Journal: Texila International Journal of Medicine
Publisher: Texila International Journal
ISSN: 2520-3118
Volume 9 Issue 2, 2026
DOI: 10.21522/TIJMD.2013.09.02.Art004

A Mixed-Method Study on the Factors Associated with Emigration of Nurses and Impact on Nursing Profession and Health Sectors

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Abstract

The migration of registered nurses from Saint Vincent and the Grenadines to wealthy countries such as the United Kingdom and the United States of America raises concerns. This is a multidimensional subject that can only be completely investigated with a hybrid approach. This study aimed to identify the factors associated with nurse emigration from SVG and to examine its implications for the nursing profession and health sector. A sequential explanatory mixed-method design was employed between October 2024 and April 2025. Quantitative data were collected using structured paper-based and online questionnaires from 103 registered nurses. Qualitative data were obtained through in-depth interviews with 20 purposively selected participants. Quantitative data were analyzed using SPSS version 26, while thematic analysis was applied to qualitative data. Quantitative findings revealed a statistically significant association between religion and migration ($\chi^2(12) = 21.753$, $p = 0.040$), and regression analysis identified economic incentives as a significant predictor of outward migration ($p = 0.008$). Qualitative analysis identified inadequate salaries, unfavorable working conditions, limited career advancement, political interference, influence of family abroad, and dissatisfaction with governance as key drivers of migration. Nurse migration from SVG is primarily driven by economic and systemic health system factors rather than sociodemographic characteristics alone. Improving remuneration, working conditions, merit-based promotion, and nurse involvement in policy development is essential to strengthening retention and sustaining the national healthcare workforce.

Keywords: *Factors, Health System, Implication, Migration, Registered Nurses, Saint Vincent and the Grenadines.*

Introduction

A well-distributed, adequately trained, and motivated nursing workforce is fundamental to achieving universal health coverage and delivering high-quality healthcare. Nurses constitute the largest segment of the global health workforce; however, persistent shortages continue to affect many low- and middle-income countries (LMICs), largely due to large-scale international migration to high-income countries (HICs) [1]. The Caribbean region has experienced sustained emigration over the past five decades, with Saint Vincent and the Grenadines (SVG) recording among the highest migration rates relative to population size. Nurses represent a substantial proportion of this migrant population, contributing to workforce instability, increased workloads, and compromised healthcare delivery. Post–COVID-19 international recruitment efforts have further intensified this trend. Evidence indicates that more than five million individuals have emigrated from the Caribbean over the

Received: 14.01.2026 ***Accepted: 29.01.2026*** ***Published on: 29.04.2026***
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past 50 years, with SVG and Guyana experiencing some of the highest relative population losses [2]. Migration within the region is highly feminized, reflecting the gender composition of the nursing profession. A significant proportion of these migrants are healthcare workers, particularly nurses, resulting in critical workforce shortages and exacerbating health system strain.

In SVG, nurse attrition has reached unprecedented levels. Reports indicate that 58 nurses resigned from hospital services in 2021 alone, followed by continued resignations in subsequent years [3–7]. In response, government officials have acknowledged the growing nursing shortage and proposed policy measures, including bonding arrangements for newly trained nurses [4]. Despite these efforts, international recruitment opportunities and persistent dissatisfaction with local working conditions continue to fuel outward migration. Migration decisions among nurses are shaped by a complex interaction of economic, professional, organizational, social, and political factors. While income disparities remain a dominant driver, emerging evidence highlights the importance of working conditions, career development opportunities, governance, and social networks. However, limited empirical research has examined these dynamics within the context of SVG. This study therefore aims to identify the key factors influencing nurse migration from Saint Vincent and the Grenadines and to assess the implications for the nursing profession and healthcare system. The findings are intended to inform evidence-based policy interventions to improve nurse retention and workforce sustainability.

