

The gendered drivers of absenteeism in the Nigerian health system

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Abstract

The ability to deliver primary care in Nigeria is undermined by chronic absenteeism, but an understanding of its drivers is needed if effective responses are to be developed. While there is a small but growing body of relevant research, the gendered dynamics of absenteeism remains largely unexplored. We apply a gendered perspective to understanding absenteeism and propose targeted strategies that appear likely to reduce it. We did so by means of a qualitative study that was part of a larger project examining corruption within the health system in six primary healthcare facilities across rural and urban regions in Enugu State, south-east Nigeria. We conducted 30 in-depth interviews with frontline health workers, healthcare managers and community members of the health facility committee. Six focus group discussions were held with male and female service users. Data were analysed using thematic analysis. Participants described markedly gendered differences in the factors contributing to health worker absenteeism that were related to gender norms. Absence by female health workers was attributed to domestic and caregiving responsibilities, including housekeeping, childcare, cooking, washing and non-commercial farming used to support their families. Male health workers were most often absent to fulfil expectations related to their role as breadwinners, with dual practice and work in other sectors to generate additional income generation as their formal salaries were considered irregular and poor. Demands arising from socio-cultural and religious events affected the attendance of both male and female health workers. Both men and women were subject to sanctions, but managers and facility chairs were more lenient with women when absence was due to caregiving and other domestic responsibilities. In summary, gender roles influence absenteeism amongst primary healthcare workers in Nigeria and thus should be taken into account in developing nuanced responses that take account of the social, economic and cultural factors that underpin these roles.

Keywords: Absenteeism, health workers, gender, gender norms, primary health centres, socio-cultural

Introduction

Absenteeism threatens the achievement of universal health coverage (UHC) (Kress *et al.*, 2016), exacerbating already low staffing levels, especially at the primary care level (Okereke *et al.*, 2020). It takes various forms within the public sector, including engagement in private pursuits outside work or taking unauthorized leisure time within scheduled working hours, total absence from work for a day or more, arriving late to work or leaving the workplace early (Belita *et al.*, 2013; Kress *et al.*, 2016; Onwujekwe *et al.*, 2019; Agwu *et al.*, 2020). It has consequences for health, including the disruption of healthcare delivery, reduced productivity of health systems and diversion of patients to unlicensed health providers who

provide ineffective care (Isah *et al.*, 2008; Kisakye *et al.*, 2016; Onwujekwe *et al.*, 2019).

Primary healthcare (PHC) centres are the first point of contact in many health systems. PHCs are expected to deliver accessible health that are close to people's homes and are the only settings for care in rural hard-to-reach areas in Nigeria (Obioha and Molale, 2011). They are core components of UHC and make a crucial contribution to achieving the health-related sustainable development goals (Rao and Pilot, 2014). In Nigeria where the study was carried out, PHCs are characterized by weak governance arrangements and low levels of accountability, enabling absenteeism by health workers that makes them struggle to meet the basic needs of the

Key messages

- Absenteeism undermines the achievement of universal health coverage.
- Gender roles and norms shape expectations and work structures among frontline health workers in Nigeria.
- Women health workers are saddled with stress incurred from triple burdens of paid work, unpaid domestic and care work and communal obligations; this drives absenteeism.
- Approaches to absenteeism must take account of gender norms in finding feasible, high impact solutions to this problem.

communities. Absenteeism by health workers in Nigeria is widespread. [Oche et al. \(2018\)](#) surveyed 242 health workers, finding that 110 had at least one spell of absenteeism (defined as loss of scheduled time due to unscheduled work absence) in a year. Another study by [Obodoechi et al. \(2021\)](#) of 412 PHC workers found that 320 had been absent from work within a year, 54.6% ($n = 225$) had missed 10 days or fewer, 14.1% ($n = 58$) had missed 11–20 days and 4.4% ($n = 18$) and 4.6% ($n = 19$) were absent between 21–30 days and over 30 days, respectively. Once seen as inevitable, absenteeism in increasingly being viewed as a form of corruption, with some arguing that it is the most common manifestation of corruption in the Nigerian health sector ([Onwujekwe et al., 2018, 2019](#); [Bruckner, 2019](#)).

Traditional responses view absenteeism as an individual problem, a disciplinary issue addressed by holding staff to accountable if they fail to come to work. Yet these approaches have limited success in settings where rule breaking is widespread ([Khan et al., 2016](#); [Hutchinson et al., 2020](#)). The anti-corruption and transparency units in Nigeria's Ministries, Departments, and Agencies were established by the independent corrupt practices and other related offences to monitor, report and prevent corrupt practices. However, they have had little success. They lack funds and many have been undermined by senior management, who often perceive them as 'spies' who put others at risk of loss of employment. This also reflects a low sense of public duty and fear of the dangers that they and their families may face ([Independent Corrupt Practices & Other Related Offences Commission, 2021](#)). More recent thinking emphasizes context-specific measures based on a deep understanding of the structural and systemic factors that drive informal practice and corruption ([Khan et al., 2016](#); [Hutchinson et al., 2020](#)). This recognizes that rule breaking can be a response to a dysfunctional system that may have social, economic and political roots ([Marquette and Peiffer, 2020](#)). Rule breaking thus becomes a means of coping in a difficult situation. An example would be where health workers see little point in attending health facilities whose ability to offer care is compromised by powerful political networks that determine the distribution of health workers and potential for promotion ([Hutchinson et al., 2020](#)), where there are few medicines and little equipment or where health workers face threats from dissatisfied patients but lack the means to help them ([Onwujekwe et al., 2019](#); [Naher et al., 2022](#)).

