

# Establishing Incidence of Health Provider Absenteeism in Bushenyi District

By

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(UNHCO)



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May 2010

## List of Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
ARVs	Antiretroviral drugs
CAO	Chief Administrative Officer
CBO	Community Based Organization.
CSO	Civil Society Organization
DDHS	District Director of Health Services
DHTs	District Health Teams
DHO	District Health Officer
DSC	District Service Commission
GHWA	Global Health Workforce Alliance
LC	Local Council
RBA	Rights Based Approach
HC	Health Center
HIV	Human Immuno-Deficiency Virus
HR	Human Resources
HRH	Human Resources for Health
HSC	Health Service Commission
HSSP	Health Sector Strategic Plan
HSSP II	Health Sector Strategic Plan II
HUMCs	Health Unit Management Committees
MDGS	Millennium Development Goals
MOH	Ministry Of Health
NGO	Non Governmental Organization
NHP	National Hospital Policy
PEAP	Poverty Eradication Action Plan
PHP	Private Health Practitioners
PNFP	Private Not-For Profit
TB	Tuberculosis
TCMPs	Traditional and Complimentary Health Practitioners
UNHCO	Uganda National Health Consumers' Organization
WHO	World Health Organization
VHTs	Village Health Teams

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## Acknowledgement

The Uganda National Health Consumers'/Users Organization,(UNHCO) wishes to acknowledge and appreciate the support and invaluable information received from various groups of people, institutions and officials in the course of gathering the data on which this report is based. Special reorganization goes to the District Health Officer Bushenyi and his team for the advice and reviewing the tools and finally authorizing data collection. We also wish to thank the team of research assistants and their supervisors for working tirelessly during data collection stage.

Other agencies and institutions that provided invaluable logistical support and information included the, Ministry of Health, District local government staff Bushenyi district, Medical Superintendents of Comboni missionary, Ishaka Adventist and Kitagata Hospitals, and all the Facility –in charges of all Health Centers sampled in Bushenyi District. UNHCO is also deeply indebted to the Transparency Accountability Programme for the funding the study.

We also met many individuals who provided us with information upon which the synthesis, conclusions and recommendations of this report are drawn. They all slotted our presence into their daily schedules to give us unlimited attention, through active participation in the key informant interviews. Without their inputs, this assignment would not have been completed. Shortcomings, and interpretations made herein, however, do not necessarily reflect the views of the respondents as the author stakes responsibility for them all.

## **Abstract**

*UNHCO study **Prevalence and Factors Associated with Absenteeism of Health Providers from Work** draws results from the study made to 78 health facilities in Bushenyi District, including literature review and unannounced visits. The intention of the study was to document the prevalence, determinants and consequences of absenteeism of health providers in the health sector of Uganda, and recommend appropriate remedies for the identified causes in order to promote efficiency and effectiveness in the utilization of public resources.*

*The average rate of absenteeism was 47.9% and after desegregation of key health cadres, 24% of the Nursing Officers were not present at the health facility, followed by Nursing Assistants and Enrolled Nurses both at 18%. The Enrolled 15% of the Enrolled Midwives were not present. The important determinants of health provider absenteeism found from this study included the work environment, supervision, Job satisfaction with different incentives, level of education, and location of health facility (remoteness), length of service in the current facility, job stress, and Marital Status. To minimize absenteeism in health care in Uganda there is need for increased monitoring and supervision of the health providers, In addition, a policy should be designed to encourage health providers retention, reduced on probation time of the health providers, improve on health provider work environment ,hardship and risk allowance to health care providers serving in remote areas.*



# 1. INTRODUCTION AND BACKGROUND

In Uganda, the delivery of health care services is faced by numerous challenges that affect both the quantity and quality of health care services provided by the health system. For the health related MDGs goals to be achieved, considerable progress will need to be made for instance, improving the quantity and quality of health care providers hence addressing big problem of the human resources for health. However, success will also depend heavily on adopting the right policies for the health sector, and in particular implementing measures that are aimed at enhancing the effectiveness and efficiency of public resources that are allocated to the sector. WHO has estimated that to meet the ambitious targets of the millennium development goals, African health services will need to train and retain an extra one million health providers by 2010 (WHO 2004). Beyond the shortages, imbalances in geographic distributions especially - between rural and urban areas exacerbate the crisis.

Like sub-Saharan African countries, Uganda's 30 million people face huge health challenges, including HIV, malaria, TB, maternal mortality (880 per 100,000 live births) and child mortality (79 per 1000 live births). Uganda spends about 1.3 percent of its gross national product on health, or about \$23 per person per year (HSSP III 2009). One of the challenges of the health sector in Uganda is human resources for health, which faces setbacks such as health care worker absenteeism, poor retention, poor motivation and remuneration and poor skills all which stem from sector under funding. Absenteeism, although not well documented in Uganda is a major barrier to effective health service delivery, which requires a change at both policy and management level.

## 1.1 Background to UNHCO

UNHCO is a health advocacy organization, which has for over 10 years engaged the Ministry of Health, districts and health facilities in dialogue on how to improve quality of health care through the rights based approach. This effort has been enhanced by the development of the Patient's Charter aimed at improving responsiveness of the health care system to the rights of patients and or clients. UNHCO's advocacy campaigns have been mainly supported by research and information collected through their monitoring activities. Therefore UNHCO has garnered adequate skills, expertise and experience in using research recommendations to develop policy advocacy plans and dialogue at the national and sub-national levels on realistic human resources for health interventions which will improve performance, under the prevailing circumstances, and for the different groups of health providers. In addition, UNHCO provides evidence to the health sector and partners through research as well sharing monitoring information on the right to health. This aims at promoting accountability, transparency and community participation in healthcare service delivery. The study on health provider absenteeism therefore will provide evidence required to improve health provider performance specifically addressing national level shortages, imbalances in geographic distributions especially-between rural and urban areas. The findings of the study will further be used to develop policy advocacy agenda to find solutions on how to reduce health provider absenteeism.

## 1.2 Background to the Uganda Health Sector

According to Uganda Human Resources for Health (HRH) Policy, human resources for health embrace all people with or without formal training who contribute to the protection and improvement of health. Human Resources are also recognized as a critical input if Uganda is to achieve its sector objectives. For this reason, the Ministry of Health (MoH) together with development partners through the Health Sector Strategic Plan (HSSP) have made steps, building

human resources capacity at various levels particularly capacity of health training institutions to improve the quality and quantity of output as well as providing tools and an enabling environment for improved work performance. These efforts were further enhanced by the World Health Organization (WHO) Global Workforce Alliance (GHW) Kampala declaration March 2008 that emphasized the need for collective and sustainable political, structural, systemic and economic intervention to address the global health workforce crisis. However, despite the initiatives, the HRH challenges facing the health sector include among others, inadequate capacity of the country to train, manage and sustain requisite health workforce resulting in shortage and poor performance of health providers. Others are poor distribution of staff, low salaries, poor incentives, lack of career progression to enhance staff motivation, retention, performance, poor or lack of supervision, poor output, high level absenteeism and poor working conditions.