Material and Method

Study Design

A sequential explanatory mixed-methods design was used to examine factors associated with the emigration of registered nurses from Saint Vincent and the Grenadines (SVG). Quantitative data were collected first and subsequently complemented with qualitative data to explain and contextualize the statistical findings. The study was conducted within public healthcare facilities in Saint Vincent and the Grenadines, with emphasis on the Milton Cato Memorial Hospital, the country’s primary referral hospital with 215 beds serving approximately 100,616 residents. The study population consisted of registered nurses trained in SVG who were either currently employed by the Ministry of Health, Wellness, and the Environment or had migrated within the past ten years. A purposive sampling technique was employed. A total of 103 nurses participated in the quantitative phase, and 20 nurses participated in the qualitative phase.

Data Collection

Quantitative data were collected using a structured questionnaire administered in both paper-based and online formats. The questionnaire captured sociodemographic characteristics, job satisfaction, migration intentions, and perceived push and pull factors. Qualitative data were collected through in-depth semi-structured interviews conducted between April 17 and April 26, 2025. Interviews were conducted in private offices or via telephone, audio-recorded with consent, and supported by field notes. Interviews lasted 11–35 minutes and continued until data saturation was achieved.

Data Analysis

Quantitative data were analyzed using SPSS version 26. Descriptive statistics summarized participant characteristics, while inferential statistics—including chi-square tests, regression analysis, cross-tabulation, and ANOVA—were used to examine associations. Statistical significance was set at $p < 0.05$. Qualitative data were analyzed using Braun and Clarke’s six-step thematic analysis. Coding and theme development were conducted

independently by the researchers, with consensus achieved through discussion.

Ethical Considerations

Ethical approval was obtained from the Texila American University Ethics Committee, the Saint Vincent and the Grenadines Ethics Committee, and the Hospital Administration of the Milton Cato Memorial Hospital. Participation was voluntary, informed consent was obtained, confidentiality was maintained, and no foreseeable risks were identified.

Results

Quantitative Analysis

Table 1. Frequency and Percentage of Sociodemographic Characteristics of Registered Nurse (N-103)

Sl. No	Sociodemographic variables	Frequency (F)	Percentage (%)
1	**Age (in years)**		
	20-25	6	5.8
	26-30	12	11.7
	30-35	15	14.6
	36-40	31	30.1
	41-45	15	14.6
	46-50	11	10.7
	51 and over	12	11.7
2	**Gender**		
	Male	16	15.5
	Female	86	83.5
3	**Ethnicity**		
	African Descent	84	81.6
	East Indian	1	1.0
	Mixed	17	16.5
	Other	1	1.0
4	**Education**		
	Registered Nurse	47	45.6
	Midwifery	8	7.8
	Bachelors	28	27.2
	Masters	19	18.4
5	**Marital Status**		
	Single	52	50.5
	Married	39	37.9
	Divorced	3	2.9
	Separated	3	2.9
	Cohabiting	6	5.8
6	**Religion**		
	Catholic	5	4.9

	Anglican	7	6.8
	Methodist	11	10.7
	Seventh day Adventist	27	26.2
	Pentecostal	37	35.9
	Jehovah witness	1	1.0
	Other	11	10.7
7	**Monthly Income**		
	> $4000	23	22.3
	$3000–$4000	43	41.7
	$2600–$3000	28	27.2
	< $2500.	9	8.7
8	**Length of time**		
	<1 year	11	10.7
	2-5 years	18	17.5
	6-10 years	15	14.6
	11-15 years	23	22.3
	16-20 years	11	10.7
	0ver 20 years	22	21.4
9	**Family Status**		
	Living alone	13	12.6
	Joint/ extended	30	29.1
	Nuclear	54	52.4
	Other	3	2.9
10	**District**		
	Georgetown	4	3.9
	Calliaqua	24	23.3
	Chateaubelair	6	5.8
	Marriaqua	16	15.5
	Kingstown	32	31.1
	Cedars	1	1.0
	Pembroke	19	18.4

Table 1 shows the frequency and percentage of demographic characteristics of respondents Regarding age the majority were within the 36–40 age group (30.1%), followed by those aged 30–35 (14.6%) and 41–45 (14.6%). With respect to gender, the profession was heavily skewed toward female respondents (83.5%), reflecting established global trends in the nursing field. Males accounted for just 15.5%, with 1% not disclosing gender. Regarding the ethnicity, majority (81.6%) were of African descent followed by those of mixed ethnicity (16.5%). This reflects the general demographic distribution of the national population, where African heritage is dominant.

