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RESEARCH ARTICLE

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Targeting systems not individuals: Institutional and structural drivers of absenteeism among primary healthcare workers in Nigeria

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Abstract

Universal Health Coverage (UHC) can only be achieved if people receive good quality care from health workers, yet in Nigeria, as in many other low- and middle-income countries (LMICs), many health workers are absent from work. Absenteeism is a well-known phenomenon but is often considered as the self-serving behaviour of individuals, independent from the characteristics of health systems structures and processes and the broader contexts that enable it. We undertook a qualitative inquiry among 40 key informants, comprising health facility heads and workers, community leaders and state-level health policymakers in Nigeria. We employed a phenomenology approach to examine their lived experiences and grouped findings into thematic clusters. Absenteeism by health workers was found to be a response to structural problems at two levels –midstream (facility-level) and upstream (government level) – rather than being a result of moral failure of individuals. The problems at midstream level pointed to an inconsistent and unfair application of rules and regulations in facilities and ineffective management, while the upstream drivers relate mainly to political interference and suboptimal health system

leadership. Reducing absenteeism requires two-pronged interventions that tackle defects in the upstream and midstream rather than just focusing on sanctioning deviant staff (downstream).

KEYWORDS
absenteeism, anticorruption, corruption, health systems, primary healthcare, structural drivers

Highlights

- Absenteeism ranks highly among types of corruption in health systems in Nigeria.
- Vertical top-down enforcement of rules against absenteeism alone has proven ineffective.
- A holistic approach to resolving absenteeism is to consider the several levels of administration of rules in health systems, identify deficiencies, and address them.
- Successful harmonisation of capacities at up- and mid-stream levels, while tackling weaknesses at the individual level, can foster commitment to appropriate behaviour by frontline staff working at the downstream level.

1 | INTRODUCTION

The health sector is notoriously prone to corruption, with health workers' absenteeism one manifestation that profoundly affects people's lives.[1] A predominant view of absenteeism, as with other types of corruption, is that it is an inevitable consequence of inadequate resources and weak governance. The implication is that absenteeism will decline as resources increase and governance improves. Most solutions proposed have adopted 'carrot and stick' policies targeting absent individuals, although recent work has highlighted the role of networks and local politics in enabling corruption.[2,3] However, there has been relatively little research on the health systems and structural enablers and solutions to absenteeism of health workers, which has been ranked first among types of corruption in health sectors in sub-Saharan Africa.[4]

The systemic factors that enable corruption are missing from the widely used definition, the abuse of publicly entrusted powers for private gain.[5] Thus, a new definition has sought to broaden this perspective to take account of how individuals' behaviours are enabled by social and institutional environments. This sees corruption as 'the abuse or complicity in abuse, of public or private position, power or authority to benefit oneself, a group, an organisation or others close to oneself in a way which diverts institutions from their core aims'.[2] This definition makes two important shifts – first; it recognises the importance of organisational and socio-economic contexts of socio-political and professional networks in shaping corruption. And second, it emphasizes that the harms caused by corruption extend beyond individual behaviour to distort the system's operation. Understood in this way, absenteeism – as a form of corruption in the health sector – can be seen not just as a moral failure, but a system-wide problem that is a major obstacle to achieving Universal Health Coverage (UHC).

A 2019 survey in Nigeria rated the health sector among the top five most corrupt institutions.[6] The same year, a study ranked absenteeism, informal payments, procurement irregularities, health financing and employment malpractices as the leading forms of corruption undermining the Nigerian health system.[4] Among all of these,

absenteeism, defined as the loss of contracted work hours for private gain, was seen as the most damaging due to its direct impact on health services, especially in primary health care and poorly resourced locations. Onwujekwe and colleagues extended the definition of absenteeism to capture lateness in arriving at work, being present at work but not doing one's job (presenteeism), leaving before the end of shift, and using work time to pursue other private businesses (including private practice and farming), as well as attending social functions and undertaking domestic responsibilities.[7]

Effective action to tackle absenteeism must consider the factors preventing health workers from coming to work and those encouraging them to take advantage of the system for their own benefit.[8,9] This is particularly important in Nigeria's primary healthcare system, where some healthcare workers are absent because of the demands of economic survival and/or concerns about physical safety.[10] There are also chronic systemic weaknesses, including irregular salaries, clientelism, and godfatherism (powerful figures protecting rule-breaking staff from sanctions), all encouraging absenteeism.[11]

