and turnover intentions in the Nigeria's public health sector. I discussed these themes and sub-themes using participants' excerpts, theoretical concepts, and scholars' opinions.

The themes and sub-themes that emerged showed the findings about the impacts of turnover and turnover intentions on Nigeria's public health administration. Participants' responses provided links to the fulfillment of research concepts and questions about their perceptions and experiences of turnover, turnover intentions, and leadership effectiveness. The responses of the employer were matched with those of the employees to answer the research questions.

The data analysis indicated that the government (the employer) failed to effectively reverse the high turnover and intention trend. The high exit intention trend persisted viciously because of inadequate staff motivations, labor shortages, employee burnouts from excess workloads, poor overall leadership effectiveness, ineffectiveness of the employer, and inefficiencies in public health administration. The data availed the reasons why Nigerian public health professionals were not exiting their jobs for foreign engagements and the reasons why turnover intentions persisted. In Chapter 5, I discuss

the interpretation of findings, social change implications, the research limitations, and recommendations.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this phenomenological study was to explore and understand the current perceptions of stakeholders and impacts of turnover, turnover intention, and leadership effectiveness on stakeholders' lives. The need to understand the prevailing association between an employer's leadership (managership) and employees' responses to the impacts of turnover and leadership effectiveness warranted Heidegger's phenomenological study to help evolve ways of resolving the problems in focusing on the lived experiences and perceptions of stakeholders. The research questions during the investigation involved knowing the perceptions and lived experiences of the employer and the employees about the effects of government leadership on turnover and turnover intentions in the public health sector. It included the impacts of the employees' perceptions and consequent actions on leadership effectiveness.

The key findings were that the government was overwhelmed, incapacitated, lackadaisical, and apathetically unprepared to resolve the vicious impacts of turnover and turnover intentions. The employee participants complained of poor remunerations and welfare, inadequate equipment, inadequate trainings or educational opportunities, job dissatisfaction, insecurity of lives and property, harsh political environment, burnouts through excess work volume, staff shortage, interprofessional groups' discriminations/rivalries, poor effectiveness, and employer's inefficiency. The employer participants corroborated the responses of the employee participants in being overwhelmed, limited, and incapacitated to resolve the vicious impacts of turnover, including labor shortage and excess workloads. The employees' consequent actions on

the ineffectiveness of government's leadership included high turnover intentions—91.43%—embarking on strikes, complaining helplessly, poor service delivery, aggression transfers to patients/society, and sympathy for the employer's failures. The employer's failure enhanced the fulfillment of the push and pull factors of turnover and exit intentions.

Interpretation of Findings

The research questions during the investigation were the following:

1. What are the perceptions and lived experiences of the professional employer and the Nigerian public health employees about the effects of government leadership on turnover and turnover intentions in the sector?
2. What are the impacts of the employees' perceptions and consequent actions on the employer's leadership effectiveness?

Theme 1: Poor Sectoral Leadership

Employee participants' responses indicated that the employer's welfare, remunerations, and CSR systems were poor and that the executed policies were ineffective and inefficient in the public health sector. That underscored the CSR report of Jamali et al. (2008) and Stewart et al. (2011) that employees expect legal, economic, and ethical fulfillment of obligations from the organization leaders to be appraised/perceived as responsible leaders. Thus, in the mind of an average employee, the employer is not responsible, effective, and comprehensively diligent in CSR services. This negative experience/perception is in sync with the report of Akinola et al. (2022) that citizens have

exiguous trust in the employer (government) in addition to citizens' belief that the Nigerian system is corrupt.

Ogaboh et al. (2020) and Omoleke and Taleat (2017) stated that the Nigerian health care system lacked optimal safety, policy formulation, trainings/updates, and inclusive leadership. The problem of inclusive leadership exacerbated other issues because of disharmony among different interprofessional teams dominated by doctors. Alubo and Hunduh (2017) and Mohammed et al. (2022) found that interprofessional discriminations and rivalry persist in the Nigerian health care sector because the Nigerian health care policy and leaders permitted doctors superiority and dominance against other professionals. That rivalry and superiority conflicts had contributed to the organization of Joint Health Sectors Unions (JOHESU) by the victims of that discrimination. Thus, JOHESU members pursued migration to foreign countries for better recognition, fair treatment, and professional harmony. Participant PD0038 expressed a perception/experience about the employer's apathy and taunting of the employees:

> So I think if we're gonna be speaking about discouragement, understand that my employer is federal ministry health like you said and by extension the federal government, I would say not the, I don't want, I don't want to use apathy, but the negligence of um, [Sigh of pity] I don't know, negligence paid to the health care system is just alarming sometimes … It feels like, okay, so I'm sure you heard that there was a recent strike … So, it seems like things just happened or it comes, oh, there's a strike. Oh what do they want? Okay, let's promise them this. Then they go back to work and then the same old cycle repeats and they're back to the joint

> table they gave after a few months that this same thing we're talking about 2 years ago, we're still doing talking about it now, but government said they didn't notice. So, it's, it creates, I don't know. And I think it might be responsible for a lot of demotivation.

The Herzberg et al. (1959) MHT was tested on the participants. According to Herzberg et al., employees with intrinsic passion qualities exhibited without rewards or threat of punishment are better satisfied on the job than those employees who require extrinsic influences of high salary/bonus and penalty to work. Notably, 31 employee participants in Figure 17 (88.57% of employee participants and 79.49% of all participants) indicated being passionate, patriotic, and committed to the patient's positive outcomes on their jobs. These qualities are more or less innate qualities referenced in the motivation theory.

Furthermore, Perry (1996) established that attraction and commitment to public good are factors of PSM. Thus, these 31 employees who were committed to the public good in being passionate, patriotic, and cooperative in patient care could be optimally developed by the employer for self-actualization in public health care. However, participants complained about little or no motivation. Participant PD0007 insisted that

> the motivation is zero … there is no motivation from anywhere. We hardly go for … trainings, for seminars that will impact our knowledge or whatever. If we have to go, you will have to sponsor yourself most of the time.

Participant PD0010 was low spirited and emphatic about the employer's treatment: "No motivation. Nothing. Just like you are working in a slave camp. No motivation. Nothing."