As part of sub-Saharan Africa, Uganda's 30 million people face huge health challenges, including HIV, malaria, TB, maternal mortality 880 per 100,000 live births and child mortality 79 per 1000 live births (1995 Demographic and Health Survey). Uganda spends about 1.3 percent of its gross national product on health, or about \$23 per person per year. Uganda's per capita health budget stands at \$10 which covers less than 40 per cent of the cost of providing the Uganda Minimum Health Care Package which by 2005 Ministry of Health figures costs approximately \$28 per capita. This also falls short of the Abuja Declaration on sector allocation target of 15 per cent of a country's national budget.

The HRH plan targets to have 98,000 health providers in the public and private sectors by 2020. The problem with this is that projection is based on a baseline number of 59,680 health providers obtained from secondary analysis of the 2002 census data (Human Resource policy, April 2006). The figure includes persons with either a health occupation, or a non-health occupation, but working in the health sector. These included 2,929 medical doctors, 88 dentists, 150 pharmacists, 20,186 with nursing and midwifery occupations, 3,785 clinical allied health providers, 15,228 nursing aids /assistants, and 4,530 traditional practitioners / faith healers. The combined number of health providers in government and Private-Not-For-Profit facilities, were 30,000 in 2004 (HSSP II) and is a small number compared to the ever increasing population growing at 3.4% per annum. *“Too few overburdened and overstressed health providers, without the support they so badly need – losing the fight. Many are collapsing under the strain; many are dying, especially from AIDS; and many are seeking a better life and more rewarding work by departing for the richer countries...are what comprises Uganda's health workforce”*. Dr. Sam Orach, Assistant Executive Secretary Uganda Catholic medical Bureau while presenting a strategic paper at the MOH. The quality of services offered at public compared to private health facilities is another influencing factor in the utilization of public health services. While majority of Ugandans seek health care services from public health facilities, the majority of Ugandans above the poverty line prefer private health facilities. The poor patient still purchase items recommended at the public health facilities, elsewhere, especially the unlicensed drug shops. The active poor go to private sector health facilities where the queue moves faster and where payment is made over the counter, and in the open compared to public health facilities where payments are done under the counter or table and even where women in labor will not have to deliver in the bush adjacent to the health facility because the newly-built health facility is locked. The private health facilities have stayed in business by merely correcting the ills of the public health facilities in relative terms: ensuring availability of all types of medicines, readily accessible diagnostic equipment, paying better salaries, prompt attendance to patients, very low absenteeism rates.

Uganda has implemented several health sector reforms in an attempt to improve service delivery including decentralization, increase on the number of health providers by encouraging students to study science subjects and increasing on the number of training institutions in the country. The other reform is the introduction of health sub-district strategy that has helped achieve the broader goal of bringing services nearer to the people. This has to a greater measure been successful considering a Ministry of Health Report in 2005 showing the proportion of residents living within 5 kms radius of a health facility stood at 72 per cent. However living within the vicinity of a health centre does not necessarily mean equal access. In Uganda health providers prefer to work in urban over rural areas. Uganda Ministry of Health statistics report that 64 percent of all nurses and midwifery professional cadres work in Uganda's central (most urban) region, where only 27 percent of the population resides, indicating that the rural areas are severely understaffed.

The Ministry of Health initiated a process to carry out technical support supervisions to general hospitals and health sub districts. Technical supervision in the areas of supervision has hitherto been done by specialized personnel from the national referral hospitals of Mulago and Butabika. Other partners in the health sector have been conducting separate support supervision without harmonized programme for these outreach activities. However effects of health providers' absenteeism are of much concern in Uganda because of the economic loss associated. According to the *Daily Monitor*, April 23<sup>rd</sup> 2009, 30 billion shillings in the Ministry of Health budget is lost due to personnel absenteeism. According to the review for the financial year 2006 / 2007 by the World Bank, health providers in Uganda are absent half of the time although they still earn a full salary. The World Bank estimates the rate of absenteeism among primary healthcare workers in Uganda to be more than 35%. The study on absenteeism will therefore be able to estimate the incidence and give reasons for health provider absenteeism which will be used by the sector to plan and institute effective policy and management remedies.

#### ***Stakeholders in the health care service delivery***

Uganda's health system comprises the public sector (MOH, the private health delivery system consisting of private not- for profit organizations (PNFP), private health practitioners (PHPs), traditional and complimentary health practitioners (TCMPs) and Civil Society which is made up of Non-Governmental Organisations who largely offer non facility based community mobilization services. A critical stakeholder is the Development Partners/Donors who provide the bulk of the funding for the health sector.

The PNFP Organisations include agencies that provide health services from an established static health unit/facility to the population and those that work with communities and other counterparts to provide non facility based health services. They account for 42% of all the hospitals and 28% of the lower level units in the country.

#### ***Human Resources for Health policy in Uganda***

The Human Resources for Health Policy (MoH, April 2006) rationale is to provide a framework and guidance for effective and efficient implementation of the National Health Policy in pursuit of Government of Uganda's development goals. The Policy guides the Human Resource Strategic Plan which is developed in the context of the Health Sector Strategic Plan (HSSP) and the overall Uganda vision 2025 for poverty reduction and economic development. The HSSP recognizes Human Resources as central to effective implementation of country health systems and one of the most important inputs for the attainment of health sector objectives. Human Resources for Health Policy therefore targets factors impacting performance including absenteeism with a focus on reducing the disease burden and population growth rate. The overall HSSP III objective on HRH

is to increase availability of trained and motivated staff (public and PNFP staff) that are equitably distributed throughout the country who will contribute to the effective delivery of the Uganda National Minimum Health Care Package.

The policy goal is to develop and maintain a health workforce that is appropriately sized, structured, skilled, well balanced, distributed, resourced, committed and performing efficiently and effectively in order to provide all Ugandans with equal access to a minimum health care package, sufficient to meet Uganda's health development targets within affordable resources.

The Plan was drawn on seven assumptions amongst which are, that public expenditure will decline in the short to medium term but increase significantly in the long run and that there will be some shift in the recurrent budget with a higher proportion assigned to personnel costs than currently.