To address the gap in knowledge described above, our paper seeks to examine the structural or systemic drivers within the Nigerian health system and their roles in the various manifestations of absenteeism. It draws on the idea of structural functionality in public health to explain the influences of structures, organisational rules and ways of operation, on absenteeism.[12]

1.1 | Structural influences on health worker absenteeism: A novel framing

Brownson and colleagues describe three interactive governance streams in a health system – the upstream, midstream and downstream, representing government, facility, and personnel factors, respectively.[12] These three streams are interactive, combining to deliver the good governance needed for a well-functioning healthcare system. The authors argued that a health worker's attitude (downstream level) is a consequence of the two structures (upstream level [government-controlled systems beyond health facilities] and midstream [systems within health facilities]). This is underpinned by the idea that health systems are socially constructed, and services are impacted by factors arising by the specific contexts, in this case, political and social connections that protect absent health workers or those skipping work because of insecure facilities.[13]

These complex interdependencies point to a need to adopt a structural approach since weaknesses in governance (upstream and midstream), as well as the normalization of rule breaking behaviours in particular social and political contexts,[14] will have consequences for downstream actions – health workers' attitudes and relationship with service users. Figure 1 illustrates the structural interactions that incentivise absenteeism of healthcare staff, showing how factors acting within government encourage maladaptive behaviours by health workers and inefficiencies. The arrows in Figure 1 indicate influences of these factors flowing downward and responses flowing upward.

2 | METHODOLOGY

Our study objectives were: (a) To identify structural drivers of absenteeism of PHC workers in Nigeria; (b) To distinguish among those structural drivers that relate to the government or the facility; (c) To explain how health workers react to the structural drivers demonstrated through their commitment to work.

2.1 | Context of the study

The study was conducted in Enugu, a south-eastern state of Nigeria. The state has 17 Local Government Areas (LGAs), mostly rural, and about 558 public primary healthcare facilities.[15] Public primary healthcare facilities are

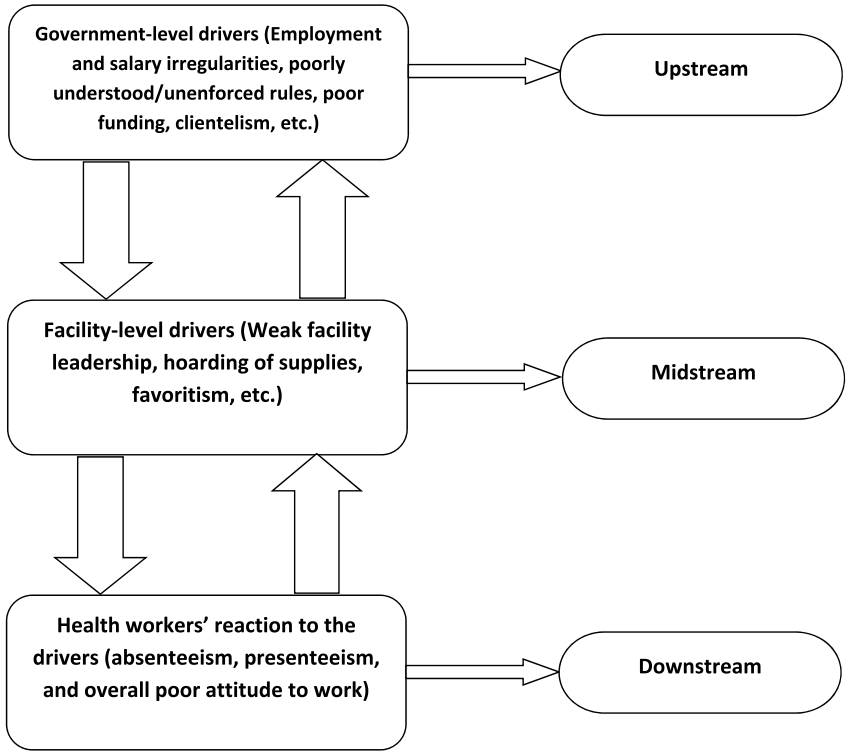

FIGURE 1 Structural influences on absenteeism of healthcare staff.

