Implications of absenteeism of health workers on achieving universal health coverage in Nigeria

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Table 1: Summary of sociodemographic attributes of sampled health workers and policymakers

Variables	**Health workers (n=42)**	**Policymakers (n=6)**
Gender		
Male	2 (4.8%)	4 (66.7%)
Female	40 (95.2%)	2 (33.3%)
Age		
18-30 years	28 (66.7%)	0 (0%)
>30 years	14 (33.3%)	6 (100%)
Location		
Urban	21 (50%)	3 (50%)
Rural	21 (50%)	3 (50%)
Level of education		
CHEW	20 (47.6%)	N/A
Community Health Officer	10 (23.8%)	N/A
BSc	8 (19%)	3 (50%)
MSc	2 (4.8%)	1 (16.7%)
MBBS	2 (4.8%)	N/A
Environmental Officer	N/A	2 (33.3%)
Cadre/Position		
Facility Manager (OIC)	6 (14.2%)	N/A
Doctor	2 (4.8%)	N/A
Volunteers	18 (43%)	N/A
Others	16 (38%)	N/A
Supervisor	N/A	2 (33.3%)
Head of Department	N/A	4 (66.7%)

Table 2: Summary of sociodemographic attributes of sampled health facility committee members and service users

Variables	**Health facility Committee members (n=6)**	**Service users (n=96)**
Gender		
Male	6 (100%)	48 (50%)
Female	0	48 (50%)
Age		
18-30 years	0	39 (41%)
>30 years	6 (100%)	57 (59%)
Location		
Urban	3 (50%)	48 (50%)
Rural	3 (50%)	48 (50%)
Level of Education		
Primary education	3 (50%)	21 (21.9%)
Secondary education	2 (33.3%)	49 (51%)
Tertiary education	1 (17%)	26 (27.1%)