The factors contributing to absence were harmonized by [Belita et al. \(2013\)](#) and divided into three categories. The first, related to the workplace, included the size of the organization ([Josephson et al., 2008](#)), facility location ([Isah et al., 2008](#); [Muthama, 2008](#)), workload ([Kivimäki et al., 2001](#); [Plant and Coombes, 2003](#); [Josephson et al., 2008](#); [Franche et al., 2011](#)) and poor working conditions, including bullying, violence ([Josephson et al., 2008](#); [Fujishiro et al., 2011](#)) and poor teamwork. Among personal factors, marital status ([Kivimäki et al., 2001](#)), age ([Kivimäki et al., 2001](#); [Isah et al., 2008](#); [Tripathi et al., 2010](#)) and individual health status ([Kivimäki et al., 2001](#); [Plant and Coombes, 2003](#); [Gorman et al., 2010](#)) were important. Finally, they explored organizational factors ([Verhaeghe et al., 2006](#); [Josephson et al., 2008](#)) and cultural expectations ([Isah et al., 2008](#)). Their findings were consistent with subsequent research that identified economic pressure, infrastructural deficiencies and defective leadership as important drivers of absenteeism ([Bruckner, 2019](#); [Onwujekwe et al., 2019](#)). Recent research on absenteeism by junior doctors working in rural PHC centres in Bangladesh has shown how failing to attend work is driven by difficult and sometimes dangerous postings, which make professional development almost impossible, with responses organized through networks that run throughout society ([Hutchinson et al., 2020](#)). Recent work on Nigeria by [Agwu et al. \(2020\)](#) has referred to this as 'survival absenteeism', where health workers take on other jobs in order to meet essential personal and household needs when salaries are delayed or inadequate. [Agwu et al. \(2020\)](#) also examine the influence of structures that are external to or cut across the lives of health workers inside and beyond the health system.

While this literature provides a detailed understanding of the drivers of absenteeism within different health systems, there has been a striking lack of attention to the different strategies that men and women might employ and how gender roles and norms shape absenteeism. Social norms are known to drive both formal and informal or unwritten rules that guide and govern behaviour, and gender norms are critical to the distribution of resources and work ([Mackie et al., 2015](#); [Cislaghi and Heise, 2020](#)). While the ways in which social norms shape informal governance and rule breaking have recently been explored ([Camargo and Koechlin, 2018](#); [Nicaise, 2019](#)), the role of gender has largely been overlooked.

In this study, we explore the ways in which gendered norms and roles shape the decision to be absent and how it is justified by frontline health workers. While we include both men and women, we give more space to women's roles and the gendered norms that underpin them as 60% of the paid health workforce in Nigeria is female ([United Nations Nigeria, 2019](#); [USAID, 2019](#)). Specifically, we focus on (1) the role of women and gender norms around housekeeping and care giving duties, (2) the role of men and women and gender norms in relation to economic provision within families and (3) gender norms and obligations associated with communal activities (attending weddings and burial ceremonies).

Background and theoretical framework—gender roles and norms

Gender norms are a subset of social norms that define acceptable and appropriate actions for women and men in a given group or society ([Cislaghi and Heise, 2020](#)). Gender norms

Table 1. Gender-related division of household and community tasks

Male household tasks	Female household task	Male household tasks	Female household tasks
Provide for family	Cook	Settling disputes	Process agricultural products
Maintain house, walls and roof	Sweep the floor/compound	Repair/maintain/footpaths	Care for small livestock in household
Remove cobwebs	Bath small children	Attend ceremonies	Cook at ceremonies
Fetch firewood	Fetch firewood (<i>except in North</i>)	Pay taxes and levies	Sweeping market
Split firewood	Fetch water (except in north)	Dredge gutters	Cleaning village square, town hall, church or mosque
Pay school fees	Discipline children	Attend community meetings	Visiting the sick or bereaved
Iron clothes	Wash dishes and pots	defence/security of town	Teach children
Wash cars	Wash clothes	Naming babies	Drying cocoa or other agricultural produce
Fetch water (<i>mostly only in the north</i>)	Grind pepper/process grains	Arranging wedding contracts	Singing and dancing at ceremonies and festivals
Discipline children	Nurse babies/care for small children	Lead prayers	
Dig wells	Cut vegetables	Teach Koran (<i>for Muslim communities</i>)	
Cut grass around compound	Lay beds	Harvest crops	
Pay medical bills	Go to market (<i>except in north</i>)	Carry masquerades	
Buy food/bring home (<i>North only</i>)			

Source: Olawoye *et al.* (2004).

are part of the wider processes that define men and women as different in socially significant ways and they interact with the gender roles, gender socialization and gendered power relations that exist in all societies (Ridgeway and Smith-Lovin, 1999; Cislighi and Heise, 2020). Gender norms are embedded in formal and informal institutions but also in the minds of individuals. They emerge through social interactions (socialization in the family, the media and engagement with institutions) and language (Cislighi and Heise, 2020). Gender norms and roles differ across societies and as they are socially constructed, they also change over time. Common across many societies, however, is an understanding that deviating from gender norms can have unfavourable consequences, creating conflicts and social pressure to conform, with failure to do so risking (potentially violent) sanctions (Olawoye *et al.*, 2004).

