Where are the doctors? A study of absenteeism among doctors in rural Bangladesh

Nahitun Naher,[1] Eleanor Hutchinson,[2] Dina Balabanova,[2] Syed Masud Ahmed[1]

October 2020

[1] Centre of Excellence for Health Systems and Universal Health Coverage (CoE-HS&UHC), BRAC James P Grant School of Public Health (BRAC JPGSPH), BRAC University, Dhaka, Bangladesh

[2] London School of Hygiene and Tropical Medicine (LSHTM), London, United Kingdom

All correspondence to: Dr Nahitun Naher (nahitun.naher@bracu.ac.bd)

Contents

Boxes

Tables

Acronyms and abbreviations

BRAC JPGSPH BRAC James P Grant School of Public Health
DGHS   Directorate General of Health Services
DD   Divisional Director
IDIs   In-depth interviews
LSHTM   London School of Hygiene and Tropical Medicine
MoHFW   Ministry of Health and Family Welfare
SACMO   Sub-Assistant Community Medical Officer
SOAS ACE   SOAS University of London, Anti-Corruption Evidence research consortium
UHFPO   Upazila Health & Family Planning Officer
WHO   World Health Organisation

Acknowledgements

Executive summary

Absenteeism – unauthorised employee absence from the workplace – is one of the most common forms of corruption among frontline health workers. Despite having an extensive infrastructure, the healthcare system in Bangladesh suffers from staff shortages, maldistribution of the workforce, and poor retention of employees and service providers, especially in rural and remote areas. Among doctors in particular, absenteeism has also been a long-standing problem.

Although absenteeism has long been recognised by the Bangladesh national authorities, and multi-lateral and donor agencies, the regulatory approaches that they have employed have so far failed to yield successful results. This is, in part, because they have largely failed to consider or manage the challenges of implementing transparency and accountability measures in the face of poorly funded health systems, misaligned incentives and the influence of socio-political networks on the distribution of urban and rural positions.

This study has been conducted to support the development of a new approach to anti-corruption that takes the socio-economic and political context into account in the construction of novel interventions. It is a qualitative study that seeks to explore the realities of working in the Bangladesh health system, with a particular focus on the factors that influence and shape the nature of doctors' absenteeism in rural facilities. We conducted 30 in-depth interviews with doctors of various levels (junior = 18, mid-level = 5, senior = 7) from three divisions: Sylhet (northern), Barisal (southern) and Dhaka (central). Rural facilities with higher vacancy rates were purposively selected from these divisions.

The findings show that poor working conditions, threats to career progression, desires for private practice, gender inequality, poor social relations with the local community and weak regulatory mechanisms are important underlying factors influencing absenteeism. In addition, local political systems and poor infrastructure make rural placements difficult and, on some occasions, dangerous for health workers.

Despite the equal distribution of these problems, challenges and threats in rural health centres, absenteeism among doctors manifests in different ways. Those doctors who are linked to political and economic elites manage to avoid rural placements easily; others who are from less powerful backgrounds but who have some useful political connections and financial resources manage absence from health centres by making unofficial payments to bureaucrats. In contrast, some doctors rarely take unauthorised time away from their work. Some adjust to their rural position; these doctors usually belong to that locality and/or have maintained good relations with the local community.

Our findings indicate that the most important contributory factors that influence doctors' absenteeism in rural Bangladesh can be traced to structural and health system issues. Those with influence, power and access to networks are able to be absent for longer periods, which overburdens and de-motivates the doctors who are present. A possible solution lies in the design of feasible incentives that tackle the most difficult health systems issues (relating to infrastructure and safety) and career progression, and that draw together forms of collective action among doctors who are differently positioned in the social and political networks.

1. Introduction

1.1. Overview of corruption in health systems

Corruption is a complex phenomenon. Its roots lie deep in bureaucratic and political institutions, and its effect on development varies with country conditions. The World Bank (1999) and Transparency International (2009) define corruption as the abuse of public office or entrusted power for private gain. As anti-corruption has become more central in health systems research, newer definitions have emerged that attend to the complex and multi-faced challenges brought about by corruption. Recognising that corrupt activity is likely to constrain the ability of the healthcare system to deliver high quality, effective care to the people who can benefit most, we define corruption as: 'The abuse or complicity in abuse of public or private position, power or authority to benefit oneself, a group, an organization or others close to oneself in a way which diverts institutions from their core aims; where the benefits may be financial, material or non-material' (Gaitonde et al., 2016, cited in Hutchinson et al., 2020: 1).

Corruption pervades health systems around the world, with offences ranging from smaller-scale to larger-scale corrupt acts. Corruption in the health sector has been found to take many forms in various areas, such as in health facility construction; equipment and supply purchasing; pharmaceutical distribution and use; health worker education; falsification of medical research (Vian, 2008); and, most important for this research, absenteeism of healthcare providers. Transparency International's *Global Corruption Report 2006* identifies many of these issues, providing robust evidence and calls for action. Yet, more than 14 years later, many countries and health systems face the same challenges.

Corruption in the health sector intensifies inequality as poor people and other marginalised groups are often hit the hardest (UNDP, 2011). There is growing evidence that high levels of corruption impoverish populations, increase inequality and cause health status to deteriorate, especially among the most vulnerable population groups (Ensor and Duran-Moreno, 2002; DFID, 2015). A 2018 report from the World Health Organization (WHO, 2018: 1) has identified health system corruption as both a 'significant drain on domestic health resources', and 'a major barrier to efforts to transform health systems as a part of the universal health coverage agenda'. But, despite promises and fragmented efforts (for example, regulatory interventions and particular innovations) it seems likely that corruption is on the rise (U4 Anti-corruption, 2015; Naher et al., 2018).

How to tackle corruption is a neglected area within health systems research, in part because it often concerns hidden behaviours but also because of the sensitivities involved and the lack of evidence on the scale of the problem. Challenges also lie in the fact that some corrupt practices actually serve to make dysfunctional systems work, that a focus on corruption can be seen as a form of victim blaming that ignores larger issues, and that evidence is lacking on anti-corruption measures that actually work (Hutchinson et al., 2020). One of the biggest challenges is that the drivers of corruption vary widely between different

healthcare settings and country contexts (Politzer, 2019) and so there is no blueprint for tackling it. Together, these issues make it difficult to acknowledge and address corruption in the health sector (ibid.).

1.2. Absenteeism

Absenteeism – unauthorised employee absence from the workplace – is one of the most common forms of corruption among frontline staff (Kisakye et al., 2016). It is a major cause of staff shortages in healthcare settings and has a clear negative effect on the delivery of quality healthcare services (Politzer, 2019). Globally, about 7% of healthcare workers are reported as having at least one spell of absence each week. In rural Nigeria, absenteeism is so common that many health clinics may only be open one or two days a week (Agwu et al., 2019), while an all-India survey conducted in 2003 found that nearly 40% of doctors and medical service providers were absent from work on a typical day (Muralidharan et al. 2011). In a multi-country study of absenteeism among medical professionals, unannounced visits made to health facilities revealed high rates of absenteeism in Bangladesh (35%), Uganda (37%) and in India (40%) (Chaudhury and Hammer, 2004).

1.3. Absenteeism of doctors in Bangladesh

The health system infrastructure in Bangladesh spans different tiers and involves a broad workforce (WHO, 2015). It is under the jurisdiction of the Directorate General of Health Services (DGHS) within the Ministry of Health and Family Welfare (MoHFW) and has six tiers:

1   *national*, with specialised hospitals and institutions.
2   *divisional*, with divisional medical college hospitals.
3   *district*, with district hospitals.
4   *upazila* (sub-district), with upazila health complexes.
5   *union*, with union sub-centres and union health and family welfare centres.
6   *ward*, with community clinics that each serve an average of 6,000 people (NIPORT, 2017).

