HEALTH SYSTEMS & REFORM
2023, VOL. 9, NO. 1, 2199515
https://doi.org/10.1080/23288604.2023.2199515

Taylor & Francis
Taylor & Francis Group

RESEARCH ARTICLE

The Promise of Grassroots Approaches to Solving Absenteeism in Primary Health-Care Facilities in Nigeria: Evidence from a Qualitative Study

Obinna Onwujekwe[a,b], Prince Agwu [a,c], Pallavi Roy[d], Eleanor Hutchinson[e], Charles Orjiakor[a,f], Martin McKee[e], Aloysius Odii[a,g], Chukwudi Nwokolo[a,h], Mushtaq Khan[d], Susannah Mayhew[e], and Dina Balabanova[e]

[a]Health Policy Research Group, Department of Pharmacology and Therapeutics, College of Medicine, University of Nigeria, Enugu, Nigeria; [b]Department of Health Administration and Management, University of Nigeria, Enugu, Nigeria; [c]Department of Social Work, University of Nigeria, Nsukka, Nigeria; [d]Department of Global Health and Development, School of Oriental and African Studies (SOAS), London, UK; [e]Department of Global Health and Development, London School of Hygiene and Tropical Medicine, London, UK; [f]Department of Psychology, University of Nigeria, Nsukka, Nigeria; [g]Department of Sociology, University of Nigeria, Nsukka, Nigeria; [h]Department of Economics, University of Nigeria, Nsukka, Nigeria

ABSTRACT

Absenteeism among primary health-care (PHC) workers in Nigeria is widespread and is a major obstacle to achieving Universal Health Coverage (UHC). There is increasing research on the forms it takes and what drives them, but limited evidence on how to address it. The dominant approach has involved government-led topdown solutions (vertical approach). However, these have rarely been successful in countries such as Nigeria. This paper explores alternative approaches based on grassroots (horizontal) approaches. Data collected from interviews with 40 PHC stakeholders in Enugu, Nigeria, were organized in thematic clusters that explored the contribution of horizontal interventions to solving absenteeism in primary health-care facilities. We applied phenomenology to analyze the lived (practical) experiences of respondents. Absenteeism by PHC workers was prevalent and is encouraged by the complex configuration of the PHC system and its operating environment, which constrains topdown interventions. We identified several horizontal approaches that may create effective incentives and compulsions to reduce absenteeism, which include leveraging community resources to improve security of facilities, tapping the resources of philanthropic individuals and organizations to provide accommodation for health workers, and engaging trained health workers as volunteers or placeholders to address shortages of health-care staff. Nevertheless, a holistic response to absenteeism must complement horizontal approaches with vertical measures, with the government supporting and encouraging the health system to develop self-enforcing mechanisms to tackle absenteeism.

ARTICLE HISTORY
Received 18 October 2022
Revised 31 March 2023
Accepted 31 March 2023

KEYWORDS
Absenteeism; anticorruption; anticorruption evidence; corruption; horizontal interventions; vertical interventions

Introduction

Absenteeism by health workers in primary health-care (PHC) facilities in Nigeria is becoming an urgent concern as it limits accessibility and affordability of health services, thereby preventing the achievement of Universal Health Coverage (UHC).[1–3] Many health workers are absent from their publicly funded posts, often pursuing private interests,[4,5] meeting the definition of corruption as the abuse of public office for private gain.[6]

Studies in Nigeria have revealed widespread absenteeism in the health sector, with adverse consequences for health care. A quantitative study undertaken in southern Nigeria, the setting of the study reported in this paper, found that 77.7% of health workers were absent at least once over the course of a year,[7] while in northern Nigeria another health-sector study reported a figure of about 50%.[8] Absenteeism has major consequences for health care, with the literature describing loss of value of health investments, excessive workload on present staff, low-quality service delivery, and poor care leading to increased morbidity and mortality of patients.[2] A study in South Africa reported that of 83% of health workers who said absenteeism increased their workloads, 59% committed medical errors.[9] This echoes a Nigerian study that identified poor patient safety as a consequence of absenteeism.[10]

Where absenteeism is common, it can be considered a failure of governance.[11,12] It takes various forms, such as arriving late or skipping work completely, leaving early, or being physically present but not working.[13] It is self-evident that this will impact adversely on

CONTACT Prince Agwu prince.agwu@unn.edu.ng Health Policy Research Group, Department of Pharmacology and Therapeutics, College of Medicine and Department of Social Work, University of Nigeria, Nsukka 410001 Nigeria

patients.[14] Hence, we need feasible interventions, especially in low-resource settings where it further depletes the few staff employed.