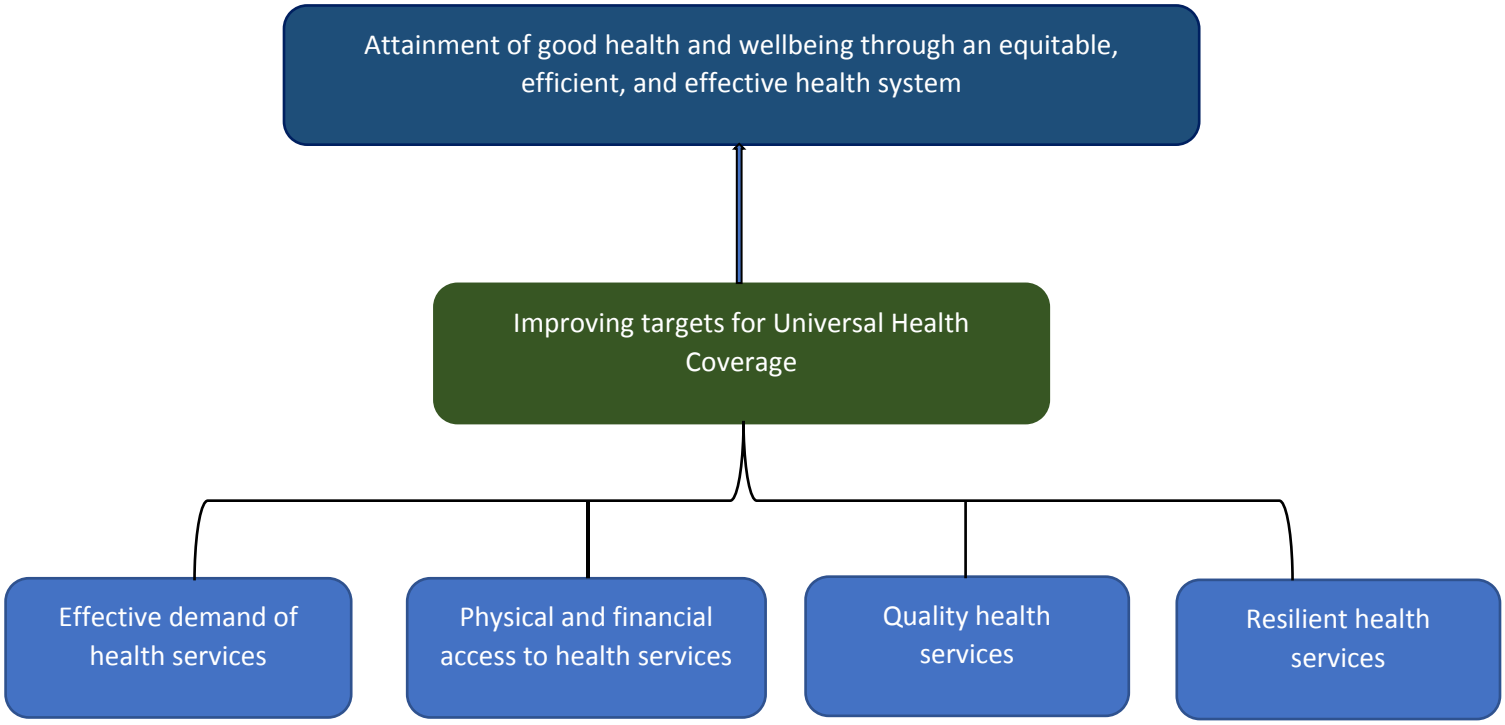

Figure 1: WHO-AFRO framework for health systems development toward achieving UHC

Highlights

- Absenteeism of health workers at the primary healthcare level is rife, driven by systemic defects, and compromises health security of those, especially poor and middle-class persons who largely depend on primary healthcare.
- The indicators of attainment of Universal Health Coverage as designed by the WHO-African Region, are all constrained by absenteeism of health workers in Nigeria, leading to weak trust in PHCs, poor access and demand for PHC services, and utilization of unsafe and high-cost alternative healthcare.
- The constraints posed by absenteeism on Nigeria's achievement of UHC by 2030 should catalyse urgent and effective solutions based on evidence.

Implications of absenteeism of health workers on achieving Universal Health Coverage in Nigeria: Exploring lived experiences in primary healthcare

Abstract

Background: Primary Healthcare **(**PHC) facilities are the bedrock for achieving Universal Health Coverage (UHC) because of their closeness to the grassroots and provision of healthcare at low cost. Unfortunately, in Nigeria, the access and quality of health services in public Primary Healthcare Centres (PHCs) are suboptimal, linked with persistent occurrence of absenteeism of health workers. We used a UHC framework developed by World Health Organization-African Region (WHO-AFRO) to examine the link between absenteeism and the possible achievement of UHC in Nigeria.

Methods: We undertook a qualitative study to elicit lived experiences of healthcare providers, service users, chairpersons of committees of the health facilities, and policymakers across six PHCs from six local government areas in Enugu, southeast Nigeria. One-hundred and fifty participants sourced from the four groups were either interviewed or participated in group discussions. The WHO-AFRO UHC framework and phenomenological approach were used to frame data analysis.

Results: Absenteeism was very prevalent in the PHCs, where it constrained the possible contribution of PHCs to the achievement of UHC. The four indicators toward achievement of UHC, which are demand, access, quality, and resilience of health services were all grossly affected by absenteeism. Absenteeism also weakened public trust in PHCs, resulting to an increase in patronage of both informal and private health providers, with negative effects on quality and cost of care.

Conclusion: It is important that great attention is paid to both availability and productivity of human resources for health at the PHC level. These factors would help in reversing the dangers of absenteeism in primary healthcare and strengthening Nigeria's aspirations of achieving UHC.

Keywords: Absenteeism, corruption, health systems strengthening, universal health coverage, UHC

Introduction

In 2015, African countries, inclusive of Nigeria, signed up to implement the Sustainable Development Goals (SDGs), thereby making inadvertent commitment to SDG 3 which emphasizes the achievement of Universal Health Coverage (UHC) by 2030. The aim of UHC is to ensure that everyone can access quality healthcare, whenever they choose to, and without facing financial hardship [1]. About eight years since Nigeria's commitment to UHC, its UHC index has stagnated below 50% [2]. This stagnation is partly because of inefficiencies and shortcomings like absenteeism of health workers, that have largely characterized human resource for health in Primary Healthcare [3].

Absenteeism has far-reaching negative impacts on human resource for health in low resource regions, with knock-on effects on UHC aspirations [4, 5]. A systematic review and nominal group technique revealed that absenteeism was the foremost and most damaging corruption issue in Nigeria's health sector [6, 7]. Studies on primary health care in Nigeria identified absenteeism as a major cause of inefficiency, with severe consequences on delivery of care, affecting poor people the most, and encouraging healthcare inequities [8, 9]. Unfortunately, many low-and-middle-income countries (LMICs) are affected by health workers' absenteeism, with rates clustered between 45% and 70% [4, 5].

