BMJ Global Health

Absenteeism in primary health centres in Nigeria: leveraging power, politics and kinship

Aloysius Odii ,[1] Obinna Onwujekwe,[2] Eleanor Hutchinson,[3] Prince Agwu,[4] Charles Tochukwu Orjiakor,[5] Pamela Ogbozor,[6] Pallavi Roy,[7] Martin McKee ,[8] Dina Balabanova [3]

To cite: Odii A, Onwujekwe O, Hutchinson E, *et al*. Absenteeism in primary health centres in Nigeria: leveraging power, politics and kinship. *BMJ Global Health* 2022;**7**:e010542. doi:10.1136/bmjgh-2022-010542

Handling editor Seye Abimbola

Received 31 August 2022
Accepted 19 November 2022

For numbered affiliations see end of article.

Correspondence to
Aloysius Odii;
aloysius.odii@unn.edu.ng

ABSTRACT

Background Primary health centres (PHCs) in Nigeria suffer critical shortages of health workers, aggravated by chronic absenteeism that has been attributed to insufficient resources to govern the system and adequately meet their welfare needs. However, the political drivers of this phenomenon are rarely considered. We have asked how political power and networks influence absenteeism in the Nigerian health sector, information that can inform the development of holistic solutions.

Methods Data were obtained from in-depth interviews with three health administrators, 30 health workers and 6 health facility committee chairmen in 15 PHCs in Enugu State, Nigeria. Our analysis explored how political configurations and the resulting distribution of power influence absenteeism in Nigeria's health systems.

Results We found that health workers leverage social networks with powerful and politically connected individuals to be absent from duty and escape sanctions. This reflects the dominant political settlement. Thus, the formal governance structures that are meant to regulate the operations of the health system are weak, thereby allowing powerful individuals to exert influence using informal means. As a result, health managers do not confront absentees who have a relationship with political actors for fear of repercussions, including retaliation through informal pressure. In addition, we found that while health system structures cannot effectively handle widespread absenteeism, networks of local actors, when interested and involved, could address absenteeism by enabling health managers to call politically connected staff to order.

Conclusion The formal governance mechanisms to reduce absenteeism are insufficient, and building alliances (often informal) with local elites interested in improving service delivery locally may help to reduce interference by other powerful actors.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ The poor state of Nigeria's health sector has been partly blamed on endemic corruption which impairs service delivery and restricts access to care.
⇒ In the African context, corruption has frequently been linked to kinship. Public officials have been shown to offer employment, opportunity and resources to family members using their position and influence.

WHAT THIS STUDY ADDS

⇒ Health system governance is located within a complex network of political power and patronage whose connections are often beyond the reach of managers and regulators within the health system.
⇒ This informal 'system' enables some providers to use informal relationships to bypass governance systems and be absent from duty.
⇒ Health workers who are absent leverage kinship and political networks characterised by ties with powerful individuals, to avoid sanctions.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Policies aimed at curtailing absenteeism in primary health centres must target the influence of political actors and their actions in the health system.
⇒ New anticorruption approaches may need to rely on political settlements that balance local actors' incentives and combat absenteeism using both vertical and horizontal strategies.

INTRODUCTION

Most countries in sub-Saharan Africa now face a critical crisis in human resources for health.[1] This is particularly so in primary health centres (PHC), the first point of contact for most people and a key requirement for attaining health-related Sustainable Development Goals.[2] The problem is aggravated when available health workers (HWs) regularly stay away from their duty posts. While efforts are in place to increase supply of HWs, an immediate response involves ensuring that existing workers are present at their posts. Corruption occurs when HWs are voluntarily absent from health facilities to attend to their personal needs and this is common in the health systems of low-resource countries in terms of human resources.[3–7]

Although all forms of corruption are detrimental to health systems, discussions with key stakeholders at all levels of the Nigerian health sector confirmed that they included absenteeism by HWs as one, and indeed the most important priority for action.[8] This was in part because of the scale of damage it inflicts on the health sector but also because, while all types of corruption are difficult to tackle because of their complexity, there may be feasible strategies to address it due to its visibility, impact on services and the potential to galvanise local actors.[9]

The challenge of designing and implementing effective legal and regulatory sanctions for absent staff is hampered by the complexity of the Nigerian health system. It relates to three tiers of government (federal, state and local) that oversee three levels of healthcare: primary, secondary and tertiary. The political and health system governance structures are intertwined. Thus, local government (LG) is the administrative unit regulating, managing and funding primary healthcare. They comprise elected executives who are political heads (LG chairpersons/councillors), and administrative heads (ie, head of department of health (HOD).

The Primary Health Care Under One Roof concept was introduced in 2010 and approved by the National Council on Health in 2011 to reduce the fragmentation of primary care.[10] It places PHCs under one authority, the State Primary Health Care Development Agency/Board (SPHCDA/B), which provides PHC services, human resources and advisory services. At the LG level, the Local Government Health Authority (LGHA), headed by the LG chair and other directors/heads of department, closely supervises PHCs at the community and facility level and reports to the state PHC board (see figure 1).[11]

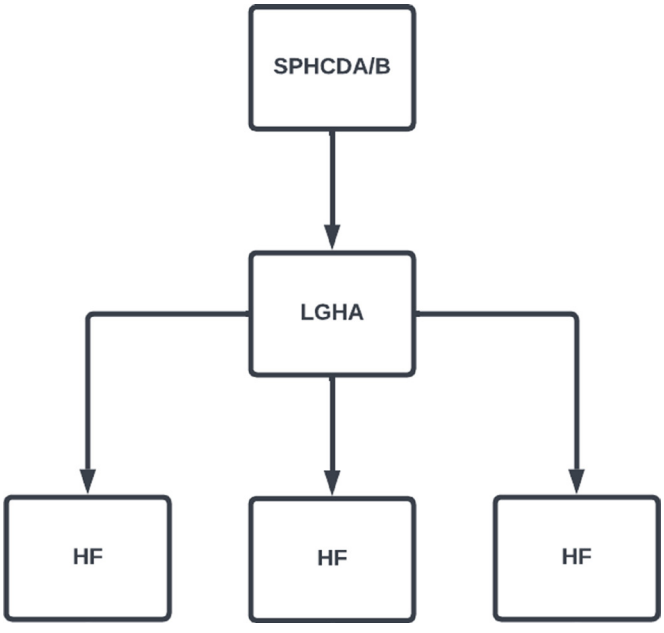

Figure 1 Organisational structure of primary health care under one roof (source: adapted from National Primary Health Care Development Agency.[11]

However, most SPHCDA/B do not yet have dedicated budgets so coordination, monitoring and payment of HWs are handled by the LG service commission.[12]

In a systematic review of factors influencing absenteeism, Belita *et al*[13] identified the influence of health system factors like workplace characteristics (salary, facility location and size), work content (workload, working conditions and organisational changes) and individual factors such as marital status, age or gender. These factors have received increasing attention from researchers and policymakers in recent years, given the detrimental effects of absenteeism, especially at the front line, yet political influences have remained underexplored. Recent findings from Bangladesh and Nigeria showed that some HWs have political support when absent from duties, something that could make it more difficult to tackle this kind of absenteeism from within the health system.[3 9 14] This is because political patronage is often accepted as normal and thus is uncontested, even in formal structures.