According to the educational background, majority (45.6%) were registered nurses, (27.2%) has a bachelor's degrees, (18.4%)

master's degrees, and (7.8%) with midwifery certification. This suggests a well-qualified nursing workforce. With respect to marital status most participants were single (50.5%) and (37.9%) were married representing a small proportion were cohabiting, divorced, or separated. This may be influenced by work-related migration, long hours, or other professional pressures impacting personal relationships.

The most common religious affiliation was Pentecostal (35.9%), followed by Seventh Day Adventist (26.2%) and Methodist (10.7%). With respect to family structure, over half (52.4%) lived in nuclear families, followed by (29.1%) in joint/extended family settings. Only (12.6%) lived alone. The largest proportion of respondents earned between $3000–$4000 monthly (41.7%), suggesting a modest income distribution. About (27.2%) earned $2600–$3000, while (22.3%) earned more than $4000. Only (8.7%) earned less than $2500.

Regarding the length of employment, most respondents had been in service for over 10 years, with the largest groups being those employed for 11–15 years (22.3%) and over 20 years (21.4%). This demonstrates a relatively experienced workforce. These results indicate that familial responsibilities and support systems may influence decisions to migrate or remain in the current job setting. The largest group of respondents (31.1%) were from Kingstown, followed by Calliaqua (23.3%) and Pembroke (18.4%). These are predominantly urban districts, suggesting that urban centers are hubs for healthcare employment.

Six themes emerged:

1. Increasing visibility of nurse migration
2. Strategies to prevent migration
3. Influence of family and social networks
4. Push factors within the health system
5. Influence of salary and cost of living
6. Political and workplace governance issues.

Participants consistently cited low salaries, poor working conditions, limited career advancement, outdated infrastructure, and political interference as major reasons for migration.

The Rationale Behind Nurses' Relocation

Accordingly figure 1 depicts participants views about job satisfaction. The majority (47.6%) of respondents reported dissatisfaction with their current work environment, while only (31.1%) expressed satisfaction. The remaining (21.4%) were uncertain. In table 2 when asked about the intention to migrate (69.9%) of participants responded yes while (26.2%) responded no and (3.8%) did not answer that question , Table 3 shows that among possible migration destinations, England emerged as the most favored location, with (69.9%) of respondents indicating interest, followed by the United States (25.2%), Canada (20.4%), and the British Virgin Islands (17.5%). In table 4 the findings revealed that age (χ^2 - 4.893, p-0 .961); gender (χ^2-2.267, p-0.687); ethnicity (χ^2 -0 .622, p-0.996); education level (χ^2- 6.580, p-0 .361); marital Status (χ^2- 11.405, p -0 .180); income (χ^2- 2.561, p -0 .862); family status (χ^2- 7.526, p- 0.275) and length of time in organization (χ^2- 7.782, p-0.650) were found to have no significant association. Only religion (χ^2- 21.753, p-0.040) had significant association. Suggesting there is a tendency for people to migrate based on their religion. In table 5 the findings re); income and religion (χ^2- 7.816, p-0.799); gender (χ^2-4.869, p-0.301); ethnicity (χ^2 -6 .143, p-0.407); education level (χ^2- 4.184, p-0 .652); marital Status (χ^2- 5.331, p -0.722);income (χ^2- 6.262, p -0 .394; family status (χ^2- 5.191, p- 0.520) and length of time in organization (χ^2- 11.259, p-0.338) were found to have no significant association. Only age had (χ^2-21.647, p-0 .042) significant association.