Within this context and health system framework, Bangladesh suffers from staff shortages, maldistribution of the workforce, and poor retention of employees and service providers (Ahmed et al., 2011; Darkwa et al., 2015). Available data indicate that there are approximately five physicians and two nurses per 10,000 people, which is far short of WHO requirements (Bangladesh Health Watch, 2008; Ahmed et al., 2011). A health facility survey conducted in 2013 found more than 25% of physician positions and 22% of nurse positions at upazila (sub-district) health complexes are vacant (Khan et al., 2013). On top of this, absenteeism remains a longstanding problem in Bangladesh, particularly among doctors and nurses posted to rural locations (Belita et al., 2013; Darkwa et al., 2015; Joarder et al., 2018).

1.3.1.   Current approaches to tackle absenteeism in Bangladesh

Absenteeism has become an acute and persistent problem in Bangladesh (*Dhaka Tribune*, 2015). A survey by the Anti-Corruption Commission (ACC) conducted in 2018 suggests that absenteeism is a critical problem among frontline staff – in unannounced visits to 11 government hospitals and union complexes in different districts, 40% of doctors (92 out of 230) were found to be absent (*Dhaka Tribune*, 2019). The situation outside the capital city of Dhaka is worse, with 62% of doctors found to be absent across eight regional hospitals *(The Independent*, 2019). Indeed, while addressing the Physicians' Conference in 2018, Prime Minister Sheikh Hasina stressed that rural people would not receive basic healthcare services if the culture of absenteeism among doctors at upazila-level hospitals continued (*The Independent*, 2018; *The Daily Star*, 2018).

To address this long-standing issue, the government has made some significant progress over the years in developing and implementing relevant policies and strategies. In its National Health Policy 11 (GoB, 2011) the government made a constitutional and political commitment to ensure health for all, identifying doctor absenteeism as a critical challenge for healthcare delivery, particularly in rural areas. Other efforts include the Bangladesh Health Workforce Strategy 2015, the Human Resource Management (HRM) Operational Plan 2011–2016 and the Health Nutrition and Population Sector Development Program 2011–2016 that all pay attention to workforce retention in rural areas, particularly among medical doctors. Additional measures include:

1   **'Hello Doctor':** In 2015, the government launched an initiative named 'Hello Doctor' to ensure doctors' attendance in the state-run hospitals and other healthcare facilities around the country. A 66-member committee was formed to run the initiative, headed by an additional secretary, under which officials were assigned to make unexpected calls to supervisors in healthcare facilities at least twice a month to inquire about doctors' attendance (*Dhaka Tribune*, 2015).

2   **Biometric testing:** The government has also introduced biometric testing in an attempt to tackle absenteeism among doctors. Between 2012 and 2014, a system was gradually rolled out that uses biometric fingerprint detection to monitor office attendance in all sub-district and district-level government hospitals of Bangladesh. The system records the arrival and departure dates/times of staff and allows data to be aggregated and read at a central level. This new system replaced a previous paper-based system of recording office attendance and was introduced to monitor and improve attendance, particularly in remote health facilities.

The data for all public hospitals is published on the DGHS website,[1] with reports available on sanctioned, filled and vacant posts and the vacancy rate; as well as the number of

---

[1] http://103.247.238.92/dghseams/attend/

staff registered within a facility; the number who are present, absent and on leave; and the attendance rate. This data reveals the reality of absenteeism within health facilities in Bangladesh.

3   **Rural compulsory service and career progression:** Since the 1980s, newly recruited medical doctors have been required to complete a compulsory rural posting. This requirement was reinforced in 2008 in a revised policy – known as the 'Transfer and posting policy for officers in the health service' – which stipulates that doctors must serve at least two years in rural areas. This measure was seen as a means to improve rural retention, but research by Joarder et al. (2018) suggests that the policy is not being implemented effectively. While this was a short survey, the study strongly suggests that attempts to tackle absenteeism through this top-down process to improve transparency and accountability have been ineffective.

Within Bangladesh, novel ways are needed to tackle absenteeism among doctors and nurses with a particular focus on rural areas. To understand the drivers of absenteeism in this context, we conducted an explorative qualitative study to capture the perspectives of doctors who have prior experience of working at healthcare facilities in the sub-districts and at lower levels of the system. Using this evidence and drawing on the SOAS ACE approach to anti-corruption, it becomes possible to identify feasible solutions to absenteeism.

2.   Conceptual framework

Across other sectors, the failure of traditional anti-corruption approaches has spurred innovative analysis (Khan, 2012; Levy, 2014; Marquette and Peiffer, 2015; Khan et al., 2019). The failures point to assumptions about the context in which corruption occurs, whether rule-breaking is widespread or not, and the availability of resources – all of which lead to ineffective policy. In the new and re-formulated anti-corruption approaches, history matters; understanding the legacy of colonial institutions and the on-going impact that these have on distributions of power in post-colonial states is critical.

The point here is not that high-income countries are free from corruption. But, rather, that the ways in which corruption manifests in countries with a combination of a relatively low tax base and a history of imposed colonial institutions (versus the growth of institutions from existing power structures) shape how rules are made and followed. While it is beyond the scope of this paper to explore these arguments in detail (for an in-depth examination, see Hutchinson et al., forthcoming), new frameworks have emerged that take social, political and historical context into account and recognise the following:

1   Corruption is most often a structural matter, not an outcome of the morality of particular individuals.

2   In poorly funded health systems, rule-breaking or corruption can simultaneously create and solve structural problems.

3   Anti-corruption strategies need to be designed that ensure a functioning health system and that do not incur social costs.

4   Targeted strategies are likely to be much more effective than general measures. These can impact the most detrimental forms of corruption rather than seek overall changes in behaviour.

The SOAS Anti-Corruption Evidence consortium (SOAS ACE) posits that anti-corruption efforts need substantial insider support so they are seen to operate in the interests of those who will be subject to any intervention or mechanism. SOAS ACE proposes four types of intervention that we have adapted for a health systems approach (see Box 1).

Box 1: SOAS ACE strategies to tackle corruption

(Re-)Aligning incentives – The structure of incentives in some sectors may have evolved such that effective working patterns and the effective distribution of staff and resources become risky or render health workers precarious. Those who want to engage in corruption or rule-breaking may do so and this often becomes the dominant way of working in a system. Re-aligning (social, economic, professional) incentives is an effective way to tackle this type of corruption.

Designing for difference – anti-corruption strategies in health rarely attend to differences between cadres and mostly see the same cadres as homogenous groups with the same capacity, demands, needs and wants. But these differences and the capacity to be corrupt (i.e. to be absent or take informal payments without sanction) must be taken into account to create effective incentives for different groups and to identify those who are likely to support any anti-corruption strategy.

Building coalitions – Sometimes anti-corruption efforts depend on constructing effective coalitions to assist with the enforcement of rules. However, not all collective action to fight corruption is likely to be effective in developing countries. Any anti-corruption strategy needs to take account of the coalitions that are likely to emerge from both top-down and bottom-up perspectives.

Resolving rights – A further cluster of corruption problems can emerge because there are overlapping or contested rights of different parties, and the only resolution available to them is to engage in corruption to resolve disputes.

Source: Khan et al. (2019)

To design effective anti-corruption strategies to counter absenteeism among doctors in Bangladesh, we first need to understand what pushes doctors to be absent in this particular context and how rural placements intersect with the social, professional and economic interests of different groups of doctors. This will identify the structural changes that need to occur for absenteeism to be addressed while achieving a social goal (i.e. improvements in the health system). Second, we need to understand how the opportunities to be absent without sanction are distributed through networks and with what effect. This will identify the doctors who are likely to support and oppose any anti-corruption policy.