Olawoye *et al.* (2004) describe the distribution of gendered roles in Nigeria (Table 1). In the eastern part of Nigeria, where this study was carried out, the authors find that gender norms identify men as the primary breadwinners within households, tasked with providing money to pay for housing, school fees and healthcare bills. Women are primarily expected to take responsibility for domestic and childcare activities, including cooking, cleaning, washing and caring for sick relatives.

These gender roles often conflict with expectations at work (Ugwu *et al.*, 2016) in ways that are likely to influence absenteeism when, e.g. women seek to manage the double burden of domestic labour including childcare and paid work outside the home and men seek to fulfil the model of male breadwinner and seek an income elsewhere (Ugwu *et al.*, 2016). As gender norms in Nigeria change, especially in the light of ongoing economic hardship, women appear to be increasingly expected to make a substantial economic contribution to family income so taking up additional roles providing income that were traditionally reserved for men (Odunaike, 2012; Joseph *et al.*, 2018). This double burden of women's work is of particular concern for the health system.

Methods

Study setting and population

The study was undertaken in Enugu State, south-eastern Nigeria. Enugu has a population of 3.3 million with an annual growth of rate of 2.8% (Federal Republic of Nigeria, 2010).

There are 7 district hospitals, 36 cottage hospitals, 366 PHC centres (including comprehensive health centres and health posts) and 700 private facilities (comprising private non-profit, private for profit and faith-based facilities) in Enugu State (Benjamin *et al.*, 2015). However, there are no available data showing the gender breakdown at the time this paper was written. We focussed on PHC centres, the first level of contact for most people. The study is part of the Anti-Corruption Evidence project, which focuses on identifying health system corruption and anti-corruption strategies that can be implemented, using a variety of approaches including a systematic review, nominal group techniques and qualitative and quantitative studies. The present study emerged from qualitative research identifying gender as a factor in understanding the drivers of absenteeism and feasible solutions to it in the PHC level in Enugu (Onwujekwe *et al.*, 2019).

Three of the 17 local government areas (LGAs) in the Enugu State were purposively selected to ensure rural and urban representation (Enugu North, Nkanu East and Nsukka). Two PHCs in each LGA were purposively selected, making a total of six. Study participants comprised frontline health workers: 4 nurses (F = 4), 4 midwives (F = 4), 2 doctors (F = 1, M = 1) and 2 community health extension workers (F = 2); 12 healthcare managers [6 officers in-charge (OIC) (F = 6), 3 heads of department (HOD) (F = 2, M = 1)]; and 3 supervisors of health (M = 3) and 6 health facility committee chairs (M = 6). Six focus group discussions (FGD) were conducted with service users (3 groups with male and 3 groups with female participants), two in each LGA. The number of participants in each group of FGD was 10, except for one that had 8. Table 2 and 3 show the characteristics of the study participants for IDI and FGD.

Data collection

Researchers approached facility OIC, introduced themselves, provided details of the study and obtained informed consent. Interviewees were recruited with the assistance of the OICs, while the health facility committee chairs assisted in recruiting service users for the FGD.

Data from in-depth interviews and FGD were collected using guides pre-tested at two PHCs in a different LGA and were then revised by the research team. These sought

Table 2. Demographic characteristics of in-depth interview respondents

S/N	Cadre	Gender	Local government area	Age	Length of professional experience (years)	Highest education
1	Visiting doctor	Female	Enugu North	31	3	Bachelor of Medicine and Surgery
2	Nurse	Female	Enugu North	46	15	Registered Nurse Midwife
3	Chief Nursing Officer	Female	Enugu North	50	30	Registered Nurse Midwife
4	Head of Department; Health	Male	Enugu North	53	32	B.Sc. Environmental Health Sciences
5	Assistant Officer In-Charge	Female	Enugu North	51	30	Registered Nurse Midwife
6	Officer In-Charge	Female	Enugu North	46	26	B.Sc. Health and Physical Education
7	Health Facility Committee; Chairman	Male	Enugu North	40	8	HND Mass Communication
8	Community Health Extension Worker	Female	Nsukka	49	18	Community Health Education
9	Officer In-Charge	Female	Nsukka	54	16	Community Health Education
10	Senior Community Health Extension Worker	Female	Nsukka	38	15	Community Health Education
10	Nurse	Female	Nsukka	29	10	Community Health Education
11	Supervisor for health	Female	Nsukka	50	22	B.Sc. Environmental science
12	Health Facility Committee Chairman	Male	Nsukka	55	7	Senior Secondary Certificate Examination
13	Community Health Extension Worker	Female	Nsukka	28	6	Community Health Education
14	Officer In-Charge	Female	Nsukka	43	18	PGD Public Health
15	Community Health Extension Worker	Female	Nkanu East	49	26	Community Health Education
16	Community Health Worker	Female	Nkanu East	25	3	Community Health Education
17	Officer In-charge	Female	Nkanu East	48	24	Community Health Education

