

Exploring health-sector absenteeism and feasible solutions: evidence from the primary healthcare level in Enugu, South East Nigeria

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Summary

Many studies have found that absenteeism undermines the effective delivery of healthcare. However, most studies focus on high-income countries and low-income countries – which suffer from a shortage of health workers – have been largely ignored in the literature.

This study explores absenteeism in primary health centres (PHCs) in Enugu State, Nigeria – a level of the health system identified as susceptible to absenteeism. Ten PHCs were purposively selected from six local governments in Enugu State. In-depth interviews and focus group discussions were conducted with frontline health workers, managers, service users and health facility committee chairpersons.

Absenteeism was found to be highly prevalent among health workers, and represents an even bigger burden within PHCs when lateness is also considered. The impact of absenteeism is felt by both service users and co-workers, but it is not always deliberate. Economic pressures, ill-health, challenges regarding transportation and other structural inefficiencies, and managerial/organisational dynamics contribute to the absence of health workers.

Although measures exist that aim to reduce absenteeism in PHCs, our findings show that these can be easily circumvented and are ineffective due to implementation and structural issues. The Anti-Corruption Evidence (ACE) approach could be useful here, which seeks to involve and change the incentives of influential stakeholders in the system such that they support efficiency-enhancing policies and ultimately provide effective service delivery. By engaging stakeholders and boundary partners at the grassroots and the level of service delivery, efforts can be made to change behaviours and radically reduce absenteeism at the PHC level.

List of Acronyms

ACE	Anti-Corruption Evidence
CHEWs	Community Health Extension Workers
FGD	Focus group discussion
FMOH	Federal Ministry of Health
HFC	Health Facility Committee
HFCC	Health Facility Committee Chairperson
HOD	Head of Department of Health
HPM	Head of Personnel Management
IDI	In-depth interview
LGA	Local government area
NPHCDA	National Primary Healthcare Development Agency
NYSC	National Youth Service Corps
OIC	Officer-in-Charge of Health Facility
PHC	Primary health centre
UHC	Universal health coverage

1. Introduction

1.1. Absenteeism as a form of corruption

Corruption is the abuse of public office for private gain (Transparency International, 2017). Absenteeism is defined as the failure to appear for scheduled work (Kisakye et al., 2016) or the loss of scheduled time to unscheduled work. Absenteeism is a type of corruption, therefore, particularly when individuals choose to be absent from work to pursue their private interests while working in critical public sectors like health services. This may lead to arriving late to work, leaving earlier than scheduled or irregular attendance (Diestel et al., 2014).

Addressing absenteeism is a high priority in the West African Anglophone region, especially in Nigeria. A recent systematic literature review of corruption in the health sector shows that absenteeism has been identified as a core concern in public health facilities across this region (Onwujekwe et al., 2018). This finding is further validated in a forthcoming paper that utilises the nominal group technique to reach a consensus among frontline health workers (Onwujekwe et al., forthcoming). Within primary health centres (PHCs), Daniel et al. (2016) revealed that Nigeria has the second highest absence rate among health providers based on primary healthcare performance indicators.

Genuine concerns and pressures can mean that health workers cannot avoid being absent. Though there may be overlaps and grey areas, Belita et al.'s (2013) typology classifies absenteeism as 'planned or unplanned' and 'voluntary or involuntary' in an attempt to clarify whether an absence qualifies as corruption or not. One key concern of the research is instances of absenteeism that stem from the power asymmetry between individuals working in the health system, usually as a result of political or social connections. Such well-connected individuals can avoid disciplinary procedures that would otherwise ensure that they discharge their duties as required and deliver an effective service. In other words, attendance rules are imposed selectively. In the Anti-Corruption Evidence (ACE) framework, this is what we identify as 'rule *by* law' and an 'adverse context' for governance where anti-corruption reforms often fail as a result of selective or partial enforcement of policies (Khan et al., 2016). Rule *of* law, on the other hand, is a situation where law enforcement is relatively impartial and top-down 'vertical' reforms are enforced across powerful organisations.

In developing countries – and Nigeria is no exception – politics takes the form of informal transactions between pyramidal networks of patrons and clients (Joseph, 1983; Lewis, 1996; Khan, 1998). Much of the early literature on patron–client politics in Nigeria analysed it through the lens of ethnic ties (Sklar, 1963; Cohen, 1974; Diamond, 1983). However later scholars have described how these networks have also evolved to become more instrumentalised through the introduction of clientelist competitive politics (Joseph, 1983; Albert, 2005; Aderonke and Awosika, 2013; Morgan et al., 2010; Ombowale and Olutayo 2010). In essence, patron–client groupings are pyramidal networks based on personalised, informal interactions and where politics is organised as a form of redistributive coalition

(Khan, 2005). Literature on Nigeria identifies patron–client politics as the means through which resources are distributed and projects are implemented, including for instance where health centres are built or how donor-funded health programmes are used to distribute patronage across geopolitical regions (Smith, 2003; Morgan et al., 2010; Ombowale and Olutayo, 2010). Typically leaders at the top of the pyramid offer payoffs to their supporters in return for loyalty. This makes rule-following behaviour and indeed the enforcement of formal rules very difficult. An agent who wants to conform to rules is in danger of being sidelined by the ‘system’ as the incentives to follow rules in this adverse context do not exist.

The healthcare sector in many developing countries can often be typified by patron–client networks and political interference due to a combination of factors. It is a priority sector where budgetary resources – both internally mobilised and donor-driven – can be fairly high given its public-good nature. It is also state-owned (even where there is substantial private-sector presence). This source of sustained funding in the hands of public officials, whether elected or not and across tertiary, secondary and primary levels, ensures that they are able to cultivate a network of clients. This phenomenon remains understudied specifically in the health sector and our analysis is a contribution to opening up further research in this area.

One key finding of our research is that so-called ‘godparents’ (who are more often than not godfathers rather than godmothers) play a role in influencing absentee behaviour by providing protection from disciplinary actions, as outlined later in section 3.4.2. These godparents control large amounts of monetary resources and, in the words of political scientist Dr Jibrin Ibrahim, these are ‘men who have the power personally to determine who gets nominated and who wins [an election] in a state’ (Albert, 2005). Nigerian godparents can be immensely powerful at the level of provincial politics but there are also locally powerful godparents who are important in that context. This can also be defined as another variant of patron–client relationships. Our research has credibly picked up how this affects the behaviour of primary healthcare professionals who are protected by local godparents, as they escape censure by their seniors when they are absent with little reason, especially when they also engage in private practice.

The SOAS-ACE framework on anti-corruption is not just about identifying the causes behind corruption, however. Instead, our strategy is to identify types of corruption in particular contexts that have adverse developmental outcomes. At the same time, we also identify corrupt processes that can be addressed and reversed with policy that is feasible to implement given the interests and relative power of organisations that are set to benefit. Our interest is to look for groups of powerful stakeholders who will horizontally enforce policy in their own interest in a context where vertical ‘big-bang’ enforcement is not possible. However, this incremental horizontal approach has to be complemented with vertical policies in the longer term.

The SOAS-ACE theory of change is that supporting incremental efficiency-enhancing improvements will empower groups to make the distribution of power in society broad-based and more equitable. This, in turn, will create the space for progressively ambitious anti-corruption strategies that will improve development outcomes (Khan et al., 2016). Reaching out to local godparents and using their influence to discipline absentee workers in

this context would be a strategy to explore further. This is already being deployed informally by some supervisors in the sector as outlined in section 3.6.3.

In sub-Saharan Africa, health-worker density is already below the World Health Organization's (WHO) minimum recommendation of 4.45 health workers per 1,000 population (WHO, 2016). Therefore, absenteeism is likely to worsen health outcomes and stall progress towards achieving universal health coverage (UHC). The consequences of absenteeism may include workload increases for the few available staff, poor-quality delivery of health services and incidences of mortality, hence it poses a serious threat to the health of communities. PHCs and the government face declining productivity levels amongst workers and financial losses also. Given how deeply entrenched absenteeism is in sub-Saharan Africa, developing anti-corruption policies in progressive steps rather than focusing only on vertical, top-down reforms could be the smarter way of addressing the issue.

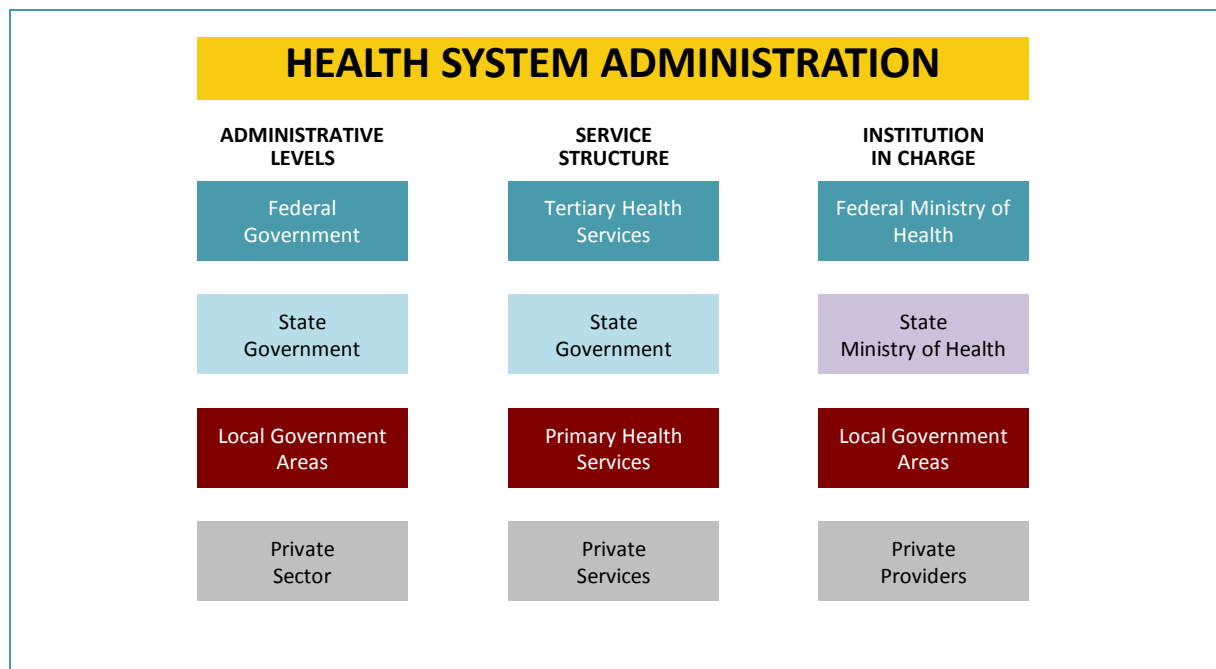
1.2. Context: the structure and function of Nigeria's health system

Nigeria's national healthcare system is organised across three levels: primary, secondary and tertiary healthcare. Primary healthcare is largely the responsibility of the local government, supported by the Federal Ministry of Health through the National Primary Healthcare Development Agency (NPHCDA) and the State Ministries of Health through the State Primary Healthcare Development Agencies or Boards. Facilities operating at the primary healthcare level provide general preventive, curative, promotion and rehabilitative health services.

Secondary healthcare is largely the responsibility of the state governments and provides specialist services for patients referred from the primary level. Tertiary healthcare is the responsibility of the federal and state governments. Tertiary hospitals mostly provide specialised healthcare for patients, including advanced medical investigation and treatment usually on referral from primary and secondary healthcare. In addition to these services, they provide medical education, clinical research and training sites for medical practitioners. The federal government oversees the Federal Ministry of Health (FMOH) and agencies under it, such as the NPHCDA. The FMOH also leads the formulation of healthcare policies, national goals, targets and indicators, strategic planning and provision of highly specialised services.