Very few studies have explored in any depth the realities on the ground for differently positioned junior doctors in Bangladesh, although research has described the difficult and often stressful working conditions that contribute to absenteeism in this context (Chaudhury and Hammer, 2004; TIB, 2008). This SOAS ACE study goes some way to fill this evidence gap.

3. Methodology

We conducted an explorative qualitative study through in-depth interviews (IDIs) with doctors who have experience of working at healthcare facilities at sub-district level and below. Our aim was to capture the perspectives of doctors working within rural facilities to understand the factors that drive absenteeism within this context.

3.1. Study setting and time frame

We conducted IDIs with doctors of various levels who had a minimum of two years of experience working in rural areas. The doctors worked in one of three divisions in Bangladesh: Sylhet (north), Barisal (south) and Dhaka (central). According to DGHS attendance data, Sylhet has the highest vacancy rate (42.45%) in the country and Barisal has the third highest (32.86%).[2] Dhaka is the capital of Bangladesh and has been included to reach some of those doctors who had past experience of working in rural facilities.

In Sylhet and Barisal, the IDIs were conducted in two settings: at the divisional medical college hospital and at sub-district health facilities (upazila health complexes). Throughout October and November 2018, we conducted the last phase interviews in Dhaka division. The IDIs were conducted in the capital with doctors who had recent experience of working in upazila health complexes in different parts of the country but who currently work in peri-urban areas. Table 1 summarises the location and number of IDIs in each phase of the study.

Table 1: Study area, type of facility and number of IDIs

Phase	Division	Facility type	No. of interviews
1st Phase	Sylhet	Upazila Health Complex	5
		Division Hospital	8
1st phase sub-total			13
2nd Phase	Barisal	Upazila Health Complex	5
		Division Hospital	4
2nd phase sub-total			9
3rd phase	Dhaka	Directorate General of Health Services (DGHS)	2
		Specialised Hospital	1
		Tertiary Training Hospital	2
		Ex-Bangladesh Civil Service (BCS)	2
		Medical College Hospital	1
3rd phase sub- total			8
Total			**30**

---

[2] See http://103.247.238.92/dghseams/attend/

3.2. Study population and sampling

A total of 30 doctors participated in this study: 12 from the division medical college hospitals, 10 from 4 upazila health complexes situated in Sylhet and Barisal and 8 from Dhaka with experience of working in upazila health complexes in recent years. At the divisional medical college hospital and upazila health complex the doctors were selected purposively using convenience sampling based on availability in the facility and doctors' willingness to participate in the study. Respondents from Dhaka were selected using a snowball approach to interview doctors with past experience of working in rural facilities and who had managed to escape/transfer from rural placements through various ways. Given time constraints, a wider and more representative sample could not be accommodated. However, the study areas were selected purposively with consideration given to vacancy rates and also diverse characteristics to obtain in-depth understanding of absenteeism in Bangladesh.

Table 2 gives an overview of the respondents in terms of age, marital status, gender, home division, professional level, the type of medical college each doctor studied at and whether they studied in their home division or elsewhere.

Table 2: Overview of respondents

Age range (yrs)	27-58
Marital status	Married = 27, Unmarried = 3
Gender	Male = 13, Female = 17
Home division	Dhaka = 7, Chittagong = 2, Sylhet = 8, Barishal = 10, Khulna = 1, Rahshahi = 2
Type of medical college attended	Public = 24, Private = 6
Studied in home division or other division	Home = 17, Other = 13
Position/level	Junior = 18, Mid-level = 5, Senior = 7

3.3. Data collection, management and analysis

The IDIs explored the doctors' experiences of working in rural facilities, personal and job-related environmental factors that lead to absenteeism and possible solutions. Interviews were recorded with respondents' approval and handwritten notes were also taken by the research assistants. These two records were then used to prepare transcripts on the same evening once the study team had returned from a facility. Full transcripts were prepared first in Bangla by the research assistants and then each transcript was discussed the next day to clarify any issues. Next, senior researchers translated the Bangla transcript into English, before these were circulated among the team for corrections if required.

We applied a thematic analysis drawing on Gale et al. (2013), using theory-based and data-based codes. Data were analysed using ATLAS.ti to generate frequency reports of the most prominent features of each phase of the study. A combined frequency report was then produced that rated the most dominant issues from one to ten.

3.4. Ethical considerations

Ethical clearance was obtained from BRAC School of Public Health (IRB reference no. 2018-02) and LSHTM (IRB reference no. 14540). Approval to collect data in health facilities was provided by the DGHS and the MoHFW. We met the respective managers of each facility and obtained verbal permission before approaching the doctors for interview. Informed written consent was taken from each participant prior to starting the interviews. We conducted the IDIs at the doctors' preferred location (e.g. doctors' rest room, office) and preferred time (e.g. after work when off duty). The IDIs were paused if a respondent needed to attend to a patient.

4. Findings

4.1. Why are doctors absent from rural facilities?

Traditional approaches to anti-corruption focus on corrupt acts that stem from opportunity and the ability to justify the practice. In our research, however, we are concerned with understanding the drivers of corruption to make sense of the push factors that mean that doctors do not wish to practice in rural facilities in Bangladesh and the pull factors that draw them into other parts of the health system.

While it should be noted that not all doctors wish to leave upazila health complexes (4 respondents), the majority (16) of our interviewees did and many of them felt very strongly about this. We have identified particular reasons within the health system, the local political system and infrastructure that make rural placements difficult and, on some occasions, dangerous for health workers. Table 3 summarises the drivers of absenteeism under major themes and sub-themes, which we discuss in turn in the remainder of this chapter.

Table 3: Drivers of absenteeism

Theme	Sub-theme
Poor working conditions	Poor infrastructure (inadequate living arrangements)
	No transport
	Security issues and threats to doctors
	Excessive workload
	Inadequate basic supplies
Threat to career progression	No opportunity to prepare for post-graduation exams
	Transfer and promotion are non-transparent and complicated processes
Desire for private practice	Scope for higher income from private practice in urban/peri-urban areas
Gender issues	Rural placements unprepared for female doctors
	Non-cooperation from colleagues and the community
Poor relationship with the local community	Lack of community understanding
	Local political pressure
	Cadre discrimination and lack of recognition by the community
Weak regulatory mechanisms	Limitations with biometric attendance monitoring
	Lengthy and complicated disciplinary process

4.1.1. Poor working conditions

Poor infrastructure (inadequate living arrangements)

The health facilities that we visited provided accommodation for doctors and nurses. In rural areas these are usually within the facility compound, but this is not always the case as postings at union or community level sometimes have no accommodation provision (see below). Almost all respondents mentioned that their accommodation was of a poor standard, with small rooms and inadequate basic amenities (e.g. unreliable electricity, water and gas supplies). The respondents also said that their accommodation was of a lower standard than that allocated to other professional cadres.

The first problem was the infrastructure, which was really not suitable for living. The building was not appropriate for living

(Male junior doctor)

Living environment was not good at all. There was no water, electricity most of the time

(Female junior doctor)

Doctors may also be deployed to sub-centres and community clinics with no residential support provided. One female respondent who was transferred to a community clinic mentioned that no housing was available there for her to stay in – the community clinic was situated in a village with no hotel or house to rent so she had to stay in a hotel in the division city and later stayed at a distant relatives' place.

There was no dormitory to stay. I had no option, later I found one of my distant relative and moved up to his home. I do not know there is no living arrangement for the doctors who are transferred at community clinic. I asked the local people whether I could rent a house there and stay there. They said, look madam this is a village, there is no such house for rent. The locality was not secured for me, I was an outsider and completely unknown. My son was only seven months old that time, how and where I can stay with the infant there. So first one week I stayed in the hotel and used to travel to workplace daily crossing the river and then taking the paddle van. Then I shifted to my relative's house. I was lucky that I had a relative there to stay, not everyone will have a relative to give this support.