Corruption has traditionally been tied to kinship within the African context. Public officials are expected to provide employment, opportunities and resources to members of their kin because people lack confidence that the formal public services can meet their needs.[15] The concept of kinship transcends family connections and extends to friends, associates and various other relationships that intersect with family structures.[16] Baez-Camargo and Passas[17] argued that anticorruption efforts thus need to consider social norms and informal contexts. This is because informal social networks or relationships can be used as a coping strategy and enable informal or illicit practices such as absenteeism. However, these networks are predominantly social and the authors do not consider how their operation is mediated by political power, something that may explain different levels of absenteeism among categories of HWs.[9]

HWs who have close relationships with politicians are often absent without formal permission.[3 18] However, to understand this phenomenon we first need to reflect on some of the reasons why people are absent. Some engage in dual practice, such as working in more than one health facility or engaging in other additional economic activities like farming or trading during work hours as a means to augment their income.[19] Others respond to social norms outside the health system that pressurise some HWs, particularly women, to be absent to allow them to meet family responsibilities and generate additional income.[20] Others are absent simply because they can do very little in health facilities that are severely underresourced and lack equipment.[13] Thus, as these examples show, there can be a variety of reasons, some overlapping.

So far, the main approaches to tackling corruption have focused on regulating the behaviour of individuals, for example, by using sanctions, with much less attention to structures and the political drivers underpinning them.[5 9 21] Thus, most proposed solutions in low-income and middle-income countries (LMICs) have been within

the health system, using bureaucratic structures and processes, focused mainly on enacting regulations to prevent rent-seeking and sanctioning perpetrators.

Khan and Roy[22] argue that the reason anticorruption mechanisms that depend on top-down rule enforcement have failed in LMICs is because of the high levels of informality that lead to formal rules often being bypassed. This has roots in the postcolonial transition of low-income countries and gives rise to informal arrangements, including coalitions and agreements between groups of actors, which then lead to a particular distribution of power (political settlement) that results in distortions of formal policy.[23] Yet there has been limited recognition of the political determinants of corruption and how the health system might address it. We have, however, found that these informal arrangements have encouraged politically enabled absenteeism.[18]

Drawing on this new theoretical approach to eliminating corruption, we now ask how political networks shape absenteeism in the Nigerian health system. Nigeria has 36 states, but we focused on Enugu because of existing literatures that shows how common HWs' absence is in PHCs.[3 19 20] We explore kinship and the political drivers of absenteeism and suggest feasible strategies to address the problem.

METHODS

Study design/site selection

The phenomenological qualitative research approach served as the study's main guide in examining, through interviews, the lived experiences and perspectives of HWs and their managers on the kinship and political drivers of absenteeism. The study was conducted in Enugu State, southeast Nigeria. Enugu has a population of 3.3 million people with an annual growth rate of 2.8% (National Population Commission, 2010. The state has 17 LGAs. There are 6 district hospitals in Enugu, 36 cottage hospitals and at least 366 PHCs and comprehensive health centres.[24] Three LGAs were purposefully selected after considering their characteristics. Enugu North LGA is an urban location, Oji River LGA is semi-urban, and Nsukka is rural. These areas were known to experience high rates of absenteeism in PHCs.[8 19 25]

Study participants

First, we obtained the list of PHCs and the record of staff from the Enugu State Primary Healthcare Development Agency (EN-SPHCDA) that oversees primary healthcare in the State. The list guided the purposive selection of 15 PHCs for the study; five from each of the three LGAs. Our criteria for purposive selection included centrality of the PHCs in the LGAs, as well as functionality.

We purposively selected HODs based on their experiences in governance issues of PHCs and willing HWs that indicated having lived experiences of political influence on the behaviours of HWs in the system. We approached the HODs in their offices and informed them of the study that had the approval of the ENSPHCDA. They provided the assistance in getting through to the facilities and presented themselves to be interviewed. Thus, we interviewed three HODs, representing three LGAs. At the PHC level, we approached two staff each that included the officers in-charge (OICs) as they are the administrative authority in PHCs, as well as a front-line HWs resident in the study area because they are well informed about events in the community, including the nature of political relationships.

In addition to these 33 respondents, we interviewed 6 health facility committee members (indigenous persons elected to involve in decision making at the PHCs), 2 from each LGA, to obtain their insights about informal relationships that shape practices at the facility and in the community. We were keen on those that have been actively engaged in the affairs and activities of the PHCs, and we got them through the OICs.

Instrument and data collection

A qualitative guide was developed and reviewed by researchers with long-term experience researching health sector corruption and had conducted series of research embedded in PHC facilities in the study area. From prior research experiences, they had been exposed to the local political dynamics within the primary healthcare system, which came handy during the design of the study tool. The tools included questions about recent cases of absenteeism, the attitude of people to absences, factors leading to absences, the role of social relationships, and the influence of powerful actors.

Given the sensitive nature of the study, the interviewers underwent training that prepared them for when respondents were concerned with confidentiality or unable to separate cases of corruption from 'life as usual'. In addition, we were keen on interviewing respondents who showed the willingness to be interviewed after full disclosure of the study's objectives and contents. The guide was piloted among HWs in Nsukka (an LGA in Enugu State). At the end of the interview, the team met to share experiences and discuss issues emerging from the pilot, which were used to revise the tool.

Each respondent was informed about the study in advance to obtain consent and schedule the interview. All interviews took place in a private area in the facility during the COVID-19 pandemic, with all guidelines being followed.