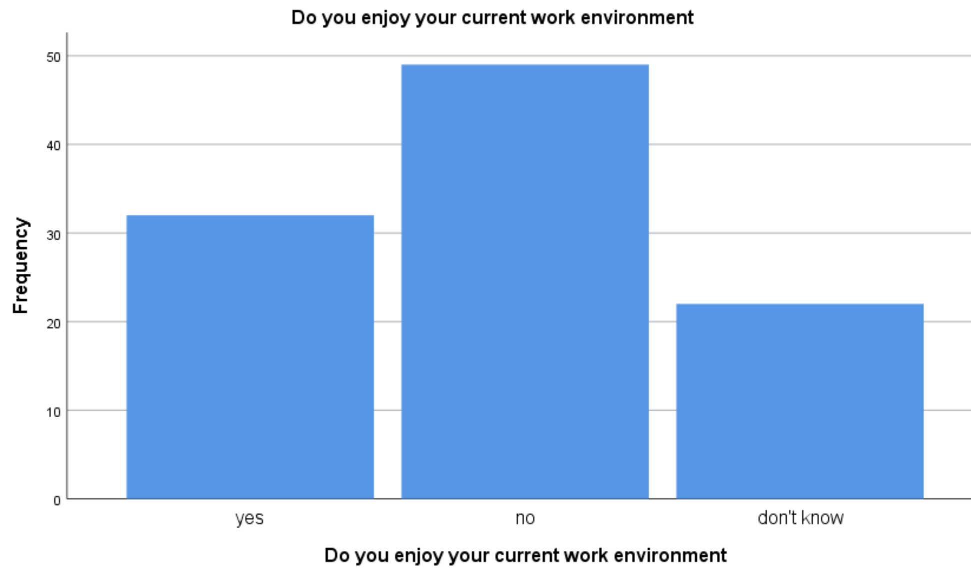

Figure 1. Job Satisfaction Among Registered Nurses (N-103)

Table 2. Intention to Migrate Among Registered Nurses (N-103)

Responses	Frequency (F)	Percentage (%)
Yes	72	69.9
No	27	26.2
Don't Know	0	0

Table 3. Countries Selected for Migration by the Registered Nurses (N-103)

Countries	Status	Frequency (F)	Percentage (%)
England	Yes	72	69.9
	No	27	26.2
America	Yes	26	25.2
	No	72	69.9
Canada	Yes	21	20.4
	No	77	74.8
BVI	Yes	18	17.5
	No	80	77.7
Trinidad	Yes	2	1.9
	No	96	93.2
Barbados	Yes	2	1.9
	No	96	93.2
Other	Yes	9	8.7
	No	89	86.4

Table 4. Association Between the Migration Factors with Socio-Demographic Variables of Registered Nurses (N-103)

Sl. No	**Sociodemographic variables**	**Yes**	**No**	**Don't Know**	**χ^2 value (df)**	**p-value**
1	**Age (in years)**					
	20-25	5	0	1	4.1893 (12)	0.961
	26-30	10	0	2		
	30-35	13	1	1		
	36-40	27	1	3		
	41-45	12	1	2		
	46-50	10	0	1		
	51 and over	11	1	0		
2	**Gender**					
	Male	12	1	3	2.267 (4)	0.687
	Female	76	3	7		
3	**Ethnicity**					
	African Descent	73	3	8	0.622 (6)	0.996
	East Indian	1	0	0		
	Mixed	14	1	2		
	Other	1	0	0		
4	**Education**					
	Registered Nurse	41	1	5	6.580 (6)	0.361
	Midwifery	5	1	2		
	Bachelors	24	2	2		
	Masters	18	0	1		
5	**Marital Status**					
	Single	44	2	6	11.405 (8)	0.180
	Married	35	1	3		
	Divorced	1	1	1		
	Separated	3	0	0		
	Cohabiting	6	0	0		
6	**Religion**					
	Catholic	4	0	1	21.753 (12)	0.040
	Anglican	7	0	0		
	Methodist	6	1	4		
	Seventh day Adventist	22	9	5		
	Pentecost	34	3	0		
	Jehovah witness	1	0	0		
	Other	11	0	0		
7	**Monthly Income**					
	> $4000	20	1	2	2.561 (6)	0.862
	$3000–$4000	37	2	4		