(Female junior doctor)

No transport

Due to the inadequate accommodation in many facilities, some respondents and their colleagues had to travel everyday to their clinic. In many places there was no public transport or the transport available was unsafe for them to use. Some doctors reported that they had to borrow cars and pay for petrol themselves. Respondents working in hard-to-reach areas seemed to suffer most from this and female junior doctors complained that the stress of travelling to and from work and the physical abuse that they suffered made them feel unwell and demotivated. One female respondent who was transferred to a community clinic in a remote, hard-to-reach area shared her experience: the centre had no electricity and no equipment. Rather than pay a bribe or use her social network to manage her absence, she was told by the Sub-Assistant Community Medical Officer (SACMO) that she should 'sign in' in advance and then remain absent to avoid the trouble of regular travel.

The SACMO keep telling me 'Madam, why you are taking this hassle of coming everyday here? SACMO suggested me to give advance two weeks signature and leave the clinic.

(Female junior doctor)

My father have car and I used that car to go to facility which needed petrol of 300 taka each day. Obviously my father paid.
(Female junior doctor)

I used to travel by boat to cross the river and then take a paddle van to reach the facility as there were no bus and the roads were really bad.
(Female junior doctor)

The condition of those local buses was horrible with bad body orders in the whole bus. Boys used to tease, and males travelling in those buses use to stand intentionally so closely so that their penis get touched with my body! I was traumatized. Started having tension headache and I started taking Triptine medicine.
(Female junior doctor)

Security issues and threats to doctors

Security was a major concern for all respondents. Almost all interviewees reported that they felt insecure at their rural workplace and they discussed the lack of security measures in place within the facility compound (e.g. no dedicated security guard and in some places no perimeter around the facility). Respondents admitted that they struggled to attend their health facility and provide a service stress-free because of this.

Incidences of theft and robbery were reported as commonplace. Respondents were still responsible for their own personal safety if they lived on site, which encouraged doctors to live elsewhere. Some (both male and female) respondents stated that absenteeism was more common among female doctors as they felt unsafe at work and in their accommodation.

Incidence of theft was regular. I need to keep the window closed always.
(Female junior doctor)

We had to take the responsibility of our own security; the facility did not and will not too
(Female junior doctor)

Security is not good. We have no security guard, sometimes even the patients and attendants broke down to our house even if I am not in duty. So, doctors prefer to stay outside the compound.
(Male junior doctor)

Respondents also shared their experience of being threatened, as well as the experiences of colleagues who faced extreme violence such as attempted murder from within the local community. Despite being threatened and abused verbally or physically, the respondents reported that no action was taken by the authorities.

Patients' attendant threatened me over phone. We regularly get threatened by patients and attendants during first six months.

(Male junior doctor)

Our medical officer was attacked by local people. They tried to burn his house. Doctor filed police case, but eventually had to withdraw the case due to the pressure from local community.

(Male mid-level doctor)

Excessive workload

According to the respondents, upazila health complexes usually have nine sanctioned posts for doctors of which four are consultants and meant to be senior/specialist doctors. And the number of posts is the same, despite the fact that the population coverage varies across complexes. None of the health complexes that the respondents worked in had a full complement of doctors – somewhere between one-third and half of the posts remained vacant.

In some cases, improvements in the health facilities meant that the number of beds had increased (e.g. from 30 to 50 beds), but there had been no increase in the number of doctors employed. In facilities with few doctors, there was no scope to work a routine eight-hour shift: available doctors had to work long hours to keep the facility running, attending to between 50 and 100 patients in a day.

There are nine sanctioned posts for doctors but four is absent. They are not absent actually, the authorities could not give posting anyone in these four posts. So, the posts remain vacant. And because of these vacant posts sometimes we even have to do 56 hours emergency duty

(Male junior doctor)

And, as well as regular service provision, respondents were required to take on additional tasks as well. Some upazila health complexes had a large number of sub-centres under their provision that needed regular field visits to monitor. There were additional duties too for organising campaigns for special days like World Health Day, Breastfeeding Day and Independence Day, and for vaccinations programmes too. Respondents mentioned difficulties in maintaining a healthy work–life balance and that they hardly had time for their personal life. The respondents felt additional pressure around certain festivals – for example, during Eid non-Muslim doctors often cover the duties of their Muslim colleagues, but if a facility does not have non-Muslim doctors then Muslim doctors must miss the celebration.

We also need a routine life; we need time for work and for personal life as well. We need time to take a break, for having lunch, even for taking a bath. These are basic needs.

(Male junior doctor)

> *I don't have Hindu staff. So, both of them have to work alternatively during Eid.*
> (Female senior doctor and facility manager)

Almost all respondents from upazila health complexes described a lack of support staff in the health facilities. In some cases, doctors recruited additional staff themselves and paid their salaries out of their own pockets in order to keep the facility clean and manage the queues of patients.

> *We have posts for them, but, right now, the recruitment process is postponed. We recruited him [support staff] locally and paying from out of our pockets to manage his salary so that we can keep the facility clean.*
> (Female junior doctor)

Inadequate basic supplies

Most of the respondents reported shortages of medicine, equipment and other basic supplies. Stock-outs often occurred during the first half of the month and often powerful local actors would take medicines from the facilities' supplies. There was almost nothing the doctors could do in these circumstances.

Poor diagnostic facilities also meant that many patients had to be referred on and that there were no amenities to serve the local population at sub-centres and in community clinics. Despite having the expertise and willingness to practice and being physically present at a health facility, respondents could not provide a full range of services to their patients. This de-motivated the doctors and prevented them from utilising or expanding their expertise.

> *Doctors are unable to work in the sub-centers because there are no infrastructures including medical apparatus.*
> (Female junior doctor)

> *I am a gynaecologist but I can only provide symptomatic treatment here, then what is the use of being here?*
> (Female senior doctor)

4.1.2.   Threat to career progression

No opportunity to prepare for post-graduation exams

All respondents stressed the need for higher education and post-graduation training, but our interviews strongly suggest that junior doctors have very little time to prepare for entry exams. Those who want to take post-graduation exams need to go to a city for both preparatory classes and the exams themselves as these are not available in rural health complexes. And those who wish to enrol in the post-graduation exam are very often absent during December in order to prepare for the admission exam in January.

While we did not find evidence of these sort of absences among respondents themselves, the interviewees shared various experiences from colleagues. Some respondents also shared examples of colleagues who remained absent over a longer to prepare for their exams since their remote workplace had no facilities for studying. One respondent disclosed her experience of being absent to attend coaching for post-graduation preparation in the city. Another respondent described how some doctors remained absent to study and were not concerned about any disciplinary action.

> *I don't get the opportunity to study and prepare. No one can study here in this environment. This is the reason it took me four years to prepare for the exam. I'll give the exam in coming November But, I couldn't study properly due to working 24 hours.*
>
> (Male junior doctor)

> *I got admitted in coaching for post-graduation. Once I gave my attendance in the healthcare facility at 9 am than then went to Dhaka to attend the class test in the coaching. Once a journalist came and picks the photo of my empty chair as not being in duty.*
>
> (Female junior doctor)

> *There was no library, no environment for study. One doctor left this Upazila to Dhaka or Mymensingh to study in library for post-graduation admission.*
>
> (Male junior doctor)

> *Their excuse was they need to go to Dhaka for study and preparing for the exam. That was difficult time for us in the facility, we were overloaded with work. They applied for leave, the [Upazila Health and Family Planning Officer] did not allow but they even didn't bother, they just left anyhow.*
>
> (Female mid-level doctor)

Transfer and promotion are non-transparent and complicated processes

The promotion process in Bangladesh is complicated and competitive. One can apply after four years of service but there are a number of pre-requisites and qualifying tests. These include foundation training plus a departmental exam, senior scale exam and post-graduation exam to ensure a promotion. Prolonged service within a rural facility is not considered a criterion for promotion. As promotion is not guaranteed or automatic, doctors must qualify through the arduous exam process or lobby their networks to by-pass the queue.