Poor remunerations were identified by Walton-Roberts et al. (2017) as a cause of turnover and turnover intentions. The employee participants complained that their remunerations were poor and did not fairly meet their needs. Roth et al. (2022) reported that employees feel better recognized, valued, and accepted when higher remuneration offers accrue to them. Commensurate increases that are competitive with developing countries constitute a consideration for a resolution of the problem in addition to bilateral mediations between countries. A consultant doctor, Participant PD0033, complained of inadequate earnings despite being at the peak of the profession and despite enjoying higher remuneration scale than other professional groups in the public health service:

> ... remuneration is discouraging unless you are a patriot. If I want to compare my own salary with my peers, yes, it's nothing to write home about if I change my own salary to pound sterling. For example, it is more or less what maybe the doctor starting newly in the, in the UK would take. Meanwhile, I'm at the peak of my own career here. I'm a consultant. And to, to, to everybody, Oh, the consultant is the peak. In fact, they are the highest paid in the country.

The authors recommended adequate salary and welfare packages as a solution to high trend of turnover and exit intentions.

Omonijo et al., (2015) and Oruh et al. (2020) reported frequent health workers' union strikes in a year on matters relating to inadequate equipment, poor maintenance on infrastructure, poor remunerations, neglect, and poor welfare. Participant PD0033 complained about inadequate or no office equipment:

> You want to measure the height. The stadiometer is not, is not there, you know, and those little, little things, I mean, furniture … You want to write; you want to type a letter. They're telling you there's no paper. I mean those are discouraging. Those are, can make you become disenchanted with the system. That even a paper. How can there be no paper or you want to print? They tell you there is no ink to print, to print.

Similarly, Participant PD0034 complained about the government's weakness in breaching/reneging on promises after an agreement:

> Strikes, strikes. I mean, no equipment. The strikes, I mean the, the, the, eheh, the, they agree with the government of something. And they're not fulfilling that promise. I mean maybe the association, the union have agreed and it's all publicized, sign memorandum of understanding. And there's no understanding after that, that one too is really, it puts, it puts me off … Then third thing is being able to replace these people because what makes people now go again is because the work is now getting enormous for the few that are in the system. So, they leave too, making it more enormous for people that are in the system.

Ramoo et al. (2017) and Sonzogno et al. (2022) reported that the search for career development and self-fulfillment was an overriding factor for migration to other regions and positions. The employee participants complained of little or no employer-sponsored study leave, updated courses, or job trainings on best practices using modern tools. The authors stated that the denial of adequate training was a factor for meditating and carrying out an exit to foreign countries in search of fulfilment.

Hussain et al. (2021) and Olumade et al. (2020) stated that insecurity posed grave dangers to all health care professionals. The high insecurity profiles limited accessibility and the availability of professionals to services. That compounds and hinders prompt resolution of disease conditions and any outbreaks in areas that are worst affected. Furthermore, Roth et al. (2022) and Sonzogno et al. (2022) reported that professionals migrated away from hostile environments to areas where stability was guaranteed or perceived to be stable. Thus, the feeling of insecurity, traumatic exposure threats, and the lack of stable sociopolitical environment make workers contemplate turnover and migrate to countries perceived to be safer.

Theme 2: Negative Employees' Impacts and Reactions

The following emerged as negative employee reactions to the employer's leadership approach: (a) high turnover intentions—turnover as vicious cycle factors; (b) sympathy for the employer's failures—Stockholm or attachment syndrome; (c) employees' frequent strike rituals and despondency; (d) aggression transfers to patients, patients' relatives, and society; (e) complaints and feelings of discouragement; and (f) poor health service delivery.

High Turnover Intentions and Turnover as Vicious Cycle Factors

The high trend of turnover intentions was a factor for the continuous turnover, which recycled viciously to harm the health services because of the lackadaisical response of the employer (government) to its incidence. Hence, 32 employee participants indicated in Figure 3 (91.43% of employee participants and 82.05% of all participants) showed high turnover intentions while grappling with shortfalls of labor with excess

workloads, economic hardships, and poor medical facilities. These conditions warranted Participant PD0039 to react that:

> Nobody wants to stay. Even the older ones are leaving now … Yes, I would still want to leave … it is not just about the health sector … not just about, oh, I'm a doc. It's about the, um, the economy, society … security.

Participant PD0036 was inclined to leave and complained of an inadequate work environment: "I mentioned earlier that I don't really, I'm, I'm not really cool with my work environment. That's the only reason I will accept to leave." Participant PD0032 frankly indicated a plan to exit: "I'm working towards leaving, but as of the time I'm going to leave, I don't think I'm ready to disclose that. But definitely every doctor wishes." Participant PD0030 revealed of an exit plan, "It is on my mind. And I know that any moment from now, I'll be gone."

Participant PD0004 was ready to switch organizations within or abroad: "So, if I have an opportunity of leaving here or leaving this institution or going anywhere where I'm paid enough to look back and say I'm taking care of my responsibilities, I will take it." Participant PD0009 expressed a readiness to exit the job for offers abroad:

> I don't want anything Nigeria. I want outside … Yes, because that side, they pay per hour. If you worked 1 hour, you know how much you are making. Here, I'll start night duty by 5, sometimes 9:00 a.m., I've not, 5 p.m. By 9:00 a.m. I have not finished handing over and the salary remains the same. Sometimes you do this night shift twice in a month … If I see the opportunity, I'll go.

Participant PD0012 (a renowned consultant surgeon) affirmed a willingness to take an offer in a better working condition abroad: “I will, I will … So, if somebody has offered me an appointment at this level outside this or this, I will take it because in 2 years’ time, they’re going to drive me away, anyway.”

Osibanjo et al. (2020) reported that Nigerian health professionals are highly sought and offered lucrative welfare conditions and social amenities. The employer Participant PD0026 alluded to better working conditions and economy as a solution to reverse the high trend of turnover. Thus, as an employer, Participant PD0026 wanted “to make our own economy much better and make the work environment much more attractive to the extent that those going abroad will not see anything to go there.” The feasibility of the employer’s wish is far from reality except when it is backed up by significant comprehensive actions to mitigate the factors of turnover and turnover intentions as a way of reversing the negative trend.

Sympathy for the Employer’s Failures (Stockholm/Attachment Syndrome)

Shaughnessy et al. (2023) described a condition where victims sympathize with oppressors and defend the oppressor’s actions as a kind of attachment or Stockholm syndrome. There were experiences of sympathy and commendation/compliments (see Figure 3) in a way that suggested an attachment or emotional bonding between parties (the employee and the employer). In this act, nine employee participants in Figure 3 (25.71%) showed sympathetic attachment to the employer despite complaining about the employer’s scanty motivations, little appreciation/encouragement, empathy, high work

volume, and shortages of labor. Participant PD0008 made an "honest" complaint of being discouraged by the employer and felt little appreciation:

> Well, ehm, to, to be honest, employees' appreciation from the employer has been very low … I don't think there is appreciation in the public sector … There was a time when one of those our facility had issues … it's discouraging.