	$2600–$3000	25	0	3		
	< $2500.	7	1	1		
8	**Length of time**					
	< 1year	10	0	1	7.782 (10)	0.650
	2-5 years	13	1	4		
	6-10 years	12	1	2		
	11-15 years	21	0	2		
	16-20 years	10	1	0		
	0ver 20 years	20	1	1		
9	**Family Status**					
	Living alone	10	0	3	7.526 (6)	0.275
	Joint/ extended	27	0	3		
	Nuclear	47	4	3		
	Other	3	0	0		

Table 5. Association Between Intention to Migrate with Socio-Demographic Variables of Registered Nurses (N-103)

Sl. No	Sociodemographic variables	Yes	No	Don't Know	χ^2 value (df)	p-value
1	**Age (in years)**					
	20-25	0	1	5	21.647 (12)	0.042
	26-30	6	0	6		
	30-35	6	0	9		
	36-40	14	6	11		
	41-45	4	5	6		
	46-50	4	0	6		
	51 and over	3	5	4		
2	**Gender**					
	Male	5	5	5	4.869 (4)	0.301
	Female	31	13	42		
3	**Ethnicity**					
	African Descent	32	17	34	6.143 (6)	0.407
	East Indian	0	0	1		
	Mixed	5	1	11		
	Other	0	0	1		
4	**Education**					
	Registered Nurse	14	6	26	4.184 (6)	0.652
	Midwifery	3	2	3		
	Bachelors	11	5	12		
	Masters	9	4	6		
5	**Marital Status**					
	Single	19	6	27	5.331 (8)	0.722
	Married	14	9	16		
	Divorced	0	1	1		

	Separated	1	1	1		
	Cohabiting	3	1	2		
6	**Religion**					
	Catholic	1	0	3	7.816(12)	0.799
	Anglican	3	0	3		
	Methodist	4	1	5		
	Seventh day Adventist	13	9	11		
	Pentecost	11	3	17		
	Jehovah witness	0	0	1		
	Other	2	0	6		
7	**Monthly Income**					
	> $4000	10	5	7	6.262 (6)	0.394
	$3000–$4000	17	8	18		
	$2600–$3000	9	3	16		
	< $2500.	1	2	6		
8	**Length of time**					
	< 1year	3	1	7	11.259 (10)	0.338
	2-5 years	7	0	11		
	6-10 years	5	3	7		
	11-15 years	11	4	8		
	16-20 years	5	2	4		
	0ver 20 years	6	7	8		
9	**Family Status**					
	Living alone	3	2	7	5.191 (6)	0.520
	Joint/ extended	10	8	12		
	Nuclear	22	7	25		
	Other	0	1	2		

Discussion

This study investigated the relationship between sociodemographic characteristics and outward migration from informal settlements, with a focus on three primary hypotheses: (1) sociodemographic factors influence outward migration (2) lack of upward mobility drives migration and (3) relationship between increased salary and migration. Age and religion were the only sociodemographic variables significantly related to migration. Data showed that the age group 36-40 represented 30.1% of the persons surveyed. This finding is similar to several studies conducted by [8-12], most nurses who migrated were under 40 years old.

On the other hand, a study by [8], nurses in industrialized nations like Australia, New Zealand, and the United States were comparatively younger, with over 60% of them being 34 years of age or younger, whereas nurses in developing nations like India and Pakistan tended to be older than 40. Age and the likelihood of migration are strongly correlated, according to numerous research. Due to their increased adaptability, desire for school or work, and lack of familial responsibilities, younger people are typically more mobile [13, 14] According to research, age also affects the

kind of migration; younger individuals are more inclined to travel abroad or to an urban area, whereas elderly persons may relocate for retirement or to be with their family [15]. Through political, social, and cultural channels, religion can have a big impact on migratory decisions. Migration may be a way for religious minority to seek asylum or better religious freedom in situations where they are persecuted or discriminated against [16, 17]. Furthermore, religious networks frequently aid migration by offering networks of support in the places of destination [18]. Additionally, according to some research, religious identity may influence integration experiences in host nations, affecting both individual adaptation and policy responses [19]. Over the past decade, the World Health Organization (WHO) has reported a 60% increase in health workforce emigration to higher income countries (HICs) [20, 21]. The shortage of nurses in HICs has led to this situation. For example, the United States projected a 550,000-nurse employment gap in 2019 [22].