constitutionally within the local government's jurisdiction, although with intermittent oversight from the state and federal governments. The workforce in Nigerian PHCs mainly comprise Community Health Extension Workers (CHEWs) and Community Health Officers (CHOs). There are a few nurses, midwives, and doctors in PHCs, and they earn less than their counterparts at the secondary and tertiary levels.[16]

The management structure for PHCs links the State Primary Healthcare Development Agency (SPHCDA), Local Government, and the State Ministry of Health. The Health Department in every local government is responsible for the PHCs, and it is headed by a Head of Department (HOD) answerable to authorities above them (local government chairperson, supervisor for health, Executive Secretary of the SPHCDA and authorities at the State Ministry of Health). It is important to note that the SPHCDA is the umbrella agency that oversees primary healthcare in the state, working with the Health Departments across the local government areas and the Ministry of Health to galvanize primary healthcare leadership and management. To facilitate grassroots participation in healthcare, there is a provision to establish a Health Facility Committee (HFC), which comprises community members who work with the health workers and the broader leadership structure to ensure the quality of work.

2.2 | Sampling

Data were collected from six purposively selected sites in Enugu, evenly representing urban and rural LGAs. In each of the LGAs, we interacted with two senior healthcare managers, two facility managers, and one member of the HFC, making a total of 30 respondents. In addition, ten health workers were interviewed from the selected rural and urban LGAs, leading to the grand sum of 40 respondents for the study. LGAs and facilities were selected purposively, based on broad representation and accessibility. We used purposive sampling to select health workers that had long-term experience in primary healthcare and availability sampling in line with the topic's sensitivity, that is, respondents who

felt uncomfortable speaking about absenteeism were excused. This procedure is consistent with a similar study.[17] Reassuringly, we achieved data saturation when interviews stopped yielding exclusive new information, a key consideration for sample size determination in qualitative studies.[18]

2.3 | Ethics

The study was approved by the Ethics Committee of the university that hosted the study location, with approval number – NHREC/05/01/2008B-FWA00002458-IRB00002323. Respondents were given an informed consent form with full details of the study, the promise of anonymity and confidentiality, their right to withdraw at any time and permission to audio record. The signatures of the participants were obtained on the written informed consent form, confirming their willingness to participate.

2.4 | Data collection

We pre-tested the in-depth interview (IDI) guide in a different LGA. Results of the pre-test were used to modify the guide before the main study. Interviews were conducted in offices or at health facilities, based on the choice and convenience of the respondents and were designed not to exceed 1 hour, so as to reduce fatigue on the part of the respondents.

2.5 | Data analysis

Phenomenology was used to guide our data analysis. The phenomena were the drivers emanating from structures and processes that influence absenteeism. To understand these phenomena, we explored the lived experiences of health workers and healthcare managers. Leveraging their lived experiences, we examined the different worlds surrounding them – government, politics, facility, culture, and norms, seeking to understand the interrelationship between these worlds and absenteeism. These worlds were examined as structures with their own layers and rules to achieve a good understanding of their functioning and impact on absenteeism.[19]

In line with the layering used in phenomenology, thematic clusters were used to categorize the lived experiences of the respondents. The themes included: (a) government-level influences on absenteeism (upstream), (b) facility-level influences on absenteeism (midstream), and (c) health workers' reaction to structural influences on their commitment to work (downstream). Some thematic clusters have subthemes, as presented in the results section.

Data was entered into a coded MS Word Excel spreadsheet. Afterwards, given the value of triangulating observations,[20] the spreadsheets were internally reviewed to ensure that responses were placed appropriately within themes or subthemes. We also adopted peer debriefing, as two of the authors went through the harmonized spreadsheet to ensure that responses were appropriately placed and addressed the study's objectives.

3 | RESULTS

3.1 | Sociodemographic features of respondents

We interviewed 40 stakeholders in six local sites in urban and rural settings. Of these 40, 12 were senior healthcare managers (HODs and supervisors for health), 12 were facility managers (OICs), 6 were members of health facility committees, and 10 were health workers comprising doctors, nurses, community health extension workers (CHEWs), and midwives. Most were female (80%) and above 30 years of age (75%) and married (75%). Twenty-five per cent worked in urban facilities. Table 1 presents their socio-demographic features.

TABLE 1 Summary of sociodemographic features of respondents.