> *If any doctor did their job for 10 years and didn't have any degree, he will not be promoted, while, in admin cadre, people became [Upazila Nirbahi Officer] or ADC [Additional Divisional Commissioner]without any further degree.*
>
> (Male junior doctor)

> *The promotion is not auto, sometimes juniors get promotion applying political network.*
> (Female mid-level doctor)

4.1.3.   Desire for private practice

Scope for higher income from private practice in urban/peri-urban areas

Private practice appeared to be very important to most of the doctors interviewed, not only as a source of additional income but also to enhance their clinical skills.

According to some of the respondents, private practice was one reason to remain absent from a rural posting. Not all upazilas had scope for private practice as households within the locality were poor and could not afford private fees – one respondent working in a remote upazila shared an example of colleagues who did not find it profitable to be present at work as they could not practice privately in that rural area. In other areas, local people felt more comfortable paying privately to visit a SACMO and therefore there were fewer patients willing to visit the private clinics of doctors.

Within *sadar* (district) upazilas with higher-income households, many clinics and better transport systems, some doctors (especially males) undertake dual practice. This is where doctors sign their attendance at a public clinic at the start and end of the day but practice in a private clinic in between. Some respondents shared examples of colleagues who have managed to work under dual practice and who are absent from government-run facilities in order to work privately elsewhere.

> *People of that Upazila were very poor. Some doctors left from Atpara Upazila as there was no scope for private practice. They thought they might not have any financial benefit from this Upazila.*
> (Male junior doctor)

> *Private practice is very important for doctors, at upazillas SACMOs practice using doctor signboard.*
> (Male junior doctor)

> *This doctor will come to [the upazila health complex] and after giving attendance will leave for doing private practice or will be working in some clinic.*
> (Male junior doctor)

4.1.4.   Gender-related issues

Rural placements unprepared for female doctors

Many respondents (both female and male) reported that the work and living environment was unsafe and unfriendly for female doctors in rural facilities. Respondents also mentioned that absenteeism is often higher among female doctors because of health, personal and

family issues. One female respondent shared her own experience of absenteeism and explained that her attendance was irregular as she had to look after her baby.

> *I did not go regularly as my baby was small. One day the [Civil Surgeon] went for visit and found me absent. He called and asked me why I am not present, I lied, said some family problem.*
> (Female mid-level doctor)

Interviewees also described how female doctors felt unsafe doing emergency and night shift duties and that male colleagues usually covered night duties. As personal safety remained the responsibility of individual doctors and no additional arrangements were in place to safeguard female doctors, respondents reported that it was really hard for female doctors to provide a service to patients. Some respondents paid support staff out of their own pockets to ensure that they weren't alone during night duty, while others took a family member or someone else to accompany them on their night shift. Because of inadequate security measures at rural health facilities, outsiders had easy access, especially during late hours. Respondents indicated that this created an uncomfortable environment for female doctors in particular.

> *Absenteeism is higher among female doctors compared to male doctors. Because they are taking lots of leave due to family reasons, including maternity leave and they are unable to live in any place due to security concern.*
> (Male senior doctor and facility manager)

> *I took my father with me at [the upazila health complex] for safety concern.*
> (Female junior doctor)

Non-cooperation from colleagues and the community

Apart from safety issues, some female respondents reported that they experienced non-cooperation and even threats of abusive behaviour from colleagues. A female respondent who was appointed as facility manager faced opposition from male colleagues – since the position was a senior one with many administrative responsibilities and was usually filled by a male doctor, the respondent's male colleagues who were much senior in age refused to work under her command. Another female respondent faced challenges in terms of acceptance by the community during her rural placement – patients in the village were not interested in seeing a female doctor and some were not convinced that she was actually the doctor: they were more comfortable seeing the elderly male assistant.

As some respondents pointed out, such issues provoke female doctors to drop out of their rural postings or even the medical profession entirely.

> *A senior colleague did grouping against me saying that they won't work under me as I am much junior and again a female. They had ego problem actually.*
> (Female mid-level doctor and facility manager)

The patients were not interested to see me because I am female.
(Female junior doctor)

More female students are studying medicine but if there is no safety at work we cannot retain them, authorities need to look into these issues.
(Male junior doctor)

4.1.5. Poor relationship with the local community

Lack of community understanding

Poor relationships with the community and a lack of understanding among local people regarding the system of service delivery were stressed as drivers of absenteeism by the respondents. Nearly every doctor admitted during interview that they faced pressure from local leaders and other influential and powerful people for various reasons which eventually made their stay difficult within rural facilities.

Respondents complained that patients and attendants from the local community demanded health services on a priority basis. They also said that easy access to the facility caused a large number of patients which created chaos and an unmanageable environment. Respondents thought that local people in rural areas were less rule-following than in urban facilities and that they were not willing to wait for their turn to see the doctor. This was especially true for locally influential people.

As well as the large number of people who attended rural clinics, respondents also described visitors who demanded additional services like 'document attest' (as a government official, doctors can authorise certain documents with their seal and signature). Respondents complained that local people found it much easier to pressure doctors to authorise their documents instead of other government officials. Respondents also reported lack of understanding among community people on health-seeking behaviour, non-compliance with prescriptions and medical advice, and demands for unnecessary medicine, treatment and referrals. Equally, some doctors can show a lack of interest in interacting with local people, which can widen the gap in terms of mutual understanding.

Ten patients enter in my room and then all of them want me to see them right then. No one wants to wait.
(Male junior doctor)

Sometimes influential people came and said, you have to treat my patient first leaving other patients and I had to do it.
(Female junior doctor)

We have other government officials who can do it but people do not go there. I do not understand why, maybe those officials are not easily accessible like doctors to general people or people are afraid of them but not of doctors.
(Male junior doctor)

Local political pressure

Respondents indicated that political pressure at local level was a common problem in rural areas. Locally influential people pressured doctors to issue false medical certificates, while there were reports of forced admissions to clinics or referrals so that local rival parties could report false injuries or altercations to the police. Politically connected people also often forced doctors to make home visits at a late hour, which meant that health facilities were left unattended.

> *The victim party put pressure on us for grievous certificate while anti-party also put pressure to issue certificate of simple injury.*
> (Male junior doctor)

> *They want us to go to their home for patient consultation even for simple cough problem. They took us to their home showing their political power. If we disagree to go considering other patients' condition, they will create problem for us.*
> (Male mid-level doctor)

Cadre discrimination and lack of recognition in the community

Many of the respondents felt dissatisfied that doctors received less respect and lacked administrative power compared to other government officials. Some felt they had been abused like public property.

Respondents pointed out that it is disrespectful when doctors who work in a rural environment suffer poorer facilities and privileges than those in junior positions within other cadres. Some reported that in the case of any dispute between doctors and members of the local community, usually doctors have had to offer an apology no matter who is at fault. Such incidences were humiliating and frustrating for respondents. In many cases local people pressurised doctors to deliver a service without any understanding of the limitations that they face.