to elicit information on experience, knowledge, perception, attitude and practice of absenteeism in participants' current jobs; gender issues surrounding absenteeism and perceived feasible interventions to reduce absenteeism, with a focus on gender differences. Participants were interviewed in different settings; frontline health workers and health facility committee chairs were interviewed in the health facilities; health managers were interviewed at their offices in the respective LGAs, while FGD were conducted in a location away from the facility, designed to enable participants to air their views as freely as possible. All interviews were conducted in English, except the FGD, which were conducted in Igbo, the language indigenous to the region. The interviews were audio-recorded and detailed notes were taken by researchers. In-depth interviews lasted an average of 40 min while the FGD lasted, on average, 1 h.

Data analysis

Verbatim transcription of all English language interviews was undertaken to ensure that no information was missed. Interviews in Igbo were translated into English by bilingual members of the team. Analysis began with thorough reading of transcripts and field notes to achieve immersion. Coding was conducted using theory and data-driven codes. The theory-driven codes were developed drawing on the anti-corruption literature that focused on structural rather than moral or individual drivers of corruption (Khan *et al.*, 2016; Hutchinson *et al.*, 2020). This was followed by the development of codes and a codebook for analysis. Generated codes were reviewed by the research team to avoid duplication, achieve consensus and ensure validity of themes. Gender norms were identified first from the data-driven codes, and thematic content

analysis was conducted drawing on Olawoye and colleagues' description of Nigerian gender norms (Olawoye *et al.*, 2004).

Ethical approval

Ethical approval was obtained from the authors institutes.

Results

In the FGD with community members and in-depth interviews with health workers, health managers and health facility committee chairs presented absenteeism as a major problem in the health sector, forcing patients out of public health facilities, with those who can afford private ones receiving care while the poor die waiting or resort to ineffective or possibly harmful traditional medicines.

We have to go to private hospitals where we pay expensively. Normally people want to go to public hospitals but sometimes they will not attend to you. Some people die waiting for the doctor, and no person questions them, I have experienced that (Enugu North, FGD participant, female).

It could lead to death or more severe complications if health workers are absent. For example, a woman in this community was in labour and was rushed to the hospital but it was only the voluntary health worker was there to assist and deliver her baby. She started bleeding and no experienced staff was around. Unfortunately, the woman died. The women in that community came and locked up the health centre for two weeks. The matter was handled at the LGA (Nkanu East, FGD, male).

Table 3. Demographic characteristics of focused group discussion (FGD)

Participant	Age	Occupation	State of origin	Highest education
FGD 1, Female, Nkanu East				
P1	65	Retired farmer	Enugu	No formal education
P2	42	Farmer	Enugu	Primary
P3	65	Farmer	Enugu	No formal education
P4	50	Farmer	Enugu	Primary
P5	22	Student	Enugu	Secondary
P6	19	Student	Enugu	Secondary
P7	23	Student	Enugu	Secondary
P8	72	Farmer	Enugu	Secondary
P9	36	Civil servant	Enugu	Secondary
P10	62	Farmer	Enugu	Primary
FGD 2, Female, Enugu North				
P1	35	Student	Enugu	Ordinary national diploma
P2	31	Student	Enugu	Secondary
P3	29	Trader	Enugu	Ordinary national diploma
P4	27	Trader	Enugu	Secondary
P5	30	Trader	Enugu	Secondary
P6	25	Trader	Imo	Higher national diploma
P7	31	Student	Enugu	Bachelor of science
P8	36	Trader	Enugu	Ordinary national diploma
P9	37	Trader	Enugu	Secondary
P10	58	Farmer	Enugu	Primary
FGD 3, Female, Nsukka				
P1	48	Farmer	Enugu	Primary
P2	30	Trader	Enugu	Primary
P3	76	Farmer	Enugu	No formal education
P4	50	Trader	Enugu	No formal education
P5	45	Farmer	Enugu	Primary
P6	30	Trader	Enugu	Primary
P7	30	Tailor	Enugu	Secondary
P8	42	Farmer	Enugu	Primary
P9	31	Famer	Enugu	Primary
P10	41	Trader	Enugu	Secondary
FGD 4, Male, Nkanu East				
P1	65	Retired farmer	Enugu	No formal education
P2	42	Farmer	Enugu	Primary
P3	65	Farmer	Enugu	None
P4	50	Farmer	Enugu	Primary
P5	22	Student	Enugu	Secondary
P6	19	Student	Enugu	Secondary
P7	23	Student	Enugu	Secondary
P8	72	Farmer	Enugu	Secondary
P9	36	Civil servant	Enugu	Secondary
P10	62	Farmer	Enugu	Primary
FGD 5 Male, Enugu North				
P1	70	Retired civil servant	Enugu	Secondary
P2	56	Trader	Enugu	Primary
P3	52	Engineer	Enugu	Higher National Diploma
P4	61	Farmer	Enugu	Primary
P5	63	Trader	Enugu	Secondary