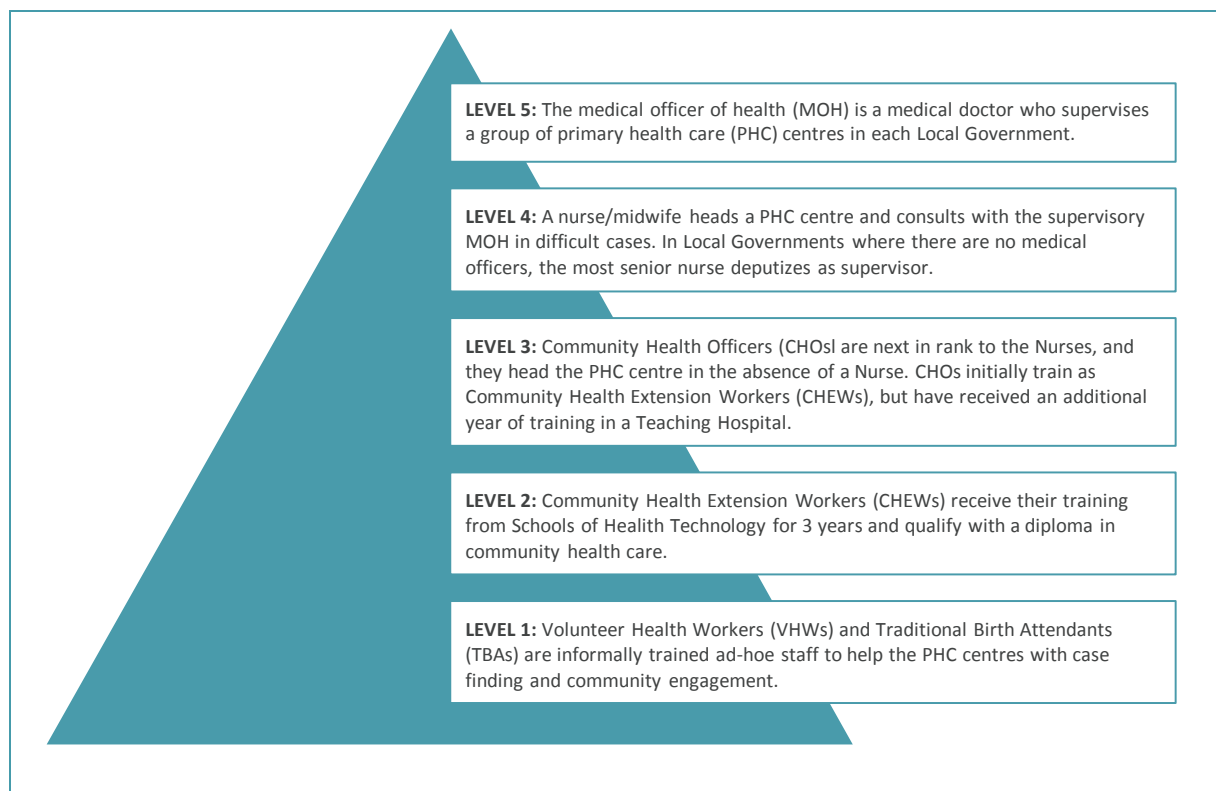
Figures 1 and 2 illustrate the administrative structure and staff structure within Nigeria's health system, and Table 1 presents the salary scales for health workers within PHCs.

Figure 1: Administrative structure of Nigeria’s health system



Source: Uzoma (2017)

Figure 2: Staff structure within PHCs



Source: Abdulmalik et al. (2013)

Table 1: Salary scale of PHC workers

Type of health worker	Level	Salary per month (gross)
Senior Community Health Extension Worker	Level 14	N95,000 (US\$263)
Senior Community Health Extension Worker	Level 10	N48,286 (US\$134)
Midwife	Level 10	N47,000 (US\$130)
Laboratory Technician	Level 9	N41,000 (US\$113)
Senior Community Health Extension Worker	Level 8	N39,000 (US\$108)
Senior Community Health Extension Worker	Level 7	N28,500 (US\$79)
Health Attendant	Level 4	N21,000 (US\$58)
Junior Community Health Extension Worker	Level 4	N20,000 (US\$55)

Source: Onwujekwe et al. (forthcoming)

In Nigeria, PHCs are the first port of call for communities and individuals seeking healthcare, especially during emergencies for people residing in rural and hard-to-reach areas (Obioha and Molale, 2011). However, despite their importance, PHCs are marred with many challenges ranging from inadequate equipment to insufficient access to drugs and materials and unreliable power supply. These challenges are further compounded by a shortage of personnel on the one hand, and the practice of unqualified personnel on the other (Daniel et al., 2016). Often, PHC health workers are unavailable to attend to the health needs of individuals who may not have alternative access to health services.

1.3. Objectives of the study

The SOAS-ACE research consortium uses a granular approach to corruption, suggesting that anti-corruption strategies are more beneficial if they target the types of corruption that are feasible to address and that have the highest impact on development (Khan et al., 2016).

The purpose of this study is to examine absenteeism as a type of corruption in the Nigerian health sector in order to better understand its different dimensions and identify specific actors that can be incentivised to support feasible anti-corruption activities. This knowledge can inform policy-makers on innovative strategies and feasible interventions to curb absenteeism at the grassroots level, which will ultimately strengthen PHCs and accelerate progress towards UHC.

We have undertaken an in-depth exploration of absenteeism at the primary healthcare level, investigating the drivers of absenteeism among different staff cadres and categories. The study examines absenteeism as being planned or unplanned, and includes failure to appear for scheduled work, coming to work late, being present at work and not performing one's job, and leaving work earlier than the appropriate time for closure.

The specific research objectives are to:

- 1 determine the level of occurrence of absenteeism at urban and rural PHCs in Enugu State in South East Nigeria
- 2 identify staff groups and cadres who are most absent

- 3 identify key political, economic, gender, sociocultural, individual and organisational drivers of absenteeism
- 4 examine the effectiveness of existing strategies/interventions for eliminating absenteeism among frontline health workers
- 5 identify where absenteeism is related to corruption and devise feasible and impactful policy solutions that are in-keeping with the ACE framework.

2. Method

2.1. Study area and study sites

The study was conducted in Enugu State in South East Nigeria. The state boasts 366 PHCs and around 700 private health facilities which are scattered across its 17 local government areas (LGAs) (Uzochukwu et al., 2015) to serve a population of over 3.3 million people (National Population Commission, 2010). The State's high density of facilities is yet to translate into improved health outcomes, however, with absenteeism suggested as one of several reasons why (Daniel et al., 2016).

The study was conducted in six purposively selected LGAs, namely: Nsukka, Enugu North, Oji River, Igbo Etiti, Nkanu East and Ezeagu. Two PHCs were purposively selected in each of Nsukka, Enugu North, Igbo-Etiti and Nkanu East, while one PHC was selected in Oji River and also Ezeagu LGA. Hence, a total of 10 PHCs were included in the study. The study areas and sites were selected with consideration given to urban and rural characteristics in order to maximise our understanding of the diverse practice of absenteeism across different areas.

2.2. Study design and selection of participants

A cross-sectional qualitative research design was used. The study population included frontline health workers (doctors, Community Health Extension Workers [CHEWs], nurses, midwives and Officers-in-Charge [OICs]), their managers (Head of Department of Health [HOD] and Supervisors for Health), male and female service users and Health Facility Committee Chairpersons (HFCCs) drawn from the 10 selected PHCs. In all, 27 frontline health workers, 9 healthcare managers and 4 HFCCs were sampled. Participants were purposively selected from the local government headquarters (Supervisors for Health and HODs), PHCs (frontline health workers) and the facility catchment areas (service users and HFCCs).

2.3. Data collection

In total, 42 in-depth interviews (IDIs) were conducted with supervisors, HODs, frontline health workers and HFCCs, and 9 focus group discussions (FGDs) were conducted with service users.

Before the study commenced, the researchers visited the selected PHCs and local government headquarters to mobilise the IDI participants. The participants were first briefed on the objectives and modalities for the study so as to allow for their informed and voluntary participation. Those who were interested and gave consent in participating were asked to schedule the dates and times that were most convenient for them. The service users for FGDs were recruited through the help of the HFCCs and OICs. Most of the interviews were conducted in English, with a few exceptions in Igbo (the principal language used in South East Nigeria). This did not pose any problem to the researchers as they are fluent in both languages.

The interviews were held within the selected health facilities or, in the case of health managers, in their respective offices in the local government headquarters. FGDs were conducted at central venues away from the health facilities to enable participants to talk freely without being overheard by health workers. The IDIs lasted an average of 45 minutes and the FGDs an average of one hour.

Different topic guides were used for the IDIs and FGDs (see Annexes 1 and 2). The interviews were recorded using audio recorders with the consent of the participants. One participant (a supervisor) requested that their interview must not be recorded but agreed for notes to be taken.

The topic guides were piloted with 12 frontline health workers and their managers as well as 20 patients selected from two facilities in two LGAs in Enugu State that were not part of the main study. This pre-test helped validate the topic guides, particularly in terms of understanding ambiguous questions, identifying missing areas of the study that had not been captured in the current questions, and time management. The guides were further revised based on the outputs from the pre-test and then used to guide the IDIs and FGDs.

2.4. Data analysis

All recorded conversations were transcribed verbatim in English, with care taken not to lose meaning (van Nes et al., 2010). Data analysis then followed a thematic process whereby quotes were organised into common themes and subthemes. The researchers read five randomly selected transcripts individually to identify possible codes for categorisation. The team then met multiple times to review and merge the codes into a single set which later served as the guide for coding all transcripts. The researchers arranged their analysis according to themes and subthemes that reflected important issues that had arisen in the study as well as those raised in the reviewed literature.

2.5. Ethical considerations and approval

The study was approved by the Ethics Committee of the University of Nigeria Teaching Hospital, Ituku-Ozalla, Enugu State. In addition, ethical clearance was also obtained from the Enugu State Ministry of Health and research approval was obtained from the Enugu State Primary Healthcare Development Agency (ENS-PHCDA). All study participants provided written informed consent.

3. Findings

In this section we present a summary of our findings which is structured as: 3.1) the sociodemographic characteristics of respondents; 3.2) description of absenteeism in PHCs; 3.3) impact of absenteeism; 3.4) drivers of absenteeism; 3.5) differentials in absenteeism of health workers; 3.6) existing strategies to tackling absenteeism; 3.7) the effectiveness of existing strategies; and 3.8) challenges to tackling absenteeism.

3.1. Sociodemographic characteristics of respondents

In-depth interviews were conducted in Enugu North LGA with six frontline health workers comprising of a medical doctor, two OICs, two CHEWs and a nurse. Respondents were aged between 29 to 55 years with their educational status ranging from certificate in community health to Bachelor of Medicine and Bachelor of Surgery (MBBS) for the medical doctors. The FGD sessions were conducted for two groups (males and females) and both had 10 participants each. In Ezeagu LGA, the participants included three health workers (a midwife, CHEW and OIC), two managers (a supervisor for health and HOD), and one health facility committee secretary. The age range of participants was 31 to 58 years, with the highest educational qualification being a postgraduate diploma. In Nkanu East LGA, eight participants were interviewed of whom five were frontline health workers comprising of a nurse, three CHEWs and one OIC. The two managers interviewed included one HOD and one supervisor for health. There were more females (6) than males and the ages ranged from 44 to 60 years. Three FGDs were conducted in this LGA, two for females and one for males. Most of the participants in these FGDs had low educational qualifications, with 10 of them only having completed secondary school.