Conversely, Participant PD0008 complimented the employer's work as being seamless in a manner that overruled the complaints: "I work in a unit where we need some technology and I can say in this hospital, my employer has done so well by providing us what we need. So, our work is always seamless."

Participant PD0024 chanted complaints that

> appreciation for me is not there. Is not there. It's not there … you should be aware of the recent … strike action by the Nigerian Association of Resident Doctors … we are doing a lot more than … the way they're appreciating us.

However, Participant PD0024 put a defense that the employer was empathic, visionary, encouraging, and interactive: "our employer … he's a visionary person … he tries to create this connection between his employee and himself … because of the effects that he has on his staffs, trying to empathize with them."

Employees' Frequent Strike Rituals and Despondency

Nine employee participants in Figure 3 (25.71%) felt despondent and neglected. Participant PD0038 relived the despondent experience and the fruitless strikes:

> there was a recent strike … So, it seems like things just happened or it comes, oh, there's a strike. Oh what do they want? Okay, let's promise them this. Then they

go back to work and then the same old cycle repeats and they're back to the joint table they gave after a few months that this same thing we're talking about 2 years ago, we're still doing talking about it now, but government said they didn't notice … I think it might be responsible for a lot of demotivation … Yes. It's discouraging. It's very discouraging. It's just, it just makes you feel … you are not so important … Anybody that is not frustrated with where the country is going now is not, is probably just joking … we were speaking … but just not heard. And nobody really cared … nobody really, um, really appreciates the efforts you actually put in as a medical personnel.

Participant PD0034 shared the experience of frustrations and frequent strikes: Strikes, strikes. I mean, no equipment. The strikes, I mean the, the, the, eheh, the, they agree with the government of something. And they're not fulfilling that promise … the association, the union have agreed and it's all publicized, sign memorandum of understanding. And there's no understanding after that, that one too is really, it puts, it puts me off … It happens a lot. In a year, resident doctors may go on strike like 4, 5 times … In one single year. Yeah, I mean, I mean, I'm sure. That, my friend that I said came, left again. He, he counted one strike once, and they did seven strikes in a year. He was counting, because he was showing it to me. He was outside the country for a long time, he was counting. Me, I don't know the reason he was counting. He was counting and counted I think six or seven that same year … So if doctors go like 3 or 4 times, they may go like another 3, 4 times … A lot. A lot. A lot. Because it disrupts everything.

Aggression Transfer to Patients, Patients' Relatives, and Society

Seven employee participants in Figure 15 (20.00% of employee participants and 17.95% of all participants) clarified bases for aggressive behaviors to patients, relatives of patients, and society. Consequently, participant PD0017 responded that "an angry hungry nurse will be an angry nurse. There will be transfer of aggression. And patient … suffer it." Participant PD0021 expounded the team members aggression transfers: "If you're not somebody that is prayerful … you won't be able to work … most times they are antagonistic to some patients, they are antagonistic to people, to relatives … because of what they see around them." Participant PD0014 explained the complexity of labor shortage burden that stir aggression/provocations towards patients: "the manpower is not there. The people that are still managing … If you are already discouraged … You will just be angry while you're doing your job. The person you're angry with is the one paying … for the service."

Participant PD0038 unleashed the blame on society for not understanding "most medical workers as humans. It's just, they see you as a doctor, they see you as a nurse, you know. They expect you to always be in that capacity at any point in time." Participant PD0038 blamed society instead of the employer for not being helpful to health workers: "I feel that society is not, uh, helping … when the health sector is agitated with these same issues, you readily hear somebody say … is it only money, multiple pay? Like is there, is there always money, money, money."

Complaints and Feelings of Discouragement (Being Unmotivated)

Thirty-four employee participants (97.14%) in Figures 3 and 6 regularly felt discouraged (unmotivated) by the employer in the workplace. Participant PD0033 was discouraged because of excess workload occasioned by labor shortage:

> Like I said, inadequate replacement of personnel that has, that has left. You know, it leads to more pressure on the remaining people in the system. And that one, you know, it brings up its own added pressure. Pressure of work, pressure, your own physical health is being challenged also because you are working, stretching yourself to the limits. Your own mental health is being challenged also … And it's discouraging. So, this issue of people leaving the system and then not able to bring in other personnel, that's replacement … Quitting job is an everyday thing.

Participant PD0023 felt discouraged because of paltry earnings compared to politicians' jumbo pay: "I would say very poor compared to the politicians who are taking off money every now and then for not doing much work." Furthermore, participant PD0023 complained of being excluded from a treasured service operation:

> I can do ultrasound; I can do MRI. I can do CT. FMC Ebute-Meta has regulated or has kind of limited us to normal x-rays. Uh, at least to ionizing radiations, which is the x-ray, and the rest. And they are depriving us of doing ultrasonography, most of us have been qualified, we've done the PG program … Yes, because I have love for ultrasonography and oncology. That's what brought me to radiography.

Participant PD0029 showed a loathsome expression about transiting a call duty to another duty without rest:

> One of my worst moments is also during one of these postings that you would've to be on 24-hour calls for 7 days and you'll be expected to resume 8:00 AM the following week to go about in normal activity … You will come back and resume 8:00 AM the following morning to work up to 4 for the next week, and resume 24-hours call again the following week … So in those postings, I've actually felt like quitting my job over and over again. Because I was overstressed, overworked, and the scenarios where senior colleagues don't even show gratitude despite the fact that you've been working a lot … But working here, it feels like you're always at work and even when you go, they keep calling you about things that you might have even sorted out. I personally don't believe anybody should call you after 4:00 if you are not on call … I think a doctor is supposed to rest after a 24-hour call.

Poor Health Service Delivery

Twenty employee participants in Figure 13 (57.14%) shared experiences of poor service delivery. On the employee coping technique at work, Participant PD0018 stated that patients upsurge led to reduced productivity:

> Yes, but the problem is because our health care, primary health care facility is actually not functioning. Because for the patients we see they're supposed to be treated at the level of the primary or the secondary care facility. So there's a huge burden on the tertiary health care facility. So patients that have headaches that

> should have been sorted out at the level of the primary health care. OK, if it can't be sorted out, you go to the second, secondary health care. You find everybody *ab initio* emptying themselves into the tertiary facility. So there is more burden, much more workload, reduced productivity. And I will tell you the reasons why there's reduced productivity … As the clinic runs you get tired. I've not stood up, as in standing up to take my time off with me to get myself and come back to sit and see patient. As I keep seeing patients, my attention span drops, my ability to pay attention to close details drops. So you find patients coming for things that would have been sorted out while they were seeing me … For example, I forgot to ask you to do this test, you should have done this test for surgery next week. But the patient was seeing me at the time when I was at my, at my lowest. I didn't request for that. I forgot requesting for that. So, by the time the patient comes in and I say, Oh, no, you can't, you can't, you can't have your surgery done. The fault is not the patient's fault.