(continued)

Table 3. (Continued)

Participant	Age	Occupation	State of origin	Highest education
P6	55	Trader	Enugu	Secondary
P7	60	Trader	Enugu	Secondary
P8	63	Retired civil servant	Enugu	University
P9	64	Engineer	Enugu	Highest national diploma
P10	51	Trader	Enugu	Secondary
FGD 6, Male, Nsukka				
P1	73	Retired police man	Enugu	Secondary
P2	80	Farmer	Enugu	No formal education
P3	84	Retired civil servant/farmer	Enugu	Secondary
P4	42	Farmer	Enugu	Primary
P5	38	Electrician	Enugu	Secondary
P6	72	Farmer/	Enugu	Secondary
P7	45	Business man	Enugu	Primary
P8	38	Business man	Enugu	Secondary

As we looked for gendered structural drivers of corruption in the Nigerian health system, the following data-driven codes emerged as drivers of absenteeism: domestic labour and care work, the need to raise additional income, communal obligations and response to absenteeism. These themes were explored in details.

Domestic labour and care work as a driver of absenteeism

In all health centres, interviewees linked absence from work to the heavy burden of domestic labour faced by many health workers. Tasks described included cleaning homes, washing clothes and preparing meals for family members. All of these activities were identified as women’s responsibility and the pressure on women to complete these tasks often pushed them to leave work early. For example,

It has not been easy to combine family with work. I am a priest’s wife, and it comes with commitments too. I do sneak out from work at 3pm. When I get home, I will prepare meal for my family, because I must be in church by 5pm. And this happens every day. So, because of this, I absent myself from work some days so I could do some house chores, wash some clothes, and cook for my family. Work-family life isn’t so fair on women (Enugu North, female visiting doctor).

That quotation shows that these demands also affected relatively senior health workers (in this case, a doctor) and the requirement that women undertake household chores does not necessarily disappear when they take on better paid positions. In this case, the doctor also had to combine domestic labour with her role as a wife supporting her husband’s career by attending church. This combination of factors made it difficult for her to meet all the expectations on her with the work she did in the health system.

In addition to cooking and cleaning the home, focus group participants and interviewees described how caring for family members, including children, drove absenteeism. Again, this was linked to roles that men were excused from. Women

were often described as being responsible for caring for sick relatives, including elderly parents. In one instance, a female nurse stopped attending a rural clinic entirely because she spent her time caring for her sick husband. Mothers of young children were often described as being most affected as they were providing labour-intensive childcare (especially preparing children for school every morning before reporting for duty). While evening meals and attending church caused the doctor quoted above to leave work early, in these cases, health workers would also report to work late. Health workers who were interviewed and focus group participants were often sympathetic to these pressures on women, describing the challenges they faced combining childcare responsibilities with work.

Young mothers who are within or still giving birth have more childcare responsibilities (i.e. attending to children in the morning, taking them to school) with other chores in the house always find it challenging to combine these with work and most times do absent themselves from work or arrive at their workplace late (Enugu North, female nurse).

Participants also recognized that this triple burden of domestic work, caring for children and paid work in the facilities left many women exhausted. In addition to the pressures on women health workers time, focus groups with both men and women identified how fatigue led to women either being absent or coming into work late.

Also, their role in the family—to take care of their family, cook, wash and will be so exhausted from these chores and will not be able to go to work that day even she want to (Nkanu East, FGD, male).

Unlike women working in health facilities, their male counterparts were never described as needing to take regular time off to undertake household chores, care for children or because they were exhausted or ill. The quotation below is an example of the ways in which men rarely shouldered the burden associated with childcare and how concerns about their children rarely disturbed them when they were at work.

Sometimes, they will be like there is no need of coming to work again because time has elapsed. Housework, school runs, and others rest on the women. If she is here and remember that her daughter has closed from the school, she will not concentrate on what she is doing, she will leave it and go and get her child, but male will keep on doing what they are doing (Enugu North, FGD participant, female).

Beyond the ways that women faced exhaustion from domestic work and caring for children, both men and women recognized the role that menstruation and pregnancy could play in absenteeism, while embodied experiences were rarely described as the cause of absenteeism by men. The impact varied, as would be expected given the varying severity of symptoms, with some of those affected coming to work late but others absenting themselves for entire days.

Yes, I was having menstrual pains and because of that I couldn't go to work on time, I came by 9am rather than 8am (Nsukka, CHEW, female).

I usually have painful and heavy menstrual flow and most times I am so weak to go to work especially the first two days despite taking some drugs. My colleagues know this and always cover up my shifts if I am on duty (Enugu North, female nurse).

Unsurprisingly, pregnancy was described as a time when women were more likely to be away from work, although the reasons were rarely elaborated precisely. For example, 'Biologically, women are more prone to absenteeism because of childbearing (pregnancy) and its accompanied challenges' (Enugu North, HOD, male). Few participants openly criticized women for wanting to take time away from the health facility during their period or when they were pregnant. In one of the male focus groups, however, while participants who accepted that menstruation and pregnancy may make women feel unwell, they framed their responses as being unwilling rather than unable to go to work.