Sociodemographic	Frequency	%
Gender		
Male	8	20
Female	32	80
Total	40	100
Cadre		
Top healthcare managers	12	30
Facility managers	12	30
Health facility committee members	6	15
Health workers	10	25
Total	40	100
Marital status		
Married at present	30	75
Not married at present	10	25
Total	40	100
Geographical location		
Urban	10	25
Rural	30	75
Total	40	100
Age		
>30 years	30	75
≤30 years	10	25
Total	40	100
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
Total	40	100

We structured our findings to offer insights into the three thematic categories set out in Figure 1 that guided this study: government- and facility-level influences on absenteeism and reactions of health workers to structural influences – including their decision to be present or absent.

3.2 | Government-level influences on absenteeism (upstream)

The Nigerian national government is responsible for policy, creating the rules that govern recruitment, promotion, payment of salaries, supply of consumables and equipment, and levels of funding of health centres. However, its power is dispersed, reflecting the federal structure and the continued roles of traditional leaders, which vary among the different 36 states in Nigeria, including the Federal Capital Territory. The influence on absenteeism of those

holding this power can be profound, especially regarding the five subthemes we identified: (i) infrastructural gaps; (ii) security; (iii) political protection and interference; (iv) poor welfare provision; (v) unclear and unenforced rules.

i. Infrastructural gaps, including deficiencies in healthcare supplies

Concerns about infrastructure were frequently identified in our interviews as a reason why health workers avoid being present at work. These included the dilapidated state of health facilities, poor work environment, lack of or very poor-quality living quarters, and poor road communications. As a health worker in a rural facility describes, a lack of medicines meant that patients rarely come to their facility, which encouraged them to be absent.

> There are times when drugs are not available, and sincerely, the facility lacks equipment. When patients come around, they are discouraged. We could stay for a long time without seeing any patient. During such time, we just lock the facility, instead of wasting transport fare to come to work and not attend to anyone **[Health worker, Rural Facility, 41 years]**

Several respondents complained about the need for more acceptable accommodation within the premises of the facility, which caused them to travel long distances each day, often at high cost. A facility manager noted that:

> I stay far from the facility. If there is a good staff quarter here, I do not mind staying here, and maybe bring my family with me. Sometimes, I will be at home and they will be calling me to come to the facility. How do you want me to do it? It takes up to 2 hours to come here. It is even more when the road is bad or when there is traffic **[OIC, Rural Facility, 51 years]**

Those living far from the health facilities were more often absent, partly due to the lack of an efficient public transportation system, high fares, and poor roads.

ii. Absence of security arrangements

The security of most facilities was considered poor or non-existent and encouraged absenteeism. Many health workers reported having had personal belongings and hospital equipment stolen and experiencing harassment within and around the health facilities. This was a common reason why staff were absent at night. One of the facilities had to provide an ad-hoc security staff to secure the facility at night, yet safety was considered inadequate.

> Our facility is secure because we have fence, and we have someone who we invite to help us watch over us at night. He is an old man, though. We pay him from the money we generate in the facility. But we have one problem. There is no security light around the facility. At nights, we use kerosene lanterns. To intensify the security, we need a big security light, so that we can easily see anyone that hangs around the facility at night **[OIC, Urban Facility, 49 years]**

iii. Political protection:

The respondents frequently cited political interference in recruitment and retention of staff, transfers, and the application of disciplinary sanctions as having a huge influence on absenteeism. Those in authority often exert influence in various ways favouring their relatives and acquaintances. For example, a senior healthcare manager said:

> The HOD is approached by these powerful people to influence the posting of the person they are protecting to an inactive facility where supervision is very weak, and him or her cannot say no **[Healthcare manager, Urban LGA, 53 years]**

This influence exploited tribal and ethnic affiliations or trade in favours, allowing individuals with protection impunity when absent. Those charged with implementing and enforcing sanctions in facilities, like the HOD and OIC, would rather try to save their jobs than confront protected staff, knowing that they risk retaliation, such as transfer to remote facilities or removal from office. A facility manager describes this scenario:

> As an OIC, you have to be very careful when dealing with such people. When the HOD is careful, who are you not to be careful. My job is important to me. The much I can do is to report to the HOD. If she acts, it is her concern **[OIC, Urban Facility, 49 years]**

A senior healthcare manager discussed the role of political relationships in employment at the local government level, which override the formal merit-based systems.