In Nsukka LGA, the participants for the IDIs included five frontline health workers, two managers and one HFCC. The frontline health workers included two midwives, two OICs and one CHEW. The managers included one HOD and one supervisor for health. Ten females were interviewed in the first FGD, and their ages ranged from 30 to 76 years. Only two of the participants had completed secondary school. The second FGD involved eight male participants who were aged between 38 and 84 years. In Igbo-Etiti LGA, IDIs were held with five frontline health workers and two managers (one HOD and supervisor for health, and one HFCC). More females than males were interviewed here. The age of the participants ranged from 27 to 69 years while the highest educational qualification was a Bachelor of Science. Finally, in Oji River LGA, only four IDIs were conducted, with three being conducted among CHEWs. Two FGDs were conducted in this area (one for females and one for males).

3.2. Descriptions of absenteeism in PHCs

Across all of the facilities studied there was at least one case of absenteeism in the days preceding the interview. Furthermore, all participants reported that there is always a case of absenteeism anytime they visit their health facility. According to participants, health workers' absence can be divided into planned and unplanned absence. When planned, co-workers

and the OIC are aware of the intended absence of a health worker and, in most cases, make provisions to fill the gaps in personnel. However, when an absence is unplanned, health workers stay away from duty without properly informing the OIC and their co-workers are left with no choice but to take on the extra workload. The study participants acknowledged absenteeism as having severe consequences for health outcomes and generally spoke against it:

'there are places you will visit and you may not see anybody, like a place like Uzo-uwani, workers normally don't stay there' (Enugu North, female FGD participant, 35 years old).

'In one of the centres... the OIC reported that there was a worker who was absent from work for a long time' (Oji River, female HOD, 49 years old).

'On a Sunday, I came to the facility but found it locked, so I asked about the nurse's house and was directed...' (Nkanu East, female FGD participant, 31 years old).

'For instance, there is a worker who is supposed to be on night duty but she didn't come and didn't tell the staff who she is meant to hand over to her and I was called by 11pm to report the lady, we called her but she switched off her phone and because of that it was the health workers that handled the labour we had then' (Nsukka, female OIC, 42 years old).

In certain communities some service users expressed satisfaction with the service delivery by health workers in the health centre. However, they also stated that there are times that the health workers are absent. In some PHCs service users reported that:

'...the workers here are very good... if you come in early, like before 7 eh 8 or 9 [am]...or in the weekends you do not expect to see anyone here...but we have their numbers. If it is urgent you can call them, then they will tell you to wait that they are here or there or if it is urgent, you can come to where they are' (Oji River, female FGD participant).

Here, it is interesting to notice how service users have adjusted to the absence of health workers, and may in fact not see it as unusual.

3.3. The impact of absenteeism

3.3.1. On service users

Service users seem to suffer the most detrimental effects of absenteeism. If patients do not receive the attention, treatment or medication that they need, they then turn to other facilities, most likely private clinics or service providers where they are charged high prices for medical care:

'patients... opt to go to private centres, private hospitals and where they pay so highly' (Oji River, female CHEW, 40 years old).

Respondents also reported that poor patients, especially in rural areas, are forced to resort to traditional medicine and to patronise unskilled persons, which leads to increases in incidences of mortality:

'It might lead to death. For instance, on people with cardiac attack, it could also lead to death or complications for women in labour' (Nsukka, female supervisor, 37 years old).

3.3.2. On male versus female patients

Although respondents agreed that absenteeism affects both genders, most participants expressed their belief that females are affected more, especially pregnant and nursing mothers. It was felt that mothers and their babies access PHC services most out of all patient groups, and therefore feel the greatest impact if health workers are absent:

'... what we see mainly in our facility are mothers and their babies ... mothers that are having babies that are sick ... female patients are prone to diseases...' (Igbo Etit, male HOD, 48 years old).

3.3.3. On co-workers

Co-workers are also impacted by absenteeism. The most obvious impact of absenteeism on other staff is an increase in their workload when they are required to cover for absent staff. Sometimes nurses and CHEWs take on the responsibilities of absent doctors, which undermines the quality of services delivered to patients.

'The workload becomes too much on the one covering up for the other person that is absent. If it is me covering for someone, it stresses me' (Ezeagu, female CHEW, 50 years old).

'Because some of the nurses have been into this practice for years, they become so good. They even could teach the doctor some things. So they cover up for the doctor, especially in PHCs. The nurses will strive to handle the case. It is only when it is beyond them that they will start calling you' (Enugu North, female Doctor, 31 years old).

3.4. Drivers of absenteeism

3.4.1. Economic drivers

Poor wage/remuneration stood out in the analysis as one of the main drivers of absenteeism. This affects health workers' motivation to work, their transport provisions and their ability to comfortably cover domestic outgoings and expenses. Hence, many health workers look for ways to supplement what they earn from the government. Other studies equally suggest that economic factors are the biggest driver of absenteeism among health workers (Dieleman et al., 2011; Belita et al., 2013; Ackers et al., 2016; Iles, 2019). Poor pay or delayed payment of salaries were reported by many study participants, and were given as justification for why health workers engage in other activities including dual practice. Ownership of private health facilities was associated more with doctors, while low-cadre

health workers were found to engage in other activities like farming and trading to help themselves financially.

'I only engage myself in farming to sustain my family because my salary is too small due to the fact that we are being denied of certain allowances unlike our Ebonyi state counterparts. I engage in farming activities so that I won't be buying certain food stuffs like garri and abacha (food products from cassava)' (Ezeagu, OIC, female, 43 years old).

'some [doctors] own private clinics because the [public] pay is small, if they pay well no staff would stress themselves over other jobs' (Igbo Etiti, female nurse, 40 years old).

'Doctors don't always come to work because they practice elsewhere... they do it as to make ends meet'' (Nkanu East, female CHEW, 26 years old).

Participants also reported that health workers diverted patients for financial gain:

'some of them will go to her (health worker) instead of coming to government /private facility for treatment. This reduces revenue to be generated by the hospital' (Enugu North, female CHEW, 29 years old).

Health workers reportedly sought additional income, despite efforts being made to provide accommodation for them:

'... when the doctor arrived, we set a place for him to stay. An honourable member of our community released a room in his house for the doctor, furnished it with our own money, yet he never lived here, not for once! It is the same thing for the OIC. We built a house very close-by. We had an OIC who lived here for 3 years, unlike these new staff, who never tried to live here for once, and that is because they have other practice. Even when they would come to work, it would be by 10 am' (Nsukka, male FGD participant, 72 years old).

Frontline health workers tend to engage in supplementary activities such as owning businesses or pharmacies, and some (especially doctors) engage in private practice in an effort to generate additional income. Many doctors at the PHC level also believe that their salary is not commensurate to the cost of their training or their inputs at work, especially when a doctor is required to cover several facilities in an LGA.

The relatively low salaries mean that many health workers struggle to meet outgoings such as transport costs and therefore find it challenging to report regularly to work. Dual practice provides a means to attain supplementary income, and hence reinforces absenteeism. It also leads to health workers diverting patients to their private clinics, which subsequently affects the revenue that PHCs are expected to generate to maintain facilities and ultimately revenue-generation for the government.

3.4.2. Drivers related to politics, power and hierarchy

Political drivers of absenteeism are multifarious and tend to arise from corrupt employment practices. Many health workers reported using the assistance of political influencers to

secure jobs when they were first recruited as health workers. And this influence continues throughout employment in order to control postings to areas where individuals can be absent from work without repercussions – either by being posted to less busy facilities, or to centres or areas where individuals have an interest that will work in their favour.

Relatives (i.e. uncles) and non-relatives (i.e. friends) who are highly regarded in a community often help people connected to them to gain employment and provide protection when the need arises. The study did not explore how this relates to the political ambitions of the so-called ‘godparents’ (powerful individuals that are not necessarily health workers that have the influence and connections to easily influence decision-making in the public sector, especially at the local government-level). However, we discovered that godparents who are highly placed use their influence in this way to protect their own relevance among the powerful clique of society or to improve their ‘scorecards’ in their communities, while others use their influence to advance friendship ties with those health workers who they protect.

‘What they do is that the political father or mother will like to link up with the HOD, to take care of the posting. And the HOD knows the capacity of each OIC, and knows who will admit nonsense or who will not...’ (Oji River, female CHEW, 50 years old).

‘sometimes, the OIC feels like reporting people ... in short I don't know... some OICs are afraid because almost all these junior workers were given jobs by politicians but don't do it because most OICs are afraid to report such people’ (Igbo Etiti, female nurse, 40 years old).

‘For me I don't know but from the little I know, it makes some of them arrogant. They would tell you to do anything you like because they have “Abraham” as a father and when you follow it civilly, you would find out that the person has someone that would make you lose your job’ (Oji River, female HOD, 49 years old).

Often the protection offered by political ‘godparents’ emboldens health workers to be lackadaisical and arrogant at work. Disciplinary actions are rarely taken against them because their managers fear the consequences, including loss of their own job.

Equally, health workers who are connected with OICs enjoy some level of protection. These relationships often result in favouritism in the work place based on affection or friendship, tribal connections or bribery in return for preferential treatment. OICs who have a good relationship with particular health workers reportedly turn a blind eye when those individuals are absent from duty.

‘A similar case is there can be favouritism in the workplace in which the OIC favours certain people more. Also, there can be bribery to those in authority; they can have an arrangement with the Officer in Charge to be collecting some percentage of his/her salary to avoid reporting to them. The person giving the bribe can do whatever they like, be present at work anytime they feel like’ (Nkanu East, female FGD participant, 30 years old).

In order to navigate this problem, one supervisor described how they always reported an absentee health worker to his or her godparent, so perhaps they could issue the warning

instead. This may be because the supervisor also has some standing in the community. Another way through which power and politics influence absenteeism is that with system deficiencies, poor transportation and a lack of living quarters in rural areas, it makes sense to retain health workers who are indigenous to those settings. However, there is a challenge with this approach. Indigenous health workers often become complacent, as they tend to be immune to sanctions and are sometimes protected by their communities. They are also difficult to replace as other health workers do not want to be posted to rural, hard-to-reach settings.

'Sometimes, the senior ones might find it difficult sanctioning a junior one, because he or she is an indigene of the place where the facility is sited' (Enugu North, male FGD participant, 52 years old).

3.4.3. Health status-related drivers

Health workers are absent for health reasons too, which is considered unplanned absenteeism. This could manifest in two major ways – either due to ill-health of the health worker or due to ill-health of relatives or those close to them. Study participants explained that ill-health can be a driver of absenteeism when health workers are ill themselves, or when those who are close to them fall sick and require care. In this case, the health worker could take sick-leave or may be granted permission to take time off to care for his or her loved one.

'I could not come to work last week. I was ill as a result from stress. I overworked myself. So I had to rest' (Enugu North, female doctor, Female, 31 years old).

'[F]or some, it will be ill health ... like I have one of my staff that have been absent for more than 2 weeks now. So, when I called and called, I see that the situation is not all that okay' (Igbo Etiti, female OIC, 37 years old).

3.4.4. Sociocultural drivers

Respondents reported sociocultural causes of absenteeism for health workers, which involve unavoidable domestic commitments or responsibilities. We observed that this affects women more than men. These factors include domestic work such as home-keeping, cleaning, cooking, washing, and caring for others such as children, the sick and the elderly.

'Attending social activities like weddings and funerals which is unavoidable as human beings could cause it. I skipped work last Friday as I went for a burial ceremony' (Ezeagu, female OIC, 43 years old).

'There is my sister who has eye problem. I am the one that usually takes her to Park-Lane Enugu for treatment and each day I go, like last Friday, it will make me to miss work. The other day, one of them complained that her child is sick. Also, one of us had a minor accident and it is inhuman to tell her to resume work immediately in that condition. So, I volunteered myself to cover her' (Nkanu East, female OIC, 51 years old).