Females are more absent from work because of their role in the family and body hormones [body changes that may occur with pregnancy or menstruation which mostly manifest as a feeling of unwell]. Maybe she is still young at childbirth bearing age. She may wake up in the morning and will say that there are some changes in her body, then will not want to go to work (Nkanu East, FGD, male).

The need to raise additional income as a driver of absenteeism

Whereas domestic and care work was described as predominantly in the domain of women rather than men, the need to take on additional paid work to supplement small, irregular salaries affected both men and women. Women were especially likely to work elsewhere to provide school fees for their children. One chief nursing officer identified women as having five roles: caring for children, cooking, cleaning, providing additional money for school fees and working in the health facility.

Women are usually absent in the facility because they take care of their children like caring for them when they are sick, cooking, cleaning the house even support payment of school fees. They tend to be busier and absent themselves from work (Enugu North, female chief nursing officer).

Female health workers traded in local markets and worked on farms when they needed additional money, often at weekends and so adding to their burden (as in the first quotation below), it could also, however, take place during the working week. For example,

I only engage myself in farming to sustain my family because my salary is too small due to the fact that we are being denied of certain allowances unlike our Ebonyi state counterparts. So, instead of staying idle during weekends or when we are less busy, I engage in farming activities so that I won't be buying certain food stuffs like garri and abacha (Enugu North, OIC, female).

In contrast to what was seen as women's work, farming and selling foodstuffs, male health workers and doctors engaged

in a variety of economic ventures. Just as women's domestic and farming activities took them out of the health facility, these activities often took priority over their main job at government owned facilities. It was reported that positions in facilities permitting flexible work schedules were sought after as they could be away from them on certain days without taking unofficial absence. Participants also noted the greater opportunities in urban areas, where men could operate their own business or take on additional employment in private clinics for several days each week.

What I know is that they (men) work for their redeployment, so that they are transferred to a place they will be free to do their business (Nsukka, female senior community health extension worker).

There was a time we were having problem with the doctors we did all we could to get doctor and when he decides to be always absent, I queried the man and he said he doesn't come every day because he has his own practice and we know that owning a private facility affects the health centre and we keep telling them but he ignores (Enugu North, male ward development chairman).

Communal obligations as drivers of absenteeism

Both male and female doctors and other health workers would absent themselves when they had communal obligations such as funerals, weddings and religious rites. Health workers described the expectation that they would return to their villages for burials, with no allowance made for those formally employed:

Since this is done at the grassroots, and eh at the grassroots you know, in getting to the villages, especially for those who are from that village, anything that happens you expect them to be there. That you are a civil servant is not an excuse. Sometimes you find people taking permissions that there is a burial they want to attend, that someone died, and they are going to the funeral rites (Nsukka, female midwife).

Men or women who failed to attend these rites and who were from certain groups faced stiff financial penalties that would be imposed by the community. Women health workers who belonged to different traditional groups were said to be particularly vulnerable to these demands to go to funerals. As one health worker explained:

Health workers, especially women belong to various traditional groups, that's cultural group, you understand? Our culture doesn't observe Saturdays and Sundays but it's the market days. Like funerals are done on market days. They will say Nkwo we are going for this person's final funeral... And if you don't come, the penalty is one thousand or two thousand naira (Nsukka, supervisor for health, female).

Response to absenteeism

Even though there are gendered differences in reasons for absenteeism, official sanctions for health workers are expected to be the same. Informally, however, it was reported that female health workers who were absent without permission

may be treated more leniently, especially if their absence is traced to childcare and homecare responsibilities.

It (HW absenteeism) should be handled the same way. Although, females are supposed to be treated differently because of their roles in the family. Maybe their child is sick, you have to be lenient when handling their absenteeism cases (Nkanu East, CHEW, female).

There are very many of them such as one's child being ill or hospitalized or that one's daughter or daughter in law has put to bed. In such contexts, I can show some level of understanding and that is why we have volunteer workers around us to cover up in such situation (Enugu North, OIC, female).

Some health workers, however, had the ability to be absent from health centres without sanction. In these cases, the families that made demands on women's time and energy (see above) became an important resource for women health workers. Those related to powerful political actors and civil servants within the bureaucracy could leave work without fear of reproach from their OICs or health facility committees. These connections were described as leaving these health workers untouchable and the dangers of reporting well-connected health workers for being absent were recognized by many we interviewed. As the OIC below reports, those who report people connected to powerful individuals (here the local government chairman) risk losing their positions within their health centres.

She [OIC] couldn't have done anything because even if she reported to the Local Government Service commission, nothing will be done because they relate very fine with the local government chairman. Hence, she didn't want to take it up. Also, her fear may be that if she had insisted, they will remove her and replace her with another person that will be piloting the affairs of the HC. She was simply protecting her job (Enugu North, assistant OIC/nurse, female).

For some OICs, however, fear that an employee might be well-connected meant that they would not complain about any absent health worker. As OIC in Nsukka explained:

The issue is that in such a case the OIC may not even have the guts to write a letter because she knows that if she writes she might be the one to...either she is transferred from that place or her letter will be neglected. And that is why most of the OICs they don't even complain, even when things are bad because they know that when they write it will not yield anything. They (commissioners or Head of Departments) will just call, that this person is my relation, or this person is... I'm interested in her case. That just ends it (Nsukka, OIC, female).