It foresees Uganda having a population growth of 1.7 % (from 2.5%), HIV infection rate of 0.5% (from 2.5%), Infant Mortality Rate of only 10 per 1,000 live births and a Maternal Mortality Rate of 200 per 100, 000 live births and total fertility rate of 3.4 children (from 6.9). It foresees Ugandans having 5,000 persons per doctor (from 18,600) and 1,000 persons per nurse (from 7,700) and assumes that the Poverty Eradication Plan (PEAP) developed in 1997 and revised in 2000 will have improved life of the poor. By implication these mean there will be less disease burden to deal with.

The combined number of health providers in government and Private-Not-For-Profit facilities, were 30,000 in 2004 (HSSP II). In June 2005 there were about 9,500 health professionals working exclusively in the private sector, commonly called the private-for-profit (Andrea Mandelli, Lennie Bazira Kyomuhangi and Susan Scribner 2005). This means that excluding the 4,530 traditional / faith healers, Uganda had about 15,650 health providers practicing other trades.

The HRH plan targets to have 98,000 health providers in the public and private sectors by 2020. One problem is that this projection is based on a baseline number of 59,680 health providers obtained from secondary analysis of the 2002 census data (Human Resource policy, April 2006). The HRH strategic plan recognizes that by 2020 there will still be 11,617 "clinical support staff" besides 1,463 "other non-health semi-skilled" and 14, 182 other support staff. The clinical support staffs will still make a good 11.9% of the workforce then, down from the baseline of 15,228 (25.7%). These will include the nursing aids, nursing assistants, and complementary cadres mentioned earlier.

### ***Health infrastructure in Uganda***

The health delivery system is grouped into levels depending on minimum health service standards set for each tier. The details of the infrastructure level, administrative level, target population and services provided are summarized in the Table 1.

**Table 1: showing health care system and target population**

<b>Level of infrastructure</b>	<b>Administrative level</b>	<b>Target population (Number of people should be serving)</b>	<b>Services provided</b>
<b>HC I</b>	Village	1,000	Community based prevention and promotion of health services through the Village Health Teams(VHTs)
<b>HCII</b>	Parish	5,000	Preventive, promotive and out patient curative services, outreach care
<b>HCIII</b>	Sub- county	20,000	Preventive, promotive and out patient curative, maternity, inpatient services, and laboratory services
<b>HC IV</b>	County	100,000	Preventive, promotive and out patient curative, maternity, inpatient services, emergency surgery and blood transfusion and laboratory services
<b>DISTRICT</b>	General Hospital	500,000	In addition to the services offered at HC IV other general services such as x-ray and ultra sound services and advanced laboratory tests are undertaken. It also provides in- service training, consultation and research to community based health care programmes
<b>REGIONAL</b>	Regional referral hospital	2,000,000	In addition to services offered at the general hospital, specialist services are offered at this level. Such services include: psychiatry, ear, nose and throat(ENT), Ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical and medical services
<b>NATIONAL</b>	National referral hospital	30,000,000	In addition to services offered at the regional referral hospitals these hospitals provide comprehensive specialist services including but not limited to cardio- thoracic surgery, computerized, tomography (CT scanning) , oral surgical procedures and laboratory procedures, treatment of cancers, ECG, treatment of mental problems and performing pediatric surgery in addition, they are involved in teaching and research

### ***Human Resource Development and Management***

In Uganda, training of health providers is done by the government, Private Not For Profit (PNFP) organisations and privately-owned training institutions. The health sector has four professional councils with which all practicing health providers in the country are supposed to register with; Uganda Medical and Dental Practitioners Council (UMDPC), Uganda Nurses and Midwives Council (UNMC), Allied Health Professional Council (AHPC) and Uganda Pharmacy Council (UPC). For health providers who are employed by PNFP, any appointment made while the registration process has not yet been concluded is conditional, the employee concerned has to produce the required registration certification within a period of three months from the date of appointment otherwise their appointment will be null and void. Information obtained from UNMC indicates that 56% of nurses and midwives are not licensed. A total of 5,028 allied health professionals of different cadres and grades have been registered with the AHPC; 24.1% female, 75.9% male. In terms of equitable distribution of training institutions, each region of the country

has at least one school for nurses and midwives (32% of these are located in the city, Kampala) while allied health training schools vary in size and their intake has been steadily increasing since 2000.

The greatest demand for nurses and midwives lies at lower level health facilities, particularly at HC IIs and HC IIIs. At HC IIIs, the proportion of filled positions is 46% leaving a vacancy rate of 54%; at HC IIs, the proportion of filled positions is 47% leaving a vacancy rate of 53%. Therefore the demand for health workforce is more pronounced at HC IIs and HC IIIs than at hospital level. These two levels are very critical for health system improvement as they are nearer to the rural poor. At the hospital level, the highest demand for nursing cadres exists in the general public hospitals which have a vacancy rate of 53%. Some of these general hospitals are located in the rural remote areas that may not be very attractive to the nursing staff.

In Uganda, the Health Service Commission is responsible for recruiting health providers for the Ministry of Health headquarters, National and Regional Referral Hospitals and Specialized Health Institutions under the Ministry of Health. At the district level a similar process is carried out. MoH is represented by the Directorate of Health Services, and instead of HSC, there is the District Service Commission (DSC) that has similar functions as the HSC. Often there is a failure of recruitment by some districts due to lack of District Service Commissions to carry out the recruitment function. The limited HRH funding for recruitment, salaries and wages has resulted in recruitment levels being lower than planned. Health providers are also de-motivated due to delayed promotions and inadequate in-service especially at district level. The lack of attraction and retention of staff across the country remains a critical factor (Human Resources for Health strategy 2006).

The decentralization system in Uganda makes local health managers responsible for improving the way health services are targeted to meet priority health needs, organized and managed within the available budget. To do this, they need a workforce whose staff numbers and mix are as appropriate as possible to these needs, and whose cost is affordable. In many developing countries, Uganda inclusive, decentralization has confused supervision responsibility, diminished technical supervision capacity, and reduced the number of supervision visits. Part of this confusion is the result of some health programs being decentralized, while others remain central responsibilities.

### **1.3 Rationale for the study**

Health provider absenteeism is of interest to policymakers because Uganda, like any other poor country in Africa has suffered from inadequate human resources for health in terms of quantity, quality, distribution, retention, absenteeism, performance and motivation. The study will therefore provide the much needed evidence by the health sector to minimize absenteeism as one of the key human resource challenges facing the sector. The information will be used by CSOs such as UNHCO to advocate for; increased control at the local level specifically to empower the districts and facility management specifically the health unit management committee to be able to monitor attendance of health providers.

With regard to the health sector the study findings will be used to support development of human resources for health plans and strategies with a focus of reviewing and implementing attractive remuneration packages and improve facility and work conditions such as provision of houses

hence reducing absenteeism. To the health providers the study finding will be of interest because this will support their campaign on improving their work conditions.