The finding that sociocultural factors are a major driver of absenteeism among health workers was expected, based on existing studies (Dieleman et al., 2011; Oche et al., 2018). This is because cultural practices play a central role in the daily lives of Nigerians. Events like funerals, wedding ceremonies and religious gatherings were listed by study respondents as other sociocultural factors that cause absenteeism of both male and female health workers. In these cases, we found that health workers generally manage to arrange cover for their work, whereby a colleague will take on a shift and the same favour is returned at another time. Of course, health services suffer if another health worker cannot be posted to cover for the duties of an absent colleague.

Since cultural roles and responsibilities are understood and accepted in the community studied, health managers often hesitate to sanction (female) health workers who are absent for such reasons. This poses a challenge for efforts to curb absenteeism, however. One of the participants elaborated: *'women, child-bearing women, they always give excuse with their children going for school run, their children, they give excuses'* (Igbo Etiti, female OIC, 37 years old). Family and domestic responsibilities often determine whether disciplinary actions are taken against female health workers.

Related to this, Isah et al. (2008) report that married health workers are absent more frequently than their unmarried colleagues, which could be associated with the mostly unpaid work that is expected of married women. Hence, while women are absent from work primarily due to household chores and childcare, men are absent as they engage in dual practice and private businesses in order to earn additional income and fulfil their role as their household breadwinner.

3.4.5. Drivers related to road infrastructure and access to transport

All study participants reported that transport-related factors influence absenteeism. They reported that most health workers do not live close to the health facility within which they work, and that the majority rely on public transport which brings with it challenges regarding reliability, access and cost. Many respondents complained of being unable to pay for their transport fares, owing to poor wages or delays in payment. Participants also mentioned distance and bad roads that make health facilities inaccessible for some workers. Cases were mentioned where National Youth Service Corps (NYSC)¹ doctors reject deployment to such rural areas and where supervisors shun their responsibilities. These challenges are heightened during the rainy seasons, when roads to PHCs in rural areas may become even less accessible. The lack of available living quarters close to PHCs makes matters worse for health workers.

¹ The NYSC scheme was set up by the Federal Government of Nigeria in 1973 to involve Nigerian graduates in a compulsory one-year service to the nation. It is a mandatory service scheme for all graduates of higher education who are below 30 years, which aims to involve Nigerian graduates in nation-building and development of the country. The young graduates can be posted to anywhere in the country. They are usually monitored and failure to meet the requirements for successful completion may lead to sanctions such as an extension of service period. This may have contributed to the reported dedication of NYSC doctors.

'You see, when I say mobility, the system of transportation here is very expensive ... for me to go to Udeme from here, you must spend N500 or more to go to that particular health centre, and also coming back. You see, you know the implication' (Igbo Etiti, male HOD, 48 years old).

Transportation difficulties are further compounded by poor pay and climatic conditions:

'I sometimes run out of funds and I have to walk a long distance to come to work. Also, in the afternoon if I should remember the sun I wouldn't want to go out' (Nsukka, female midwife, 25 years old).

'...even health workers find it difficult to trek long distances because of bad roads, it is worse during rainy seasons' (Nkanu East, female CHEW, 50 years old).

To navigate this problem, health workers reportedly design rotational shift patterns that may require staff to cover shifts spanning as long as a week, while other colleagues stay absent. Such arrangements enable individuals to save money and/or limit the difficulties they face when travelling to their health facility.

3.4.6. Health system-related drivers

Particular inefficiencies in the primary healthcare system also encourage absenteeism. This includes poorly patronised facilities, understaffing, shortages of equipment, inadequate working conditions/amenities, lack of security and weak supervision/sanctions.

'Nurses come late because patients don't come on time. For instance, a nurse may come by 10am and patients come from 12 noon, some patients will go home to come back later. The nurse will not like to come early because there will be no patient to attend to, if she is early. At a point they continued having few patients' (Nkanu East, male FGD participant, 50 years old).

Low rates of service use for some health facilities can relate to the lack of equipment in such PHCs – users know that certain centres will be unable to offer particular services to them because of their structural limitations:

'Another reason for absenteeism is government stoppage of free drugs at PHC level. This makes people not to visit health centre unlike before. Sometimes in a day, nobody will enter the health centre to check his/her blood pressure. This makes health workers to prefer staying at home than wasting transport fare which could have been planned better. They will just lock up the facility and go home...' (Nkanu East, female HOD, 49 years old).

Similarly, some participants were of the opinion that health workers are also absent because they lack the equipment that they are supposed to work with. These shortages in resources reduce the number of patients that attend facilities, which results in even more health workers choosing to be absent – a vicious circle. To the other extreme, there are facilities where health workers face excess workloads and therefore might be too weak to report for work the following day. This is common in rural areas where staff shortages result in excess

workloads for the few staff serving a particular facility, which often also lacks basic amenities and is hard to reach as well. In circumstances such as this, opportunities arise for health workers (especially senior ones) to employ volunteers to cover for them whenever they are absent, which results in even worse service provision by unqualified individuals.

Regarding understaffing, participants opined how difficult it can be for poorly staffed facilities to manage planned absences, especially when a health worker might need to attend official assignments outside the facility. This could mean that less competent health workers take on responsibilities that are beyond their skills or qualifications at critical times. It also causes stress for the few health workers who have to cover colleagues' absences, which in turn could cause them to not attend work for a period of time.

'when the staff are too small, you come to one PHC, you see three staff managing a PHC, not morning, not afternoon, but three managing the whole facility for the whole period' (Oji-River, female CHEW, 50 years old).

'...it might be attributed to workload because when you look at the strength of the workers at the facility, they are often short staffed' (Igbo Etiti, male HOD, 48 years old).

Participants also cited official responsibilities as enabling or causing health workers to be absent from their PHC during working hours. This includes trainings/workshops/seminars, immunisations, reporting accounts or attending meetings at the LGA headquarters, depositing money at banks and purchasing drugs, all of which provide legitimate reasons for a health worker to be absent from their primary place of work.

'...sometimes as the OIC I run errands like going to collect drugs from the central medical store in Enugu, going for calls at the centre... most of the time I will not be in the health centre, but my second will be there...' (Oji River, female OIC, 50)

Scheduled meetings with the LGA Chairman or HOD at the local government headquarters can be a challenge for some health workers, as the headquarters may be situated far from their PHCs.

'...we may have meeting with chairman, with all the OICs coming for the meeting ... something like that... definitely it will affect them...' (Igbo Etiti, female CHEW, 27 years old).

Lack of living quarters and insecurity were also found to encourage absenteeism, especially for night shifts. This is a particular concern for the predominantly female workforce within PHCs:

'The distance affects, because before the OIC ought to live in the portal (a staff quarter) where she can be called at any time because of emergency. But because of the situation of the government now, we don't have such a portal anymore, and this is why I live outside the premises. If I am called that there is emergency, I might find it hard to get to the facility' (Nsukka, female OIC, 42 years old).

'When there is no security in health facilities, the workers become afraid to live in the staff quarters or work at night shifts. Security personnel should be provided in the PHC. Ideally, young male security personnel to protect female health workers and challenge any notorious activities around the facility. At least two should be employed. One will work in the morning and the other at night' (Nkanu East, female CHEW, 50 years old).

Weak security provisions make many health workers uneasy in their workplace – especially during night shifts – which can mean that staff leave before clinics are due to close. Respondents cited fear of attack or rape, which is a very real threat to the female workforce. In some cases, workers choose to stay at home and provide their phone numbers on facility noticeboards so that patients can contact them when they arrive. Respondents reported issues such as poor power supplies at PHCs and risks such as malaria as driving absenteeism among health workers too:

'The facility is secured, that is why we do night shift. But we have lots of mosquitoes here which makes us to have malaria, especially those in night shifts. Also, no power supply. And it disturbs the night shift very well, which could make one absent' (Enugu North, female CHEW, 54 years old).

Study participants also described how supervision can be ineffective – particularly in rural areas where roads are poor and transport costs cannot be met – which means that absenteeism continues unchecked. Indeed, poorly supervised facilities were found to have more frequent occurrences of absenteeism than facilities that were often supervised:

'places without supervisions have more absenteeism, this is because they know no one is coming to supervise them. If supervision is high, coming to work is consistent unlike places that lack supervision' (Nsukka, female OIC, 42 years old).

'...these workers, if you don't supervise them, they wouldn't go to work' (Nsukka, female midwife, 25 years old).

At the same time, supervisors complained of the numerous facilities that fall under their responsibility as well as the facilities in hard-to-reach areas that pose challenges to them too:

'... being the HOD, my job is elaborate. I have 37 health care centres to supervise and in this case, I will only know about absenteeism in these health centres when I am informed. Monthly, I plan for visitation to know the number of staff present in a facility' (Nsukka, female HOD, 48 years old).

'We can't close the hospital at any time because it is along the road even when there is no supervision going on. It is a must that the supervisors would come here, and even during Christmas periods, we don't close the health centre. If you are on duty on Sunday, you can't go to church' (Igbo Etit, female CHEW, 38 years old).

Finally, not considering the families of health workers when postings are allocated to staff was seen as poor practice by study participants. This is because health workers who are posted far from their families often give excuses to visit their families, which results in absenteeism. Doctors being posted to work at multiple facilities within the LGA is a further inefficiency.

While some of these infrastructural defects and issues of weak governance are reported in previous studies (Kiwanuka et al., 2011; Obioha and Molale, 2011; Belita et al., 2013), many are novel findings.

3.4.7. Gender

Participants agreed on some gender-based attributes of absenteeism, including that males engage in planned absenteeism through dual practice more than female health workers, and that they are also more likely to engage in other economic activities like private businesses before reporting to their PHC. It was felt that this predominantly male behaviour was so that the individuals in question could make more money to fulfil their breadwinning role within their family.

'... women are more punctual to work by nature. They are more sympathetic than men. Men are always anxious how to get money to take care of their families. They don't care even if someone will die' (Enugu North, male FGD participant, 52 years old).

However, given that PHCs are mainly populated by female health workers, some respondents felt it was difficult to make specific statements regarding gender dynamics as male health workers are scarce and therefore comparisons cannot be made.

One respondent said, 'it is difficult to answer this because PHCs are like primary schools, where you have almost everyone as females' (Enugu North, female doctor, 31 years old).

However, another respondent stated that: 'Women are more absent from work because of their roles in the family and biological makeup. Maybe she is still young and at child-birth bearing age. She may wake up in the morning and will say that there are some changes in her body, then will not want to go to work. Also, their roles in the family to look after their families, cook and wash. They will be tired before going to work. She can even decide not to bother going to work that day' (Nkanu East, female FGD participant, 33 years old).

Also, as mentioned above, caregiving and domestic responsibilities affect women more than men, therefore gender dynamics are at play here. Participants suggested that female health workers were absent more often than male colleagues, but this reflects the fact that PHCs have a predominantly female workforce and that women bear the burden of caregiving and domestic responsibilities in their household. We observed the trend that female health workers who have adult children feel this burden less as their childrearing responsibilities dwindle over the years, but participants also mentioned that such individuals might still have older parents to look after.

Marital status is also a factor, as married women face increased household responsibilities that they must balance with their professional lives. Some husbands can put pressure on their wives to avoid working night shifts too:

'A staff was posted on night duty and the husband was saying he would be the last to let his wife come on night duty and we had to plead with him to let his wife finish for that week' (Nsukka, female OIC, 42 years old).