> During employment, these political office holders at the local government, including those at the state and federal government levels, use these jobs to compensate persons around them. It is not possible that people employ that way will be committed, although we have a few. Secondly, those employed that way are seen as sacred cows **[Healthcare Manager, Rural LGA, 54 years]**

There were instances of victimization of health workers and managers who attempted to get in the way of the political elites, with a case of a manager who was replaced when she tried to deal with a staff member who was related to an "opinion leader in the community". This taught others not to challenge those with power capable of influencing the health system.

iv. Poor welfare protection:

There was an overwhelming consensus that health workers were inadequately remunerated, and the new minimum wage, still considered inadequate given rising inflation, was yet to be implemented as of the time of writing. Respondents complained about insufficient and inconsistent payment of salaries, which meant they could not meet most of their needs, including the cost of transportation to their duty posts.

> Farming is the best option for me. My salary cannot take care of the needs at home. It is worst when we are not paid early enough, or not paid at all. You do not expect someone like me to keep working while my family starve. I need to go do something **[Health worker, Rural Facility, 33 years]**

Insufficient staffing of facilities and, as a consequence, increased workload, also contributes to absenteeism. There was a widespread view that if the government really cared about the productivity of healthcare staff, it would improve their working conditions and employ more competent health workers. The OICs were not just managers of the facilities but also delivered much of the healthcare. This created continuing conflict, for example, when the OIC is required to attend managerial meetings while rendering services in the health facility. The problem is described below:

> An important aspect of our welfare no one talks about is the low manpower we have. Most of us overwork ourselves because in some facilities you only find one, two or three managing the entire affairs of the facility. At times, we are down and might not be able to come to work. Sometimes too, we might go for meetings at the local government or ministry and there is no one to stand in for us. We just have to lock the facility, except if we have a volunteer. We are humans for God's sake **[OIC, Rural Facility, 51 years]**

v. Unclear and unenforced rules:
Lastly, we found need for clarity in the rules guiding health workers, with many of the healthcare and facility managers and health workers reporting that they do not have rules peculiar to the health workers at the primary health level. They mentioned that the rule book for civil servants was too generic and difficult to apply to health workers.

> *We rely on our moral consciousness to do this work because you cannot point anyone to documented rules that have been faulted and what the corresponding punishment should be. At best, you give query, which would be very effective when you have a document to cite […]* **[Healthcare Manager, Rural LGA, 54 years]**

Despite the lack of rules that should be peculiar to the health sector, local government officials who are expected to enforce the civil service rules and regulations in the meantime, often fail to do so. Health workers exploit this situation, as described by a volunteer doctor:

> If nobody comes to supervise you, there is the tendency that you will become a god unto yourself. This is what is happening, especially in rural areas. Some health workers can just employ a volunteer and go about their private businesses because no one is checking on them **[Health worker, Urban Facility, 34 years]**

3.3 | Facility-level influences on absenteeism (midstream)

Factors associated with midstream or facility-level absenteeism arose from: (i) poor organization and weak facility leadership, (ii) very low service uptake, and (iii) inappropriate professional influence.

i. Poor organization and weak facility leadership
Respondents described many examples of poor management and organizational inefficiencies at the facility level that encouraged absenteeism. Some OICs lack leadership qualities and are incapable of managing the facility so are unable to control deviant behaviours such as absenteeism. However, others were complicit in absenteeism by their staff.

> Some OICs make the work difficult. They have those they like in their facilities and even cover for the ones that give them bribes or cuts from their salaries. In such facility, you do not expect any health worker to give her best **[Healthcare manager, Rural LGA, 53 years]**

ii. Poorly patronized facilities
Health workers did not come to work in some facilities because very few users sought care in their poorly equipped facilities. This was further emphasised by a member of one of the health facility committees:

> In some places, the health workers come late or do not come at all because they do not see patients often. They feel it is better to be useful to themselves doing some other things than coming to work and doing nothing **[Member, HFC, Urban LGA, 58 years]**

iii. Undue professional influence
There were indications that senior health workers, such as doctors, were more likely to be absent and are rarely monitored and sanctioned due to the power they exercised. Longer serving staff often consider themselves superior to other health workers at the PHC level, as indicated by a health facility committee member and a senior health worker, respectively:

> Doctors are considered and seen as demi-gods. If they come to the facility or not, no one talks to them. To them, they feel that they are doing us a favour by working at this level. Yet they are the better paid, and could even see their salaries before all other health workers **[Member, HFC, Urban LGA, 58 years]**
> In all honesty, the senior ones are usually absent. The junior ones are sometimes absent, but they could be scared of sanctions. But the senior ones do not care **[Health worker, Urban Facility, 55 years]**

3.4 | Reactions of health workers to structural influences (downstream level)

Structural problems at the upstream and midstream levels can trigger certain coping mechanisms that can spiral into absenteeism, poor work ethics, and other corrupt practices. Poor and irregular remuneration drive health workers to seek supplementary sources of income, such as retailing drugs, subsistence farming, and petty trading for those in rural areas. While those in urban areas find additional work, especially in other health facilities (usually private), to supplement their salary. Most respondents acknowledged that such dual practice is very common, although mainly among doctors. According to a volunteer (informally employed) doctor:

> Doctors do a lot of private practice and they can work in many places. They are doing so because the pay they get is not good enough and that they are not checked. That is why it is hard to see them around. Today they are here, tomorrow they are somewhere else. **[Health worker, Urban Facility, 34 years]**

Other cadres of health workers are more likely to engage in different economic activities, such as small businesses, including retail drug sales, artisanal work, growing crops and animal husbandry, and food processing. These economic activities take health workers further away from their official duties. A poor and undependable pension scheme encourages other private income-generation ventures as well.

In addition, transportation difficulties and the lack of accommodation near facilities also played a role, in that staff might adopt an informal rota that would allow them to choose days to be absent from work. Each worker takes it in turn to cover the facility for a week while their colleagues are absent. This enables them to reduce transport costs arising from daily journeys to and from the health facility and maintain shifts for the few staff employed. Additionally, one health worker explained how health workers who are poorly supervised react:

> When a facility is closed to the seat of governance you have to be very careful. Anyone can walk in as a supervisor. But you see those ones that are interior and hard-to-reach, health workers act as they like without regards for rules **[Health worker, Rural Facility, 27 years]**

And another emphasised that those who are politically protected may react differently to these facility constraints, acting with impunity.

> This is Nigeria; once there is someone that is backing you, nobody talks to you anyhow **[Health Worker, Urban Facility, 29 years]**

4 | DISCUSSION

Absenteeism at health facilities is a recognised problem in many countries but so far, most management and governance solutions have been ineffective.[21] The solutions have concentrated on measures against individual workers, monitoring their attendance and punishing unauthorised absences.[8,16,22] A study described how supervisors blame workers for poor work attendance behaviours, leaving out external influences.[23]

However, as we have shown, absenteeism is enabled by important institutional and structural factors which have received little attention. Thus, Sheikh et al. argue for the need to understand the relationship between the software (values and norms) and hardware (human resources, service infrastructure, and finance) of health systems, and the broader social and political contexts within which decision-making takes place.[13] This point has been recently advanced by studies on organisational behaviour, but less is known about how these interactions shape health sector corruption.[23,24]

Brownson's approach helps us to categorise these drivers of absenteeism, relating them to structures, operational rules and practices and culture that act at, and between, the system's upstream, midstream and downstream levels. At the upstream level, we see how the local government has limited capacity to manage the PHC facilities under its jurisdiction, leading to inadequate funding and staffing coupled with the loss of authority over certain human resource issues due to influences from state and federal powers. This has affected the quality of decision-making within the health system structures,[13] consequently affecting reactions at the downstream. Health workers are absent because they argue that they need extra income to survive[8] or feel threatened by insecurity and lack of welfare protection[25] or struggle with pressing domestic issues.[26]