Similarly, Participant PD0006 indicated a low productivity with excess workload burden:

> Ok, the employee turnover and turnover intention has greatly impacted on the level of care we give to patients. Like I said, when you're supposed to have four patients to a nurse and you are having 10–12 patients. You understand that the nurse will not be able to put in all, ehm, that's needed in the care of patients.

Furthermore, Participant PD0025 explained spending less quality time with increased patient load:

> the effectiveness, you can't get, you can't get it hundred percent. So, what it means is that you have to, as a psychiatrist, for instance, I need to, if I run a clinic, I may need to spend like 30, 45 minutes with a patient. So, but with this load, so that luxury, it's not, uh, affordable. So instead of saying, I want to spend 30, 45 minutes, maybe I need to, I can just call down the time I spend with the patient to like maybe 10, 15 minutes … The patient don't get up to what they're supposed to get. So, everybody's affected, the professionals are affected, the patients are affected.

Participant PD0014 showed low delivery at increased work volume, that "The workload is much, and the people are not giving effective treatments … it's affecting the delivery system to the clients … If you are already discouraged … You will just be angry while you're doing your job." Participant PD0012 noted that "The patient is at the brunt of everything. They are the ones that suffer for it." According to Participant PD0025 "The patient don't get up to what they're supposed to get … everybody's affected, the professionals are affected, the patients are affected." Thus, poor service delivery disadvantage affects the patients, the health worker, and society.

Theme 3: Knowledge Gaps

Ogaboh et al. (2020) reported that the Nigerian public health sector leadership was inefficient and operated an inefficient policy, trainings, and safety systems. The participants' experiences and perceptions that were captured in the data provided information for analysis about the public health administration/policies, which corroborated an ineffective and inefficient system as discussed in Chapter 4. The

information from the data revealed that (a) the employer and the employees were overwhelmed with work pressures, (b) nine employee participants (25.71% in Figure 3) developed sympathy-defense complex for the employer as an attachment or Stockholm syndrome, (c) five consultants or directors helped to resolve the employer's excess labor assumption, (d) the reasons employees were not migrating despite expressing high turnover intentions, and (e) the reasons turnover persist. Summarily, 35 participants in Figure 9 including 31 employee participants (88.57%) and four employer participants (100.00%) showed that the federal health administration and the policies executed in the sector to address the turnover-induced adversity of excess workloads and labor shortages were ineffective and inefficient.

Employer and Employees Overwhelmed With Work Pressures

Oruh et al. (2020) asserted that employees in the public health sector are pressured and overwhelmed in their jobs. These job pressures originate from managers and supervisors of teams who are desperately inclined to achieve or surpass work targets through their subordinates. However, the burdensome impacts of excess workloads transcend the employees and their managers to the employers. All 39 participants that were interviewed complained about stressful excess workload. Thus, the employer shared experiences of being stressed and incapacitated in resolving labor shortage problems despite the introduction of locum (a temporary staff replacement policy). All four (100%) employer participants in Figure 9 indicated being overwhelmed and could not fulfill the staffing functions of management (administration). In fact, employer administrators relinquished their positions for abroad offers in search of greener pastures.

Consequently, 32 employee participants in Figures 3 and 5 showed high turnover intentions to exit their jobs in preference for better working conditions and packages abroad or locally. All the 35 employee participants in Figure 18 indicated reasons for not migrating abroad or exiting their jobs (as discussed in Chapter 4). However, the reasons did not minimize the reality of the high turnover intentions of the 32 participants searching for better service conditions but exposed the different prevailing decisions and conditions that had kept them stuck in their jobs in the public health sector.

All four (100%) employer participants in Figure 9 had experiences that were overwhelming. The clarifications from the four employer participants showed that they were shackled by the federal ministry of health (the government) in carrying out their responsibilities. The handicap of the hospital administrator-employers by political leaders gave rise to the lethargic experience of all categories of the employer. Thus, hospital administrator-employers are involved in a puppet relationship whereby the politicians are their masters and control them in a way that may hinder statutory duties and the public interest of making the health service efficient and effective for citizens.

In fact, Participant PD0001 was incapacitated, fettered, and could not effectively cope to carry out staffing functions as evidenced in the employer's reaction that "in terms of coping, I don't think we are coping." The employer Participant PD0001 indicated being restricted and responded that: "as an administration, we are centrally regulated from the federal ministry. So it's not always that quick to get approval to employ replacement when people leave." Participant PD0001 indicated the result of the restriction and stated that: "it has actually severely affected the hospital services. It has

also impacted on the existing, the permanent staff who are still here, and have to do more work than they would have."

In the same vein, Participant PD0026 was overwhelmed and puzzled to resolve the high trend of turnover-induced labor shortage. Participant PD0026 reported that "as we make effort to recruit, to solve the problem, but the problem persists." Similarly, the federal authorities' handicap stopped the employer Participant PD0028 from performing an efficient/effective staffing function:

> we ask for replacement from the federal government, they will not give that approval at that particular time … The only thing, we have challenges is the number of people that are working at that same time … If the federal government will do same by helping us to replace those people that exit service, it'll go a long way to help the system.

The experience of employer Participant PD0031 was not spared but suffered upset, stress and limitation as shown in a complaint: "We don't have medical doctors o, that's why we are recruiting. As we are recruiting, they are leaving … It's stressful but we are coping."

Participant PD0009 felt exhausted and referred to the overwhelming workload:

> it has not been easy for us in the nursing unit. And the workload is so much because, I want to use myself as an example when we are in the female surgical ward, the ward is 24-, 25-bedroom and we will be only two on duty because we don't have enough. They will employ somebody this, this month, within 4 months they travel. So, we that couldn't travel, it becomes an issue. Because you work

> and work and get so exhausted … The workload is much, that is just the challenge. Nobody is happy about it. No body.