Drivers of absenteeism have been underscored by previous studies [9-11]. These drivers could be about how postings are designed, insecurity of health facilities, inconsistent salaries, lack of supervision, family and social responsibilities, dual practice, to mention but a few. Many of these drivers have persisted over the years, and we are of the view that understanding the gravity of absenteeism in constraining the achievement of UHC will encourage policymakers and other health sector players to urgently pursue effective solutions. Thus, in the current study, we tapped into the lived experiences of health workers, service users, and policymakers to explain how absenteeism constrains achievement of UHC in Nigeria.

Conceptual framework

The effects of absenteeism are discussed within four indicators that measure the attainment of UHC as set by WHO-AFRO [1]. These indicators include effective demand of health services, better physical and financial access to health services, high quality health services, and robust resilience of service delivery (see Figure 1). According to the WHO-AFRO framework, UHC can be achieved when service users demand health services that are accessible, financially

affordable, of high quality, and when they exercise trust in the health system [1]. Therefore, with high rates of absenteeism, there will surely be barriers to the achievement of these indicators, which have strong potential to negatively affect the achievement of UHC.

Based on the foregoing, we asked the following research questions – (a) In what ways are demand for PHC services threatened by absenteeism? (b) How can absenteeism compromise physical access to health facilities and affordability of health services? (c) How is quality of health services affected by absenteeism? (d) How has absenteeism affected public trust in PHCs and the capacity of health facilities to be self-sustaining?

Insert Figure 1 about here

Methods

Study setting and design

The study was undertaken in Enugu state, southeast Nigeria. The state has 17 Local Government Areas [LGAs], of which 14 are considered rural. Enugu has a population of 3.3 million people [12], with about 558 public PHCs [13]. The study used a qualitative research design and relied on the Consolidated Criteria for Reporting Qualitative Research (COREQ) to guide the implementation and reporting of methods [14].

Sampling

Six LGAs were purposively selected to represent the urban and rural regions. In each of the six LGAs, we randomly selected one facility, making a total of six health facilities for the study. Seven health workers were selected from each of the six facilities, including Officers in Charge (OIC) of the facilities. One policymaker was selected from each of the six LGAs. Two focus group discussions (FGDs) – one all-male (eight participants each) and one all-female (eight participants each), were conducted in each of the six communities hosting the selected six facilities. We interviewed the heads of the health facility committees across the selected facilities. Thus, we conducted a total of 42 interviews with health workers, 6 interviews with policymakers, 6 interviews with heads of health facility committees, and 12 FGDs with 96 service users. In all, we had a total of 150 participants for the study.

Data collection

Data collection tools were pretested in a community not selected for the study, and lessons from the pretest guided the revision of study tools. In order to elicit lived experiences of participants, we ensured that our questions were guided using phenomenology [15]. The idea was to ask questions that will elicit experiential narratives. Interviews were conducted in English and Igbo languages, depending on the preferences of participants. Responses were recorded with a recording device. Respondents provided signed informed consent before they were interviewed. The informed consent forms clearly spelt out details about recording, confidentiality, anonymity, and full disclosure.

Data analysis

The interviews were first transcribed in English language. The analysis relied on deductive approach by utilizing predefined set of codes derived from the existing WHO-AFRO UHC framework. The interpretive phenomenological approach was used to convey the meanings that the participants make of their experiences of health workers' absenteeism and the researchers' interpretations of what this implies for the UHC indicators [15]. This approach allowed for the co-construction of meanings between the researchers and the participants, leading to a richer and more nuanced understanding of the issue.

Results

Sociodemographic characteristics of participants

The quota sampling technique was used to ensure equal representation of the urban and rural locations. The health workers had more females than males, which is expected owing to the frontline in primary healthcare being female-dominant. Details of the sociodemographic features can be found in Tables 1-2.

Insert Table 1 about here

Insert Table 2 about here

Consequences of absenteeism on demand for primary healthcare services by service users

Our findings revealed that absenteeism diminished demand for health services in PHCs.

> *These health workers in public facilities usually feel that they are government properties. They feel less concerned. I have stopped using them for a while. I now go to private facilities or to bigger facilities in town. Even though it is not small money you pay, but you will at least see someone that will attend to you* ***[Female, Service User, Urban, 33 years]***.

Some service users had to patronize informal health providers, further diminishing demand for health services in PHCs.

> *One thing we do in this community is that even after we have registered at the health centre, we look for those women that help people to give birth at home and identify with them. Labour usually comes at night, and you may go to the facility, and you will not see someone. It is those women that usually help us* ***[Female, Service User, Rural, 28 years]***.