#### **1.4 The Study Objectives**

The overall objective of the study was to establish the rate of health provider absenteeism in public health facilities. Specifically the study sought to:

1. Establish the incidence of Health Provider absenteeism in public health facilities in Bushenyi District
2. Assess factors that determine Health Provider absenteeism in Public Health facilities in Bushenyi District
3. Discuss implications and make recommendations for appropriate remedies to reduce Health Provider absenteeism.

#### **1.5 The Study Hypotheses**

1. The incidence of absenteeism is greater among high caliber health professionals, such as doctors
2. Health providers in rural areas are more likely to be absent from work compared to providers for urban areas.
3. Health providers from lower health facilities are more likely to be absent compared to providers from higher level health facilities.

## **2. METHODOLOGY**

### **2.1 Study Design**

The survey employed both quantitative and qualitative methods to gather primary data from health facility providers, health facility in-charges and communities surrounding the sampled health facilities.

### **2.2 Area of Study**

The study was conducted in Bushenyi district in Western Uganda. Bushenyi District was selected because it's one of the implementation districts of UNHCO and was selected randomly from a sample of 4 districts (Dokolo, Wakiso, Iganga, Bushenyi) representing the 4 political regions of Uganda. According to Uganda Bureau of Statistics 2008, Bushenyi district has a population of 916,400 with about 80% of the total population rural. The district has 5 counties and 27 sub-counties. The population growth is 3.1% and the literacy rate is 54%. About half of the population can access safe water 49.6%. With a doctor: population ratio of 30,992 and childhood malnutrition of 43%.

Bushenyi District is fairly endowed with natural resources. The economy of the district depends mainly on agriculture. Agriculture is a source of food for the population, subsistence income for most families and provides direct employment to 86.7% of the district population, as well as supplying raw materials to industries. The majority of the people are involved in subsistence agriculture with some engaged in commercial production of crops including; Coffee, Tea, Sweet bananas & Matooke. Ranching for beef and dairy farming for milk production are widely practiced on both subsistence and commercial scales in Bushenyi District. Hybrid cattle are widely raised on farms in the district. The hybrids produce more milk per animal and yield more beef per carcass and therefore are more profitable than the local breeds. Soil degradation, poor marketing and processing systems and frequent outbreak of crop and livestock diseases are some of the challenges that the farmers in the district face.

#### **Study population**

The study population was health providers in the selected health facilities and communities surrounding the selected health facilities.

### **2.3 Data Sources**

#### ***Secondary Data Review***

Health facility records including staff attendance registers and duty rosters were reviewed to understand the nature of absenteeism at the facility level. In addition documents such as Human Resources for Health Strategy 2006, HSSP II were reviewed.

#### ***Primary Data collection***

The primary sources involved interviews with facility in-charges and individual health providers. In addition provider attendance was tracked during unannounced visits to the health facilities. To get a precise estimate of the levels of absenteeism; Each of the health facilities received 5-7 unannounced visits, one visit per week for a period of seven weeks.

## **2.4 Data Collection Methods**

### ***Individual Interview***

These were conducted with health providers at the selected health facilities. The purpose was to understand and establish the factors leading to absenteeism as well as factors affecting provider performance. A structured questionnaire was designed to guide data collections for the individual health providers.

### ***Health Provider attendance tracking***

Selected health facilities were visited a number of times to track attendance of health providers. A tracking form was developed to guide the tracking. Each Facility was visited 5-7 times by trained researchers who tracked attendance of each of the staff at the facility. The visits were unannounced and were made any time of the day.

### ***Key Informant interview***

Key Informant interviews were conducted with health facility In-charges at the selected health facilities. These were targeted mainly because of their supervisory and management role at the health facility. Information captured included; reasons for absenteeism, salary structures, staff allowances and general issues with staff management at the health facility. A semi-structured guide was developed to guide the interviewers collect the data.

### ***Focus Group Discussion***

Focus group discussions were conducted with selected communities surrounding the health facilities sampled. This was in anticipation that these communities are served by the health facilities nearby. The focused discussions were mainly conducted to ascertain the gravity and effects of absenteeism on the health service beneficiaries. A Focus Group Guide was developed to guide the researchers to collect the data.

### ***Literature Review***

A number of records and documents related to human resources for health were reviewed to augment primary data collection. At the health facility level staff attendance registers and duty rosters were reviewed to understand the nature of absenteeism at the facility level. At the district level staffing norms, staff motivation, salaries and benefits, including procedures for bonuses and promotions; cash and non-cash incentive schemes for staff were reviewed. In addition, recruitment, deployment, and transfer policies and remuneration structures and plan were reviewed. At the national level, documents such as Human Resources for Health Strategy 2006, HSSP III. This was intended to give picture of what is going on and the gaps.

## **2.5 Sampling Design and size determination**

The sample design was based on the two main data collection methods; health provider tracking and health provider individual interview. With regard to health provider tracking a census was employed where all 104 health facilities in the district were targeted. A list of health facilities was obtained from the district to guide location of the health facilities. A total of 78 were visited. 22 health facilities were found closed and 4 were non-functional.

**Table 2: Showing distribution of health Facilities by classification-level- and ownership in Bushenyi District**

Level	Hospital			HC IV			HC III			HC II		Total	
Ownership	GOVT	NGO	Private	GOVT	NGO	Private	GOVT	NGO	Private	GOVT	NGO	Private	
Number	1	2	0	5	0	0	27	5	2	46	12	4	104

On the other hand, the sample design for the individual health provider interviews was random sampling using staff lists at the health facility. A total of 15 health providers were sampled in each of the health facilities. In cases where the health facility has less than 15 health providers, the researcher would interview all the providers in the health facility. A total of 139 health providers were sampled in the 78 health facilities.

**Sample size determination for qualitative methods**

A total of 10 FGDs were conducted; two per county. Selection of the FGD participants was based on the communities surrounding the health facilities. In relation to key informant interviews, 78 interviews were conducted based on the number of health facilities visited. By default 1 key informant interview was conducted in each of the health facility visited.

**2.6 Definition of Variables**

***Measurement of absenteeism***

Absenteeism is the term generally used to refer to unscheduled employee absences from the workplace. While absenteeism can be operationalized in several forms, the measurement of absenteeism can be broken down into two categories, the area measured and type of metric employed (Farrell & Stamm, 1988; Steers & Rhodes, 1978). The areas of absenteeism that can be measured include, all absences, use of sick leave versus unpaid absences, scheduled versus unscheduled, long term versus short term, medically verified versus unverified, and so forth. Absence metrics refers to how absenteeism is specifically measured. In most cases absenteeism is measured in terms of time-lost and absence index measures. Time-lost refers to the number of working hours an employee misses work in a given period of time (Scott & Taylor, 1985), whereas absence index indicate the number of episodes of absence within a particular time period regardless of their duration from scheduled work, counting an absence of more than one consecutive day as one time (Lee & Mitchell, 1994; Goldberg and Waldman, 2000).