> *They think that they can hit or assault the doctor as the doctor has no power. Doctor does not have a gun in his/her hand and will not be able to do anything. So, what should all the doctors do? Should they get assaulted by people or should they have gun in their hand and then provide service?*
> (Male junior doctor)

> *How many times could we keep patience? How much can we tolerate? We have a level of tolerance too and deserve minimum respect while providing service.*
> (Male junior doctor)

> *Doctors are not supposed to get assaulted while giving service but they are facing such situations regularly while other government officials do not need to deal with such situations. Doctor will not have the mentality to provide service anymore.*
>
> (Male junior doctor)

4.1.6. Weak regulatory mechanisms

Limitations with biometric monitoring

All of the facilities that we visited had a biometric machine to record doctors' attendance (see section 1.3.1). At upazila health complexes doctors are supposed to give their biometric fingerprint when they enter and exit the health facility as well as giving their standard signature. Respondents demonstrated mixed reactions regarding the biometric system: some considered it a good initiative to monitor attendance and send monthly reports at a central level; others considered it ineffective as doctors easily left facilities and asked colleagues to cover for them. Due to poor monitoring, some doctors took the opportunity to be absent and use that time for personal benefit (i.e. study, private practice, etc.). In facilities with severe staff shortages, the doctors found the biometric system of little use as they were working more than their duty hours but any additional time did not count for anything.

> *Biometric system is a very good initiative. Management can monitor the presence even from central level as they get regular reports.*
>
> (Male junior doctor)

Lengthy and complicated disciplinary process

Not all respondents were familiar with the disciplinary process against absenteeism; those who were reported that the process was lengthy and weak at the same time.

According to respondents, if a doctor had an unauthorised absence for more than three consecutive days, formal action was supposed to be taken by the facility manager. This includes issuing a written warning that should be sent a maximum of three times. In the case of an unsatisfactory response (or no response), the facility manager should inform the authorities at central level. Annual leave or salary payments may be deducted as punishment. Of course, this course of action depends on the facility manager. One respondent added that in the majority of cases warning letters did not reach a doctor's actual address, that absent doctors did not bother to respond or that they gave a lame excuse for their absence.

In the case of long-term absences, the respondents explained that disciplinary action should be taken to suspend the accused doctor but that they would continue to receive their salary (albeit with no allowance or increments) and still not need to attend their workplace. Further action includes a hearing at central level. If the accused doctor demonstrated any valid reason for their absence or proved the allegation wrong, then the suspension would be

cancelled. Final disciplinary action against long-term absenteeism would result in the authorities issuing a legal notice to dismiss the doctor which would be published in newspapers. Respondents mentioned that this process easily takes two–four years at a minimum, however. Thus, at facility level, local authorities had limited authority and the actions taken varied from person to person.

> *These letters usually do not reach to address or may give a response like suffering from back pain, and authorities accept such responses.*
>
> (Female junior doctor)

> *Suspension means the doctor will have the basic salary and will not come to office for the mentioned period of time. This is the benefit of the government job.*
>
> (Female junior doctor)

4.2. How is absenteeism facilitated in rural facilities?

4.2.1. Informal payments

There is no auto-transfer or promotion system in the Bangladesh health system. Furthermore, according to the formal process, doctors are not eligible to apply for a transfer within the first two years of a compulsory rural placement. After this time, eligible doctors must apply for a transfer through their facility manager to the civil surgeon within the office of the divisional director (DD). Almost all respondents reported that the transfer process is not transparent and that bribery and unofficial payments are common. Rather, unofficial payments are almost a given to manage a transfer and the amount varies based on transfer site and the position of the doctor. Transfers in remote/rural places need lower payments compared to a 'good transfer' in urban/peri-urban areas.

Respondents stated that the value of unofficial payments also depended on how networked the doctors were. For some who had a strong political background, their identity was enough to ensure a good transfer and they need not make any payment. According to one respondent, the practice of manipulating a transfer was more common up to 7th grade among Bangladesh civil servants, which was managed by DGHS: a transfer from 6th grade and above was managed by the MoHFW itself. Respondents described how unofficial payments were mainly demanded by clerks or 4th grade staff to move a file from one table to another.

> *We spent approximately 15,000 BDT for this posting for the couple transfer.*
>
> (Female senior doctor)

> *My father took me to the DD office and DD helped me with the forwarding to the DGHS office. DD of Dhaka DD office instructed his staff to find out vacant place and immediately instructed to give me posting at...*
>
> (Female junior doctor)

One female respondent shared her frustration at being treated differently as her requests for leave were denied while her female colleague remained absent for long periods during her compulsory rural placement. She reported that this was likely because her colleague had made an unofficial payment. Respondents also reported that dual practice was sometimes managed through unofficial payments like a 'half-salary' where a doctor had a mutual understanding with staff – they shared half their additional salary on a regular basis with staff at the rural facility on the condition that their absences were not reported.

I know one of my colleague's wife who was transferred in……. she managed to remain absent; she used political network and might have paid unofficially also. She was not punished for her absence at least I have not heard so.

(Female junior doctor)

One of my friend's first transfers was in ……. but he did not join from the very beginning. He was working somewhere else in a private organization. He got notices but did not response. This way four years went by. I have no idea whether he still have the government job.

(Female junior doctor)

I met the civil surgeon again and asked for his advice. He said, 'Being the authority, I cannot advise you directly to leave the facility. Then I actually understood what he meant to say. I went to Dhaka for lobbying without taking any leave.

(Female junior doctor)

4.2.2. *Social networks*

Absenteeism depends on the social network and economic position of a doctor. We identified a group of doctors who were able to arrive at their rural health facility and leave shortly afterwards, or who were posted to a rural facility but never arrived. The majority of these doctors were able to be absent without any sanctions by drawing on their political, professional or social networks to secure a posting in an urban centre.

I remember one case, a female gynaecology doctor, who was transferred here. She was niece of one of our current ministers… She joined here and attended office only for three to four days and then left and never came back.

(Male junior doctor)

Some people don't need to spend money even. Daughter of…. Sir, after working for few months in the upazilla, she applied for changing her posting from upazilla. Immediately, after her application, all of the staff were instructed to search vacant position for her and issue the order. She was transferred to the nearest location to her house in Dhaka, from where she can continue her office.

(Female senior doctor)

Doctors who belonged to powerful and political families seemed to have to make little effort to secure a position and transfer out of rural into urban areas. Their identity was enough, and the authorities secured a better placement on their behalf. One female respondent from a wealthy and well-connected family described how she had relied on her cousin's political network to help her secure a long period of leave to enable her to take up a position in Australia without having to formally resign.

> *I knew I have to use some political influence. My cousin had direct connection with many of the current ministers. So, I requested him. I have no idea how and what happened next. Then I came to know that my leave has been granted from the Ministry. I applied for ten days leave and fled to Australia forever. That was my last contract with the Government.*
>
> (Female junior doctor)

In contrast, we identified a group of respondents who were very rarely absent from their positions, in part because they did not have access to a social network to facilitate leave, transfers or promotions. These doctors complained about the difficulty of taking leave and said that they often had to work extremely hard to cover for absent colleagues and due to vacant posts.

One respondent had completed his two-year mandatory rural placement and had served two additional years. He wanted to transfer to Dhaka but did not have any social network to lobby on his behalf. Due to his excessive workload, the respondent also lacked the time to prepare and enrol for the post-graduation degree. He continued working in the same rural position because he felt there was no other option for him. Another female respondent described her struggle to secure a transfer. She could not prepare for the post-graduation exam as her posting was in a hard-to-reach area and, although she visited the DGHS office repeatedly, she did not have any social or political network to lobby at central level for a transfer. This young doctor ultimately resigned from her job.