Participant PD0011 lamented about the workload burden, that:

> People keep on leaving. No replacement. How will you be motivated? And they, if they are in the service where, maybe your colleagues, as colleagues we are about, say, 20 and people are leaving, no replacement and get you out to maybe eight or six, then, is there any, are there any motivations there? ... The discouragement is on, people leaving, and the workload is getting more than before.

Furthermore, Participant PD0016 corroborated the excess workload burden:

> The, the workload is too much I had to ask for permission of one of them to join me and I make sure I finish the dressing. I closed around 7:00 PM before I was transferred to this my present ward. And the present ward now, with all that we do observe, and there was a time they brought a student to me on observation and the student cannot go alone. I had to take the parents' number and called them and where they are coming from is very far. Something I'll close 4, I stayed till 9:00 PM before the mother came.

Participant PD0032 complained of no relief and that "services are not put in place to ease out stress, to ease, um, the burden of care or workload." The combined experiences of participants implied that it was not only employees that left their jobs for abroad offers but employers abandoned their positions for better prospects abroad. Thus, all the participants including the employer and the employees felt overwhelmed and

helpless with workloads but the bulk stops with the employer, especially the senior employers (politicians) with citizens' mandate to function effectively and efficiently.

Sympathy or Love for the Employer (Attachment or Stockholm Syndrome)

This sub-theme (in Figure 3) emerged and helped as an effort to interpret the conflicting appraisal of nine (25.71%) employee participants who made emphatic complaints that the employer is apathetic, discouraging, neglecting staff with little or no appreciation. In another turn, the employees expressed sympathy, compliments or commendation about the employer as being sympathetic, visionary, honest, appreciative, empathic, and interactive. There was an establishment in the participants' responses of an attachment, a bond or love for a trauma giver, described as attachment or Stockholm syndrome (Shaughnessy et al., 2023). The Stockholm syndrome is a condition in which a victim shows sympathy, love, and defense of an oppressor or an oppressor's actions.

Thus, participant PD0008 showed an experience of discouragement and low appreciation by the employer: "to be honest, employees' appreciation from the employer has been very low when you compare the private sector to the public sector … So, I don't think there is appreciation in the public sector … So, it's discouraging." Conversely, participant PD0008 praised the employer for a seamless work: "I work in a unit where we need some technology and I can say in this hospital, my employer has done so well by providing us what we need. So, our work is always seamless."

Participant PD0024, similarly, protested about lack of appreciation from the employer: "The federal ministry of health, our employer … the appreciation for me is not there. Is not there. It's not there." Conversely, participant PD0024 defended the employer

as being empathic, interactive, visionary, and encouraging: “our employer … he's a visionary person … he tries to create this connection between his employee and himself … he has on his staffs, trying to empathize with them. And trying to make them see that I see your feeling.” Perhaps, an employee participant’s personal cordial relationships/attachments to a medical director, hospital administrator, or officer are influencing the employer’s commendations to mitigate perceived grievances that was against the federal ministry of health.

Employer’s and Employees’ Reactions to Excess Professionals Assumption

Omeje (2021) reported that greater half of the 72,000 registered doctors in Medical and Dental Council of Nigeria (MDCN) are not accessible and available in Nigeria but abroad where they practice. That implied that less than 50% of Nigeria’s registered doctors practice in the Nigeria’s private and public sector. Furthermore, Oyadiran et al. (2020) reported that Nigeria has a low ratio 0.38 doctor per 1000 patients, which is below the WHO recommended ratio of 1 doctor per 600 patients. Despite these data, the employer assumed that there is an excess of medical doctors or health workers in Nigeria to justify the high trend of turnover in the country.

The employer’s excess assumption was resolved through the agreement of all the participants in Figure 7 that the public health sector suffered labor shortages, burnouts, breakdowns, and excess work volumes. Furthermore, five participants in Figure 8 (four consultant doctors and one administrator) shared their experiences about excess health workers’ assumption in Nigeria. In Figure 8, the four (80%) consultant doctors' responses showed disagreement with the assertion of excess doctors/health workers in the health

sector. The employer Participant PD0026 (at 20%) shared the sentiment of excess professionals in Nigeria despite no evidential support. Participant PD0012 debunked the employer's excess assumption and stated that it "is definitely wrong" and not validated by any scientific report. The employer Participant PD0031 refuted the excess assumption and recounted workplace experience as an employer that: "there's no excess doctor o [laugh]. We don't have medical doctors o, that's why we are recruiting. As we are recruiting, they are leaving." Thus, the consultant doctors' experiences corroborated the reports of WHO (2016) and Omeje (2021) about shortages of heath care professionals in Nigeria. However, all 39 participants in Figure 7 (including Participant PD0026 that dissented from the consultants' expert opinions and experiences) were unanimous in agreement that labor shortages persisted in the public health sector.

Limitations of the Study

The timely collection of data in vulnerable population arears in Northen Nigeria was limited because of threats of terrorism. Consequently, data collection was carried out in Southern Nigeria where threats occur less frequently. Findings are limited from generalization in the whole of Nigeria except Southern Nigeria despite one public service code and government in both regions.

The phenomenological approach relied on subjective lived experiences and perceptions of participants which limited the generalization of the study to other populations' experiences and perceptions. There were limited time constraints during interview sessions and the questions asked did not cover all experiences and perceptions including follow-up needs in the subject areas. There were delays in prompt data

collection because of influences of union strikes, safety/security threats, office bureaucracy, internet/voice connectivity, and unstable electricity supply in Nigeria.

There were difficulties getting participants in the South because of reasons about political and nondisclosure agreements implications. The perceptions and experiences of low-level junior staffers in the public health sector were not included in the data collection sessions. The focus of the study was on high level manpower in Nigeria's public health services because of the need to sample participants that were able to adequately communicate their perceptions and experiences that helped fulfill the research purpose designed for purposive and snowball sampling of participants.

Recommendations

The increased trend of migration in sub-Saharan Africa (including Nigeria) have dominated international policy debates since the 1990s with net negative impacts of increased unemployment rate at 9.01% (Adesina, 2022). The net negative impacts create a social problem that underscores further research on how to resolve the problem. Ipinnimo et al. (2023) reported that the global health workforce in sub-Saharan Africa bearing 25% burden of world disease has receded from 3% to less than 2%. Thus, the decrease in workforce yielded scarcity of health care services/professionals and negative impacts of turnover and turnover intentions. Further research is needed to monitor the extent and nature of impacts or remediation.