In this study, absenteeism was assumed to have occurred when employees are away from their duty stations at any one point in time due to either authorized or unauthorized reasons. This was because it was observed that absenteeism either authorized or not authorized does affect health service delivery and ultimately leads to poor health outcomes.

**2.7 Data collection process and quality Control**

In order to collect quality data, a team of Research Assistants went through a 3-day training to ensure good understanding of the concept of absenteeism, study methodology and the data collection process. The tools were pre-tested to further refine and standardize them. Data collection covered a period of 10 days for the health provider survey, key informant interview and focus group discussions. During data collection, team supervisors ensured the right tools are used and sampling techniques to get the interviewees and reviewed the completed questionnaires after

the interviews to ensure they are complete and accurate. Data collection for the health facility survey took 7 weeks where the researchers made 5-7 visits to each of the selected health facilities. After the data was collected it was further cleaned and handed over to the statistician for entry and cleaning. A clean data set was produced ready for analysis and report writing.

### 3. STUDY FINDINGS

#### 3.1 Background Characteristics of surveyed Health Providers

A total of 177 health workers were surveyed, 68% were female and 32% were male. Nursing Officers and Nursing Assistants formed the biggest group surveyed both with 17%, followed by enrolled nurse 14% and enrolled midwife 13%. Clinical officers were 11% and Comprehensive nurses were 7%. More than half of the health providers were on permanent terms of employment 59% and 27% of the providers were on contract basis. Most of the health providers had attained tertiary education 59%, 10% had attained Advanced Level education and 8% had attained ordinary level education. A big proportion of the providers 59% were in the age group between 20 and 30 years, followed by 30-40 years. Slightly more than half of the providers (56.5%) had worked for less than 5 years. With regard distance of their homes from the health facility 95% of the providers were within 0-5Kms as indicated in Table 3.

*Table 3: Showing Socio-Demographic Characteristics of Health Providers surveyed*

Sex	Frequency	Percentage
Male	56	31.7
Female	121	68.3
<b>Total</b>	<b>177</b>	<b>100.0</b>
<b>What is your job title</b>		
Clinical Officer/Medical Assistant	19	11.0
Medical Doctor	10	5.7
Enrolled Midwife	23	13.2
Registered Midwife	17	9.8
Comprehensive midwife-nurse	12	6.9
Enrolled nurse	24	13.8
Registered nurse	10	5.7
Nursing Aide/Assistant	30	17.2
Nursing Officer	29	16.7
<b>Total</b>	<b>174</b>	<b>100.0</b>
<b>Type of employment</b>		
Permanent	96	58.9
Fixed term/Contract	44	27.0
Voluntary	12	7.3
Casual	4	2.5
Other	7	4.3
<b>Total</b>	<b>163</b>	<b>100.0</b>
<b>Level of Education</b>		
University	28	17.8
Tertiary	93	59.2
A-Level	16	10.2
O-Level	13	8.3

Primary school	5		3.2
Other	2		1.3
<b>Total</b>	<b>157</b>		<b>100.0</b>
<b>Age</b>			
20 and below	4		2.3
21 – 30	105		59.3
31 – 40	41		23.2
41 – 50	13		7.3
51 – 60	11		6.2
Above 60	3		1.7
<b>Total</b>	<b>177</b>		<b>100.0</b>
<b>Years worked</b>			
Less than a year	32		18.9
1 - 2 years	48		28.2
3 - 4 years	16		9.4
5 - 10 years	40		23.5
More than 10 years	34		20.0
<b>Total</b>	<b>170</b>		<b>100.0</b>
<b>Distance in KMs</b>			
0- less than 5 km		162	95.3
5 - 10km		5	3.0
11+kms		3	1.7
<b>Total</b>		<b>170</b>	<b>100.0</b>

### Description of health facilities surveyed

A total of 78 health facilities were surveyed, 54% were HC IIs, 36% were HC III, 6% were HC IV and 4% was Hospitals. On the other hand 72% of the health facility were in the rural areas, 19% in were in peri-urban areas and only 9% were in the urban areas as shown in Table 4.

*Table 4: showing Health Facilities Visited*

Area	Frequency	Percentage
<b>Level of Health Facility</b>		
HC II	42	53.8
HC III	28	35.9
HC IV	5	6.4
Hospital	3	3.9
<b>Total</b>	<b>78</b>	<b>100.0</b>
<b>Location</b>		
Rural	56	71.8
Peri-urban	15	19.2
Urban	7	9.0
<b>Total</b>	<b>78</b>	<b>100.0</b>

### Description of Key informant interview respondents and FGD Respondents

Results in Table 5 reveal the descriptions of health facility in-charges who were interviewed. Majority were based at HC II (54%) and HC III (36%). With regard to job title, 42% were Enrolled Nurses, 24% were Clinical Officers and 17% were Nursing Assistants. In relation to gender 33% of the in-charges were male and 67% female.

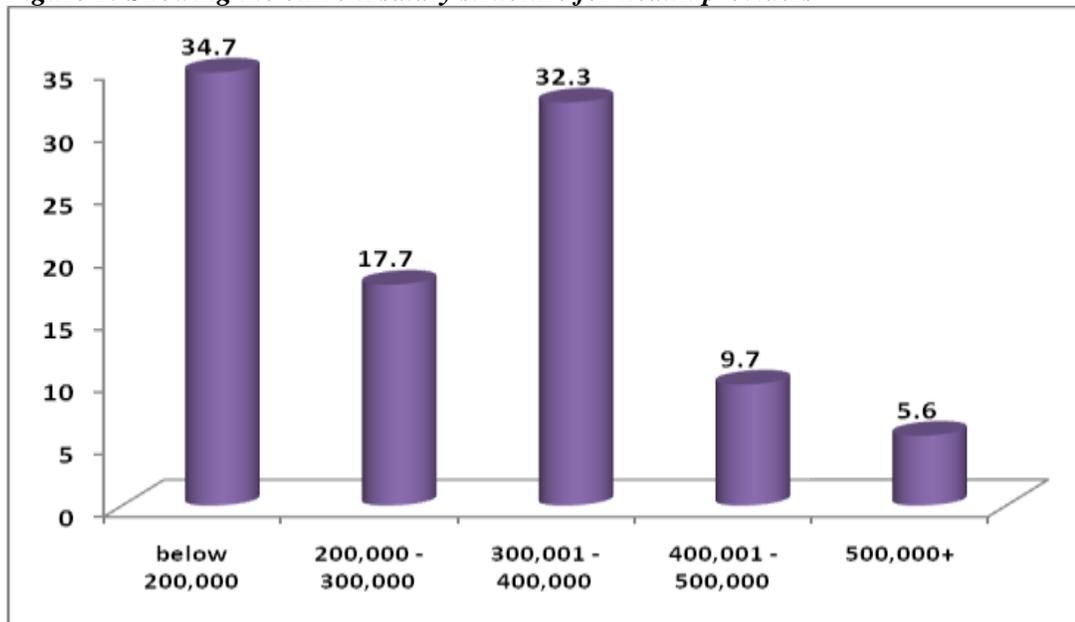
**Table 5: Describing the health facility in-charges surveyed**