We began the interviews by asking the participants to recall a case of absenteeism that they know about (witnessed or heard about in a lot of detail from a colleague) in the local health system. Most of the respondents were remarkably open and offered insightful contributions. All the interviews were conducted in English by four members of the research team across the selected LGAs using uniform tool. The interviews were audio recorded and the assistants of the researchers took notes in each session. The interviews lasted for an average of 35 min.

Data analyses

The analysis draws on reflexive thematic analysis by Braun and Clarke[26–28] and is reinforced by a critical realistic (CR) epistemological perspective. Critical realism is not a method or a theory but a way of thinking that informs investigations into reality.[29] This perspective was useful in the analysis because it helped us understand and explain absenteeism as a process that is influenced by interactions between HWs and their contexts and the formal and informal structures within which they work. CR enabled us to explore the mechanisms through which power is exercised by HWs who are part of kinship and political networks.

We applied the six phases of reflexive thematic analysis described by Braun and Clarke.[28] All the recorded data were transcribed verbatim by members of the team that are skilled in the transcription of qualitative data. The researchers also read through the texts, taking initial notes. Four members of the research team read randomly selected transcripts multiple times to develop codes and coding hierarchies. The researchers jointly reviewed coding outcomes to ensure uniformity in the process and a codebook served as a guide to themes used in the study. The researchers then looked at patterns in the codes and used them to create themes which were reviewed multiple times. Each theme was defined and named before the write-up of the finding section. Quotes with contextual or special connotations have been used to illustrate key themes in the data, contributing to a narrative on each one.

Public and patient involvement

The members of the public and patients were not involved in the research design, analysis and dissemination of the findings; however, the research focus was informed by managers' and HWs' experiences in the planning stage.

RESULTS

Thirty-nine qualitative interviews were conducted with HODs, HWs and health facility committee chair (HFCCs). Thirty (five male) were with HWs including nurses, midwives, community health extension workers (CHEWs) and junior community health extension workers (JCHEWs). Six HFCCs were included, all men and three HODs. The participants' age ranged from 26 to 63 years. All participants had secondary education at least.

The findings were presented under the following themes: informality in the health system, informality and HWs' absenteeism, mechanism for exercising power and tackling politically connected absenteeism. Across the themes, we described two different forms of informality or networks (kinship-based and political) and how they influence absenteeism.

Informality in the health system

Our study found that although HWs and their administrators should be bound by the formal rules, in reality, they are not and sanctions are rarely enforced (figure 2). Their behaviours are guided by a mix of formal and informal relationships, with the latter a quicker means to get things done. The formal relationships flow down from political heads or elected officials such as the LG chair and their executives (ie, vice chair, councillors and supervisory councillors) to administrative officers like the HOD health, head of personnel management, head of finance and the OIC—the administrative officer at the health facility level. The OICs manage HWs and other technical staff posted to the facilities. The formal structure is the official channel of communications through which corrupt behaviours such as absenteeism should be handled, at least in principle.

Our findings show how HWs bypass formal structures using informal relationships with people in key positions (see figure 2). As one respondent said:

> 'Health workers answer to the OIC, the OIC answers to HOD, the HOD answers to the HPM and the HPM answers to the Local Government Chairman. Sometimes, it depends on the person they have connection with. If it is the HOD, or LG chairman, better for them. So, they go to the direct person depending on who they have [informal] connection with. As soon as they go to the person, they have connection with, immediately, you will receive an order from them' (OIC; female; rural).

Sometimes the relationship may be indirect, via networks (see figure 2), whereby the HWs is connected to someone outside the health system but can influence those inside it. Such individuals include influential persons, elected and appointed members of legislative bodies at all levels of government. These relationships can be leveraged by HWs to disobey rules without fear of sanction:

> 'It makes some of them [connected health workers] arrogant. They would tell you to do anything you like because they have 'Abraham' as a father and when you follow it civilly, you would find out that the person has someone that would make you lose your job' (HOD; female; semi-urban).

Informality and HWs' absenteeism

As noted above, HWs can influence events if they are connected, directly or indirectly, with someone that holds political or administrative power in the local government structure. We found two predominant types of informal networks.

Kinship-based networks

We define kinship-based networks as those involving relationships with family members, friends and associates or through other social structures like religious groups and clubs. Kinship-based relationships reflect an interest to protect one's group. This can be altruistic or based on reciprocal relationships within groups. Some HWs who are chronically absent share kinship ties with political figures in the local government who use their

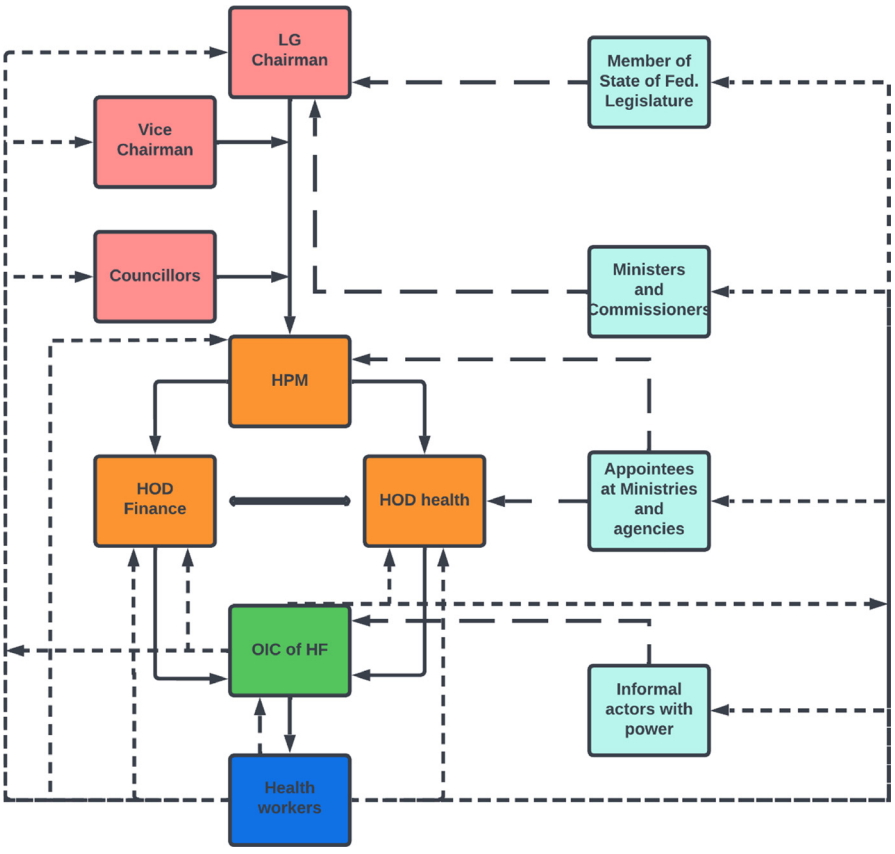

Figure 2 Relationship of health workers to administrative heads, political heads and influential figures outside the LGHA. Note: ↓ = formal relationship; ..... = informal relationship; - - - intervention lines.

discretionary power to protect their kin within their work environment. To Illustrative:

> 'Well, my joy is that these big heads [powerful political actors] are not far-fetched; they [are] all around us here within our feet [reach]. We are all seated together. Somebody may be in an office the person can be a junior staff but will not be reporting to work because they have a father maybe he has somebody from up, from the chairman, these politicians are backing them, the people feel they have them as relatives' (CHEW; female; semi-urban).