Economic factors (specifically income and job satisfaction) were strong push factors. Numerous nurses cited higher pay in another nation as a driving force behind migration [10, 23-30]. Due to the weakening economies of several source countries [24, 27], international migration was a "life-changing strategy" for these nurses [3]. According to [32], a larger proportion of foreign-trained nurses registered in the UK were from low- and middle-income nations than from high-income ones. According to other research [12, 31] migrant nurses were motivated by the desire to support their families back home by sending money as remittances. Additional economic justifications mentioned included a stronger benefit package, a means of increasing income, and financial betterment [10, 23, 31, 33]. The majority of the studies' findings confirmed the widely held belief that the potential income from migrating determined the motivation to relocate [32]. One of the most frequently cited causes of nurse migration is low pay in the nation of origin. Salary differences between source and destination countries are a significant motivator for migration, according to studies conducted in Sub-Saharan Africa, South Asia, and Southeast Asia [1]. Due to economic stagnation and a lack of performance-based incentives, nurses in developing nations sometimes look for better-paying jobs elsewhere. According to [34, 35] they found that health professionals emigrate due to various push and pull reasons, which are similar to this study's findings. They proposed that staff nurses (SNs) are motivated to move for a variety of reasons, including economics, professional advancement, social issues, the health system, and politics. According to [36] the departure of SNs is mostly driven by economic factors, either pulling or pushing. Similarly, [37, 38] migration in Ghana may be caused by a poor socio-economic climate, poor living conditions, currency devaluation, desire to work in a different environment, low professional satisfaction, and colonial connections.

The nursing profession is female-dominated and relatively well-educated. According to two surveys, a greater percentage of male nurses had either moved or planned to move [25, 26, 29] also discovered a discernible trend of university-degree-holding nurses migrating in comparison to those with technical general nursing qualifications. Nursing is a highly educated and female-dominated profession, especially for those looking for work abroad. Formal credentials like degrees or diplomas are usually held by migrant nurses, who frequently seek additional credential recognition or bridging programs in their new countries [39]. Safety concerns, social acceptance, and family-related travel decisions are just a few of the gendered ways that the feminized nature of the profession affects migration.

Most respondents reside in urban districts and come from nuclear families. According to a few studies, the majority of migrant nurses come from cities because they have greater

access to higher-quality education and more opportunities to travel abroad [40]. Additionally, compared to those in extended or multigenerational households, many came from nuclear families, which may offer fewer caregiving responsibilities and greater personal autonomy, making relocation easier.

The qualitative data also indicates that nurse migration is driven by a combination of economic necessity and aspirational motivations. Nurses in St. Vincent and the Grenadines are increasingly seeking employment overseas due to inadequate compensation, limited professional growth, and difficult working conditions at home. Conversely, foreign opportunities provide the hope of financial stability, better working environments, and enhanced personal and family well-being. The increase in migration is not seen as a temporary trend but rather a structural shift that reflects deeper systemic issues within the local healthcare and economic landscape. The pull factors associated with migration are centered around the availability of better opportunities overseas. Respondents mentioned access to higher-quality healthcare systems, educational opportunities for their children, and improved living conditions. The promise of working in technologically advanced environments and the possibility of family migration were also noted as major motivators. Example: A respondent noted that nurses "would have more options in terms of where they want to go," reflecting a perception that foreign countries offer both professional flexibility and personal security.

Migration is not only seen as an escape from local difficulties but as a strategic move toward professional and personal growth. The reference to "greener pastures" by one respondent captures the sentiment that migrating can lead to a higher quality of life and greater career fulfilment. Nurses appear to view migration as a pathway to upward mobility—a chance to escape limitations imposed by their current working conditions and socio-economic environment.

There is a strong consensus across responses that nurse migration has increased in recent years. This perception is shared regardless of how detailed the response is, suggesting that nurse migration is a visible and impactful trend within the healthcare sector in St. Vincent and the Grenadines. Even brief affirmations like "Yes, definitely," or "I strongly believe that..." reflect a collective awareness and concern about the implications of this migration pattern.