Health Facility Level	Frequency	Percentage
HC II	42	53.8
HC III	28	35.9
HC IV	5	6.4
Hospital	3	3.9
<b>Total</b>	<b>78</b>	<b>100.0</b>
<b>Position</b>		
Clinical Officer	19	24.4
Enrolled Midwife	8	10.2
Enrolled Nurse	33	42.3
Medical Officer	5	6.4
Nursing Assistant	13	16.7
<b>Total</b>	<b>78</b>	<b>100.0</b>
<b>Sex</b>		
Female	52	66.7
Male	26	33.3
<b>Total</b>	<b>78</b>	<b>100.0</b>

**Health provider Remunerations and work conditions**

The study explored the current salary structure of the health providers surveyed. The results in Figure 1 revealed that most providers were receiving a salary in the range of 300,000/=–400,000/= Uganda Shillings which is an equivalent of 150-200 USD. Analysis by title revealed that did not reveal any significant results.

**Figure 1: Showing the current salary structure for health providers**



**Job Satisfaction**

Providers were further asked if they had been confirmed on job. A big proportion 58% reported to have been confirmed and 42% were not yet confirmed. With regard to promotions, only 17% of

the providers reported to be confirmed. Analysis by title of provider did not reveal any significant results.

Results in Table 6 show reasons reported for job satisfaction. The most commonly mentioned areas of job satisfaction in order of importance were; relationship with line manager (78%), relationship with colleagues at work (75%), communication and information flow from management (70%), feedback from supervisors (63%) and on job training (59%). It's important to note that salary and allowance were rated as the lowest areas of job satisfaction both at 14%.

**Table 6: Showing job satisfaction on current job**

<b>Job satisfaction</b>	<b>Frequency</b>	<b>Percentage</b>
Salary	19	14.4
Cash allowance	18	13.8
Training opportunity	23	17.0
Opportunity for promotion	33	24.4
Job security	76	56.7
Hours of work	77	57.0
Facility Environment	77	57.0
Availability of medicines	58	43.0
Availability of equipment	55	40.7
Work pressure or stress	60	44.4
Adequacy of staffing	57	42.2
Supervision by your supervisors	84	62.7
On job training	78	58.6
Feedback from supervisors	91	67.4
Communication and information flow from management	94	69.6
Relationship with your line manager	104	77.6
Relationship with colleagues in your team	100	75.2
Opportunities to engage in other work in addition to your primary job	35	28.5

The study explored provision of supplies such as uniform and shoes as ways of increasing job satisfaction. Slightly above half of the health providers surveyed 54% reported to be getting uniforms, while only 14% reported to be provided with shoes for work. Analysis by title of provider did not reveal any significant results

### **Health Provider Work-related benefits**

Providing benefits to employees such as medical, housing, food is one of the many ways employers motivate their employees. This study investigated the different benefits health providers were receiving. Of the surveyed health providers, 67% reported to be getting free housing, majority 81% reported to be getting free medication, and only 23% said they received free lunch. In relation to transport only 11 % reported to be entitled to transport to work. Majority of the health providers 86% were entitled to annual leave.

### **Allowances for Health Providers**

The study further examined allowances received by health providers while at work. Results revealed that 20% of the providers reported to receive housing allowances, while 12% received allowances related to projects handled at the health facility and 19% said they received travel allowances. Thirty seven percent (37%) of the health providers reported to be receiving lunch allowances, 16% received medical allowances and 51% received outreach allowances. The study

further explored provision of bonuses that are based on performance only 18% reported to be receiving bonuses.

### Incidence of Absenteeism

The rate of absenteeism was measured based on all the visits made to each of the health facilities visited. The incidence of absenteeism refers to health providers who were absent at least once during each of the 7 visits. Results showed that the incidence of health provider absenteeism from all the visits made to each of the 78 health facilities was 48%. Analysis by gender showed that more male health providers 56% compared to their female counter parts 44% were absent. Health Providers at the lower health facilities HC III & HC II (52% and 27% respectively) were likely to be absent than their counter parts at higher health facility levels such as HC IV and Hospital.

Results in Table 7 show that the incidence of absenteeism between visit 1 and 5 was between 17% and 23%. Therefore, the visits didn't cause change of behaviour by the health providers. Analysis by Cadre revealed that a big proportion 24% of the Nursing Officers were not present at the health facility, followed by Nursing Assistants and Enrolled Nurses both at 18%. The Enrolled 15% of the Enrolled Midwives were not present. It's important to note that 6% of the Lab Assistants were not present at the health facilities (See Table 8). In relation to location, more health providers in the rural health facilities (67%) were not present compared to providers in peri-urban (27%) and urban areas (7%) as indicated in Table 9.

**Table 7: Showing Incidence of absenteeism by visit**

Visit	Staff member present at Health Facility		Total
	Yes	No	
1 visit	189(20.5%)	157(18.7%)	346(19.7%)
2 visits	164(17.8%)	190(22.7%)	354(20.1%)
3 visits	202(22.0%)	149(17.8%)	351(20.0%)
4 visits	181(19.7%)	169(20.2%)	350(19.9%)
5 visits	184(20.0%)	173(20.6%)	357(20.3%)
<b>Total</b>	<b>920</b>	<b>838</b>	<b>1758</b>

**Table 8: Showing Incidence of Absenteeism by title of health provider**

Title	Staff member present at Health Facility		
	Yes (n=1267 )	No (n=1164 )	Total (n=2431 )
Clinical Officer	5.8%	5.8%	5.8%
Medical Doctor	2.3%	2.0%	2.1%
Enrolled midwife	18.2%	15.1%	16.7%
Registered midwife	2.1%	1.8%	1.9%
Enrolled nurse	17.9%	17.5%	17.7%
Registered nurse	5.8%	3.9%	4.9%
Nursing Aide/assistant	20.8%	18.1%	19.5%
Dental Assistant	1.4%	1.1%	1.3%
Laboratory Assistant	5.7%	4.1%	4.9%
Records assistant	.6%	.6%	.6%
Comprehensive nurse	.1%	.2%	.1%
Nursing Officer	19.5%	29.8%	24.4%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