Previous research provided insights into several interventions to address absenteeism in the Nigerian PHC system.[2] These can be divided into those that emphasize leadership management skills of facility managers, willingness of community leadership to hold health workers accountable, and ability and incentives of authorities at the local government[a] and State Primary Health Care Development Agency (SPHCDA)[b] to enforce rules, consider welfare of health workers, and prevent undue political interference. While some findings from this work are encouraging, they also raise questions about feasibility of some government-initiated interventions in Nigeria, given concerns about widespread commitment to the rule of law and concept of public good.[15,16]

Some studies proposing interventions to address absenteeism in Nigeria do not take account of Public Service Rules (PSR) that guide PHC workers in Nigeria, who are civil servants.[17] This is understandable because, although the PSR should have reduced absenteeism among PHC workers, they are known not to have succeeded. The rules should be enforced by the SPHCDA and local government health authority but rarely are.[18] This is thought to reflect a lack of awareness about them coupled within the sociopolitical complexities of Nigeria's civil service, leading to variations in their application.[19]

Following from this, a fundamental problem in Nigeria, as in most low- and middle-income countries (LMICs), is that those higher in the hierarchy often lack power to enforce rules on those protected by informal networks, and many times, are rule breakers themselves.[20] Thus, rule-breaking in the Nigerian civil and public service has continued to thrive despite the creation of structures like the Independent Corrupt Practices Commission (ICPC), and the Service Compact with all Nigerians (SERVICOM)[21] to improve accountability in public services. This calls for alternative and supportive strategies that can complement top-down enforcement.[4,22]

The organizational structure of primary health care in Nigeria is based on the Primary Health Care under One Roof (PHCUOR) strategy, which provides for a complementary relationship between vertical and horizontal actors if implemented to the letter.[23] Vertical governance mechanisms involve, first, the SPHCDA, which answers to the Ministries of Health at the states, while receiving technical and programmatic support from the National Primary Health Care Development Agency (NPHCDA). Then, there is the Local Government Health Authority (LGHA), which joins in the coordination and supervision of primary health facilities, and equally answers to the SPHCDA. The policy recognizes horizontal actors, i.e., Ward Development Committees (WDCs), representatives of traditional rulers' council, religious leaders, women leaders, civil societies, and community-based organizations as members of the LGHA advisory team. The horizontal actors are expected to be passionate about the wellbeing of the overall community and its health facilities. In this study, we look beyond the roles of HFCs and WDCs as contained in the PHCUOR, by identifying and discussing other creative horizontal approaches to absenteeism.

Prior studies on absenteeism of health workers in Nigeria have focused exclusively on understanding its dimensions and drivers, typically criticizing the government for not doing enough to address the issue and making broad recommendations.[2–4,8] Instead, we employ the SOAS-ACE approach developed to tackle corruption as the conceptual framework for this study. This approach emphasizes an understanding of the drivers of aberrant behavior that can inform the development of contextually appropriate solutions, often using horizontal mechanisms.

A Novel Approach to Tackle the Persistent Absenteeism

Khan and Roy have summarized the SOAS-ACE[c] approach to anticorruption,[24] which has gained considerable traction in anticorruption research, used in the health and other sectors in countries such as Bangladesh[25,26] and Nigeria,[27] and particularly in absenteeism.[5,16] It emphasizes self-enforcing systems led by peers to reduce rule breaking based on their power, capabilities, and interests, but with encouragement and support from government-led actors, often working in vertical structures.[16,28] It argues that vertically enforced rules in low-income countries implicitly assume these countries are already under the "rule of law"—a state where those who break the rules will be punished no matter who they are. If the rule of law operates in these low-income countries, then detection of violations should lead to enforcement. This is not, however, the reality, as rules are selectively enforced where there is widespread informality.[29] The implication is that vertical anticorruption approaches based on imposition of rules are mostly frustrated.

Identifying anti-corruption mechanisms that are *feasible* to implement, especially if there is substantial support from local power (horizontal actors and networks), will be important when tackling

absenteeism in PHC facilities. This will strengthen vertical enforcement mechanisms embedded in formal structures, such as the LGHA and the SPHCDA.[24] Research in the education sector argues that proximal actors who are most affected by the problem are most interested in addressing it.[30] In two political-economy studies, community actors, facility managers, and health workers showed most potential to enforce rules through using horizontal mechanisms.[28,31] The idea is to create self-enforcing systems that sustain the core goals of the health system with respect to service availability and quality, even without full engagement by higher authorities.[26] However, the SOAS-ACE framework posits that although horizontal enforcement guarantees immediacy, feasibility, and sustainability of interventions in contexts where it is hard to apply rules, vertical support should not be undermined.[24]

Methodology

Setting

The study was undertaken in Enugu state, southeast Nigeria. Enugu has 558 public PHC facilities distributed across the state's 17 local government areas (LGA),[32] and to serve a population size of about 1.28 million people.[33] Numerous studies have documented often poor performance of PHC facilities, especially in the context of a rapidly growing population, and absenteeism is listed among the key problems.[10,34–36] One study has reported that under 20% of Nigeria's 30,000 PHC facilities are fully functional.[37] PHC facilities are staffed mostly by nurses, midwives, community health extension workers (CHEWs), junior community health extension workers (JCHEWS), and community health officers (CHOs). They have either no or very few doctors. Staff in PHCs earn less than their counterparts in other parts of the health system, with a difference of an estimated U$S200 per month between the highest ranking PHC staff and a mid-ranked health practitioner in secondary and tertiary facilities.[2]

It is important to note that, at the time this research was conducted, the number of PHC staff in Enugu was not known with certainty by the authorities, but a verbal estimate by the SPHCDA in Enugu puts the figure at 3,000. Disaggregated statistics of health workers based on gender and geographical spread are also missing. However, the official national figures report a health worker density of 1.95 per 1000 population, lower than the WHO's recommended 4.45 target.[38]

Data Collection

The overall data collection and reporting was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ).[39] We adopted a qualitative approach to this research, due to how underexplored our research questions are in literature. They are (a) What are the existing vertical strategies to address drivers of absenteeism of health workers? (b) What are the barriers that have hindered vertical strategies from sufficiently addressing absenteeism? (c) What are the promising horizontal interventions against absenteeism?