Absence of medical doctors in the PHCs also affected demand.

> *We have a doctor, but he hardly comes around. I have pleaded with him that patients are always asking after him. Some of them have decided to go to the private facilities where they can see a doctor. I am tired of taking consultancy on his behalf* ***[Female, Health Facility Manager, Urban, 52 years]***.

Absenteeism and availability/affordability of primary health services

Absenteeism affects availability of primary health services, and service users are forced to seek alternatives that could be financially burdensome on them.

> *I come late most times because I live far away […] Just our volunteers manage to receive patients at night. If they are not around, the facility will not function* ***[Female, CHEW, Rural, 48 years]***.

Second, absent medical doctors refer patients to their private facilities and charge them exorbitantly.

> *The doctors they employ usually work in several places. They give more attention to those other places than here. He has his own hospital. Sometimes he will refer some of our patients to his facility. And they will*

gladly go, of course he is a doctor. Patients are happy when they are attended to by doctors. That is where he will then charge them some huge amount […] ***[Female, Health Facility Manager, Urban, 49 years]***

Absenteeism compromising quality of primary healthcare services

Service users reported cases of absent doctors, forcing the CHEWs into rendering services that exceed their scope. A male service user narrated his experience with his pregnant wife.

During labour, my wife was bleeding. I noticed that the health workers were talking to the doctor on phone while my wife was in pain. He was directing them on what to do. I did not find the older health workers on duty that day. One of the ladies had to rush to call the OIC, but I had to rescue my wife, and then took her to a private hospital ***[Male, Service User, Rural, 36 years].***

The participants further mentioned that due to absenteeism, emergency services are affected, and fatalities could occur.

One of the senior health workers stays close to me. Even at mid-night, people will be banging on her door to bring her out because of complicated cases that have exceeded the volunteer nurse. But my worry is that something might happen between that time ***[Male, HFCC, Rural, 56 years].***

There was consensus that absenteeism causes overwork for those who are present, which could also compromise the quality of health services. Also, absenteeism of older health workers implies that the facilities would be in the hands of younger ones who may not be as experienced as the older ones.

Effects of absenteeism on primary healthcare resilience in the directions of trust and self-sustenance

Trust and the capacity to withstand shocks are vital components of health systems resilience. On trust, community people seem to have normalized health workers being absent from duty.

[…] One woman from one of the communities around was telling me that the health workers in her area attend to farm works and if it is on a market day, they do go and sell in the market leaving the facility locked. She was saying it as though she had no problem with that. ***[Male, Policymaker, Urban, 57 years]***

The community members expressed doubts about the primary healthcare centres handling emergencies due to absenteeism.

> *[…] Before, no matter the time you come to this facility, you will surely see the person that will attend to you, unlike now. For instance, all my children were born here and in one of the births, my wife encountered difficulties in child delivery of which the nurses here did their very best. But if it were now, my wife could have died* ***[Male, HFCC, Rural, 62 years]***

It appears the policymakers expected the facility managers to report cases of absenteeism to them, but they barely got such reports. Also, they complained about overseeing several health facilities within the local government areas, yet lacking resources to fund the logistics for an efficient supervisory exercise.

Discussion

Statement of principal findings

Our study shows how absenteeism threatens all four UHC indicators (demand, availability/affordability, quality, and resilience of PHC services) in Nigeria, casting doubts on the country's possibilities of achieving UHC. With high incidents of absenteeism of health workers, trust in the availability of PHC is threatened and service users are already reporting seeking alternative services from traditional/unorthodox practitioners and other informal and private health providers, which can be of low quality and/or financially burdensome. This shows that trust in the services delivered by the PHC system is significantly dimnishing, and achieving UHC may end up a mere aspiration. Therefore, there is an urgent need to pursue evidence-driven solutions to absenteeism in PHCs in Nigeria and similar contexts.

Strengths and limitations

While studies exist on how absenteeism is a problem and what can be done [4, 13], situating the problem in the context of derailing the attainment of UHC is scarcely discussed, which is the major strength of this study. We document in this study the enormity of damage absenteeism causes primary healthcare, especially as primary healthcare remains the cornerstone of achieving UHC. The study corroborates Nigeria's poor UHC rating, signalling the need for an aggressive approach to tackle absenteeism in view of strenghtening the PHC system vis-à-vis the overall health system.

The limitation of our study in terms of geographical spread is managed by the strength of its sample size and the lived experiences elicited from such number of persons drawn from rural and urban locations.