Similarly, HWs who share kinship relationships with administrative heads use their position to be absent.

> 'Just like the one I am talking about, the one I used as an example, the person she brags about is HPM or DPM, that is the Director of Personnel Management. That is whom she depends on' (JCHEW; female; semi-urban).

Kinship ties with OICs, who are responsible for managing absenteeism at the facility level, were also leveraged by some people to avoid sanctions. OICs can overlook absenteeism, disregarding complaints by coworkers impacted by absences. We also found OICs using their position to benefit their kin by informing them of impending inspections and informally completing attendance registers for them. For example:

> 'When I was working at [x] health centre, the OIC there has a sister posted there as well. The girl posted was a student. Whenever we have information that there is going to be supervision, (only then) the girl will show up' (CHEW, male, rural).

Besides being protected from sanctions, the HWs may gain favours from administrative heads linked by kinship ties. For example:

> 'She [the HOD] knows that the workshop was coming up so she removed those she wants to remove. So, there is this new staff who was selected to go for workshop. Those of us here for over 7yrs are not worthy to go to the workshop? Me that report to work by 7 am every day, good or bad, we are there. It was me they dumped and the new staff was sent for the workshop. Chai! [Exclamation]. They took them to that 11-days workshop. We heard they were paid over N200,000 (for) 11 days' (CHEW; female; urban).

Political networks

HWs may have political relationships with elected officials in the health system or local government, sometimes called 'godfathers', whereby they exchange votes and other forms of support for protection. These powerful individuals may even create positions for their clients or post them to desirable locations, even if this means transferring others to less attractive settings. For example:

> 'They all have interests, politicians… they bring people from other places, they are then reposted, you see? They can put anybody anywhere for them to protect their interest there. They can make some changes and they will

say 'I don't like this woman who is working here, this man (referring to the HOD) remove him for me' (OIC; male; semi-urban).

Importantly, these are reciprocal relationships. The following quotes are illustrative:

'That is protection…you know, people will do something that… requires to be punished. They will be shielded from the punishment. Somebody will be with you, will be committing atrocities and will be, you know doing some form of PR to people who are above you, and you can't do anything. The problem will still be there, it is everywhere, it is still in the health sector, and it is in every other sector within the local government' (OIC; Male; Semi-urban).

'Politicians need information (i.e., information about those opposing or working against them); once you are such a person who gives them information, they will love you and they won't bother about others' (CHEW; female; urban).

HWs who are connected to such highly placed persons can be absent knowing that they would not be sanctioned. Illustrative quotes include:

'She has 'Abraham' as a father (an expression that means having a highly placed person) …, the local government chairman and other politicians and it affected the way I related with the person such that I couldn't give the person a sanction' (OIC; female; urban).

Meanwhile, those who do not have 'direct' informal relationships with people within the local government structure can leverage connections with a wider network. This involves leveraging relationships with politicians outside local government structures but who have access to administrative or political officials in other sectors. They not only receive protection from them; they also receive privileged information about events at the health facility. For example:

'Gbam [Very affirmative response]. Even within here, they have people even in the House of Assembly [legislative body of the state government], those people cover them. I can remember vividly the last verification they did for us; you cannot see space to pass [indicating that many people came for the verification]. Yes, the crowd is so much but where are they [during working hours]? They are in various schools, they are in different businesses, they are even in offices, they stay behind in their houses resting, at the end of the month, they receive alert [bank notification of pay on their phones] even before me that is in this office' (CHEW; female; semi-urban).

Mechanism for exercising power

We explored the mechanisms through which power is exercised by HWs who are part of kinship and political networks. We found that when HWs who enjoy relationships with powerful and/or influential people are absent and about to be sanctioned, they report to the person they are connected with. That person can take various actions to protect the member of staff but the outcome depends on their position in the political or informal hierarchy. We found that this pattern manifests in both kinship-based and political networks, discussed below in more detail.

Through kinship-based networks

HWs who have relationships with powerful and/or influential persons can use these to negotiate absence without fear of sanctions. When disciplinary actions, such as withholding of salaries, are considered, they call the powerful/influential person who is their relation to intervene, and they respond by asking the administrative heads (HOD health, treasurer, HPM) to drop the case. For example, a HW who was about to be sanctioned for absenteeism reported how her co-workers' used connections with kins who are political heads. The political heads asked the HPM and treasurers to pay the HW:

'They call [intercede] regularly… like the time they wrote 'don't pay' [administrative instruction to withhold the salary of a worker until queries are addressed] to us. Many called their people for help. Some called those above (political heads). Later, some people that they wrote don't pay with us signed and said their names were not there again [indicating being cleared for payment]' (CHEW; female; rural).

There are instances where administrative heads that are expected to manage HWs' activities are aware of their absence but continue to provide necessary cover because they are related to the HW through kinship ties. If they are part of the screening (attendance monitoring) team, they ensure that their kin's name is written before the register is submitted. Likewise, if they are part of the payroll or finance, they ensure that their kin received their salary in full despite written reports of their absence. Again, OICs are helpless because their management role is constrained, with informal relationships being often stronger than the formal structure. This is seen in the following quotes:

'There was a time we had a girl [health worker] who was always absent from work, her elder sister was among the payroll officers then. No matter how you talk, you will not see her reporting to work in the office' (OIC; female; semi-urban).

The networks can also be horizontal, involving officials with similar levels of power. For example, a HW's relative within the administrative cadre may also approach other administrative heads to resolve any issues related to the enforcement of penalties concerning their kin.

'Yes, they are backing them up. The person may have a relative as maybe supervisor for anything or any office that even if DO NOT PAY is written against a worker, the person in the office can liaise with whoever has written it to pay the worker for that month' (CHEW; female; semi-urban).