> *I not have any such network that is why I have been here for more than four years. Now I do not want to stay here anymore I want to go to Dhaka and but as I do not have any powerful network or anyone at senior level so I fail to manage.*
>
> (Male junior doctor)

> *I could not even manage to speak to the [Personal Assistant] of [Directorate General] sir. The office peons said there are many like you waiting here, it is not that easy, please go and sit. Maybe I could have survived if I could do the lobbing and use the networks successfully to manage the transfer*
>
> (Female junior doctor)

4.3. The minority who cope in rural positions

A small minority of our respondents seemed satisfied with their rural positions. These feelings stemmed from two factors: 1) the doctor lived in or was from that locality or 2) the doctor had managed to maintain a good rapport with the local community.

One respondent who was working in his hometown appreciated the policy of area-based transfers – it helped retain doctors in their own rural area and provided an opportunity for doctors to stay with their family. These doctors were happy to serve their own people and, at the same time, the local community was welcoming to them. Two female respondents mentioned that they did not face any difficulties in their rural placement since they worked in their local area: people knew them and their families well.

> *The government's area-based posting helped doctors to stay and work in their area*
> (Male mid-level doctor)
>
> *I didn't face any problem to work as female doctor as that was my local area and I know almost everyone and they know me, know my grandfather, father and uncle as well.*
> (Female junior doctor)
>
> *We are from local area our family members are well known in the locality. My uncle, who died few years back, was businessman and he was well connected to the local government people like mayor, chairman and others. For example, the city Mayor was school friend of my uncle and other as well all were his friends and closely connected.*
> (Female junior doctor)

Respondents who were working in their own area and who also had connections with local politicians and influential people coped easily in their rural posts. One respondent built and maintained a good rapport with local people from the very beginning of his rural posting. He also maintained good relations with the local authorities, including the police and local government administration. This doctor indicated that monthly sub-district meetings that involved all significant stakeholders in the area was a very useful platform to discuss issues and to network.

Some respondents also used their relationship with colleagues as a coping mechanism in rural settings. In the face of staff shortages, the remaining doctors managed their excess workload through mutual understanding. According to respondents, all doctors are supposed to be present at a facility from 8:30 am to 2:30 pm every day. After 2:30 pm, two doctors are supposed to be on duty during the evening and night shift to cover emergencies. In practice, a roster is agreed between the doctors, which is approved by the Upazila Health and Family Planning Officer (UHFPO), that allows for one or two doctors at a time to cover all shifts in one go (morning, evening, night and emergency) to make it easier and more convenient for the few staff who are present.

From the very beginning of my work life there, I built rapport and good relationship with all the relevant people like UHFPO, police, administration, local government people, administrative people and local influential people.

(Male junior doctor)

All the doctors sit together at the beginning of the month in the facility and plan the duty roster as per their convenience with mutual understanding. Even, I completed my duty similar way.

(Female junior doctor)

5. Discussion and conclusion

From this explorative study we see that absenteeism can enable doctors to survive in otherwise difficult rural placements in Bangladesh. Absent doctors are driven by dissatisfaction with their work and living environment, lack of opportunity for career progression and poor relationships with local communities. These conditions are exacerbated by a complicated promotion and transfer process, inadequate disciplinary mechanisms and poor transport networks. There are few incentives for doctors to work in rural facilities and many individuals do not feel motivated to complete their two-year placements. Similar findings have been observed in studies conducted among nurses in Pakistan (Nawaz et al., 2018) and in rural Uganda (Tweheyo et al., 2019).

Those doctors who were successful and happy working in rural facilities capitalised on their social and political networks. Others were unhappy and either used their networks to facilitate transfers to other settings or paid bribes. Doctors who did not have access to financial resources or to such networks failed to move out of rural areas. – indeed, one respondent left the medical profession. Similar observations have been reported in Kenya (Tumlison et al., 2019).

Our findings suggest that if an anti-corruption strategy is likely to be effective to curb absenteeism among doctors in Bangladesh, it must recognise and address the difficulties that these doctors face in rural areas. The strategy must also take into account the social and political networks and informal payments that facilitate absenteeism and that enable doctors to be absent without sanction. A similar study conducted in Nigeria shows that although measures exist that aim to reduce absenteeism in rural facilities, they are often ineffective due to implementation and structural issues (Agwu et al., 2019).

In Bangladesh, it is apparent from our study that those who have relative power are able to be absent without sanction and therefore would not benefit from an anti-corruption strategy. Instead, any strategy needs to garner the support of other groups of doctors – those with no access to networks, who have to take up the slack of absent colleagues. These doctors are more likely to buy into a system in which the majority of doctors complete their two-year rural placements and, only then, are considered for promotion/transfer to an urban facility. The question is which of the drivers of absenteeism described in this study need to be addressed so that doctors are more willing to stay in rural health posts? Are local-level solutions needed to build a more supportive environment, working with local stakeholders who have the power and intention to improve the situation? Or should the strategy focus on better surveillance and sanctions for those guilty of absenteeism?

Our findings suggest that an anti-corruption approach that incentivises doctors and provides a novel form of collective action would be most effective in this setting. Specific incentives should be designed that are feasible and appropriate in order to create a supportive and motivating workplace for doctors in rural facilities in Bangladesh.

6. References

Agwu, P., Ogbozor, P., Odii, A., Orjiakor, C., Mbachu, C., Balabanova, D., Hutchinson, E., McKee, M., Onwujekwe, O. Obi, U. and Roy, P. (2019) *Exploring health-sector absenteeism and feasible solutions: evidence from the primary healthcare level in Enugu, South East Nigeria*. SOAS ACE working paper no. 014. London: SOAS University of London.

Ahmed, S.M., Hossain, M.A., RajaChowdhury, A.M. and Bhuiya, A.U. (2011) 'The health workforce crisis in Bangladesh: shortage, inappropriate skill-mix and inequitable distribution', *Human Resources for Health* 9 (art. 3) (doi: 10.1186/1478-4491-9-3).

Bangladesh Health Watch (2008) *Health workforce in Bangladesh: who constitutes the healthcare system?* Dhaka: James P Grant School of Public Health, BRAC University.

Belita, A., Mbindyo, P. and English, M. (2013) 'Absenteeism amongst health workers – developing a typology to support empiric work in low-income countries and characterizing reported associations', *Human Resources for Health* 11 (art. 34) (doi: 10.1186/1478-4491-11-34).

Chaudhury, N. and Hammer, J.S. (2004) 'Ghost doctors: absenteeism in rural Bangladeshi health facilities', *World Bank Economic Review* 18(3): 423-441.

Daily Star (2018) 'PM irked by doctors' absence at upazila-level hospitals', *Daily Star,* 8 October (https://www.thedailystar.net/city/news/pm-irked-doctors-absence-upazila-level-hospitals-1644034).

Darkwa E.K., Newman, M.S., Kawkab, M. and Chowdhury, M.E. (2015) 'A qualitative study of factors influencing retention of doctors and nurses at rural healthcare facilities in Bangladesh', *BMC Health Services Research* 15 (art. no. 344) (doi: 10.1186/s12913-015-1012-z).

DFID (Department for International Development) (2015) 'Why corruption matters: understanding causes, effects and how to address them'. Evidence paper on corruption. London: DFID, January.

Dhaka Tribune (2015) 'Govt clamps down on doctor absenteeism', *Dhaka Tribune*, 26 July (https://www.dhakatribune.com/uncategorized/2015/07/26/govt-clamps-down-on-doctor-absenteeism).

Dhaka Tribune (2019) 'ACC: 40% doctors absent in workplaces', *Dhaka Tribune,* 21 January (https://www.dhakatribune.com/bangladesh/nation/2019/01/21/40-doctors-absent-in-11-govt-hospitals).

Ensor, T. and Duran-Moreno, A. (2002) 'Corruption as a challenge to effective regulation in the health sector' in R.B. Saltman, R. Busse and E. Mossialos (eds) *Regulating entrepreneurial behaviour in European health care systems*. Buckingham: Open University Press.