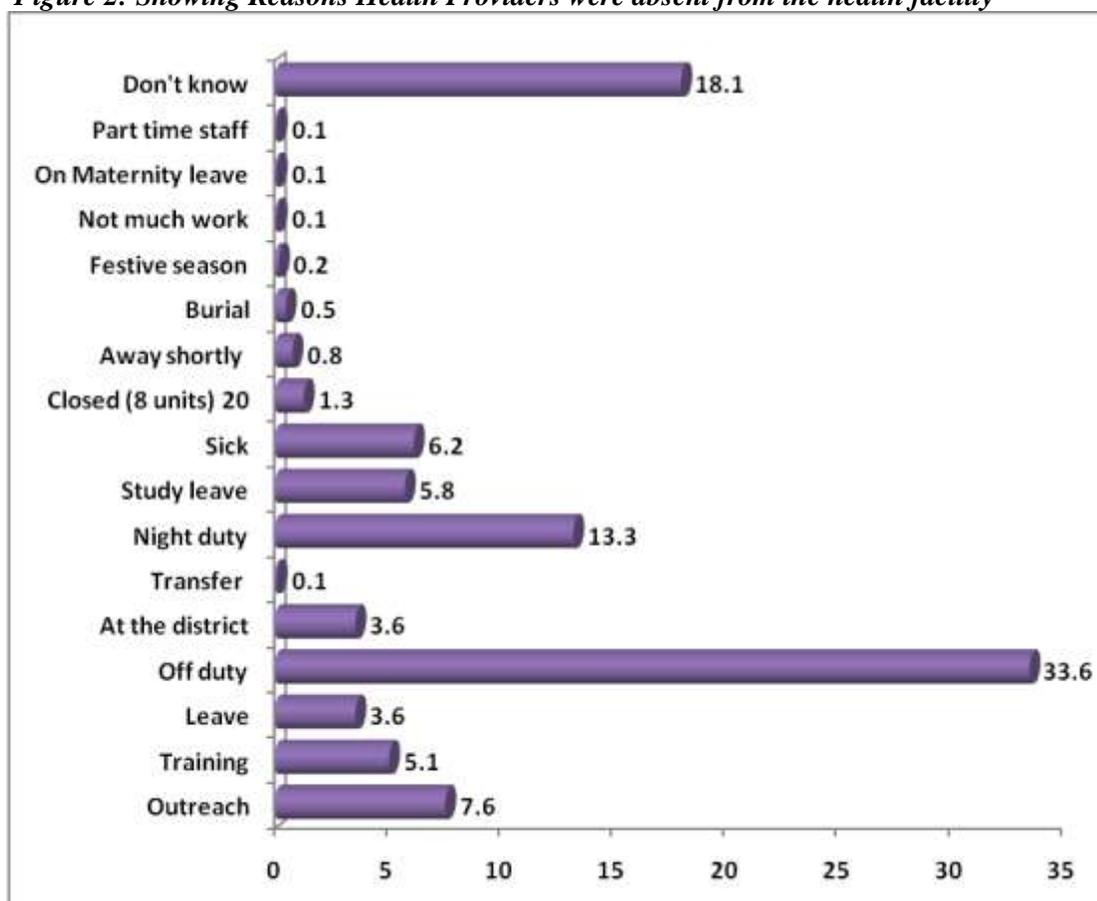
**Table 9: Showing Incidence of absenteeism by location of health facility**

Location	Staff member present at Health Facility		Total (n=2431 )
	Yes (n=1267 )	No (n=1164 )	
Rural	55.8%	66.6%	61.0%
Pre-urban	30.5%	26.5%	28.5%
Urban	13.7%	7.0%	10.5%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Reasons for Absenteeism**

The study purposed to examine reasons for health provider absenteeism for both unauthorised and authorized absenteeism. The reasons advanced for authorized absenteeism include; off duty (34%), night duty (13%) and away for outreach services 8% in that order of importance. It’s important to notes that 18% of the health providers who were absent had not given a reason for being absent as shown in Figure 2.

**Figure 2: Showing Reasons Health Providers were absent from the health facility**



## 4. Conclusions and Policy Recommendations

This study draws results from the visits made to 78 health facilities in Bushenyi District with the objective of documenting the incidence of absenteeism among health providers. Health provider absenteeism is of interest to policy makers because Uganda, like any other poor country in Africa has suffered from inadequate human resources for health in terms of quantity, quality, distribution, retention, absenteeism, performance and motivation. The study will therefore provide the much needed evidence by the health sector to understand the incidence of absenteeism and minimize it as one of the key human resource challenges affecting the sector.

The study highlights the fact that problems in health care service stems from the weaknesses in supervision and management of health care delivery. It should be noted that 17.2% of the health facility in-chargers were found to be nursing assistants who in the health sector are not considered to be unskilled. Thus an indicator of why there is poor planning and management of these health facilities.

The average percentage rate of absenteeism was reported to be 48%. When disaggregated by key health cadres, the absence rate is high for Nursing officers (24%), followed by Nursing assistants and enrolled nurses both at (18%), enrolled midwives 15%, and lab assistants 6%.

The reported reasons advanced for authorized absenteeism included; off duty (34%), night duty (13%) and away for outreach services 8% in that order of importance. It's important to note that 18% of the health providers who were absent had not given a reason for being absent

Important factors that were found to determine health care provider absenteeism include;

- Features of the health care facilities
- Individual factors
- Institutional environment

Absenteeism of health providers has both direct and indirect costs. The direct costs reported include the financial resources wasted due to health care provider's absenteeism, which is estimated at 26 billion Uganda shillings annually report according to a World Bank. Indirect costs include reduced productivity, disruption of health care delivery, and loss of lives among others.

Contrarily to, the factors that have been linked to absenteeism of health workers including salary, housing allowances and transport did not feature as highly as was expected, Job satisfaction, including relationship with line manager, colleagues at work, feedback from supervisors were rated highest.

In view of the fact that the majority of health workers earn less than 150 dollars per month on average ministry of health should design human resource policies that address work related conditions such as provision of staff allowances, benefits such as housing and lunch and provision

of a fair living wage, there should also be provision of social amenities that are not available in remote localities as a motivation factor.

The sector should also plan for useful and supportive monitoring mechanisms involving and strengthening community participation through health unit management committees and building capacity of facility managers to provide supportive supervision.

The sector should enhance internal control measures at the health facility such as introducing staff attendance registers and increase on the occurrence of supervision by the center especially to lower health facilities as a way of support to the facility managers. In addition the sector should work with the partners such as civil society organizations that are local to support supervision especially with regard to management of health facilities.