Sometimes, administrative heads orchestrate the transfer of a HW's kin to facilities where they enjoy greater liberty if the conflict between their kin and the OIC persists.

'What I know is that they work for their transfer so that they are transferred to a place they might be free to do their business' (CHEW; female, rural).

The mechanisms for benefiting from patronage are diverse. HWs who do not have informal 'direct' relationship with the administrative or political heads within the local government structure were said to leverage indirect kinship relationship with powerful/influential figures outside the local government structure who then approach the administrative or political heads on their behalf. In practice, the kinship and political networks are often intersecting resulting in a hybrid model of familial/political networks. The powerful figure intervenes for kinship reasons while the political figure responds out of political interest. To achieve this, there is an implicit code—the powerful/influential figures merely introduce themselves and state that they are interested in the case and this suggests that they expect to see a solution—as revealed by quotes from two OICs:

'So, she later used somebody, I don't know the person's rank in politics. The person called and told me that he is this and that and that he is a relation of x (the health worker), this and that… till today, I have never seen her' (OIC; female; semi-urban).

'The person is related to the House of Assembly…, before you know it, even supervisors will clamp down on you' (HOD; male, rural).

Through political networks

Health system operation is often influenced by people in positions of power. Elected representatives like the local government chair and councillors direct the affairs of the local government and that includes the activities of HWs, including their salaries, appointments and promotions. Because of this control over resources, they are very powerful in the hierarchy of actors who influence activities in the PHCs and they can bypass formal structures such as rules guiding staff discipline. The following quotes are illustrative:

'You know this country, in Nigeria, politicians have the upper hand, if you are not doing what they tell you to do then you are in trouble. What I am sure of is that the HOD is afraid of the politicians. My own is an example. Where you can see HOD that is not afraid is when he is coming [employed] from the government house, or if the HOD has a godfather, he can withstand them and work as the HOD but if you are HOD because of your rank then you can't say anything' (OIC; male; rural).

Our data also show that political actors who have HWs who are connected to them at the health facility consider it an obligation to protect them, and may have also assisted them to gain an appointment. Meanwhile, managers who are supposed to discipline these providers avoid conflict with them because of fear of retaliation—as illustrated by the following quote:

'Those that escaped sanctions, maybe they have godfathers or somebody that helped them secure employment. You know that the person will not allow his own to suffer. The person will say, 'please, leave this person because I am interested in the case for political reasons.' So, we leave it for peace to reign. Like someone we issued query she had a godfather, the query was not answered and before you know it, a call from above said to leave that person' (OIC; female; rural).

Transfer is another disciplinary measure for dealing with a staff member who consistently fails to report for duty. Transfer to another facility sometimes forces the HW to reconsider their motivation. It is mainly an administrative act carried out by the HOD but may be requested by the OIC if they feel that a HW is uncooperative. But a call from a powerful politician to the HOD can lead to the cancelling of the transfer request. In that case, the OIC has no choice but to continue to tolerate HWs' behaviour, since the OIC cannot bypass the formal reporting structure. For instance,

'It is true because I have seen many transfer processes being cancelled suddenly. This means that there is someone powerful behind it. The ideal thing to be done is to ensure that the transfer process is free and fair but as it stands now, there is some kind of influence on transfer just as the lady I mentioned' (OIC; female; urban).

'I must be sincere with you, some people posted here since September last year have not even shown their faces till today. The OIC has said a lot of things regarding that. 'Change these people, we have not seen them, they have not even reported for one day'. Why not post serious people? After such a thing, the letter remains stagnant' (CHEW, male, rural)

Constraints to tackling politically connected absenteeism

Experience of health managers

We found that tackling kinship or political absenteeism is often difficult or impossible for OIC's who express the wish to do so. OICs occupy the lowest cadre as administrative heads in their facility and when they disagree with their superiors such as the HODs and HPMs, treasurers, etc. they can be confronted informally. To illustrate this issue:

'They are the ones paying your salary, they work with the local government chairman and are the ones deciding your salary. Some are in the payroll, finance… all this monetary aspect. So, they can delay your salary and you can't say anything' (OIC; male; rural).

Similarly, political heads can put pressure on an OIC or other administrative heads who continue to trouble their protegee or kin by refusing to sign their promotion paper or preventing them from going for training or workshops. To prevent these situations, the administrative head is expected to comply with their request and ignore their client or kin who are absent from duty. For example:

'They will make you uncomfortable such that they will report the matter to some persons they have, people occupying top political positions, such that they sit on your

promotion or if there are workshops you are supposed to be sent to as an OIC, you will be denied' (OIC; female; semi-urban).

Also, our data showed that absenteeism involving kinship and politically powerful individuals is hard to tackle because of the interaction that exists between the formal and informal structures. To that end, an administrative officer may be motivated to withdraw a query to an erring staff based on the request of a politician with the hope of obtaining favour in the future. Such favour may include being added to the list of those to attend workshops organised by Non-Governmental Organisations (NGOs).

'You should know that people are constantly seeking the face of the HOD. Sycophants! Even the HOD is seeking the face of politicians to get favour from them' (JCHEW; female; semi-urban).

Considering that administrative heads cannot discipline politically connected staff, some negotiate with them to forfeit certain percentage of their salary or provide stipends as compensation for their absence. However, the benefits are only received by the administrative head:

'Sometimes, the doctors give our HODs tips that will make them overlook whatever they are doing. We have complained severally to the HOD but it has yielded no result then we stopped complaining because it is a waste of time. The doctor knows that the health committee cannot do anything because even if they would want to report, it will be those he has compromised that they will report to' (OIC; female; urban).

Managerial staff who act against protected staff may have their job threatened and informal relationships can be used to bypass formal structures. Those challenging a HOD's interests risks transfer to less desirable posting. Illustrative quotes include:

'Even when you report, if care is not taken your salary will be seized because they have godfathers. Maybe one of them is the brother/sister to the chairman or whatever' (CHEW; male; rural).

'Who are you going to fight? Who will you fight? They will transfer you, and post you to a village where a single day you spend about 2000 naira to reach the facility. Is that what I will go for? No, I can't!' (JCHEW; female; Semi-urban).