The development of the guide was informed by literature review and long-term experiences of some members of the research team who are conversant with the PHC system operation. The guide was pretested for content, structure of questions and time management, and concerns raised during the pretest were addressed before the main data collection.

Interviews were conducted after obtaining signed informed consent from the participants. The informed consent forms had full details of the study and researchers, including agreement to audio recording and the promises of confidentiality and anonymity. All interviews were designed to last for an hour, with provision for added 15 minutes to be determined by expression of respondent's fatigue.

The research team comprised four women and seven men, who were all well trained and experienced in qualitative research methods. All of them have post-graduate training in different aspects of social sciences and have been involved in previous qualitative studies in Nigeria. Of the 11 researchers, 5 of them who reside close to the study sites conducted the fieldwork using a standardized tool which all researchers contributed to base on insights from literature review and prior engagements with health-care stakeholders in the country. They were accompanied by research assistants that took notes.

Forty (40) health-care stakeholders in six purposively selected LGAs (2 health facilities in each LGA) in Enugu state were interviewed, and they were representative of geographic spread. The interviewed stakeholders represented core cadres in health, which included 12 HODs and equivalent for policymakers, 6 members of HFCs for community actors, 12 facility managers (OICs) and 10 health workers (doctors, nurses, CHEWs, and midwives) for frontliners. Our spread in the selection of locations and stakeholders guaranteed the benefits of triangulation by enhancing data quality, as recommended for studies that are exploratory.[40] Respondents chose where we conducted the interviews, which was done in private, either at the health facilities, offices, or homes.

A major criterion for the purposive selection of respondents was the expressed willingness to speak on a highly sensitive issue of absenteeism as a form of corruption as earlier studies found an unwillingness of some health workers to do so.[2,4,5,41] Recruitment took place during visits to the selected LGAs and facilities, presenting the approval of the SPHCDA and ethics committee. The HODs notified the facilities, while the OICs notified the HFCs. Those least willing to be interviewed comprised health workers who were not facility managers, citing a reluctance to criticize the system or undisclosed reasons.

We used the established principle of data saturation, with no recruitment of additional interviewees when narratives from respondents no longer yielded new information.[10,42,43] However, we also wished to ensure that we did not exclude any important demographic group amongst the respondents. Hence, we included respondents drawn from different geographic locations, age brackets, marital status, cadres, and positions at workplace, because an earlier published quantitative study showed that prevalence and perceptions of absenteeism and how it can be managed could vary across the various categories.[7]

Lastly, we drew on phenomenology to guide how we elicited data, focusing on the lived experiences of respondents about absenteeism and how it is addressed. Respondents were thus asked questions and probed in ways that permit expression of personal experiences, as against mere descriptions.[44,45] For instance, rather than ask, "What are your thoughts on how absenteeism should be addressed?" we asked, "Now that the government has not been forthcoming, what have you done to secure your health facility so that health workers can work in safe conditions?" With the latter, respondents narrated their lived experiences about the issues we presented to them. This is the reason most of the quotes presented in this study reflect personal encounters and experiences. Our utilization of phenomenology was facilitated by the experiences of the researchers in social research and anthropological methods, spanning several decades.

Data Analysis

Our use of phenomenology extended into data analysis, capturing lived experiences of respondents and explaining them in thematic clusters.[42] Following initial reading and re-reading of transcripts by all researchers, common coding categories were derived independently and inductively but with the aims of the study in mind. Codes were harmonized in a team meeting, producing the framework from the thematized narratives, which we further discussed among ourselves to ensure a good understanding of the thematically arranged lived experiences of the respondents.[44] Coding was done by the researchers who conducted and transcribed the interviews, since they were already immersed in the data. The agreed themes for coding and narratives were represented in a harmonized coded MS Excel Spreadsheet that had columns for each respondent against the rows that contained their responses. Following observer triangulation and peer debriefing, we reviewed the spreadsheet internally for coherence.[46] With triangulation, suggestions and discussions about appropriate placement of narratives under themes were held and coding reorganized, thereby improving the quality of coding.

Results

Sociodemographic Features of Respondents

Sociodemographic characteristics of respondents are reported in Table 1. Eighty percent was females; 75% were above the age of 30; 75% worked in non-urban locations, and another 75% were married. Although 10% of the respondents had no formal education, we had more respondents with several educational qualifications. A combined 25% reported having a first degree of Bachelor's equivalent, and 45% reported undergoing community health training, either as extension workers or health officers.

The findings are structured to provide insights into the three thematic categories guiding this study: (a) evidence of absenteeism, drivers, and the existing means of addressing it, (b) factors that hamper sanctions, and (c) potential of grassroots-based solutions to absenteeism.