Many participants highlighted working conditions as a determinant of whether nurses remain in the profession locally. Concerns about outdated equipment, poor infrastructure, and stressful work environments were common. "We need a better hospital… in clinics, we are unable to properly assess patients because we don't have this or that. "This indicates that poor infrastructure not only affects patient care but also contributes significantly to staff dissatisfaction and burnout.

Family and friends often offer practical assistance, such as helping nurses navigate foreign job markets, providing housing or referrals, and supporting initial transitions. Respondent 4 highlighted that *"*they have a friend or a family member who can canvas the area and see what is available and give them feedback about these opportunities.

Respondents were vocal about the disconnect between decision-makers and front-line workers. They urged policymakers to actively listen to nurses and involve them in policy formation. "Policymakers need to sit down and draft policies that are going to make nurses comfortable. Listen to their grievances". Additionally, some respondents felt that the health system itself needed structural and operational reform, including leadership renewal, merit-based promotions, and youth inclusion in management roles. Additionally, one respondent believed "The whole system just needs reshuffling bring in fresh perspectives." This highlights a desire for a

more dynamic, progressive, and transparent healthcare system.

Some respondents also identified systemic governance issues, such as nepotism and bureaucratic favoritism, which hinder merit-based promotion and professional satisfaction. Respondent 10 commented: "Because of nepotism, persons with qualifications are not given the jobs they require." This suggests that institutional dysfunction and perceived unfairness are also contributing to nurses' decisions to seek better-governed professional systems abroad.

The majority of respondents described natural disasters—such as hurricanes or volcanic eruptions—as common, manageable occurrences that have become a normal part of life in the Caribbean. Many emphasize that since such events are expected and people are acclimatized to them, they do not act as migration motivators. Respondent 15 stated: "We were born in the Caribbean. By now we have gotten accustomed to those things. That doesn't have anything to do with it." Similarly, Respondent 1 noted: "Anywhere you go, natural disaster is natural disaster… I don't think that contributes to migration." These comments suggest that nurses are familiar with this disruption and thus they do not see them as compelling reasons to leave the country. Most participants explicitly dismissed religion as a motivating factor. Respondents 1, 3, 5, 6, 7, 8, and 9 all responded unequivocally with *"no"* or similar expressions, emphasizing that spiritual beliefs do not typically impact migration intentions or decisions**.** Even for those who maintain religious convictions, migration does not appear to disrupt their practices significantly. Some participants mentioned that while individuals may not find the same denomination or church abroad, they adapt spiritually or find alternatives. Respondent 16 reflected: "Having a faith-based religion, like believing in Christ—yes. But to say that it influences migration? No. This shows that even among devout individuals**,** religious faith is not a deterrent nor a compelling motivator for migration. Instead, there is a sense of religious adaptability across borders, particularly in multicultural societies.

Contribution to Knowledge

Beyond politics and pay**,** broader systemic and administrative frustrations within the healthcare system also emerge as significant motivators for migration. Respondents expressed concerns about lack of opportunities for professional growth, the disconnect between qualifications and job placement, and minimal support for continuing education or specialization. There is a growing sense that the current system fails to reward ambition or innovation, often penalizing those who advocate for change. This lack of institutional support is compounded by outdated practices and a resistance to modernized approaches to healthcare delivery, further alienating younger or more progressive nurses. Underlying all these factors is a shared aspiration among respondents for a better standard of living and professional fulfillment. Migration is not solely a financial decision, but also a means to achieve personal growth, job satisfaction, and family well-being. Participants noted that overseas employment allows for greater respect, career advancement, and work-life balance, contrasting with their experiences of stress and burnout in SVG's health sector.

Suggestion for Further Research

While there is extensive study on nurse emigration, gaps remain in understanding the specific consequences on healthcare systems in understudied locations such as Saint Vincent and the Grenadines. Additional empirical research is required to design targeted policies and interventions to address these difficulties. Future research should consider longitudinal data and qualitative methods to further explore how religious affiliation and economic hardship interact in shaping migration behaviour.