Experience of health facility committees

A key objective for the health facilities committees—in Nigeria as in other LMICs—is to strengthen local accountability. Our findings, however, demonstrate how kinship and politically connected absenteeism are managed by health facilities committees that do not hold any political or administrative authority within the local government structure. They often report problems related to accessibility and quality of the health facilities (including absenteeism) to health managers (HOD) and community leaders (ie, traditional leaders) in hope that facility managers would intervene. But this process can be frustrating if someone who wields political influence is involved. It generates a feeling of helplessness in HFCs who are committed to cleaning up the system:

'Yes, because we have little or no backup. The highest we can do is to report to the HOD of health who is answerable to the chairman because it is a political appointment. The chairman might end up convincing the HOD to forget the case which is the end of it and we don't have such powers to act further if the HOD doesn't act because we are not employed' (HFC; male; rural).

'The sad thing is that it incapacitates one from writing petitions. For instance, you can't write a petition against someone employed by the chairman. One will simply respect himself or herself by turning a blind eye to keep them from fighting you. Those kinds of workers only come here when there is need for verification to keep their salaries going' (HFC; male; urban).

Experience of community members

We found that community members can on occasion, step in when absenteeism becomes rampant, especially when the problem is politically connected absenteeism. Community members sometime involve the Igwe (traditional rulers) or threaten to because they have the influence to compel the HOD and other civil servants in top positions to take disciplinary measures against the staff. See quotes below:

'Why they report to the Igwe is that he is the number one security officer of the community. It is not good to bypass Igwe and report to others because the Igwe has a say in the health centre. Besides, the community belongs to the Igwe. The Igwe will call the person to order and if the person did not change then he will report it to the highest authority' (OIC, male, rural).

'That is community participation. They have interest in the facility because their people always come here. So, at times they say, 'if you repeat coming late again, we will go and report to the Igwe.' The Igwe will take it up and maybe it results in non-payment. That is the highest we have seen but it has not resulted in anyone's sack' (OIC; female; rural).

Other community action includes boycotting the facility as a way of pressing home their demands. That way, they hope to force health managers to transfer the staff to another location and bring in someone who is willing to work.

'When he was around, some members of the community here used to tell me that they will not be coming to our health centre until they remove him from the community' (CHEW; female; rural).

Religious leaders and concerned politicians can force change within a community. The former are often revered in their community. They can force health managers and politicians to implement change by mobilising the community. Other politicians outside the local government structure can do this too.

'The reverend father in this community will call you and reprimand you this kind of thing repeats that he will report you to the government, that you should stop it. He can report to the government even the chairman, there is no one he cannot report to and if you don't, he will go to the bishop and report and you know that the bishop can take action' (CHEW; female; rural).

'Like the woman I told you that her child was convulsing and required surgery for jaundice…, she stopped coming to work. There is a politician, who is also a retired army officer staying at x, he came here and asked who is on duty and I told him I won't lie because my church forbade it. I told him that I am covering for one of us who was with her sick child in Enugu. So, he said she is lucky because he would have made her suffer' (CHE; female; rural).

Experience of international organisations and external actors

We found that international organisations such as WHO and UNICEF can pressurise HODs to sanction politically connected staff who are absent. This is because of the huge role they play in PHCs.

'There was a facility that was visited by Unicef some time ago but unfortunately for the person, an OIC, the facility was locked and there was no sign of anybody there. This now made Unicef demand that the OIC should be thoroughly sanctioned. Due to the pressure from Unicef, the HOD issued a transfer order to the OIC and equally demoted her to a lower health post. She was transferred by the HOD of health after which she took the transfer letter to her cousin (the LG Chairman) who wanted her to continue working in the facility. On seeing that he is trying to compromise the process, we the health facility committee deliberated and decided that she must leave the facility which she did. It took some period because of the influence the woman has on the chairman, her relative' (HFCs; male; urban).

DISCUSSION

This study extends our knowledge of the nature of absenteeism in resource-constrained LMICs, in this case, Nigeria, by highlighting the influence of powerful political connections and networks. While there are studies on the diverse drivers of absenteeism, particularly issues of economy, domestic responsibilities, leadership capacity and infrastructure deficiencies,[8 19 20 25] issues of political influence on healthcare provision have been underexplored. Respondents view often converge closely, suggesting a shared knowledge of how things work. Specifically, there is clear acceptance that health systems—in this case in PHC—are intertwined with, and shaped by, political and social networks.

We highlighted the strategies used by HWs to negotiate their absence from duty when they have connections with powerful individuals. We found two major types of informal relationships (kinship-based and political) that sustain absenteeism in the Nigerian health system. However, HWs linked to political leaders enjoy considerable protection from sanctions when they are absent from duty. This reflects the distribution of power within local government, and its concentration in elected politicians. Connection to administrative heads can offer some protection, such as blockage of queries when absent from their posts, but only those connected to politicians can engage in blatant absenteeism without concern for the consequences. In short, where political connections are rife, absenteeism is glaring, exacerbating existing weaknesses in the health system.[13 14 18] This has been reported elsewhere.[3 30] Callen *et al*,[30] for example, found that doctors connected to politicians are absent more frequently than their colleagues who do not have such connections. Onwujekwee *et al*[3] found that absenteeism is especially brazen where there is political protection, in circumstances of often weak governance.

Earlier studies had argued that corruption in Nigeria must be considered in the light of patronage within kin and community networks.[31] We found that Nigeria is transitioning from kinship to political connections, with a corresponding shift in power, where the political economy is being dominated by a network of those with political affiliations. This has implications for the health system and how it is governed and reinforces the point that relying solely on health system governance will not work since informal arrangements can stifle formal arrangements for conduct in the workplace.[32] That means, the current governance structure of Nigeria's PHC system may not guarantee optimal attendance and commitment to duty on the part of significant sections of the health workforce. The governance arrangements of vertical, top-down enforcement break down in such contexts and those meant to monitor or enforce are unable to do so.

For example, we discovered how administrators who attempt to sanction a politically protected HW often suffer consequences. This is consistent with the findings of Ogbuabor and Onwujekwe[33] in Nigeria, that OICs are afraid to query staff who are protected because of fear of their godfathers. In this study, the threat of victimisation discourages managers from taking disciplinary actions, leading to insubordination, complacency and increased workload. And as such, what becomes the use of formal rules if the designated managerial enforcers cannot enforce them? Addressing welfare-reducing informal arrangements by redesigning incentives might be the first exercise to conduct if rule-following behaviour is to emerge. And we believe that achieving this can be done horizontally both by actors who want to be rule enforcing in their own interest, as has been evidence by Khan and Roy[22] across a number of sectors, including in Nigeria, and by altruistic and bold community actors who have sufficient understanding of the implications of unsanctioned absenteeism on their health, or vertically by decisive leadership interested in getting the health sector to serve the people.