Evidence of Absenteeism, Drivers, and Conventional Strategies for Addressing It

The findings showed that absenteeism and previously cited reasons for it persist. The first was security of health workers:

> The night shift is not for us. There is no security at all. No light (power supply) even. As you can see, we are women. We could be raped if we stay longer into the dark. So, once it is almost getting dark, we leave here [CHEW, Urban Health Facility, 35 y]

The reported reasons for absenteeism included a lack of infrastructure, such as good roads and other social amenities. Others include inadequate salaries and the corresponding need for additional income, poorly equipped

Table 1. Summary of sociodemographic features of respondents.

Sociodemographic	$N = 40$	%
Gender		
Male	8	20
Female	32	80
Cadre		
Top health-care managers	12	30
Facility managers	12	30
Health facility committee members	6	15
Health workers	10	25
Marital status		
Married at present	30	75
Not married at present	10	25
Geographical location		
Urban	10	25
Rural	30	75
Age[e]		
>30 y	30	75
≤30 y	10	25
Educational qualification		
No formal education	4	10
SSCE	8	20
CHEW/CHO	18	45
BSc	5	12.5
MSc	4	10
MBBS	1	2.5

Table 2. Summary of solutions to absenteeism.

Absenteeism driver	Identified grassroots interventions	Suggested government-enabled interventions
Structural and systemic challenges	Employ local night watch men at facilities or leverage neighborhood vigilantes to improve security of night shifts	Employment of full-time security personnel
	Scout for opportunities or encourage wealthy community members that can provide staff accommodation for primary health facilities	Ensure that livable staff accommodation is provided for all primary health facilities; post health workers to facilities that are close to their place of residence or provide mass transit services
	Service charges to generate revenue to sort needs; OICs invest their personal funds into the facility hoping to gain them back through fees for services; or facilities seek funding from good-spirited and wealthy community members	Designate special funding for infrastructure; ensure that appropriations to PHC through the local governments are utilized and revive and enforce the Drug Revolving Fund (DRF) policy
	OICs employ volunteers to cover-up gaps and pay them either from personal or facility-generated resources	Regular human resource assessment for PHCs and utilize such results to employ committed staff; strengthen the personnel monitoring arm.Upward review and implementing living wages for PHC workers
Political patronage for and protection of absent staff and difficulty in implementing sanctions	OICs and HODs attempting to step down the civil service rules for health workers; Establishment of local accountability (rosters—and even telephone numbers—made public so that it's clear who is absent and how to contact them)	Specific PHC-focused rules put together to meet the accountability needs of the PHC facilities; encouraging local actors to swiftly report absenteeism through hotlines and actions taken immediately
	Encourage active and independent Health Facility Committee Chairpersons and members; including community groups to monitor health workers and enforce rules; report absenteeism to authorities. Non-state actors like WHO/international agencies and CSOs pursue advocacies toward enforcing rules against absenteeism	Immediate actions on reports of absenteeism made by community members and discouraging political interferences.Involve powerful and respected local leaders (Igwe) and women leaders in resolving cases of absenteeism, leveraging their power to counter political protectionism

facilities, low staff levels, assignments taking health workers away from the facility, and weak supervision. Some health workers could exploit informal connections with the OIC or politicians:

> The workload on the HOD is so much. I oversee a sizeable number of facilities. The OICs should make my work easier by reporting absent staff to me and keeping their staff on their toes. Rather, some go ahead to be settled (bribes – in cash or kind) by those ones that are perpetually absent, which is why they cannot stand their grounds [HOD, Rural LGA, 47 y]

These political (related to power relations) and economic (related to wages and poor economic investments in health) factors are explored in the next subthemes, which relate to existing strategies. No respondents had seen rule books for staff conduct in health facilities, and

health workers were barely aware of sanctions for violations. At best, they follow the PSR which, as noted, applies to all civil servants and do not consider specific aspects of the health system, e.g., shift working, informal payments for medicines, procurement of consumables, etc. An OIC said that she established the rules in her facility, typed them up, and issued themto the health workers she manages.

Factors Hampering Conventional (Vertical) Solutions

Application of existing procedures to address absenteeism is hampered by informal rules and norms, political influence, a disincentive to apply professionalism, social and kinship networks, and economic factors. Health workers could be absent because they are confident that the rules do not apply to them, while they can argue that they are unaware of sanctions because they are not officially documented.

> One of my staff refused to hand over her facility to me after she proceeded on study leave [. . .] She refused the health workers to run the facility [. . .] When we caught her, she even threatened me, that I should stay away from the facility, and was asking me to show her where such law is written [. . .] I understood where she was coming from, because even when I reported to the Supervisor for Health, he said I should take it easy with her [the supervisor being afraid of issuing harsh sanctions because of her connections] [. . .] So, you should understand what that means [HOD, Rural LGA, 47 y]

Some staff members leverage their seniority to be absent, especially if politically connected or able to offer bribes. Doctors were said to exploit the respect they enjoy from other health workers at the primary health-care level.