Health workers were connected to authorities in the state or local government and local politicians. Very often these powerful individuals were male relatives, husbands, male relatives of husbands or male relatives in women health workers' own biological families. While health workers could be supported by women or men (a wealthy or powerful individual able to exert political influence and control areas of interest), it

was much more likely for our research participants to describe those supporting absent women health workers as godfathers. For example,

I think it is just the issue of Godfatherism [i.e.] wealthy and powerful individuals who exert political influence and control areas of their interests]. Maybe the staff in question has somebody on the top, instead of attending to the OICs query, the OIC was transferred out and nothing was done as regards to the query. The staff will be boasting of how they got away with it. So, the staff involved might call The Godfather who might be a relation, husband or something like that and inform the person what is happening, and that person might then interfere with the punishments (Nsukka, health facility chairman, male).

In these instances, it was often important to maintain good relationships with the OIC of the facility and some women made payments to smooth over any potential conflict.

Discussion

PHC should ensure that services are accessible to the communities they serve. However, PHC in Nigeria, it is often of poor quality, with absenteeism common (Oche *et al.*, 2018; Agwu *et al.*, 2020; Onwujekwe *et al.*, 2020). New approaches to absenteeism draw on novel anti-corruption strategies that seek to identify the structural (social, economic and political) factors as well as those in the health system that drive this practice. Previous studies have begun to examine the health system drivers including weak monitoring, poor salaries, lack of equipment and consumables, insecurity, dearth of social amenities and power relations (Kress *et al.*, 2016; Tweheyo *et al.*, 2017; Onwujekwe *et al.*, 2020). Our study suggests that social norms and the gendered division of labour shape the structures within which men and women work, making different demands on their time and labour.

Although studies examining the relationship between gender and absenteeism are rare, our study is not unique in finding that traditional gender roles influenced absenteeism. For example, Mudaly and Nkosi (2015) and Tweheyo *et al.* (2017) showed how care for relatives and family responsibilities influenced the careers of female health workers in South Africa and Uganda, respectively. They were saddled with family responsibilities and were often demotivated as they felt tired and stressed, which contributed to absenteeism. Absenteeism is widespread in health systems, but in countries with few resources such as West Africa (Onwujekwe *et al.*, 2020) and East Africa, with work from Kenya (Tumlinson *et al.*, 2019). Examples from across the world include rates of 35% in Bangladesh, 37% in Uganda and 40% in India and Peru (Chaudhury and Hammer, 2003). However, as our study and others highlight, a new perspective on the issue is essential to understand the role of gender norms. As we noted above, there are measures in place but they are largely ineffective. There is a growing recognition of the need to take a contextually appropriate approach, which we now argue must include gender, so while we cannot really comment specifically on the largely dysfunction mechanisms in place, we think the addition makes the point that the new ideas are needed. The major driver of absenteeism among male health workers

was described as the quest to make additional income to provide for the needs of their extended family, leading them to engage in dual practice and other business activities to supplement the low and irregular salaries in secondary and tertiary facilities. Some resort to loans while offering their meagre salaries as collaterals (Akwataghibe *et al.*, 2013; Onwujekwe *et al.*, 2020). Failure by the health system to provide economic security to primary health workers thus propels them to seek alternative means of survival (Agwu *et al.*, 2020). This has negative consequences in their workplace—compromised quality of services and increased workload for the remaining staff.

This research raises important questions about the burden of work and access to resources experienced by female health workers. Whereas men can obtain additional income from another job, female health workers are expected to provide unpaid domestic labour. This leads to lateness, unplanned absence from the workplace and presenteeism. We did find some evidence that things are changing, with more women feeling responsible for domestic finance, taking on what Olawoye *et al.* (2004) saw as male roles, e.g. in agriculture or trading. We found no evidence that men were taking on women's gendered work within households. Gendered analyses often highlight what is often conceptualized as a triple burden on women as a result of gendered divisions of labour in productive (paid labour), reproductive (child bearing, cooking, cleaning and caring for family-children, sick and elderly) and community roles (Moser, 2012).

The persistence of this situation owes much to the patriarchal nature of Nigerian society that expects women to be wholly responsible for the management of their homes regardless of their employment status. They are often saddled with these responsibilities and experience conflicts with the competing roles they play at workplace and home (Lussier *et al.*, 2002).

Some recent work has looked at support available to higher status women in employment, such as doctors, from relatives, nannies and caregivers (Joseph *et al.*, 2018), but the account from the female doctor reported earlier shows that this is inconsistent. Also, it is not an option for less well-paid nurses.

Both men and women were influenced by social expectations to participate in social and cultural activities. Cultural events play a major role in the community, where the study is set in eastern Nigeria (Dieleman *et al.*, 2011; Oche *et al.*, 2018; Onwujekwe *et al.*, 2020). However, there are also nuances in the cultural roles adopted by men and women even at these events, with an expectation that women will undertake particular tasks that are again associated with domestic labour. Women are expected to cook and serve meals (Olawoye *et al.*, 2004). In contrast, men are invited just to attend and show solidarity, rooted in the African culture of communality. We were unsure of the ways in which this would influence absenteeism, but it is likely that women have more stressful roles to play in these events than men. This will be important to explore in future studies on gender and absenteeism and points to the need to consider cultural, community and kinship-based obligations when exploring strategies to curb absenteeism.