Interpretation within the context of the wider literature

The current study affirms that an efficient primary healthcare is the desire of the low- and middle-income groups [16, 17], which means that PHCs should be in high demand by many. Since such demands are not optimally met, service users are forced to seek alternative sources of healthcare, precisely from three sources – private providers, higher-level facilities, and informal health providers like traditional birth attendants (TBAs) and medicine vendors, thereby diminishing the demand for health services from public PHCs. Service users appear to have normalised absenteeism in the PHCs, evidenced by pregnant mothers identifying with TBAs, even after registering in PHCs, as well as discussing the subject of absenteeism with some sense of hopelessness.

Many participants worry that health facilities might not be functional at night. Locked up health facilities and/or facilities dominantly staffed by less experienced volunteers or placeholders are common. Recent studies have suggested that continuous engagement of young volunteer health workers without the presence of experienced and older health workers kills trust in the public PHCs [13, 16, 18].

Indeed infrastructural and security crisis could force facilities to stop nighttime services, but this is happening at the expense of weakened trust in public PHCs. As previous studies have documented, there is need to resolve infrastructural deficit facing facilities and guarantee the security of lives and properties in and around the facilities [19, 20]. If young volunteers must be a coping mechanism to overall human resource shortage, they should be supported by experienced health workers. Alternatively, retired health workers who are willing and able to continue health service delivery can be retained as volunteers. Our study is showing that the presence of experienced PHC workers is capable of strengthening quality in health service delivery and improving trust in the public PHCs, and vice-versa.

Doctors' absenteeism was widely reported. And when doctors are at work, there were frequent reports of inappropriate referrals/patient diversion to private facilities were service fees are substantially higher. Some service users prefered to abandon public PHCs without doctors and sought care in private and higher-level facilities. This compromises the financial protection goal of UHC. Furthermore, doctors' absenteeism often mean that lower cadre health workers like

CHEWs and CHOs might be performing healthcare operations beyond their scope [16]. This questions quality of health services, and again, diminishes trust in the public PHC system.

Implications for policy, practice and research

Our findings confirm that the level of absenteeism in primary healthcare is now very high. Policymakers expressed being helpless, especially since they are not properly funded to enforce an effective supervision, and are challenged by the lack of cooperation from the OICs who should report absent staff. Internal regulatory mechanisms to stop absenteeism in health facilities are weak. Hence, we align with the recommended solutions documented in similar studies [6, 13, 21]. These studies acknowledge the lethargy of health governance actors in getting PHCs running efficiently; potentially because of non-prioritisation of health goals, shrinking resources of government, or an outright 'tragedy of commons' where the elites permit the free fall of public goods that do not benefit them directly [13, 22].

Most of these studies mentioned above have recommended more grassroots solutions that can be enabled by commitments of government in terms of establishing clear cut rules, hotlines for reporting absenteeism, and being responsive to reports of absences of health workers. The studies also mentioned that the grassroots solutions should be accompanied by efforts to address defects in the system, which include welfare and incentives for healthcare staff [23]. Grassroots solutions should be championed by the leadership of the health facility committees resident in communities, civil societies, media, well off community members, and importantly, deployment of social justice professionals like social workers to the frontline to promote and defend health rights of service users and perform human resource management roles, which include eliciting optimal commitment to work [24].

It is important to note that our study is the first to utilize these UHC indicators developed by WHO-AFRO in mapping the problem of absenteeism in primary healthcare. We encourage more framework analysis on other corruption types using the indicators, as this will provide an objective and comprehensive assessment of Nigeria's journey toward UHC.

Conclusions

Our study has utilized the WHO-AFRO framework in explaining how Nigeria is far from attaining UHC if absenteeism persists. To address this failure, there must be concerted and urgent efforts toward scaling up demand, access, quality,

and resilience of the public PHC system, by ensuring that health workers are at work and committed. We have shown how each of these indicators is impacted by absenteeism, further emphasizing the enormity of damage it causes the health sector. Reversing this ugly scenario is to utilize both horizontal and vertical approaches, which in one hand will get health workers to their duty posts, committedly providing quality health services, and on the other hand, will address systemic shortcomings that have largely permitted absenteeism.

Declarations

Compliance with ethical standards This study was approved by the Ethical Review Board of the University of Nigeria with the reference code NHREC/05/01/2008B-FWA00002458-1RB00002323

Conflict of interest The authors have no conflicts of interest to disclose.

Data availablity The data for this study can be made available upon reasonable request to the corresponding author.

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