> The doctor we have is paid better and quicker than everyone. Yet he barely comes around. I lost a baby in my facility because the doctor was not around [. . .] They feel so entitled. They feel they are doing you a favour by coming around [. . .] [OIC, Urban health facility, 51 y]

Another health administrator reflected on how politically protected staff thwarted their extensive formal powers to enforce rules as they could not counter the influence of political "godfathers" or 'godmothers.'[d] For instance, while perpetually absent staff could, in theory, be moved to locations where they could be monitored, this was usually frustrated by powerful people who may find it difficult to continue protecting the staff if moved away from his or her jurisdiction of influence.

> I recall when I wanted to reshuffle the health workers so that they do not stay at a place for too long. Immediately, I was called on phone to stop the reshuffling [. . .] It is wise that I save my job than go against the people that own the government. [HOD, Urban LGA, 50 y]

The existence of informal deals between different actors —politicians, managers, and providers—was reiterated by another health administrator who also described payrolling of ghost staff and cover-ups of absent staff by facility managers and local government administrators in charge of human resources and finance.

> You could have 20 health workers on the list, but you end up seeing two consistently. We have written and begged the local government chairman to do something, but we keep getting empty promises. Rather, he appointed our health facility committee chairperson into a political position. And since then, the health facility chairperson stopped talking. [Health Facility Committee Member, Rural LGA, 71 y]

Evidence of Horizontal Solutions

We did find case of local solutions that have been applied, often reflecting a lack of confidence in the ability of those at higher levels in the health system to impose rules. The local solutions had potential in them to not just get health workers present at work but to ensure that they deliver services efficiently. The first example is of an OIC in a rural location who leveraged commitments from development partners to secure living quarters for her staff, as she recognized this as a major driver of absenteeism. It is important we state here that the government should, according to the Minimum Basic Package for Primary Health Care, provide accommodation for PHC facilities.[47] As this was not forthcoming, the OIC had to take horizontal action separate from the government.

> At some point, I shared the issue with a friend who told me of the Millennium Development Goals (MDGs). She said I should write. Jokingly, I did. In just few months, MDGs came here, checked if there was land available. They built twin flats for us. [OIC, Rural health facility, 53 y]

Similarly, a chairperson of an HFC took local action to obtain accommodation for staff working night shifts. Other solutions focused on improving security, which as noted above is a widespread problem in Nigeria. Two OICs had engaged neighborhood watchmen or other security personnel who would work at night.

> What I have done is to employ a night watchman. I pay him N5000 ($10) monthly. He is quite elderly. But that is what I can afford. So, he goes to his private work

> during the day, and comes here at night. [OIC, Urban health facility, 51 y]

Still on security, an OIC was explicit on how she leveraged neighborhood watchmen to prevent attack on her facility by criminal elements, with her all-female staff particularly concerned about rape.

> When they stole our power generating set that was donated to us, it became clear that one day these hoodlums can come here to rape my health workers. I immediately rushed to the neighborhood security watchmen to extend their night patrol services to our facility. They came around and shared their contacts with all the health workers. We were told to call them at anytime we sense danger. [OIC, Rural health facility, 49 y]

OICs had to engage in local fundraising to purchase medicines, while revolving the funds generated from the selling of the medicines. Money was obtained from well-off persons in their communities. Additionally, facilities have long engaged volunteers, paying them expenses and sometimes a small stipend from the private purse of the OIC or through funds generated by the facility. Although potentially risking the enabling of absenteeism to continue, volunteers have helped to address staff shortages, reduced workload of the few employed staff, and mitigated effects of involuntary absenteeism on service delivery.

> I am a volunteer here. The OIC employed me. Before now, whenever she wants to leave for meetings at the local government headquarter, or to the bank, or to buy drugs for the facility, she will have to lock the facility. It is no longer so since I came. [CHEW, Urban health facility, 26 y]

We found evidence that community-led health facility committees could enforce sanctions against erring staff, even when they are politically connected.

> Some time ago, I led some persons to the HOD to report a health worker who never comes to work. They were actually slow to act because she is connected. But we kept on pressing that she must be removed and another transferred to us. After a while, she acted by removing the health worker and replacing her with a committed one. [Health facility committee chairperson, Urban health facility, 51 y]

Some also invoked the normative power of external actors who often have leverage in addressing absenteeism:

> From time to time, we usually have different organizations like the WHO visiting us here. On one of those days they came, I had to report my colleague to the WHO group that visited, they took up the case, and she was transferred to a less busy facility. [OIC, Urban health facility, 48 y]

Crucially, traditional rulers and women's groups were reported to be well respected, and their interventions against absenteeism were hailed.