Taken together, our findings point to multiple burdens: paid work within the health system, labour in farms and markets to provide an additional income, unpaid labour within the household and unrecognized communal obligations at events, often with the expectation that they will cook at them.

Most participants emphasized the importance of engaging with those at the grassroots when developing responses to absenteeism, such as health facility committees and community leaders. Yet, specific suggestions focused on the traditional, individually focused and punitive measures that have consistently been found to have little effect. These include unannounced supervisory visits, attendance registers and biometrics for recording attendance. Our analysis, consistent with a growing body of evidence elsewhere, argues for an approach that combines different strategies in a gender-specific framework that (1) acknowledges gender differences, (2) accommodates men and women's family roles and (3) acknowledges the domestic and caregiving obligations that cannot be left unattended.

Our findings underpin the crucial need to create and adopt gender-role compliant policies that reflect gender differences in the workplace and recognize different roles played by men and women in the home and workplace. While these are changing and will continue to do so, there is still some way to go even in societies with a high degree of female empowerment. Such policies will support family-friendly policies, with flexible schedules for women, especially newly married and young mothers who are often overwhelmed by additional responsibilities imposed by childcare, pregnancy and home-care. There is also a case for provision for long-term leave to attend to pressing family needs, especially important in a setting where there is limited formal social support from the state, recognizing the need to avoid burnout in those who struggle to combine family roles and work. Other measures include opportunities for part-time employment, extended maternity leave, emergency childcare leave, family medical leave, reduced working hours or working from home, elderly care and school holiday cover. These family-friendly workplace strategies have worked in high-income countries like the UK and have lessened the burden on women (Adisa *et al.*, 2016). In the longer term, community leaders might consider the obligations placed on health workers to participate in communal events but, of course, this will be very difficult (Onwujekwe *et al.*, 2019). More reliable, prompt and improved payment of workers' salaries and allowances to cover costs of additional childcare could reduce dual practice among PHC health workers, providing greater economic security in the workplace. The importance of improved and prompt payment of salaries and allowances for PHC workers in Nigeria cannot be overemphasized, but this may be challenging without major administrative reform. Also, supportive supervision by OICs and community groups monitoring the activities of health workers could help to understand the needs of employees beyond the work environment.

Inevitably, this study had some limitations. First, it was conducted in PHC in the eastern part of Nigeria, but regional gender norms driving absenteeism may differ in other parts of this large and complex country. Second, we cannot assume that the reasons for absenteeism will be the same at higher levels of the health system. These considerations call for further research to understand this important issue and determine how generalizable our findings are.

Conclusion

This study has provided new information on the gendered nature of absenteeism among frontline health workers in PHC facilities in Nigeria. Many healthcare workers are absent

because of the need to survive. Women health workers must balance work with responsibilities of housekeeping and care giving, while their male counterparts seek opportunities to supplement their incomes and provide for their families. Other socio-cultural demands affect both genders. These findings can contribute to developing mechanisms to curb absenteeism that will be effective and sustainable, incorporating insights from the gendered nature of drivers of absenteeism in primary care in Nigeria.

Data availability

Data sets will be available to readers on request. Requests to access these datasets should be directed to Pamela Ogbzor, pamelaogbozor@gmail.com.

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Author contributions

O.O., E.H., D.B. and M.M. contributed to the conception and design of the study; P.O., C.O., A.O., P.A. and U.O. collected the data; O.O., P.O., P.A., C.O., U.O. and A.O. analysed and interpreted the data; P.O. wrote the first draft of the manuscript; O.O., P.A., C.O., U.O., A.O., M.M., D.B. and E.H. reviewed and wrote sections of the manuscript; and E.H., O.O., P.A., D.B. and M.M. critically revised the manuscript. All authors read and approved the submitted version.

Reflexivity statement

The authors comprise four females and four males from two countries—Nigeria and UK—span across multiple levels of seniority and expertise. Five of the authors specialize in health system policy and governance, public health, anti-corruption, accountability and health economics in West Africa and Europe. Four other authors are social scientists with expertise in social determinants of health, organizational policy, gender, medical anthropology, clinical, work-life balance and positive psychology. The social scientists also have extensive experience conducting qualitative, ethnography and quantitative fieldwork in Nigeria, especially in south-eastern and northern states—Enugu, Anambra, Rivers and the Federal Capital Territory Abuja.

Ethical approval. Ethical approval was obtained from University of Nigeria Teaching Hospital Ituku-Ozalla, Nigeria (Approval No.: NHREC/05/01/2008B-FWA00002458-IRB00002323), Enugu State Ministry of Health Nigeria and Health Research Ethics Committee of LSHTM (LSHTM Ref.: 14540-1). Individual consent was obtained from each participant, while individual and group permissions for audio recording were obtained for in-depth interviews and focus group discussions, respectively.

Conflict of interest statement. None was declared by the authors.

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