The unchecked influence of political interference affects the availability and distribution of human resources in the system, as recruitment could be based on

political connections over merit. HWs recruited through such means tend to enjoy political protection. Sharma,[34] Vian[21] and Lewis[35] similarly reported politically motivated appointments of HWs in Nepal, Kosovo and Ethiopia, and the Dominican Republic, respectively. In this study, helping a HW secure a job may be borne out of kinship ties or a form of patronage by career politicians seeking to exert influence. Ojo *et al*[15] described this as a network where the clients are provided with their needs while the patron enjoys political legitimacy and authority. In this study, the clients are protected while also working for the interests of the patrons like mobilising votes and providing useful information to keep the political godfathers relevant within the system. Unfortunately, these exercises could be to the detriment of clinical responsibilities and commitment.

Our findings align with the position that informal power networks are powerful enough to distort the decision-making process in settings such as Nigeria.[22 33] Khan and Roy argued that as LMICs are constrained by a distribution of power where formal rules are weakly enforced and often violated as they transition to higher-income status. This is one reason why rent-seeking behaviour is common in LMICs. Their work outlines how top-down enforcement is difficult when large sections of society are violating the law thereby ensuring even those who do not want to break it have little incentive to be rule-abiding if they have to transact with those who are not. But rules are violated for different reasons and we need to distinguish between those who evade rules because they have little other choice and those who do so deliberately, for instance through their political connections.[33]

Khan and Roy's[22] argument that formal structures are weakly enforced was supported as we narrowed the study to ask how politically connected absenteeism is tackled. Responses using only a top-down approach often yield little or no result. This explains why requests for transfer by OICs and petitions by HFCs asking health managers to sanction erring staff are ignored. Thus, informal structures serve as the interlocking structures that organise the conduct of HW and their managers.

Our work suggests that dominant paradigms based on regulatory and disciplinary measures are likely to fail given the complex web of informal relationships and patronage. New anticorruption approaches relying on political settlement offer promise,[20] with measures that align incentives of local actors and pursue absenteeism using vertical and horizontal means. We saw that engaging HFCs, community leaders, religious leaders and international organisations may be useful in reducing politically connected absenteeism. Adie *et al*[36] had earlier found that small communities can strengthen health services with active community participation. As such, the HFCs are recognised as the link between the facility and the community. They often visit the facility and report their findings to the community and health managers in local government. However, these organisations may be insufficient by themselves and may need to connect to powerful local elites who are interested in improving service delivery for different reasons. They can be linked to traditional authorities and religious leaders to support the enforcement of rules against absenteeism. Likewise, we found evidence that local politicians can take an interest in the conduct of HWs in their facilities. Linking these persons could make an impactful change. Also, the interest of traditional rulers can be harnessed to reduce politically connected absenteeism by pressing the formal structure to work in the interest of the community.

Essentially, our study points to an opportunity for building alliances and resolving conflicts among community actors at the local and district levels. These horizontal solutions are essential because conventional anticorruption strategies that target the improvement of rule-following behaviours among public officials have recorded limited success. There is therefore the need to design anticorruption strategies that beat the influence of political actors and top civil servants at different levels of government and where rules are enforced in the self-actors of the relevant actors. Rule enforcement depends not just on the two actors directly involved but as argued by Khan and Roy,[22] it is also dependent on the presence of effective 'horizontal monitors' like the community actors or traditional leaders identified in our study, who stand to benefit if rules are followed. Thus, our study suggests the need to align with the interests of these actors so that they can force administrative and political heads to take action against absent staff.

The study has some limitations. It was conducted in one of six geo-political zones in Nigeria (the southeast) so the findings may not be applicable to other parts of the country or more widely to West Africa or to LMICs in general. However, given the critical importance of the topic, similar studies are needed in other settings. Second, we were unable to include political leaders as study participants, an omission that will be remedied in future work.

CONCLUSION

Health system governance is influenced by social, economic and political networks operating at societal level. HWs who are connected to politicians and top civil servants leverage their connections to absent from duty. Our findings expose both the kinship and political structures that permit absenteeism to thrive and the reasons why solutions entirely focused on strengthening health system governance fails. The influence of powerful individuals backing absentee staff weakens the health system and creates a poor work climate and culture. Consequently, understanding the underlying political dimensions of absenteeism in primary healthcare facilities is an important first step in ensuring that primary healthcare workers are committed to attending work and in designing potential solutions that seek to engage with the informal power structures and networks. Grassroots mechanisms may be promising in reducing

adverse political influences on absenteeism and helping to address the problem of politically backed absenteeism.

Author affiliations
[1]Sociology/Anthropology, University of Nigeria, Nsukka, Nigeria
[2]Health Administration & Management and Pharmacology and Therapeutics, University of Nigeria - Enugu Campus, Enugu, Nigeria
[3]Global Health and Development, London School of Hygiene & Tropical Medicine, London, UK
[4]Social Work, University of Nigeria, Nsukka, Nigeria
[5]Psychology, University of Nigeria, Nsukka, Nigeria
[6]Psychology, Enugu State University of Science and Technology, Enugu, Nigeria
[7]Centre for International Studies and Diplomacy, SOAS, London, UK
[8]Health Services Research and Policy, London School of Hygiene & Tropical Medicine, London, UK

Twitter Aloysius Odii @Aloysius_Odii and Dina Balabanova @dinabalabanova

Acknowledgements This publication is an output of the SOAS Anti-Corruption Evidence (ACE) research consortium. 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 organisations. For more information on SOAS-ACE visit www.ace.soas.ac.uk

Contributors AO, OO, EH and DB conceptualised and designed the study. AO, PA, TCO and PO were involved in data collection. AO, OO, EH, PA, TCO, PO, PR, MM and DB analysed, drafted and approved all versions of the manuscript. AO is the guarantor and corresponding author.

Funding This study is funded by UK aid from the UK Government, Contract (P0 7073).

Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval The study protocol was approved by the Ethical Board of the University of Nigeria Teaching Hospital and LSHTM's Ethics Committee with identification code—NHREC/05/01/2008B-FWA00002458-1RB00002323. Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available on reasonable request.