> The health workers have so much respect for the "Igwe" (the traditional ruler). They behave themselves whenever he is mentioned. He visits the facility from time to time, and when we take complaints to him about any health worker that is misbehaving, he calls and advices the person. If the person continues misbehaving, all he needs to do is to put a call across to the authorities, and they will take the person out. He has done it severally. [Health Facility Committee Chairperson, Urban health facility, 51 y]

A facility manager added:

> Why they report to the Igwe (King) is that he is the number one security officer of the community. He owns the health center and the community. Igwe is not core a politician. Igwe is not easily dethroned so they tend to remain as Igwe till they die, but politicians have tenure that is why they act the way they do. Because of that they are well respected. Just a call from him and they will remove that health worker that continuously misses work. [OIC, Rural health facility, 44 y]

On the other hand, we found an HFC Chairperson who encouraged the health workers in his community to make their contacts publicly available by placing their phone numbers against their names. Another OIC tried to show that financial or in-kind rewards can incentivize health workers to come to work. Finally, community actors also emphasized the need for a trade-off between sanctioning of absentee staff and retaining them as providers of essential care locally, thus requiring some negotiation:

> I do threaten him that if he keeps acting that way, that he should get ready to face whatever the community will do to him. However, he will be active for that moment after which he will relapse again, but he is a very nice doctor which is the more reason why we don't want to lose him. The devil you know is better than the angel you have not seen. So, we keep negotiating with him. [Health Facility Committee Member, Rural LGA, 71 y]

Discussion

We found that absenteeism in PHC continues to be common in southern and northern Nigeria, making it a widespread health system issue and that existing vertical responses rarely work.[8] As identified in other studies and confirmed by ours, the drivers of absenteeism that result from the intersections of defects in pay, supervision, enforcement of rules, and security, among others, require sustained government

investments in health and responsive political structures.[2,5,48] Yet top-down (vertical) enforcement by higher authorities using administrative measures has been ineffective, hence, necessitating alternative solutions.

Some of the drivers of absenteeism are due to extraneous factors that could be addressed if grassroots actors are mobilized to support the provision of services in PHC facilities. Abimbola and colleagues advocated enhancement of community structures and local (grassroots) actors as a way to address the "tragedy of commons" in the health system. This is the bane of health facilities because those who govern are not interested in optimizing health systems, thus compromising the effectiveness of service delivery.[49] An instance of a type of "tragedy of commons" is the security of health facilities, causing service users and health workers to fear using facilities where they may be attacked. Despite budgets for health care and security, as well as concerns raised with formal security services like the police, many health facilities lack any security or even the infrastructure necessary to provide it, like power supplies, perimeter fences, and lockable gates.[50] Consequently, facilities are effectively nonfunctional once it is dusk, yet those in vertical structures seem unconcerned, even when there are allocated material and non-material resources.[51] Nevertheless, we found some facility managers being creative in providing solutions to insecurity of their facilities dominated by women, by leveraging local watchmen only at night.

Our study identifies some examples of promising horizontal solutions that can be employed where vertical ones have failed to eliminate absenteeism and its drivers. Engaging diverse stakeholders at the grassroots (often beyond the health system structures) offers great promise and is potentially feasible, with benefits for health service coverage. This aligns with the SOAS-ACE approach on horizontal enforcement of rules.[20] We found them important for three reasons. First, the actors involved—facility managers, community leaders and members, civil societies, etc.—are closest to the health facilities and this proximity helps them understand the local context, and ensure reasons for rule breaking are addressed locally, and that rules are upheld. Second, these actors are most affected by absenteeism, so they are motivated to find solutions that work in the long term. And the third reason is that they fill a gap created by a lack of action by those in vertical authorities.

As in a similar study that adopted the SOAS-ACE approach,[28] those in positions of authority in vertical structures who are unwilling or feel constrained from acting can look to these horizontal systems to keep the primary health system going. They can do this by incentivizing horizontal actors, acting speedily on their recommendations, enacting supportive legislations and policies, etc., to encourage and sustain them. Although, the SOAS-ACE approach recognizes that ideally there should be harmonization of vertical and horizontal efforts, it maintains that enabling horizontal actors to address rule breaking behaviors like absenteeism is sustainable in the long-run, as it will produce a system that will be self-enforcing.[24] The current study presents evidence that this is indeed possible.

It is important to note that many of the local solutions involve informal agreements and second-best solutions. There are, however, concerns about the sustainability of grassroot solutions, including the possibility that they could perpetuate advantage for some staff members (those being often absent but able to negotiate better terms informally) and create opportunities for other forms of malpractice or corruption. Some of the interventions (e.g., drawing up facility-specific rules, adjusting duty rosters, allowing flexible working hours through agreement, employing volunteers and security personnel to cover for absent staff, self-purchase of medicines away from regulations, use of rewards, etc.), especially those involving the OICs, risk public facilities being run as a private venture to generate profit to pay for overhead costs of the additional staff or other investments. The OICs may also seek personal profit from their investments. There is also the possibility of exploiting volunteers since OICs are their direct employers.

Nevertheless, promising horizontal measures to address absenteeism initiated collectively by OICs in collaboration with the Facility Health Committees and local leaders (Igwe [King], women leaders, President General of the communities, etc.) appeared to fare better because of the in-built checks. In case of political patronage and pressure to ignore absences, involving the Igwe and local leaders may be critical in conflict resolution. It is, however, important to find ways to support the communities in upholding the commitments of health workers. An instance was the public display of the duty roster, including phone contacts for the health workers on the roster. Well-performing health workers can be recognized, thereby contributing to their health system record.