This study indicated that the employer (government) is inefficient and ineffective in addressing the problems of turnover and turnover intention. Ogaboh et al. (2020) reported that there was persistent maladministration of the Nigerian health sector in terms

of leadership, staff trainings, and policy effectiveness. The employer and employee participants alluded to poor leadership effectiveness in their responses. Akinola et al. (2022) reported that citizens have low trust in government because of high systemic corruption that had ravaged all sectors including the health sector. Participants complained of complications from the use of substandard materials/drugs or when corrupt officials deliver substandard medical items/equipment. Further studies are needed on how corruption and citizens' perceptions affect turnover and turnover intentions.

A major problem identified was poor motivation of health care workers. In the learning resource, Herzberg et al. (1959) recommended performance reflections and the training of administrators on the effective use of motivators and the hygiene factors. Training resource is a suitable priority orientation for public service administrators and the ruling class for them to be conscious of the knowledge of global best practices. All government officials including the president and commander-in-chief should humbly submit to undergo anticorruption, effectiveness/efficiency trainings on the job.

Sonzogno et al. (2022) reported that career training/development is an important attraction for employees to migrate to other regions. Participants complained about little or no employer-sponsored training. The employer stated that the trainings of employees were selective because of cost implications. That implied possibility of favoritism and abuse of fairness, equality, and equity in the selections. The government should partner with researchers to study and implement contemporary training methods for all staff categories without excluding anyone.

Herzberg et al. (1959) stated that the training "reflections apply to supervisors on any level, from the foreman over a group of machinists to a company president dealing with his department heads" (p. 136). That covered all stakeholders' training. Government officials and hospital administrators should be intentional in: (a) training on motivation methods; (b) the identification of red flags of turnover and turnover intentions; and (c) the ways of ensuring that the effectiveness, efficiency, and stability of the health sector administration are practiced daily. Further motivation studies are needed to monitor the motivation behaviors of stakeholders for specific productivity training needs and to determine whether employees' behaviors in a perceived oppressive, corrupt, or insensitive regime constituted any forms of attachment or Stockholm syndrome.

Roth et al. (2022) reported that employees feel valued and recognized when their remunerations are competitively high. It implied that an adequate employee remuneration package is an important motivation tool considered and regularly revised according to economic realities. In Herzberg et al. (1959) motivation-hygiene theory, salary is an external maintenance (hygiene) factor for the reduction of dissatisfaction. However, the extent of lowness of employee salary may render it worse than a maintenance factor and require a sufficient increase. There is a need to study the suitability of employee remunerations/salary as a hygiene factor of motivation, as a motivator factor, or as contextually dependent factor.

The purchasing power parity of Nigerian public health workers and minimum wage earners are poorly remunerated below the poverty line ($1.90) (Ejike, 2022; Sasu, 2022). This reference to poor earnings was the pain of all employee participants. For

instance, an experienced consultant doctor at the peak of the medical profession that exceeded other professional groups with higher earning scale lamented earnings as low and equivalent to that of a beginner in UK. Ogaboh et al. (2020) reported that employees immigrate to developed countries in search of an improved standard of living, better remunerations, and skills enhancement. Employees complained about poor welfare, manning levels, and ineffective NHIS (National Health Insurance Scheme) policy that did not cover all health costs. Further studies are needed to determine (a) suitable methods for implementing a competitive remuneration increase, (b) better health policy that included a 100% of employees' expenses when they are sick, and (c) how the developed countries have prioritized employee welfare and attractive health infrastructures.

Oruh et al. (2020) reported that employees' jobs are pressured by supervisors to achieve work targets. That job pressure becomes worse when manning levels are below optimum. The current staffing level is 0.38 doctors per 1000 patients which is below the WHO recommendation of 1 doctor per 600 patients (Omeje, 2021; Oyadiran et al., 2020). Participants (doctors, nurses, pharmacists, radiographers, and medical laboratory scientists) complained of labor shortages. Further research is needed on the barriers of WHO global best practices in Nigeria especially manning levels required to relieve workers' plight of burnouts from excess workloads.

Hussain et al. (2021) and Olumade et al. (2020) stated that health care professionals are exposed to threats of insecurity in the health sector. There are terror exposures from Boko haram, Fulani herdsmen, and the ISWAP (Islamic State's West Africa Province). These terrorists maim, harass, kidnap, or kill their victims regularly in

villages/cities despite government's presence. That reduces availability and accessibility of the professionals to render much needed services to citizens/patients. The government should fulfill its responsibility of securing lives and property while moderating research on a productive political environment for health service.

Oruh et al. (2020) reported that health workers' strikes occur frequently to agitate for better services including the provision of adequate equipment, fair remunerations, better welfare, better attention, and proper maintenance of infrastructure/equipment. Availability of work tools/equipment is important for prompt delivery of services. Participants complained of obsolescence, scarcity, or absence of office equipment including core medical hardware/equipment, office tools, chairs, tables, office apartments, air conditioning units, water, and theatre amenities. Logically, the absence of these equipment promotes medical tourism. The government should implement a planned effective maintenance system on available infrastructure and amenities. It is important for government to ban all elected and appointed government officials from medical tourism to compel them to partner with researchers to study, evolve, and ensure a functional public health system in the country.

The Nigerian government committed to the Abuja Summit of the African Union 2001 to annually execute 15% (at least) of the total budget on health care but annually lagged at about 4% appropriation for health care (Abang, 2019; Omeje, 2021). That is evidence that the government is insensitive towards adequate health services needed to mitigate the high trend in turnover. It further corroborated Akinola et al. (2022) report that citizens hardly trust government and that all sectors suffered high systemic rut in

corruption. That leadership insensitivity complicates human and material resources management and compels intolerant staffers to exit job positions. Further research is needed on the reasons why government is insensitive and not committed to agreements that promote the mitigation of high turnover/intention trend.

Alubo and Hunduh (2017) and Mohammed et al. (2022) showed that leaders in the health sector favored medical doctors' dominance to entrench interprofessional rivalries against nurses, radiographers, pharmacists, physiotherapists, and laboratory scientists. The discriminatory leadership process hinders team spirit and frustrates those that are disadvantaged to seek positions abroad where they will feel valued and fairly treated. Further research is needed on the roles of policy reforms and conciliations in mitigating team conflicts in the health sector so that team spirit and fairness in job evaluations will be based on equity and equality.