ORCID iDs
Aloysius Odii http://orcid.org/0000-0002-2222-0835
Martin McKee http://orcid.org/0000-0002-0121-9683
Dina Balabanova http://orcid.org/0000-0001-7163-3428

REFERENCES

1 Willcox ML, Peersman W, Daou P, *et al*. Human resources for primary health care in sub-Saharan Africa: progress or stagnation? *Hum Resour Health* 2015;13.
2 Abubakar I, Dalglish SL, Angell B, *et al*. The lancet nigeria commission: investing in health and the future of the nation. *The Lancet* 2022;399:1155–200.
3 Onwujekwe O, Odii A, Agwu P. *Exploring health-sector absenteeism and feasible solutions: evidence from the primary healthcare level in Enugu, South East Nigeria*. SOAS ACE Consortium (Working Paper 014), 2019a.
4 World Bank. *World development indicators 2015*. Washington, DC, 2015. http://elibrary.worldbank.org
5 Vian T. Anti-corruption, transparency and accountability in health: concepts, frameworks, and approaches. *Glob Health Action* 2020;13:sup1.
6 Hutchinson E, Balabanova D, McKee M. We need to talk about corruption in health systems. *Int J Health Policy Manag* 2019;8:191–4.
7 Langlois EV, McKenzie A, Schneider H, *et al*. Measures to strengthen primary health-care systems in low- and middle-income countries. *Bull World Health Organ* 2020;98:781–91.
8 Onwujekwe O, Orjiakor TC, Hutchinson E, *et al*. Where do we start? building concensus on drivers of health sector corruption in Nigeria and ways to address it. *Int J Health Policy Manag* 2020:1–11.
9 Hutchinson E, Naher N, Roy P, *et al*. Targeting anticorruption interventions at the front line: developmental governance in health systems. *BMJ Glob Health* 2020;5:e003092.
10 Ugwu GO, Enebe NO, Onah CK. Primary health care under one roof: knowledge and predictors among primary health care workers in Enugu state, South East, Nigeria. *Niger J Med* 2020;29:649–54.
11 National Primary Health Care Development Agency. *Implementation guidelines for primary health care under one roof (PHCUOR)*. Nigeria: Federal Republic of Nigeria, 2018.
12 Eboreime EA, Abimbola S, Obi FA, *et al*. Evaluating the sub-national fidelity of national initiatives in decentralized health systems: integrated primary health care governance in Nigeria. *BMC Health Serv Res* 2017;17:227.
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.
14 Naher N, Balabanova D, McKee M, *et al*. Absenteeism among doctors in the Bangladesh health system: what are the structural drivers? *SSM - Qualitative Research in Health* 2022;2:100089.
15 Ojo JS, Lamidi KO, Odewale AD, *et al*. Enemy within the state: the pathology of boko haram insurgency, military corruption, and fallacy of arms procurement in Nigeria. *Int J Public Adm* 2020;43:1068–82.
16 Oindo JO, Oyugi E, Samita Z. How African kinship system contributes to corruption in Kenya. *Open J Soc Sci* 2021;09:21–38.
17 Baez-Camargo C, Passas N. Hidden agendas, social norms and why we need to re-think anti-corruption, in working paper series, 22 Basel Institute on Governance, Presented at the OECD Global Anti-Corruption & Integrity Forum 2017 in a form of a poster presentation; 2017.
18 Onwujekwe O, Agwu P, Orjiakor C, *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* 2019b;34:529–43.
19 Agwu P, Ogbozor P, Odii A, *et al*. Private money-making indulgence and inefficiency of primary healthcare in Nigeria: a qualitative study of health workers' absenteeism. *Int J Public Health* 2020;65:1019–26.
20 Ogbozor P, Onwujekwe O, Balabanova D, *et al*. The gendered drivers of absenteeism in the Nigerian health system. *Health Policy Plan* 2022;37:1267–77.
21 Vian T. Review of corruption in the health sector: theory, methods and interventions. *Health Policy Plan* 2008;23:83–94.
22 Khan MH, Roy P. Making Anti-Corruption Real: Using a 'Power Capabilities and Interest Approach' to Stop Wasting Money and Start Making Progress. SOAS-ACE Synthesis Paper No. 1. London SOAS University of London; 2022. <https://ace.soas.ac.uk/publication/making-anti-corruption-real/>.2022 [Accessed 30 May 2022].
23 Khan MH. *Political settlements and the governance of growth-enhancing institutions. research paper series on governance for growth*. London: SOAS University of London, 2010.
24 Uzochukwu B, Onwujekwe O, Ezumah N. The district health system in Enugu state, Nigeria: an analysis of policy development and implementation. *AJHE* 2014;03:01–14.
25 Obodoechi DN, Onwujekwe O, McKee M, *et al*. Health worker absenteeism in selected health facilities in Enugu state: do internal and external supervision matter? *Front Public Health* 2021;9:752932.
26 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
27 Braun V, Clarke V. Reflecting on reflexive thematic analysis. *Qual Res Sport Exerc Health* 2019;11:589–97.
28 Braun V, Clarke V. One size fits all? what counts as quality practice in (reflexive) thematic analysis? *Qual Res Psychol* 2021;18:328–52.
29 Archer M, Decoteau C, Gorski P. *What is critical realism?* . 38. Perspectives, 2016: 38. 4–9. http://www.asatheory.org/current-newsletter-online/what-is-critical-realism
30 Callen M, Gulzar S, Hasanain AS. The political economy of public sector absence: experimental evidence from Pakistan (working paper no 22340), 2016. Available: http://scholar.harvard.edu/files/michael-callen/files/pe_absence_june5.pdf?m=1466002769

31 Smith DJ. Kinship and corruption in contemporary Nigeria. *Ethnos* 2001;66:344–64.
32 Roy P. Anti-corruption in Nigeria: a political settlements analysis Anti-Corruption Evidence (working paper 002); 2017. https://ace.soas.ac.uk/wp-content/uploads/2017/08/ACE-WorkingPaper002-Nigeria-AntiCorruption-170822.pdf [Accessed Jan 2022].
33 Ogbuabor DC, Onwujekwe OE. Implementation of free maternal and child healthcare policies: assessment of influence of context and institutional capacity of health facilities in south-east Nigeria. *Glob Health Action* 2018;11:1535031.
34 Sharma SP. Politics and corruption MAR health care in Nepal. *Lancet* 2010;375:2063–4.
35 Lewis M. Governance and corruption in public health care systems. *SSRN Electronic Journal* 2006.
36 Adie H, Igbang T, Otu A, Out A, *et al*. Strengthening primary healthcare through community involvement in cross river state, Nigeria: a descriptive study. *Pan Afr Med J* 2014;17.