The health sector should assess the health facilities with a view of establishing feasible strategies that can be used to address arrangement of human resource issues including health provider absenteeism.

The sector should address issues of management skills of the in-charges of health facilities as most do not have managerial skills thus need to be trained.

The sector needs to consider staff establishment by recruitment of enough health workers to avoid overloading which is one of the root causes of absenteeism in the health sector.

## 5. Memorable quotations from the field

*“I have been working for over a year now without a contract and my name is not even on the payroll.....I am starting to lose hope in this profession.”* – **Nursing Assistant at Nsiika III**

*“Although we are supposed to monitor the health unit, we have not been able due to. Some members of the committee are chosen by the political leaders and therefore can not serve independently.”* – **A member of HUMC in Katungulu HC III**

*“Do you have jobs in your organization so that I come and work with you? Am really frustrated by the pay”* – **Nursing Assistant at Ishaka Adventist Hospital**

*“How do you expect me to be at the health center when I have been working for the government for the last twenty years without promotion?”* – **Midwife at Shuuku HCIII**

*“I sit here for many hours a day and get paid very little yet I have a small piece of land which I could use to make a better living. Sometimes when I am working on my land I even do not feel guilty. I think I do not have an option.”* – **Nursing Assistants Engaju HC II**

*“When there is a burial in the village, which happens often, nearly the whole community attends. This is why the nurses are not at the health center today.”* – **Community member in Nyabubare**

*“I have been working at this health center for over 5 years alone with the security guard and now my only motivation is because this is my home area otherwise I see no prospects.”* - **Enrolled nurse at Kyabandara HC II.**

*“There is only one health provider here and as a community we appreciate her efforts. Even when she is not around we understand.”* - **Community member Kyabandara**

*“The decentralization policy that seeks to ensure that people work in their districts of operation is limiting health providers from working in other districts that might be of their choice”. – Health provider in Katungulu HC III*

## Appendix

Table showing List of Health facilities visited, positions of In-charges and their gender

Name of Health Facility	Level of Health Facility	Position	Gender
COMBONI MISSIONARY HOSPITAL	Hospital	medical officer	Female
ISHAKA ADVENTIST HOSPITAL	Hospital	medical officer	Male
KITAGATA HOPT	Hospital	Medical Officer	Female
KABWOHE HCIV	4	Medical Officer	Male
KYABUGIMBI HCIV	4	clinical officer	Female
NSIIKA H/C IV	4	Clinical Officer	Male
MITOOMA HC IV	4	Enrolled Nurse	Female
RUGAZI HC IV	4	Nursing Ass	Female
KABUSHAHO	3	clinical officer	Male
BIHANGA	3	clinical officer	Male
KIGARAMA	3	clinical officer	Male
KARUNGU	3	Registered Nurse	Female
KATERERA	3	Clinical Officer	Female
KYENZAZA	3	Clinical Officer	Female
KAJUNJU	3	Enrolled Midwife	Female
KYEIZOBA	3	Enrolled Midwife	Female
BUSHENYI MC	3	Clinical Officer	Female
KABIRA	3	Registered Nurse	Female
BITEREKO	3	Clinical Officer	Female
BUBANGIZI	3	Clinical Officer	Female
SHUKU	3	Clinical Officer	Male
BUGONGI	3	Enrolled Midwife	Female
MUSHANGA	3	Enrolled Midwife	Female
KYANGENYI	3	Enrolled Midwife	Female
KANYABWANGA	3	Clinical Officer	Female
KYAMUHUUNGA	3	Enrolled Midwife	Female
KAKANJU	3	Clinical Officer	Male
MUTARA	3	Enrolled Midwife	Female
KASHENSHERO	3	Enrolled Midwife	Female
NYAKATISIRO	3	Enrolled Midwife	Female
RWOBURUNGA	3	Clinical Officer	Female
BUTARE	3	Clinical Officer	Female
NYAKASYAKA	3	Clinical Officer	Female
KATUNGU	3	Registered Nurse	Male
BITOOMA	3	Registered Nurse	Female
NYARUGOTE	3	Registered Nurse	Female
IGARA TEA FACRORY	2	Nursing Ass	Male
RWENZORI TEA FACTORY	2	Nursing Ass	Female
KIZIBA	2	Enrolled Nurse	Female
KYEIHARA	2	clinical officer	Female
BIGONA	2	Enrolled Nurse	Female
BURARO	2	Enrolled Nurse	Male
BUYANJA	2	Enrolled Nurse	Male
BWERA	2	Nursing Ass	Female
KAINAMO	2	Enrolled Nurse	Female
KARERA	2	Enrolled Nurse	Male
KARUGORORA	2	Enrolled Nurse	Female
KASANA PRIVATE	2	Enrolled Nurse	Female
KASHOZI	2	Enrolled Nurse	Male
KIGYENDE	2	Enrolled Nurse	Male
KIHUNDA	2	Enrolled Nurse	Female
KIZIBA	2	Nursing Ass	Male
KYEYARE	2	security Guard	Male
MABAARE	2	Nursing Ass	Female
MIGINA	2	Enrolled Nurse	Male

<b>MITSYORO</b>	2	Enrolled Nurse	Female
<b>MUZIRA</b>	2	Nursing Ass	Male
<b>RUGARAMA</b>	2	Nursing Ass	Male
<b>RUHUMURO</b>	2	Nursing Ass	Male
<b>RUKONDO</b>	2	Enrolled Nurse	Female
<b>RUSHOOZI</b>	2	Enrolled Nurse	Male
<b>SWAZI</b>	2	Enrolled Nurse	Female
<b>BITSYA</b>	2	Enrolled Nurse	Female
<b>BUTOHA</b>	2	Enrolled Nurse	Male
<b>BUKUBA</b>	2	Nursing Ass	Male
<b>BUKONGORO</b>	2	Enrolled Nurse	Female
<b>BWOGA</b>	2	Enrolled Nurse	Male
<b>KASHAKA</b>	2	Enrolled Nurse	Male
<b>KAZINGA</b>	2	Nursing Ass	Male
<b>KISHENYI</b>	2	Enrolled Nurse	Female
<b>NYAKIYANJA</b>	2	Nursing Ass	Male
<b>KYABAKARA</b>	2	Nursing Ass	Female
<b>MAYANGA I</b>	2	Enrolled Nurse	Female
<b>ENGANJU</b>	2	Enrolled Nurse	Female
<b>RUTOTO</b>	2	Enrolled Nurse	Female
<b>MUSHASHA</b>	2	Enrolled Nurse	Male
<b>RUGAZI MISSION</b>	2	Nursing Ass	Female
<b>KYABANDALA</b>	2	Enrolled Nurse	Female

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