3.5. Differentials in health worker absenteeism

3.5.1. Clinical role: doctors versus nurses

The study respondents – particularly patients – expressed their belief that doctors are more absent than nurses, since they are hardly seen within PHCs. Various other reasons were given for doctors' absences, including: that they are not paid commensurate to their work inputs which motivates dual and/or private practice or other economic activities to improve earnings; that doctors feel that certain tasks can be performed by nurses or CHEWs, so they leave the work for them; that doctors are usually employed part-time by the local government to provide services in several PHCs in return for low or no incentive at all; and finally, that doctors consider themselves above sanctions by the OICs in PHCs or HODs that are mostly nurses or CHEWS, because of their superior training and because doctors are central to the politics of health-sector leadership.

'...it is very common among doctors. They will have more than one health centres where they work. That is why you don't see them around when you need them' (Enugu North, female FGD participant, 31 years old).

'Doctors take themselves as demi-gods. When the doctor comes to a health facility, they just feel that every person should bow to him or her. Whether he comes at 12pm or 1pm, nobody talks to him. He already knows that any patient coming to the facility is looking for a doctor... You can see that even the Chief Medical Director won't have the boldness to caution an erring colleague who is a doctor like himself or herself. Ministers and Commissioners of Health are all doctors, and that is why it seems the doctors have this immunity from sanctions' (Enugu North, male FGD participant, 52 years old).

Doctors tend to be the most qualified and highest ranked staff within health facilities (although they may not be in charge of PHC facilities), which can make them feel superior to other health workers, including the OIC.

Participants agreed that doctors on the compulsory NYSC scheme are more dedicated than others. However, it was felt that most of these doctors reject postings to PHCs because of distance and transport difficulties. Instead, doctors at the PHCs are primarily visiting doctors, who are frequently absent or late to work, especially in rural areas.

'There is need to encourage them but the doctor is not always there, even on Mondays that they said he comes. Even if he will come, it will be as from 12 noon. He is working in another

facility which hinders him coming through on time’ (Nkanu East, female FGD participant, 21 years old).

Lastly, one respondent – a doctor – felt that nurses are absent more often than doctors, but that they are protected by the shift patterns of work:

‘... But I know that nurses run shifts, and it makes it quite difficult to know when they are absent’ (Enugu North, female doctor, 31 years old).

In summary, the participants stated that doctors were more absent than nurses and that doctors are hardly seen around the facilities due to several reasons such as poor pay, dual/private practice, engaging in other economic activities, poor amenities, and having to work across several facilities. Additionally, participants suggested that the status and superiority of a doctor within the health sector can influence absenteeism. In particular, Kisakye et al. (2016) reported high absence rates among doctors who are responsible for mentoring other health workers.

3.5.2. Professional level: junior versus senior staff

Absenteeism was found to be more pronounced among senior health workers than junior staff, owing to the hierarchy within PHCs that affords senior health workers more authority. As such, senior staff can be absent consistently without any form of resistance from junior colleagues:

‘...the thing is this, as you grow in practice, you tend to control so many people. And when you are the boss, less check on you. So our consultants are more absent’ (Enugu North, female doctor, 31 years old).

‘It is mostly common among senior workers ... the junior ones adhere more to work’ (Nkanu East, female OIC, 51 years old).

A few respondents argued that absenteeism is a general phenomenon and it isn’t limited to senior staff. When individuals are confronted about their absences, however, junior health workers appear to show some remorse while senior workers do not:

‘Sometimes we catch the junior ones while other times, we catch the seniors but most times they barely show concern, unlike the juniors who would listen to you, the seniors don’t’ (Nsukka, male HFCC, 47 years old).

Often it is junior health workers who run a facility, but patients prefer to be attended to by senior staff. Patients get discouraged, therefore, whenever senior practitioners are unavailable. Participants felt that senior health workers possessed the connections to employ volunteers to work for them in their absence. Although some participants argued that absenteeism occurs equally among junior and senior health workers, they explained that junior staff are quicker to show remorse when they are caught. Absenteeism by junior staff is often tied to political protection by ‘godparents’ or other powerful persons who carry authority in their place of employment.

3.5.3. Geographical location: urban versus rural staff

Absenteeism occurs in both rural and urban areas, but incidence levels differ, owing to geographical particularities. In some rural areas health workers receive less supervision because bad roads and large distances hinder regular visitations from their supervisors. This can result in rural workers paying less regard to their posts than their counterparts in urban areas who receive closer supervision. Study participants mentioned that health workers in rural facilities can leave their duty posts to attend to farm responsibilities and even to sell produce at markets. It was reported that some rural workers even employ volunteers to work for them:

'It is the rural areas because workers don't come to work and others will go as far as employing some volunteer workers who will be working on their behalf' (Ezeagu, female CHEW, 50 years old).

'Absenteeism is more in rural areas. The PHCs especially. And that is because of poor supervision' (Enugu North, female doctor, 31 years old).

Unlike in rural areas where PHCs face staff shortages, health centres in urban areas have large teams of staff and therefore can adjust rotas and cope when staff members are unavailable to work. Some health workers gave the dearth of social amenities as a reason why they could not work in rural postings. Given these negative attitudes towards working at rural facilities, the consequence is that PHCs in these settings are often closed and staff members turn to farming and trading as sources of supplementary income. Chaudhury et al. (2006) suggest this is why health inequities affect rural populations in Nigeria more than urban populations.

3.6. Existing strategies to tackle absenteeism in the health sector

As part of the study we considered how absenteeism is already being tackled at the primary healthcare level, looking at both internal and external strategies.

3.6.1. Facility-centred strategies

Internal strategies exist to tackle absenteeism. Study participants reported measures including staff dialogue, strict rules that are set and managed by OICs, rostering, attendance registers, the issuance of token gifts by managers to incentivise attendance by health workers, managing staff in the case of planned absences, and the withholding of salaries.

'For instance, if a junior worker doesn't come to work for two days, you ought to call her and know what is wrong and with the psychological training, you would know that the worker is going through a lot and then you permit the person' (Nsukka, female OIC, 42 years old).

'The day I resumed work as the OIC, I gave them my rules and regulations in the first meeting I had with them, and this is why some of the staff are working for a transfer when they can't work with me because I don't tolerate nonsense' (Igbo Eteni, female nurse, 40 years old).

Many study participants considered OICs to be important internal stakeholders who were in a good position to help tackle absenteeism. It was reported that OICs at times query staff absences and may refer cases to senior managers:

'I gave them a query and sent it to the HOD, who sometimes writes for some people "do not pay" [their salary], once that is done, they start running around. Ah! They instantly change, especially when they hear the salaries of those workers were seized for up to six months' (Igbo Eteni, female nurse, female, 40 years old).

Clocking in and out was considered inefficient by some study participants, while duty rosters and attendance registers were hailed:

'Biometrics does not work for health centres. And that is because the machine is at the local government headquarter. It is not possible for health workers to go to the headquarter and clock-in before coming to their facilities, due to the sensitive nature of their work. It is only this our constant check, duty roster, and possibly their time-register that can help' (Enugu North, male HFCC, 55 years old).

Token gifts were also considered effective in reinforcing the commitment of health workers:

'Yes, incentives! Sometimes I have disinfectants, detergents and bleach that I might give out to workers. But if you are the best, let us say I usually give two detergents, I would give you five and if I am giving out 3,000 naira then I might give you 5,000 naira and this would prompt them to come to work' (Nsukka, female OIC, 42 years old).

On staff cover, one participant explained: *'Except if the person would exchange her shift with someone else. Which is like someone else would work for her at that time she wants to attend the social function, and she would work during the person's own shift' (Enugu North, male HFCC, 55 years old).*

Other effective measures reported by study participants include punishing late and absent staff by taking away benefits such as days off, denying bonuses accruing to staff, and refusing permission for their attendance at seminars and workshops.

3.6.2. Community-centred measures

The effective operation of health facilities is also kept in check by the Health Facility Committees (HFCs) that comprise local community members. The committees are headed by a chairperson and include other members to form an executive team. The commitment of the HFCs to undertake regular visitations to PHCs is usually driven by the desire to see things work and the extent of engagement and recognition from the local government authorities.

These committees monitor the attendance and performance of health workers and pay attention to particular needs of health facilities that can be addressed locally. We found that in PHCs where HFCs make regular visits, participants reported low unplanned absenteeism.

'You should know that health centres in rural areas are most times monitored by community members and if there is anything they might likely report' (Oji River, female CHEW, 40 years old).

'[The HFCC] would visit on a daily basis to look at the workers and how they appear for work in their uniforms, their attitudes to patients and could provide them with minor equipment that are missing. Since they know their responsibility to the facility within their community, it helps them check the facility, they would know what is happening in their community and give us feedback' (Oji River, female HOD, 49 years old).

Although some committees seem not to feel empowered enough, others actively engage with senior figures such as paramount rulers (traditional state rulers in Nigeria) to ensure that their health facilities operate effectively:

'We write petition to the HOD through the OIC. Sometimes we extend their shifts. Though my powers are limited, that's the reason why I intimate the HOD or OIC first ... We the committee make surprise visits at times, but myself who is the chairman do come frequently. When I come I try to find out those who are on duty. If I discover that one is always absent or not serious with the work, I call the HOD ... This community does not joke with this facility. The King even comes in at any time to check what is happening' (Enugu North, male HFCC, 55 years old).

Suggestion boxes in some LGAs serve as a reporting platform and enable health service users to directly notify the local government of particular instances of absenteeism and inappropriate behaviours. Alternatively, service users can report absenteeism to community leaders or HFCs who then report incidences to the appropriate authority. Mob action was also reported by participants when community members protest about the poor attitudes of health workers and the impact this has on patients and service delivery.

3.6.3. Local-government measures

Local governments control PHCs and are headed by a chairperson. In turn, the department of health within a local government is headed by an HOD and a supervisor. The Head of Personnel Management (HPM) is also important because they are responsible for recruitment and pay-roll for healthcare staff within a local government. Together, these individuals represent important external stakeholders and opinion-formers in local government who have a role to play in tackling absenteeism.

Although implementation was reported as poor in some local governments, certain measures have been introduced in an attempt to curb absenteeism by health workers. Strategies include the use of biometrics to clock in and out of work, the withholding of salaries, transfers and unannounced supervision.

'There was a new law in Enugu State that everybody must thumbprint in the secretariat in the morning and in the evening. We did it for one week, and we found out that the health centres were closed. The chairman later agreed that health workers should not thumbprint' (Igbo Etiti, female CHEW, 38 years old).

Unfortunately, the biometrics policy did not consider the distance between the respective health facilities and the local government offices where scanners were located, transportation costs or other logistics. In the end, the policy failed and reportedly increased absenteeism: health workers would sign in at the local government headquarters and refuse to go back to their facility until it was time to sign out. Participants suggested that the scanning devices should be kept at the facilities instead of being centrally located. The local government later focused on attendance registers and queries/reported cases of absenteeism sent by individual OICs. Perpetrators are marked for possible deduction of salaries at the month end, while at times salaries are completely withheld until a health worker is invited to explain their reasons for being absent from work.

'We take the attendance register to the authorities and it is being marked and if anyone is absent, then their names are marked with a red pen, and at the end of the month, something is deducted from their salaries' (Nsukka, female OIC, 42 years old).

Implementation of such measures varies across LGAs, however, and respondents reported different levels of success. Some participants reported that attendance registers are not requested: *'they haven't requested for it since we stopped thumb printing but I don't know if they would request for it again but all of us are writing our names' (Igbo Etiti, female nurse, 40 years old).*

Absentee health workers may be transferred to another PHC, but this is not a reliable solution to absenteeism either as the individuals repeat their behaviour at their new posting.