Gale, N.K., Heath, G., Cameron, E. Rashid, S. and Redwood, S. (2013) 'Using the framework method for analysis qualitative data in multi-disciplinary health research', *BMC Medical Research Methodology* 13 (Art. no. 117) (doi: 10.1186/1471-2288-13-117).

GoB (Government of Bangladesh) (2011) *National health policy*. Dhaka: Ministry of Health and Family Welfare.

Hutchinson, E., Balabanova, D. and Mckee, M. (2020) 'Beyond talking: we need effective measures to tackle systemic corruption and the power that allows it to persist in health systems – a response to recent commentaries', *International Journal of Health Policy and Management* (doi: 10.15171/ijhpm.2020.21).

Hutchinson, E., Naher, N., Roy, P., Martin, M., Ahmed, M., Balabanova, B. (forthcoming) 'Targeting anti-corruption interventions at the front-line: developmental governance in health systems', *BMJ Global Health*.

Independent, The (2018) 'Absence of doctors at upazila hospitals', *The Independent,* 9 October (http://www.theindependentbd.com/printversion/details/169590).

Independent, The (2019) '40pc doctors absent at govt hospitals: ACC', *The Independent,* 21 January (http://m.theindependentbd.com/printversion/details/184198).

Joarder, T., Rawal, L.B., Ahmed, S.M., Uddin, A. and Evans, T. (2018) 'Retaining doctors in rural Bangladesh: a policy analysis', *International Journal of Health Policy and Management* 7(9): 847–858 (doi: 10.15171/IJHPM.2018.37).

Kisakye, A., Tweheyo, R., Ssengooba, F., Pariyo, G.W., Rutebemberwa, E. and Kiwanuka, S.N. (2016) 'Regulatory mechanisms for absenteeism in the health sector: a systematic review of strategies and their implementation', *Journal of Healthcare Leadership* 8: 81–94 (doi: 10.2147/JHL.S107746).

Khan, M.H. (2012) 'Beyond good governance: an agenda for developmental governance' in J.K. Sundaram and A. Chowdhury (eds) *Is good governance good for development?* New York: United Nations.

Khan, M.M., Hotchkiss, D.R., Dmytraczenko, T. and Ahsan K.Z. (2013) 'Use of a balanced scorecard in strengthening health systems in developing countries: an analysis based on nationally representative Bangladesh Health Facility Survey', *International Journal of Health Planning and Management* 28(2): 202–215 (doi: 10.1002/hpm.2136).

Khan, M.H., Andreoni, A. and Roy, P. (2019) *Anti-corruption in adverse contexts: strategies for improving implementation*. SOAS ACE working paper 013. London: SOAS University of London.

Levy, B. (2014) *Working with the grain: integrating governance and growth in development strategies.* Oxford: Oxford University Press.

Muralidharan K., Chaudhury, N., Hammer, J., Kremer, M. and Rogers, F.H. (2011) 'Is There a Doctor in the House? Medical Worker Absence in India'. Washington, DC: World Bank.

Marquette, H. and Peiffer, C. (2015) *Corruption and collective action*. Birmingham: Developmental Leadership Programme.

Naher, N., Shaikh Hassan, M., Hoque, R., Alamgir, N. and Ahmed, S.M (2018) *Irregularities, informal practices, and the motivation of frontline healthcare providers in Bangladesh: current scenario and future perspectives towards achieving universal health coverage by 2030*. SOAS ACE working paper 004. London: SOAS University of London.

Nawaz, K., Hussain, M., Sarwar, H., Afzal, M. and Gilani, S.A. (2018) 'Determine the factors influencing absenteeism among nursing students', *Journal of Health, Medicine and Nursing* 50 (2018).

NIPORT (National Institute of Population Research and Training) (2017) 'Bangladesh health facility survey 2017'. Dhaka: Ministry of Health and Family Welfare.

Politzer, M. (2019) 'Corruption: A neglected obstacle to achieving UHC'. Devex, Inside Development, Healthy Access, 30 September (https://www.devex.com/news/corruption-a-neglected-obstacle-to-achieving-uhc-95603).

TI (Transparency International) (2006) *Global corruption report 2006.* Ann Arbour, MI: Pluto Press (https://images.transparencycdn.org/images/2006_GCR_HealthSector_EN.pdf).

TI (2009) *Transparency international annual report 2009*. Berlin: TI (https://www.transparency.org/en/publications/transparency-internationals-annual-report-2009).

TIB (Transparency International Bangladesh) (2008) *National household survey 2007 on corruption in Bangladesh*. Dhaka: TIB (https://www.ti-bangladesh.org/research/HHSurvey07full180608%5B2%5D.pdf).

Tumlison, K., Gichane, M.W., Curtis, S.L. and LeMasters, K. (2019) 'Understanding healthcare provider absenteeism in Kenya: a qualitative analysis', *BMC Health Service Research* 19 (art. 660) (doi: 10.1186/s12913-019-4435-0).

Tweheyo, R., Reed, C., Campbell, S., Davies, L. and Daker-White, G. (2019) '"I have no love for such people, because they leave us to suffer": a qualitative study of health workers' responses and institutional adaptations to absenteeism in rural Uganda', *BMJ Global Health* 4(3): e001376.

U4 Anticorruption (2015) 'Bangladesh: overview of corruption and anti-corruption with a focus on the health sector'. U4 Expert Answer 2015:05. Bergen: U4 Anticorruption Research Centre.

UNDP (United Nations Development Programme) (2011) *Fighting corruption in the health sector methods, tools and good practices*. New York: UNDP.

Vian, T. (2008) 'Review of corruption in the health sector: theory, methods and interventions', *Health Policy and Planning* 23(2)*: 83–94.

WHO (World Health Organization) (2015) *Bangladesh health system review*. Health systems in transition. Manila: WHO Regional Office for the Western Pacific.

WHO (World Health Organization) (2018) *Integrating a focus on anti-corruption, transparency and accountability in health systems assessments*. Geneva: WHO (https://apps.who.int/iris/bitstream/handle/10665/310991/9789241515177-eng.pdf).

World Bank (1999) *Corruption in economic development*. World Bank Policy Research Paper. Washington, DC: World Bank Group.

ACE
SOAS Consortium

Anti-Corruption Evidence
Making Anti-Corruption Real

About the Anti-Corruption Evidence (ACE) Research Consortium:

ACE takes an innovative approach to anti-corruption policy and practice. Funded by UK aid, ACE is responding to the serious challenges facing people and economies affected by corruption by generating evidence that makes anti-corruption real, and using those findings to help policymakers, business and civil society adopt new, feasible, high-impact strategies to tackle corruption.

ACE is a partnership of highly experienced research and policy institutes based in Bangladesh, Nigeria, Tanzania, the United Kingdom and the USA. The lead institution is SOAS University of London. Other consortium partners are:

- BRAC Institute of Governance and Development (BIGD)
- BRAC James P. Grant School of Public Health (JPGSPH)
- Centre for Democracy and Development (CDD)
- Danish Institute for International Studies (DIIS)
- Economic and Social Research Foundation (ESRF)
- Health Policy Research Group (HPRG), University of Nigeria Nsukka (UNN)
- Ifakara Health Institute (IHI)
- London School of Hygiene and Tropical Medicine (LSHTM)
- Palladium
- REPOA
- Transparency International Bangladesh (TIB)
- University of Birmingham

ACE also has a well established network of leading research collaborators and policy/uptake experts.

Anti-Corruption Evidence (ACE) Research Consortium
SOAS University of London, Thornhaugh Street, Russell Square, London WC1H OXG
T +44 (0)20 7898 4447 • **E** ace@soas.ac.uk • **W** www.ace.soas.ac.uk

SOAS
University of London