Limitations

This study was limited to registered nurses trained in Saint Vincent and the Grenadines, those employed by the Government of Saint Vincent and the Grenadines and registered nurses who migrated during the period 2013-2023 were sampled.

Recommendation

Based on the findings of this study the following recommendations are suggested:

Policy-Level Recommendations

1. Develop and implement a five-year national nursing workforce strategic plan.
2. Review and improve salary structures, allowances, and incentives.
3. Upgrade healthcare infrastructure and modernize equipment.
4. Establish transparent, merit-based promotion systems.
5. Introduce retention incentives such as duty-free vehicle concessions and annual bonuses.
6. Engage nurses in evidence-based policy formulation.

Institutional-Level Recommendations

1. Improve staff-to-patient ratios and workplace safety.
2. Provide rest areas and supportive work environments.
3. Offer flexible scheduling and specialization opportunities.
4. Strengthen leadership training for nurse managers.
5. Implement recognition and reward programs for outstanding performance.

Conclusion

Overall, the findings highlight the nuanced role of sociodemographic variables in influencing outward migration. While most variables examined were not significantly associated with migration, religion and age emerged as influential factors, particularly in relation to perceived opportunities for upward mobility. Most notably, economic factors were the strongest predictor of outward migration, underscoring the importance of livelihood security in migration decisions. The findings reveal that while many demographic factors do not directly influence migration, economic insecurity and dissatisfaction with work conditions play central roles in the decision to migrate. Religious affiliation and age also appear to affect outward migration intentions. These results underscore the importance of improving work environments, compensation, and career mobility to retain skilled professionals within the local healthcare system. These insights contribute to a better understanding of the complex motivations behind migration from informal settlements and can inform targeted policy interventions. Politics is a powerful and often demoralizing force in the nursing profession in St. Vincent and the Grenadines. Whether through overt favoritism, systemic inequity, or political retaliation, nurses feel that their careers are constrained by forces unrelated to their competence or effort. This political interference fuels a deep frustration that significantly contributes to their decision to migrate, in hopes of finding a professional environment driven by equity, opportunity, and respect.

One of the most prominent themes identified is the influence of salary and financial incentives on migration decisions. Most respondents explicitly cited low wages and financial insecurity as a major push factor. Many described living "paycheck to paycheck" and being unable to save, invest in their families' futures, or maintain a comfortable standard of living. Several respondents noted that nursing salaries in SVG are among the lowest in the Caribbean, prompting feelings of undervaluation and frustration. In contrast, the prospect of earning three to four times more overseas, especially in countries like Canada or the United States, acts as a strong pull factor. Enhanced remuneration abroad not only allows

for better personal financial management but also enables nurses to support extended family members, pay off mortgages, and build long-term financial security. Additionally, overtime pay and comprehensive benefits offered overseas serve as further incentives.

Overall, the data illustrate that nurse migration from SVG is a multifaceted phenomenon, with financial strain, political interference, workplace frustration, and aspirations for better living forming the core drivers. Unless these systemic issues are addressed—through salary reform, depoliticized promotion systems, and investments in professional development, the country is likely to continue facing challenges in retaining its nursing workforce. A holistic, policy-driven response is therefore essential to stem the ongoing migration and build a resilient, motivated health system.

Acknowledgement

I take this opportunity to thank God for health, strength and endurance, my parents for their constant support, my husband, my work colleagues and my close friends Herona, Avette, Jasmine, Simone, Michelle and Cherry Ann for motivating me in times of giving up. Thank you to the Government of Saint Vincent and the Grenadines for granting me a tuition scholarship to complete my degree. Thank you to Mr. Wayne Young who guided me in the analysis of the quantitative data and Mr. Asif Dover who assisted in analyzing the qualitative data.

Conflict of Interest

The author declared that there is no conflict of interest related to this paper.

Data Availability

The data that support the findings of this study are openly available in crossref, academia, google scholar, International scientific indexing, ICN.

Author Contribution

SBH wrote the manuscript, conducted interviews and analysed the data. JJ assisted with analysis, supervision and review and editing. All authors reviewed the final manuscript.

Funding

“This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors”.

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