Implications

The implication of a positive social change in Nigeria's public health sector is problematic because government is adamant in its refusal to accept the high turnover trend implications for an internal and external redress of the sector. Yakubu et al. (2023) lamented the government's failure to effectively address the related problems of the SHW (skilled health worker) migration including economic policy implementation, and the negative impacts of migration. The government's failure and denial of maladministration is a continuous position of its officers. For instances, that denials of workers plight of burnout from excess workload and labor shortages in the health sector was made by the former minister of labor (Dr. Chris Ngige) and the former minister of health (Prof. Osagie

Ehanire) at different times to corroborate each other on government positions (Are, 2022; Atoyebi, 2019). The trend has not changed.

However, there are tangible improvements that could be described as positive social changes for individuals and their families involved in turnover. The pull factors from the destination host countries offer better employments and living conditions, access to social infrastructures, information networks, and stable political environment (Akanle et al., 2021; Roth et al., 2022). The direct advantage of employment includes economic/financial benefits available to the individuals and the families. Alternatively, there are opportunities for education to migrants in the host countries without disruptions through union strikes or terrorism threats.

Furthermore, there are positive social changes in terms of diaspora remittances. Nevertheless, there is no sustained outstanding positive social change to the organization (federal ministry of health) and the country (Nigeria) because of the high turnover trend. That positive effect of diaspora remittances of migrants promoted the economy for a short time before the onset of coronavirus in 2019. That was followed by the increased magnitude of inflation on the naira which reduced the value of the remittances at currency conversion point. The disadvantages of high turnover trend continued in the country in favor of host nations despite the diaspora remittances. That is because greater part of the tax benefits from diaspora earnings belonged to the host countries apart from services and labor stability advantages of the immigrants missed by the home state (Nwosa, 2021). It implied that the value of the physical presence of health professionals that promoted labor stability outweighed the benefits of diaspora remittances and

rendered their specialized diaspora skills as a lost invaluable resource gained by host nations.

There are implications of positive social changes to society and policy-related disciplines in the research outcomes of the study of turnover, turnover intentions, and government's leadership effectiveness. The report will be valuable to policy makers/reformers, administrators, scholar-practitioners, academics, and planning/enrolment officers. Those officers involved in immigration services, homeland security, teaching and research, international enrollment services, advocacy and rights groups, government agent reformers, and data vendors will find the report useful to promote positive social changes when reports are applied. The research report is a scientific tool to persuade the ruling class on the need to avoid the negative implications of turnover and turnover intentions.

The positive social change implications for the organization (government/federal ministry of health) will happen through publication of this report and the role of advocacy/rights groups when the Nigerian government exercise the political will to change its incorrect perception/position about the inadequacy of labor in the health sector and subsequently implement effective reforms and interventions. This report will be useful as a social change guide to the government authorities and scholar-practitioners in the health industry. Hence, the report will be a base for further research efforts on turnover, turnover intentions, and governments effectiveness in the public health sector administration.

Conclusions

The negative impacts of turnover and turnover intentions in the health sector had bordered me and I choose to carry out this study as a minimum way of redressing the problem. During this study, I keenly listened to all the participants share their lived experiences and perceptions. The participants trusted me and freely shared their experiences and perceptions on questions that I asked. Their responses pointed at inadequacies in leadership effectiveness and staff motivation.

During the interviews, one of the participants stated that a healthy workforce means better productivity. In the same vein, another participant responded that a healthy society is a wealthy society. Thus, it implied that the high turnover trend of health care workers pointed at diminishing the productivity, health, and wealth of the people. This report is a useful tool for scholar-practitioners, elected officials, and rights/advocacy groups to apply its knowledge in persuading government to prioritize: (a) the health care systems infrastructures, (b) harmonious administrations, and (c) optimize maintenance practices. Therefore, that priority attention of government and its fulfillment constitute a foundation for labor stability and productivity improvements in all sectors of the economy.

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Appendix A: The Interview Questions for Participants (Employee and Employer)

1. For employee: Staff migration and turnover impacts persist. How are you coping and handling it in your work? For employer: As an employer, staff migration and turnover impacts persist. How are you coping and handling it in your work?
2. How have you enjoyed your job as a health care professional?
3. What is your experience and perception of the employer's appreciation of health care employees?
4. What are your experiences on the ways the employer has motivated you on the job?
5. What are your experiences with instances on the ways the employer has discouraged you on the job?
6. As an employer, how does corporate social responsibility affect your leadership and administration of work in the health sector?
7. As an employee, what is your feeling and experience (with examples) of the impact of the organization’s corporate social responsibility and how does it affect your commitment to work and the organization?
8. From your experience as an employee, how are you enjoying the leadership effectiveness of your employer?
9. From your experience as an employer, tell me how you achieved work and leadership effectiveness with your employees?

10. Can you give me a specific example of when and how you felt like quitting your job and when and how you felt excited, happy, grateful, or fulfilled about your job?
11. Why have you continued to work within the industry for years despite increasing turnover trends in your health unit?
12. If you are offered employment at the same level of remuneration within or outside the health sector, will you accept, and why?
13. What things make you lose interest in your job?
14. How many hours (averagely) do you attend or absent from work in a week, and how many hours do you spend on recreation every week?
15. For an employee: What training courses can you remember that you attended within the last 5 years, and how did you apply the lessons learned? For an employer: What training courses can you remember that you personally supervised within the last 5 years, and how did the training outcome help the health sector?

Appendix B: The Interview Questions for an Employee Participant

1. Staff migration and turnover impacts persist. How are you coping and handling it in your work?
2. How have you enjoyed your job as a health care professional?
3. What is your experience and perception of the employer's appreciation of health care employees?
4. What are your experiences on the ways the employer has motivated you on the job?
5. What are your experiences on the ways the employer has discouraged you on the job?
6. As an employee, what is your feeling and experience (with examples) of the impact of the organization's corporate social responsibility and how does it affect your commitment to work and the organization?
7. From your experience as an employee, how are you enjoying the leadership effectiveness of your employer?
8. Can you give me a specific example of when and how you felt like quitting your job and when and how you felt excited, happy, grateful, or fulfilled about your job?
9. Why have you continued to work within the industry for years despite increasing turnover trends in your health unit?
10. If you are offered employment at the same level of remuneration within or outside the health sector, will you accept, and why?

11. What things make you lose interest in your job?
12. How many hours (averagely) do you attend or absent from work in a week, and how many hours do you spend on recreation every week?
13. What training courses can you remember that you attended within the last 5 years, and how did you apply the lessons learned?