A sustainable strategy of developmental governance would involve a combination of strategies including alternative loci of authority, appropriate incentives for health center managers, and community development strategies that convene a coalition of horizontal interests that, collectively, can put pressure on absentees. Their combined power and willingness to take action has to be sufficient to override the power and interests

of those engaged in or supporting absenteeism. These include the interests of patrons who are protecting absentees in return for extending their political influence. However, while these patrons are powerful, they risk loss of political dividends by supporting absenteeism of relatively low-level health workers. This approach aligns with ideas of social accountability, based on the principles of collective action and citizens' oversights of machineries and institutions of government.[52]

The generalizability of our study is limited by being set in only one of six geopolitical zones in Nigeria, a large and culturally complex country. Notwithstanding this, the study can offer some lessons and a menu of options on how to address absenteeism that might work elsewhere. Also, we acknowledge the limitations inherent in researching sensitive issues, especially the nonparticipation of those who might have contributed new elements to narratives. Nevertheless, the strong qualitative research experiences of the researchers and experience in studying absenteeism were important, ensuring that the reach of data saturation is indeed valid. Therefore, these findings are potentially useful to other settings, as they generate ideas and themes that can be explored elsewhere, helping to generate context-specific solutions, and importantly, a national approach to combatting absenteeism in the health sector.

We encourage stakeholders in Nigeria's health sector, especially those concerned about corruption, to take our findings as a starting point for engaging local actors. While strengthening enforcement of vertical rules and their clear communication is an ongoing critical task, horizontal strategies are crucial accompaniments, especially where vertical enforcement remains weak or absent. Furthermore, we recommend that those enforcing vertical strategies that are constrained in their ability to tackle absenteeism in the health sector can, as a matter of urgency, align with the horizontal solutions we have described, incentivizing and supporting these until they can address their own weaknesses. Ultimately, however, vertical and horizontal approaches must work together to ensure that health workers were actually working at their posts. Table 2 provides a snapshot of the drivers of absenteeism and corresponding interventions led by grassroots and government.

Notes

a. The local government is the third and least level of Nigeria's three tier governance structure. The local government is charged by law to legislate over primary health care together with the State Primary Health-Care Development Agency.
b. The coordinating agency for all primary health-care activities in the state.
c. SOAS-ACE stands for the Anti-corruption Evidence Consortium that is hosted at the School of Oriental and African Studies, London, with its project on researching corruption and anticorruption scattered across different sectors in different countries.
d. Persons with so much power, usually high-ranking politicians, civil servants, business moguls, or technocrats that could determine who gets employed in the system and are powerful enough to coerce and influence decisions of authorities on sanctions.
e. We cap the youth population in Nigeria at 30 y and below for roundness of figure (since the Commonwealth defines youths as those between 15 and 29 y).

Acknowledgments

This publication is an output of the SOAS Anti-Corruption Evidence (ACE) research consortium funded by UK aid from the UK Government [Contract P0 7073]. The views presented in this publication are those of the author(s) and do not necessarily reflect the UK government's official policies or the views of SOAS-ACE or other partner organizations. For more information on SOAS-ACE visit www.ace.soas.ac.uk

Disclosure Statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Foreign, Commonwealth & Development Office [P0 7073].

ORCID

Prince Agwu http://orcid.org/0000-0001-9224-7622

Data Availability Statement

Data used for this study is available upon reasonable request to the corresponding author.

Ethics

Ethical approval was obtained from the Institutional Review Board of the African authors (will disclose after review) – approval no: NHREC/05/01/2008B-FWA00002458-IRB00002323.