Our findings show that health workers could fail to turn up to work at facilities, knowing that they will not be monitored. Therefore, an effective and comprehensive response must address both the reasons why health workers decide to be absent and the lack of accountability when they are. This involved examining structures, rules and culture at the mid- and upstream levels. The midstream level is handicapped by ineffective facility leadership, creating an enabling environment where absenteeism can thrive. According to evidence, often, this level is characterised by weaknesses and corruption itself. OICs cannot impose discipline, adopting a laissez faire leadership style, usually because they too are not monitored or are selected based on factors that are farfetched from competence, for example, seniority, political and social relationships with powerful persons in top positions, etc. In other settings, researchers have pointed to the contribution that trained nurse managers can make to curbing absenteeism,[27] but, more generally, PHC in Nigeria lacks that strong middle management. For example, we found many examples of poor supervision, which could be attributed to simple incompetence but is also affected by the dearth of financial and human resources needed to make and enforce rules. An alternative source of supervision should be the Health Facility Committees, which are intended to represent communities. Unfortunately they were seen as ineffective and marginalised, which contradicts experience from elsewhere where community action alongside supportive response from the government have been effective against deviant behaviours in healthcare institutions.[28] Moreover, the dual roles of officers-in-charge (OICs) as both managers and clinicians due to the fact that they were usually the most experienced in some of the facilities, creates conflict of interest and drives absenteeism. Resolving this midstream factor either through employing more clinical staff or training and employing non-clinical managers is vital and should be an important conversation in the management of absenteeism, especially absenteeism of more senior and powerful clinical staff who double as facility managers.

Hence, strengthening mid-stream measures against absenteeism is critical and should be supported upstream, through policies and prompt attentiveness. Establishing rules, regulations, and organisational culture that address the specific issues arising in primary healthcare must be a priority. Our findings, consistent with those in a previous study,[17] reveal persistence of inefficiencies and rule breaking in PHC because there is a lack of instruments of rules and regulations that are clear and specifically tailored to the problems occurring there – with absenteeism as a major issue – and appropriate sanctions that can be enforced at that level. This has to take place upstream and urgently. Otherwise, good policies like the Primary Health Care Under One Roof (PHCUOR) and Basic Health Care Provision Fund (BHCPF), which should strengthen primary healthcare management and financing, may achieve little that is tangible.

Agreement to work in an organisation implies acceptance of its rules and regulations.[17,29] However, these must be as clear and unambiguous as possible and appropriate to the context. However, for this to happen in Nigeria, politicians must desist from undue interference with institutions like the health sector. A reference was when an erstwhile Nigerian president rejected any form of political interference in an agency regulating food and drugs, which led to a large rapid reduction in circulation of fake pharmaceuticals, from over 80% to under 10%.[30]

Further, interested civil societies can retool their advocacy strategies to, on the one hand, inspire productive connections between the upstream and midstream, while in the other, target midstream issues that can be addressed without necessarily involving upstream actors, for example, organising leadership capacity building for managers, encouraging wealthy community members to donate to the health facilities, discuss the health facility issues on radio to get community feedback, identifying budget appropriations due to the facilities, whistleblowing of sharp practices, etc.

Overall, we have demonstrated how absenteeism by health workers in Nigeria is not just an individual-level issue due to moral failures of those involved but reflects a combination of institutional and structural problems – often upstream and midstream. Our evidence suggests that downstream conduct, manifest as commitment to the workplace, can improve when upstream players create enforceable rules that are clear-cut, including funding and prompt attentiveness and responsiveness to the issues arising within facilities, and when those at the midstream provide diligent leadership and accountability.

This study has certain limitations. It was undertaken in just one of the six geopolitical zones in Nigeria, so the findings may not be generalizable whether within Nigeria or beyond. Given the importance of local context, we encourage others to replicate it elsewhere. Also, it is only a first but necessary step in designing effective responses that take into account the lived experiences of health workers and the formal and informal structures within which they exist.

5 | CONCLUSION

Taking steps to address absenteeism requires not just focusing on individuals seeking to benefit (downstream) but also addressing its major health system drivers stemming from the inherent deficiencies at upstream and midstream levels. Thus, the system threatens health worker survival because the structures and formal practices have failed to create an enabling environment. Others disregard rules with impunity because they cannot be challenged and sanctioned within the existing structures, and there are ineffective checks and balances. There is a need to strengthen the structures and rules to be less enabling and tolerant of absenteeism, while being able to respond to the needs of the health workers.

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CONFLICT OF INTEREST STATEMENT

The authors acknowledge no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

The Ethics Committee of the University of Nigeria Teaching Hospital, Ituku-Ozalla. (Approval No: NHREC/05/01/2008B-FWA00002458-IRB00002323) approved the study.

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