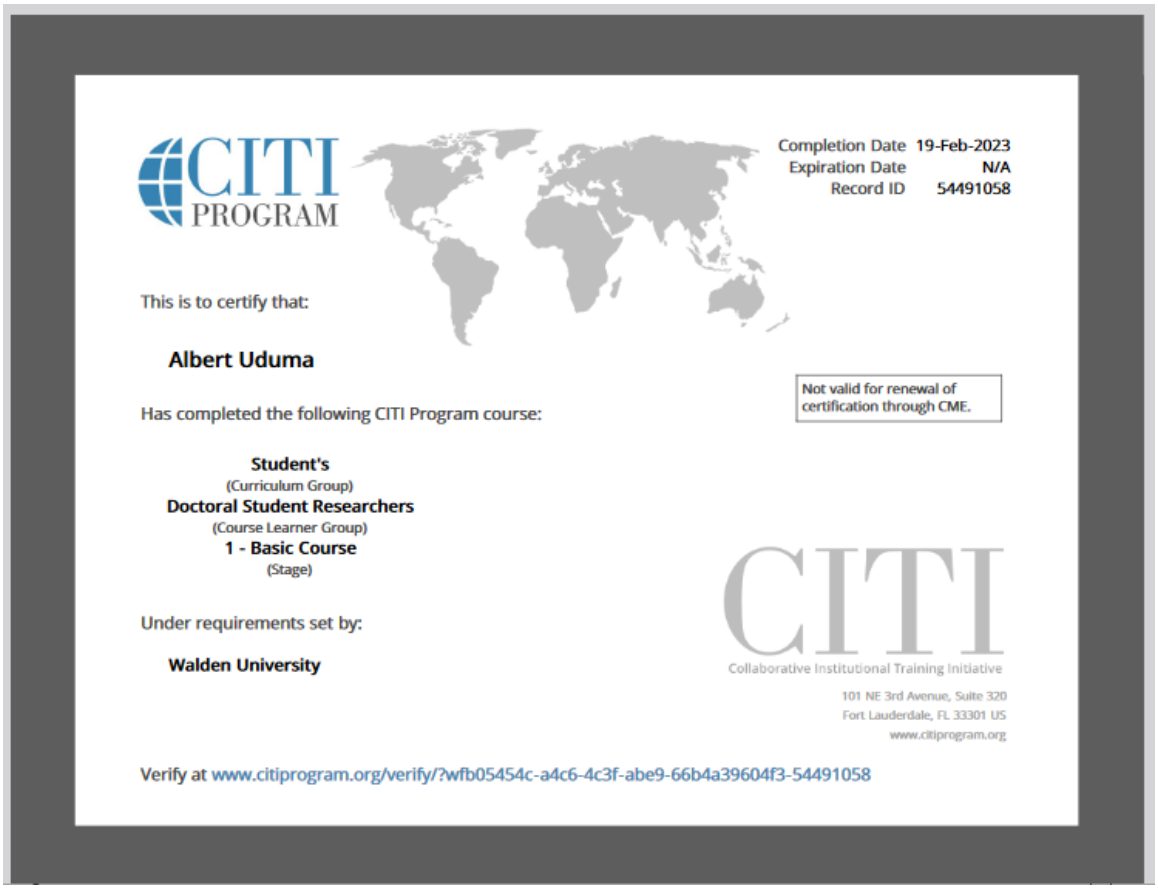
Appendix C: The Interview Questions for an Employer Participant

1. As an employer, staff migration and turnover impacts persist. How are you coping and handling it in your work?
2. As an employer, how does corporate social responsibility practically affect your leadership and administration of work?
3. From your experience as an employer, tell me how you achieved work and leadership effectiveness with your employees?
4. What training courses can you remember that you personally supervised within the last 5 years, and how did the training outcome help the health sector?

Appendix D: Interview Recruitment Flyer

If you are an employee or an employer (appointee or director) in the Nigerian public health sector working or supervising any federal public hospital or medical establishment in southern Nigeria, you are invited to be interview in a virtual or face-to-face personal interview whose outcome might help identify strategies to address the problems of turnover, turnover intentions, and government leadership effectiveness issues. The qualifications for participation include: (a) current observed engagement identity as an employee or an employer (Government appointee or a director) that is directly involved/working in the Southern part of any Nigeria's public health establishment; (b) 2 years minimum working experience in the public health sector; c) skilled qualification as a doctor, nurse, medical laboratory scientist, radiologist, administrator, or a professional in the Nigerian public health sector. Any vulnerable persons in the population that meet the inclusion criteria will be included to explore their perspectives, while protecting such participants rights to inclusion and minimal risks protection. Any noticed unqualified intending participant will be excluded without being interviewed for the study.

Appendix E: Human Research Participants Training Certificates From CITI and TRREE



CITI PROGRAM

Completion Date 19-Feb-2023
Expiration Date N/A
Record ID 54491058

This is to certify that:

Albert Uduma

Not valid for renewal of certification through CME.

Has completed the following CITI Program course:

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
101 NE 3rd Avenue, Suite 320
Fort Lauderdale, FL 33301 US
www.citiprogram.org

Verify at www.citiprogram.org/verify/?wfb05454c-a4c6-4c3f-abe9-66b4a39604f3-54491058

Zertifikat
Certificat
Certificado
Certificate

TRREE

Promouvoir les plus hauts standards éthiques dans la protection des participants à la recherche biomédicale
Promoting the highest ethical standards in the protection of biomedical research participants

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

Clinical Trials Centre
The University of Hong Kong

Albert Uduma

a complété avec succès - has successfully completed

Introduction to Research Ethics

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

Release Date: 2023/02/04

CID : euKUGH9Hnw

Professeur Dominique Sprumont
Coordinateur TRREE Coordinator

APPROVED BY SIWF FMH ISFM
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Zertifikat
Certificat
Certificado
Certificate

TRREE

Promouvoir les plus hauts standards éthiques dans la protection des participants à la recherche biomédicale
Promoting the highest ethical standards in the protection of biomedical research participants

Certificat de formation - Training Certificate

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Training in the Nigerian National Code for Health Research Ethics

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

Registration Number: NHREC/TR/08/10/2013A

Release Date: 2023/02/03

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Professeur Dominique Sprumont
Coordinateur TRREE Coordinator

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Zertifikat
Certificat
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Certificate

TRREE

Promouvoir les plus hauts standards éthiques dans la protection des participants à la recherche biomédicale
Promoting the highest ethical standards in the protection of biomedical research participants

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

Clinical Trials Centre
The University of Hong Kong

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Research Ethics Evaluation

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

Release Date: 2023/02/03
CID : RJCuvfXAan

Professeur Dominique Sprumont
Coordinateur TRREE Coordinator

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