References

1. Onwujekwe O, Agwu P, Orjiakor C, McKee M, Hutchinson E, Mbachu C, Odii A, Ogbozor P, Obi U, Ichoku H, et al. Corruption in Anglophone West Africa health systems: a systematic review of its different variants and the factors that sustain them. Health Policy Plan. 2019;34(7):529–43. doi:10.1093/heapol/czz070.
2. Onwujekwe O, Odii A, Agwu C, Orjiakor C, Ogbozor P, Hutchinson E, McKee M, Roy P, Obi U, Mbachu C. Exploring health-sector absenteeism and feasible solutions: evidence from the primary healthcare level in Enugu, South East Nigeria. 2019 https://researchonline.lshtm.ac.uk/id/eprint/4659908/.
3. Onwujekwe O, Orjiakor CT, Hutchinson E, McKee M, Agwu P, Mbachu C, Ogbozor P, Obi U, Odii A, Ichoku H, et al. Where do we start? Building consensus on drivers of health sector corruption in Nigeria and ways to address it. Int J Health Policy Manage. 2020;9:286. doi:10.15171/ijhpm.2019.128.
4. Agwu P, Ogbozor P, Odii A, Orjiakor C, Onwujekwe O. Private money-making indulgence and inefficiency of primary healthcare in Nigeria: a qualitative study of health workers' absenteeism. Int J Public Health. 2020;65(7):1019–26. doi:10.1007/s00038-020-01405-3.
5. Ogbozor P, Onwujekwe O, Balabanova D, Odii A, Agwu P, et al. The gendered drivers of absenteeism in the Nigerian Health System. Health Policy Plan . 2022;37 (10): 1267-1277. https://doi.org/10.1093/heapol/czac056
6. Transparency International. Corruption perceptions index. 2020 [accessed 2021 Mar 20]. https://www.transparency.org/en/countries/nigeria.
7. Obodoechi DN, Onwujekwe O, McKee M, Angell B, Agwu P, et al. Health worker absenteeism in selected health facilities in Enugu State: do internal and external supervision matter? Front Public Health. 2021;9:1–7. https://doi.org/10.3389/fpubh.2021.752932
8. Oche MO, Oladigbolu RA, Ango JT, Okafoagu N, Ango U. Work absenteeism amongst health care workers in a tertiary health institution in Sokoto, Nigeria. J Adv Med Med Res. 2018;26(2):1–9. doi:10.9734/JAMMR/2018/40467.
9. Mbombi MO, Mothiba TM, Malema RN, Malatji M. The effects of absenteeism on nurses remaining on duty at a tertiary hospital of Limpopo province. Curationis. 2018;41(1):e1–e5. 20181127. doi:10.4102/curationis.v41i1.1924.
10. Uzochukwu B, Agwu P, Okeke C, Uzochukwu A, Onwujekwe O. Ensuring safety of patients in complex health systems: a focus on primary healthcare service relations in Nigeria. Health Soc Work. 2022. doi:10.1093/hsw/hlac1041.
11. Kisakye AN, Tweheyo R, Ssengooba F, Pariyo G, Rutebemberwa E, Kiwanuka S. Regulatory mechanisms for absenteeism in the health sector: a systematic review of strategies and their implementation. J Healthcare Leadersh. 2016;8:81. doi:10.2147/JHL.S107746.
12. Tweheyo R, Daker-White G, Reed C, Davies L, Kiwanuka S, et al 'Nobody is after you; it is your initiative to start work': A qualitative study of health workforce absenteeism in rural Uganda. BMJ Global Health. 2017;2:1–11.
13. Belita A, Mbindyo P, English M. Absenteeism amongst health workers–developing a typology to support empiric work in low-income countries and characterizing reported associations. Hum Resour Health. 2013;11:1–10. doi:10.1186/1478-4491-11-34.
14. Dadwal V. Why fighting corruption is key to improving healthcare. 2014 [accessed 2021 Mar 24]. https://www.weforum.org/agenda/2014/10/fighting-corruption-improving-healthcare/.
15. Tweheyo R, Daker-White G, Reed C, Davies L, Kiwanuka S, Campbell S. 'Nobody is after you; it is your initiative to start work': a qualitative study of health workforce absenteeism in rural Uganda. BMJ Global Health. 2017;2(4):e000455. doi:10.1136/bmjgh-2017-000455.
16. Hutchinson E, Naher N, Roy P, McKee M, Mayhew SH, Ahmed SM, Balabanova D. Targeting anticorruption interventions at the front line: developmental governance in health systems. BMJ Global Health. 2020;5(12): e003092. doi:10.1136/bmjgh-2020-003092.
17. Federal Republic of Nigeria. Public service rules. 2007 [accessed 2022 Aug 24]. https://awajis.b-cdn.net/wp-content/uploads/2017/09/Public-Service-Rules.pdf.
18. Magbadelo JO. Understanding the Nigerian public service rules. Ann Social Sci Manage Stud. 2020;5 (4):100–06. doi:10.19080/ASM.2020.05.555666.
19. Awodele-Fayomi I. Managing discipline problems in the contemporary Nigerian civil service for sustainable national development. J Econ Sustain Dev. 2015;6:137–47.
20. Khan MH. Political settlements and the analysis of institutions. African Affairs. 2018;117(469):636–55. doi:10.1093/afraf/adx044.
21. SERVICOM. About SERVICOM. 2017 [accessed 2022 Dec 28]. https://servicom.gov.ng/our-clinic/about/.
22. Etiaba E, Manzano A, Agbawodikeizu U, Ogu U, Ebenso B, Uzochukwu B, Onwujekwe O, Ezumah N, Mirzoev T. "If you are on duty, you may be afraid to come out to attend to a person": fear of crime and security challenges in maternal acute care in Nigeria from a realist perspective. BMC Health Serv Res. 2020;20(1):1–10. doi:10.1186/s12913-020-05747-9.
23. Health Partners International. Bringing primary health care under one roof. 2014 [accessed 2022 Dec 28]. https://ngfrepository.org.ng:8443/handle/123456789/3277#:~:text=Primary%20Health%20Care%20Under%20One%20Roof%20(PHCUOR)%20is%20a%20policy,PHC%20services%20under%20one%20authority.
24. Khan M, Roy P. Summary: making anti-corruption real: using a 'Power Capabilities and Interest Approach' to stop wasting money and start making progress. 2022 [accessed 2022 Sep 30]. https://ace.soas.ac.uk/publication/summary-making-anti-corruption-real-using-a-power-capabilities-and-interest-approach-to-stop-wasting-money-and-start-making-progress/.
25. Khan M, Watkins M, Zahan I. De-risking private power in Bangladesh: how financing design can stop collusive contracting. Energy Policy. 2022;168:113146. doi:10.1016/j.enpol.2022.113146.
26. Khan M, Watkins M, Aminuzzaman S, Khair S, Khan M. Win-win: designing dual-use in climate projects for effective anti-corruption in Bangladesh. Clim Dev. 2022;1–14. doi:10.1080/17565529.2022.2143232.