Another measure often utilised by the local government to curb absenteeism is the unannounced supervision of health workers in their workplace. Such supervision is not evenly spread across facilities, however: *'there are so many facilities to cover and when you look at all these facilities, you may not cover them, considering the financial implications' (Oji River, Female HOD, 49 years old).* A supervisor in one of the LGAs developed a strategy of involving the political 'godfather' of the absentee health worker. She explained: – *'when I am sanctioning a staff that has some political protection, I talk directly to the godfathers, make them understand the implications of the actions of the staff, so we would find a solution' (Nsukka, female supervisor, 37 years old).*

Finally, respondents suggested that LGAs should consider the families of health workers when PHC postings are assigned to individuals, so that health workers are less likely to use visiting their family as an excuse to be absent from work:

'The only thing they complain about is the posting of married workers far from their families as well as where their husbands work. This is why I have a register with all the necessary information about all my workers (points at it), so that we can consider them during posting.

Since I resumed work as the supervisor of health, I discuss frequently with my HOD to make sure they are not posted wrongly' (Igbo Etiti, female CHEW, 38 years old).

3.7. The effectiveness of existing strategies to curb absenteeism

The study explored strategies that are already in place at various levels to curb absenteeism. At the facility level attendance registers and duty rosters were reported by participants as being very common. Health workers at the beginning of each working day are expected to sign-in, and duty rosters help to notify those in charge as to who should be present and working at a facility at a given time. This strategy is effective only when it is constantly requested by the local government authority and employed as a means of paying salaries. However, as our findings showed, they are hardly requested by the authorities, so this does not serve as a reliable means of curbing absenteeism. One facility in particular included health workers' phone numbers on the duty roster to enable service users or supervisors to contact absent health workers. Unfortunately, communication and transportation challenges (especially in rural areas) often delay health workers from reaching a facility during emergency periods. Another facility made use of a 'permission book', which health workers leaving a facility during working hours are expected to sign, stating where they are going, and the duration that they will be absent from the facility.

As previously described, a biometric device was introduced by LGAs for health workers to clock in/out. It was believed that this system would make clocking in easier and prevent the forgery of signatures, however study participants reported limitations. The location of the scanner in relation to PHCs resulted in lost productivity and higher transport costs for workers, and it was reported that many workers clocked in, proceeded to their private business and did not return to the facility until it was time to clock-out. Absenteeism increased because of this measure, so participants were of the view that implementation was poor and the devices were ineffective at reducing absenteeism.

Community-centred strategies towards curbing absenteeism of health workers focus on the role of the HFCs, which are able to monitor the welfare and whereabouts of health workers. Although HFCs do not have the authority to sanction health workers, they may confront or counsel individuals or report instances of absenteeism to the HOD or supervisor at the LGA headquarters for action. This strategy has been effective at curbing absenteeism to a degree. However, HFCs complained that they did not feel empowered and that they receive no incentives to perform their duties. It was also found that the traditional (paramount) rulers make surprise visits to facilities in some communities also, and that they take the issue of absenteeism seriously. This strategy is quite effective in curbing absenteeism because the traditional rulers are quite influential and could initiate the removal of a non-performing health worker. Some LGAs set up suggestion boxes at facilities to serve as a reporting platform for service users, which means that personnel at the LGA become aware of cases of absenteeism and can take appropriate action.

Existing strategies for curbing absenteeism at the LGA level have proved useful in curbing absenteeism but may not produce the desired results in the future. This may be blamed on weak or non-existent synergies between important stakeholders (i.e. HFCs and paramount rulers) in the community where the health centre is located and local government authorities like the LGA Chairpersons, Supervisors for Health, HODs and HPMs. Moreover, these strategies can be weakened by poor implementation and a lack of will to deal decisively with the issues at hand.

3.8. Challenges to tackling absenteeism in the health sector

Certain factors challenge efforts to curb absenteeism, including political influence, HFC shortcomings, infrastructure, gender and ethnicity.

3.8.1. Political interference

Many study participants agreed that political influence can hinder sanctions against absenteeism. Facility heads and even administrators at the LGA headquarters fear losing their own jobs when they are faced with sanctioning errant health workers who have a relationship with political elites:

'Well ... from what I can see now, politicians bring in their candidates ... so when you are talking to somebody, its somebody's candidate, the person will be behaving anyhow' (Igbo Eteni, female OIC, 37 years old).

'I don't know, but some people who have relatives like the chairman, governor, etc., there is the kind of punishment you will give to such person that you will be in problem. So I avoid giving punishment. The highest you can do is to report the person to the HOD, and maybe the HOD won't take it so serious, and the person would start feeling that you can't do anything to her' (Enugu North, female OIC, 46 years old).

Additionally, a Commissioner of Health who is a medical doctor may find it difficult to apply sanctions to other doctors of the same rank. For instance, a Commissioner would find it difficult sanctioning a former Commissioner of Health, who has served his term but has returned to practice in a health facility.

Less powerful protection may also be offered by OICs and HODs who assign particular absent staff to posts where less is required of them, or who refrain from punishing staff members who are connected to them. We found that some OICs favour certain staff over others even when they break rules. In addition, health workers sometimes collude, as described by one of the study participants:

'Sometimes I find out that there seems to be certain agreement between the OICs and the staff. A health centre with eight staff and they are all in good terms? you should think twice about it because it is either they have converted the health centre into private business or they might be doing some other things different from what you asked them to do, but when

you separate them, you would see war! Some would call politicians and they would question you on why you had to remove a staff. I did a transfer when I started my job and since last year I have been fighting war (Nsukka, female HOD, 48 years old).

3.8.2. Shortcomings of Health Facility Committees

Representatives of HFCs felt that they were ineffective in their roles for two reasons. First, they fund themselves and there is no incentive to regularly check on health workers. Often, individuals wrongly assume that they will receive remuneration for a role within the HFC, despite being told otherwise, which influences their decision to vie for a position. Many then back down when they realise that their responsibilities are on a voluntary basis. Moreover, many HFC members do not live close to health facilities and subsequently they find it difficult to make themselves available for meetings due to the lack of pay or allowances:

'It is not easy, they said it was a voluntary job, and in the course of our training we were told that there wasn't any form of remuneration. We thought it was a joke, and all this while there hasn't been any time they said take this or that' (Nsukka, male HFCC, 47 years old).

'To my colleagues, it has affected them seriously to the extent that when you text them to come around they wouldn't, we are 12-15 in number but during the meetings you would just see 2 members and hence our motives are being denied due to the lack of incentives' (Nsukka, male HFCC, 47 years old).

Second, most HFCs feel powerless to punish absentee health workers. This demotivates some committee members and so they make themselves unavailable for meetings and other tasks.

'That health centre you are seeing; the workers are not answerable to the community which is why we can't take certain actions. I think they are answerable to the local government. We don't even have the power to sanction any of the workers and even when you take the case up it is seen as a witch-hunt and that you want them to lose their job. So, we really don't have anyone to report to' (Oji River, male FGD participant, 53 years old).

3.8.3. Gender considerations

Since gender and family roles are understood and accepted in the community studied, health managers will hesitate to sanction workers who are absent for reasons relating to their family or domestic responsibilities. This gender dynamic poses a challenge for efforts to curb absenteeism among health workers.

4. Conclusions and recommendations

While studies exist of absenteeism among health workers in non-African countries (Belita et al., 2013; Ackers et al., 2016; Iles, 2019), there are only a few studies in African countries (Chaudhury et al., 2006; Oche et al., 2018). On the whole, existing studies concentrate on higher-level facilities and barely explore absenteeism and the related dynamics in PHCs. With its focus on absenteeism at the primary care level in Nigeria, the current study contributes towards filling this knowledge gap.

Our study participants perceived absenteeism to be common in PHCs, manifested as both planned and unplanned absences. This corroborates the findings of other studies of health-worker behaviour in Nigeria (Chaudhury et al., 2006; Oche et al., 2018). Several studies also explore the impacts of absenteeism (see, for example, Ackers et al., 2016; Oche et al., 2018; Iles, 2019). In the current study we observed that health workers are affected by excess workloads due to the absence of colleagues, but that female patients and their children feel the impact of absenteeism most, since they are the primary users of PHCs. Male patients are affected when they assist their wives or children to secure health services at a facility. Unsurprisingly, the quality of health services is affected by absenteeism too, owing to the fact that less qualified staff often take on the responsibilities of higher qualified absent staff.

We identified several factors that motivate health workers to be absent from duty, some of which mean that health workers alone cannot be blamed for their behaviour. These drivers include economic, politically induced, health-related, socio-cultural, transport-related, health structural and gender-based factors. We found that absenteeism is also influenced by the cadre of the health worker and the geographical location of the PHC.

All of the above drivers influence health workers' decisions to be absent from their place of work, but it is difficult to say which has the biggest impact. From the study participants' responses, economic causes seem to dominate (such as inadequate pay or lack of incentives to work, and opportunities to earn additional income via other means). This is followed by structural inefficiencies (understaffing, equipment shortages, lack of security, etc.), before the influence of sociocultural factors (caregiving, domestic responsibilities and religion) and political relationships.

Voluntary or planned absenteeism is often brazen, where political protection supports absenteeism or where workers decide to focus on private or dual practice for financial gain. Adaptive or unplanned absenteeism arises when health workers struggle to cope with the challenges of their roles or facilities. Distinguishing between these forms of absenteeism is important in developing anticorruption approaches.

4.1. Recommendations

Interventions will be more effective at reducing absenteeism if they focus on particular settings and types of staff such as those in rural PHCs, female health workers and doctors. It may not be possible to tackle absenteeism that results from failings in infrastructure using a

horizontal approach (feasible mechanisms that can be implemented by LGA and grassroots stakeholders working together). Instead, within-facility strategies are likely to have a greater impact, including strengthening leadership within PHCs and helping health workers to better manage competing priorities in their home and work life to reduce absenteeism.

4.1.1. Horizontal approaches to tackle absenteeism

These include transparency based approaches and partnership approaches.

4.1.1.1 Transparency based approaches

- Suggestion boxes should be installed at PHCs that are monitored regularly by LGA personnel to enable service users to anonymously report absentee health workers.
- Health workers' phone numbers should be included on duty rosters so that individuals can be contacted if they are absent from scheduled work. This will make it difficult for health workers to claim that they are unaware of particular shifts. PHCs exploring policies that are sensitive to achieving a balanced work and family life, with particular attention paid to the expected roles of women, who make up the majority of the health workforce.

4.1.1.2 Partnership-based approaches

- Given the nature of the sector and the role PHCs play in communities, partnership-based approaches could be put to better use here than in sectors that are more market-focused. HFCs could be better used to increase community ownership and participation in the supervision of health facilities and staff. HFC members may not necessarily be given a salary but they should be sensitised on the importance of their role. HFC members could be given the responsibility of monitoring attendance registers and duty rosters, for example.
- LGAs should monitor the practice of employing volunteer workers to cover for absentee health workers. Such employment should be overseen by the LGA and not the health workers themselves.
- Local influential people, including paramount rulers, should be informed of the nature of absenteeism within health facilities in their communities and should be encouraged to support the actions of HFCs in monitoring PHCs. The culture of respect given to paramount rulers in Nigeria should be used to curb absenteeism.
- Communities should reduce the involvement of health workers in certain sociocultural events such as burials or other ceremonies, or should lower the expectations for health workers to attend. It is difficult to predict how boundary partners such as community leaders will react to the exclusion of health workers from particular social events, however, and how health workers themselves will view this exclusion.
- LGAs should pay greater attention to reports of absenteeism from HFCs and should take action when they receive notification of misbehaviour. Through proper recognition and empowerment from the local and state government, health committees could help apply the pressure needed to encourage health workers to report to work.

- LGAs could build a stronger partnership with HFCs and OICs and establish clear codes of conduct on absenteeism for health workers and other key stakeholders to follow.
- OICs should be supported to apply to relevant donor agencies to provide living quarters at their facilities, to improve the amenities available and to provide the necessary equipment to deliver quality health services.

4.1.2. Vertical approaches to tackle absenteeism

Although horizontal approaches to tackling absenteeism are more feasible than vertical approaches, the latter warrant consideration as there may be some benefits. The limitations of vertical approaches, or anti-corruption policies enforced in a top down manner, are recognised as not being feasible in the short to medium term. However, as outlined in the introduction, we also recognise the need for complementary ambitious anti-corruption reform in the longer term. This section may inform decision-makers who are interested in resource allocations to plan and implement vertical approaches. Vertical approaches will involve some assistance from authorities within the State and Federal government, but it is recognised that they might not be feasible in the short term owing to political complexities. Such approaches include:

- Sufficient funding should be provided to PHCs through increased budgets. This would resolve issues such as equipment and drugs shortages, understaffing and wage delays or shortfalls.
- State and Federal governments should invest in improved facilities for health workers. The provision of comfortable living quarters within close proximity to PHCs, a reliable power supply, adequate security, affordable transport services and good road networks would go a long way in curbing absenteeism. Health workers would feel safe within the PHCs, which would increase their willingness to work (particularly at night).
- Biometric scanners should be installed at individual health centres for clocking in and out. Although costly, this would resolve the issue of health workers needing to travel to LGA headquarters to clock-in and out on daily basis.

4.2. Limitations of the study

The study was undertaken at the primary level of health care only, and therefore the findings may not fully represent all cadres of frontline health workers. Research conducted at the secondary or tertiary level would enable comparisons to be made of absenteeism across the health system and could reveal different results.

A further limitation is that we could not interview more doctors as many were shuttling between different PHCs within the LGAs. Additionally, the study relied on reports from health workers and other stakeholders, therefore future research would benefit from long-term observation of PHCs whereby researchers conduct random visits of facilities to know how and when health workers report to work.

Despite these limitations, the study has generated new knowledge about absenteeism at the primary healthcare level in Nigeria, providing insights on behaviours, drivers and mitigation strategies.

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Annexes

Annex 1: Interview guide for the in-depth interviews

Instructions to the interviewer

Please introduce yourself to the interviewee, explain the project and the objective of the study and ask him/her to sign the consent form. If they agree to the interview being recorded, please start the recorder. Remind the interviewee that their participation is entirely voluntary and they can finish the interview at any time or ask to skip a question if they do not feel comfortable answering it.

Explain that the project is looking at informal processes in the health sector as a means to make improvements that will support frontline health workers in their work. Remind them that this section of the project is interested in understanding the challenges that frontline health workers face at work. Explain that we know that there are many of these challenges, and that to enable them to overcome these, they have both formal and informal strategies in place to manage them. Please reinforce the fact that we are interested in what makes them manage their lives in the way that they do and that we are not judging what they do.

Record respondent's information appropriately	<ul style="list-style-type: none"> • Cadre • How old are you? • What is your educational qualification? • Place of origin • Working experience • Years of working in the facility? • Name of workplace of health facility?
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Domain 1: Current job experience

We would like to begin the interview with a discussion about how you came to be a health professional working in this facility and what your experience has been in your current job

Key questions	Probes	Key areas to listen out for
<ul style="list-style-type: none"> • Can you tell me about yourself and your decision to work in this facility? 	<ul style="list-style-type: none"> • How did you come to be a health worker? • What made you decide to work in this facility? • How long does it take you to get to work every day? Do you think it affects your work? 	<ul style="list-style-type: none"> • Did social/familiar networks, community resources, political connections/reciprocal arrangements help them get their job? • Did social networks fail to get them a job in town? • Opportunities for dual practice, financial incentive, weak system of monitoring, flexible work hours, travel time, family responsibility, as a bread winner?

Key questions	Probes	Key areas to listen out for
<ul style="list-style-type: none"> Let's talk a bit about your current job? 	<ul style="list-style-type: none"> Are you expected to report to work every day? How many hours a day are you expected to work? Is there flexibility? Approximately how many patients do you see per day? How is that for you? What time do you usually come to work and what time do you usually leave on each day you come to work? Why is that so? Give us an example of time where you have had to deviate from this schedule for some reason (explore health/ no health) How does distance from marital home and pressure from within the marriage to not stay long hours at work, safety issues affect your presence in work? 	<ul style="list-style-type: none"> Structural enablers of absenteeism Work schedule Gender or family responsibility as an enabler (household or childcare responsibilities)
<ul style="list-style-type: none"> Tell us about your usual routine at home and at work? What challenges hampers your ability to do your work? Are there any issues that makes it difficult for you to work a full day?? 	<ul style="list-style-type: none"> Beside the routine work, what other additional work do you need to do? (e.g. vaccine programme, health day) Are you ever involved in activities outside the health facility (such as vaccine programmes, malaria control, HIV programs, data collection)? What impact does this have on your routine work? 	<ul style="list-style-type: none"> Effect of resource availability (including personnel) on staff morale Additional work Impact Moral enablers of absenteeism
<ul style="list-style-type: none"> How is it for you to work in this facility? How do you perceive your remuneration and respect you are given? 	<ul style="list-style-type: none"> Are you happy working in this facility? Why are you happy or not happy? And what impact does it have on you? Are there other incentives? Do you think it is fair across gender? Are there other ways in which frontline health workers can gain income or support? 	<ul style="list-style-type: none"> Satisfaction, if any Dissatisfaction- Lack of financial incentives Differences in incentives by gender Adequacy of working infrastructure and tools

Domain 2: Absenteeism

We would like to focus on the connections between the pressures that frontline health workers are under to make money, manage high patient workload and the time that they spend away from public health facilities. As we explained at the beginning of the interview, we are interested in the structural reasons for spending time outside their work in public health facilities and are looking for ways to support doctors/nurses in the challenges they face with respect to absenteeism.

Questions	Probe for	Key areas to listen out for especially Planned voluntary Planned involuntary Unplanned voluntary Unplanned involuntary
Section 1: knowledge of absenteeism		
a. What can you tell us about absenteeism in the health sector?	How often does this occur? <ul style="list-style-type: none"> What are the influence of the following on absenteeism? Workload, marital status, working condition, facility location and social events 	<ul style="list-style-type: none"> Conditions under which these factors exacerbate absenteeism
b. What reasons keeps health workers away from health facilities when they should be present?	<ul style="list-style-type: none"> Which of these is the most important and why? Which of these is the most frequent, and why? Do you think these cases are influenced by political connections, social connections and other links that health workers have with influential people? 	<ul style="list-style-type: none"> The impact of political meetings, private practice, stress and overwork, attending workshops etc.

Questions	Probe for	<ul style="list-style-type: none"> Key areas to listen out for especially Planned voluntary Planned involuntary Unplanned voluntary Unplanned involuntary
Section 2: Perceptions of absenteeism		
c. What do the staff in your cadre think about absenteeism in the health sector?	<ul style="list-style-type: none"> Do they take it serious or see it as normal thing? How does your view differ from others in different cadre? Which among these cadres, do you think engage more in absenteeism? 	<ul style="list-style-type: none"> Does the views of different cadre on absenteeism differ?
Section 3: Practices of absenteeism		
d. Can you tell me about the last time that you or a colleague of yours was absent from the facility when they were rostered (scheduled) for work?	<ul style="list-style-type: none"> Can you describe the situation that led to you or your colleague being absent? (Workload, marital status, working condition, facility location, organizational changes (reforms), policies, management styles, dual/private practice, social events). On that day, how long were you/they away for? Who was involved? What made you/ the person absent on that day? What may have led to this? Were there consequences as a result of this? Why is this episode significant in some way? Does this or similar events happen often? What impact did it have on others in the health facility? 	<ul style="list-style-type: none"> These are indirect questions to know the facts and reasons for absenteeism Make participants refer to concrete episodes
e. How is the possible devotion of official work time in the government health facilities to work in private health facilities contributing to absenteeism in the public health facilities	<ul style="list-style-type: none"> Cadres that are more prone to dual practice Reasons for dual practice Effects of dual practice on service delivery Effects of dual practice on IGR of the facilities 	
Section 4: Attitude to absenteeism		
f. How did the rest of the staff manage the absence of a staff?	<ul style="list-style-type: none"> Who covered their work? Did they have to pay someone to cover their work? Did anyone criticise/punish them for being away? What was the manager's reaction about their being away? In some cases, do the authorities turn a blind eye? 	<ul style="list-style-type: none"> Type of arrangement to manage absenteeism

Questions	Probe for	<ul style="list-style-type: none"> • Key areas to listen out for especially Planned voluntary Planned involuntary Unplanned voluntary Unplanned involuntary
g. In which circumstances is absenteeism more common? Why?	<ul style="list-style-type: none"> • Cadre/ speciality/ level • Working hours (if they are part time or work particular hours and not full time) • Gender (women/farming) • Rural/urban • Seniority • PHC/type of facility • Strength of supervision • Workload • Personal factors (is it outlook or institutional drivers) vs institutional factors (delay or salary) • Burn out • Contact with patients (absence visible) • Political factors 	<ul style="list-style-type: none"> • Try to talk specifically which factors are prevalent in what areas and what levels.
Section 5: Gender Issues in absenteeism		
h. How does absenteeism differ for males and females in the health facility?	<ul style="list-style-type: none"> • Who is more absent between males and females? What is the reason? • How would the case be handled if a male was absent? • How would it be handled if a female was absent? • Would sanction be different? • Is there any preferential treatment on absenteeism based on sex? Why is this? 	<ul style="list-style-type: none"> • Note the differences in absenteeism across gender
i. How do the roles of health workers as either males or females in the society and in their homes lead to absenteeism?	<ul style="list-style-type: none"> • What roles of males and females' health workers in their homes and in the society lead to absenteeism? 	
j. How are patients affected by the absence of health workers?	<ul style="list-style-type: none"> • Who is more affected by the absence of health workers? • Is it males or females? 	
Section 6: Political economy considerations in absenteeism		
k. What types of relationships exists between health workers and those in authority or key positions?	<ul style="list-style-type: none"> • How do health workers' relationship with someone in authority aid or prevent absenteeism? The last time you or your colleague was absent, how was the case handled? • Have you or your colleague ever been absent while on the duty and was not punished because of your relationship with the head? • Are there people that go unpunished because of their relationship with the person in charge in and beyond this centre 	<ul style="list-style-type: none"> • Refer the participant to real life cases.
l. How does health workers' involvement in other economic activities lead to absenteeism?	<ul style="list-style-type: none"> • What are the different economic activities health workers are involved in? • How do these economic activities lead to absenteeism? 	

Questions	Probe for	<ul style="list-style-type: none"> Key areas to listen out for especially Planned voluntary Planned involuntary Unplanned voluntary Unplanned involuntary
Section 7: Interventions on absenteeism		
m. What mechanisms exist for checking whether staff come to work, when they come, what they do and when they leave?	<ul style="list-style-type: none"> How does this system work? Is it biometric or paper-based? How does this apply to all health workers? How effective has this system/mechanism been? Why is this so? Were these regulations made by hospital management or government? What is your opinion about these systems in terms of feasibility and effectiveness? Can you suggest other ways that doctors/nurses could be supported to reduce absenteeism? Can you tell me about other regulations that have been put in place to address absenteeism? What about (improving in work conditions, availability of tools and drugs at PHC level) reduce absenteeism among health workers? 	<ul style="list-style-type: none"> Monitoring by management Other existing formal approaches Feasible options/suggestion to address/avoid absenteeism at facility level
n. How effective has this system/mechanism been? Why is this so? Tell us examples about the system working or not working?	<ul style="list-style-type: none"> Why did the system fail? 	
o. Were these regulations developed/introduced by hospital		
p. Do you think biometric attendance signing system which is the most proposed intervention will be effective in mitigating absenteeism among health workers?	<ul style="list-style-type: none"> How effective will it be? Are there people (or drivers) that could affect how the strategy of using biometric attendance works? What about the use of sign in methods? How about improving work conditions, availability of tools and drugs at PHC level, how will it effective could it be? Will increase in salary of health workers reduce dual private/engaging in other economic activities thus reducing absenteeism? 	
q. How does the availability of staff quarters affect absenteeism?	<ul style="list-style-type: none"> What factors hinder the strategy of building staff quarters from preventing absenteeism? What factors facilitate the effectiveness of this strategy? 	
r. What do you think about the public being aware of when staff are expected to be on duty as well as public awareness of proper channels for reporting those who aren't?	<ul style="list-style-type: none"> How does the knowledge of this strategy help in reducing absenteeism in the health sector? 	

Questions	Probe for	<ul style="list-style-type: none"> Key areas to listen out for especially <ul style="list-style-type: none"> Planned voluntary Planned involuntary Unplanned voluntary Unplanned involuntary
s. What effect does the availability of pharmaceuticals (e.g. drugs) and other tools at the facility have on health workers' absenteeism	<ul style="list-style-type: none"> How can this strategy be sustained? 	
t. How does the use of Ward development committee and or health facility committee to monitor, report and punish health workers mitigate absenteeism	<ul style="list-style-type: none"> What factors make this strategy effective/non-effective? 	
u. What are the sanctions/punishment for staff who are absent	<ul style="list-style-type: none"> Tell me about the process of reporting an absent staff from work Who is responsible for reporting, documenting absenteeism and implementing sanctions? What action is taken at each level of reporting or documenting absenteeism How does sanctions apply to different staff groups (doctors' vs nurses; males vs females; indigene/non-indigene) Which group of staff are often protected from punishments? How are staff protected from sanctions? What affiliations or connections are used to protect staff who are absent from being sanctioned? In what ways can these protections be tackled? 	<ul style="list-style-type: none"> Who brings reports: colleagues/service users? Use of registers, other sanctions? Protected staff/groups Connections/affiliations to offices, groups, unions, community leaders/politicians that often protect staff from punishments How do you think these political protections will be best tackled?
Section 8: Key stakeholders to design and implement horizontal interventions		
v. Who do you think should be involved in solving cases of absenteeism in the health sector?	<ul style="list-style-type: none"> Query for the inclusion of people within and beyond the health centre What may likely be the challenge in designing and implementing horizontal intervention to curtail absenteeism? 	<ul style="list-style-type: none"> Note for how these challenges can be addressed

Section 9: Other issues

Finishing the interview

Thank you for your time and your responses to our questions. Is there anything that you would like to add about the difficulties that frontline health workers face and the reasons why they absent themselves from work?

We will be in touch with you and let you know the results of our studies.

Annex 2: Interview guide for focus group discussion

Instructions to the interviewer

Please introduce yourself to the interviewee, explain the project and the objective of the study and ask him/her to sign the consent form. If they agree to the interview being recorded, please start the recorder. Remind the interviewee that their participation is entirely voluntary and they can finish the interview at any time or ask to skip a question if they do not feel comfortable answering it.

Explain that the project is looking at informal processes in the health sector as a means to make improvements that will support frontline health workers in their work. Remind them that this section of the project is interested in understanding the challenges that frontline health workers face at work. Explain that we know that there are many of these challenges, and that to enable them to overcome these, they have both formal and informal strategies in place to manage them. Please reinforce the fact that we are interested in what makes them manage their lives in the way that they do and that we are not judging what they do.

Record respondent's information appropriately	<ul style="list-style-type: none"> • Cadre • How old are you? • What is your educational qualification? • Place of origin • Working experience • Years of working in the facility? • Name of workplace of health facility?
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Absenteeism

We would like to focus on the connections between the pressures that frontline health workers are under to make money, manage high patient workload and the time that they spend away from public health facilities. As we explained at the beginning of the interview, we are interested in the structural reasons for spending time outside their work in public health facilities and are looking for ways to support doctors/nurses in the challenges they face with respect to absenteeism.

Questions	Probe for	Key areas to listen out for especially
		<ul style="list-style-type: none"> • Planned voluntary • Planned involuntary • Unplanned voluntary • Unplanned involuntary
Section 1: knowledge of absenteeism		
<ul style="list-style-type: none"> • What can you tell us about absenteeism in the health sector? 	<ul style="list-style-type: none"> • How often does this occur? • What are the influence of the following on absenteeism? • Workload, marital status, working condition, facility location and social events 	<ul style="list-style-type: none"> • Conditions under which these factors exacerbate absenteeism
<ul style="list-style-type: none"> • What reasons keeps health workers away from health facilities when they should be present? 	<ul style="list-style-type: none"> • Which of these is the most important and why? Which of these is the most frequent, and why? 	<ul style="list-style-type: none"> • The impact of political meetings, private practice, stress and overwork, attending workshops etc.

Questions	Probe for	Key areas to listen out for especially
Section 2: Perceptions of absenteeism		
<ul style="list-style-type: none"> What do different kinds of think about absenteeism in the health sector? 	<ul style="list-style-type: none"> Do they take it serious or see it as normal thing? Which among these cadres, do you think engage more in absenteeism? 	<ul style="list-style-type: none"> Does the views of different cadre on absenteeism differ?
Section 3: Practices of absenteeism		
<ul style="list-style-type: none"> How is the possible devotion of official work time in the government health facilities to work in private health facilities contributing to absenteeism in the public health facilities 	<ul style="list-style-type: none"> Cadres that are more prone to dual practice Reasons for dual practice Effects of dual practice on service delivery Effects of dual practice on IGR of the facilities 	
Section 4: Attitude to absenteeism		
<ul style="list-style-type: none"> How did the rest of the staff manage the situation when some health workers are not available? 	<ul style="list-style-type: none"> Who covered their work? Did they have to pay someone to cover their work? Did anyone criticise/punish them for being away? What did the manager say about their being away? 	<ul style="list-style-type: none"> Type of arrangement to manage absenteeism
Section 5: Gender Issues in absenteeism		
<ul style="list-style-type: none"> How does absenteeism differ for males and females in the health facility? 	<ul style="list-style-type: none"> Who is more absent between males and females? what is the reason? How would the case be handled if a male was absent? How would it be handled if a female was absent? Would sanction be different? Is there any preferential treatment on absenteeism based on sex? Why is this? 	<ul style="list-style-type: none"> Note the differences in absenteeism across gender
<ul style="list-style-type: none"> How do the roles of health workers as either males or females in the society and in their homes lead to absenteeism? 	<ul style="list-style-type: none"> What roles of males and females' health workers in their homes and in the society lead to absenteeism? 	
<ul style="list-style-type: none"> How are patients affected by the absence of health workers? 	<ul style="list-style-type: none"> Who is more affected by the absence of health workers? Is it males or females? 	
Section 6: Political economy considerations in absenteeism		
<ul style="list-style-type: none"> How do health workers' relationship with someone in authority aid or prevent absenteeism? 	<ul style="list-style-type: none"> What are those types of relationship? The last time you or your colleague was absent, how was the case handled? Have you or your colleague ever been absent while on the duty and was not punished because of your relationship with the head? Are there people that go unpunished because of their relationship with the person in charge in and beyond this centre 	<ul style="list-style-type: none"> Refer the participant to real life cases.
<ul style="list-style-type: none"> What are the effects of health workers' involvement in other economic activities lead to absenteeism? 	<ul style="list-style-type: none"> What are the different economic activities health workers are involved in? How do these economic activities lead to absenteeism? 	

Questions	Probe for	Key areas to listen out for especially <ul style="list-style-type: none"> • Planned voluntary • Planned involuntary • Unplanned voluntary • Unplanned involuntary
Section 7: Interventions on absenteeism		
<ul style="list-style-type: none"> • What mechanisms exist for checking whether staff come to work, when they come, what they do and when they leave? 	<ul style="list-style-type: none"> • How does this system work? Is it biometric or paper-based? • How does this apply to all health workers? • How effective has this system/mechanism been? Why is this so? • Were these regulations made by hospital management or government? • What is your opinion about these systems in terms of feasibility and effectiveness? • Can you suggest other ways that doctors/nurses could be supported to reduce absenteeism? • Can you tell me about other regulations that have been put in place to address absenteeism? • What about (improving in work conditions, availability of tools and drugs at PHC level) reduce absenteeism among health workers? 	<ul style="list-style-type: none"> • Monitoring by management • Other existing formal approaches • Feasible options/suggestion to address/avoid absenteeism at facility level
<ul style="list-style-type: none"> • Do you think biometric attendance signing system which is the most proposed intervention will be effective in mitigating absenteeism among health workers? 	<ul style="list-style-type: none"> • How effective will it be? • Are there people (or drivers) that could affect how the strategy of using biometric attendance works? • What about the use of sign in methods? • How about improving work conditions, availability of tools and drugs at PHC level, how will it effective could it be? • Will increase in salary of health workers reduce dual private/engaging in other economic activities thus reducing absenteeism? 	
<ul style="list-style-type: none"> • How does the availability of staff quarters affect absenteeism? 	<ul style="list-style-type: none"> • What factors hinder the strategy of building staff quarters from preventing absenteeism? • What factors facilitate the effectiveness of this strategy? 	
<ul style="list-style-type: none"> • How does the use of Whistle blowing-mechanism curb absenteeism among health workers? 	<ul style="list-style-type: none"> • What factors make this strategy effective? • What factors decreases the effectiveness of this strategy? 	
<ul style="list-style-type: none"> • What do you think about the public being aware of when staff are expected to be on duty as well as public awareness of proper channels for reporting those who aren't? 	<ul style="list-style-type: none"> • How does the knowledge of this strategy help in reducing absenteeism in the health sector? 	
<ul style="list-style-type: none"> • What effect does the availability of pharmaceuticals (e.g. drugs) and other tools at the facility have on health workers' absenteeism 	<ul style="list-style-type: none"> • How can this strategy be sustained? 	

Questions	Probe for	Key areas to listen out for especially
<ul style="list-style-type: none"> How does the use of Ward development committee and or health facility committee to monitor, report and punish health workers mitigate absenteeism 	<ul style="list-style-type: none"> What factors make this strategy effective/non-effective? 	<ul style="list-style-type: none"> Planned voluntary Planned involuntary Unplanned voluntary Unplanned involuntary
<ul style="list-style-type: none"> What are the sanctions/punishment for staff who are absent 	<ul style="list-style-type: none"> Tell me about the process of reporting an absent staff from work Who is responsible for reporting, documenting absenteeism and implementing sanctions? What action is taken at each level of reporting or documenting absenteeism How does sanctions apply to different staff groups (doctors vs nurses; males vs females; indigene/non-indigene)? Which group of staff are often protected from punishments? How are staff protected from sanctions? What affiliations or connections are used to protect staff who are absent from being sanctioned? In what ways can these protections be tackled? 	<ul style="list-style-type: none"> Who brings reports: colleagues/service users? Use of registers, other sanctions? Protected staff/groups Connections/affiliations to offices, groups, unions, community leaders/politicians that often protect staff from punishments How do you think these political protections will be best tackled?
<p>Section 8: Key stakeholders to design and implement horizontal interventions</p>		
<ul style="list-style-type: none"> Who do you think should be involved in solving cases of absenteeism in the health sector? 	<ul style="list-style-type: none"> Query for the inclusion of people within and beyond the health centre What may likely be the challenge in designing and implementing horizontal intervention to curtail absenteeism? 	<ul style="list-style-type: none"> Note for how these challenges can be addressed

Section 9: Other issues

Finishing the interview

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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.

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