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Challenge of Absenteeism of Public Healthcare Center Workers in the Rural Area: A Study on Sylhet District, Bangladesh

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ABSTRACT: Absenteeism has been linked to ineffective healthcare delivery in several studies. This research looks at absenteeism in Bangladesh's public healthcare centers (PHCs), a health system level recognized as vulnerable to absenteeism. Front-line health workers, administrators, service consumers, and health propensity committee chairpersons were interviewed in detail and participated in focus groups. Absenteeism was shown to be quite common among healthcare employees, and it is a big problem in PHCs in rural areas when lateness is included. Absenteeism influences the pair service consumers and associates, although it is not necessarily intentional. Even though there are measures to prevent absenteeism in PHCs, our results reveal that they are readily evaded and ineffectual due to utilization and formative difficulties. The Anti-Corruption Evidence (ACE) strategy, which aims to include and improve the stimulations of significant players in the system to support efficiency-renovating measures and, in turn, ensure efficient service delivery, might be relevant in this case. In this research, we evaluate the patient satisfaction and the quality of services at PHCs, and the effect of a lack of health workers in Bangladesh's rural public healthcare centers (PHCs).

KEYWORDS: Challenge, absenteeism, public health workers, rural areas

1 INTRODUCTION

Absence is a global problem in healthcare service delivery that no country has exempted (Bamgboye, Adeleye, 1992). Locally, absence is defined as a complete departure from the workplace, arriving at the workstation after the stipulated time, or leaving the workstation before the specified time without any permission from the conventional authorities (Libet, 2001). Absence also refers to an avoidable, chronic, and unpredictable absence, as follows a source of annoyance to employers, associates, and the serving community (Kristensen, Jensen, Kreiner, and Mikkelsen, 2010). Such absences disrupt proper programming, efficiency, output, organization, and the economy and increase mortality due to complications, disabilities, or manageable conditions (Rajbhandary, Basu, 2010). In rural areas, absence is the sole most significant loss cause in the country's national health sector (Amin, 2022). Health workers' poor point of view towards customers prevails in using services. Human resource supervision and management are hesitant at all levels (Kristensen, Jensen, Kreiner, and Mikkelsen, 2010).

Uganda's total absence of healthcare workers has been identified as a significant challenge to the public healthcare system, as the low doctor-to-patient ratio in any other developing country (Garcia-Prado, Chawla, 2006). The absence of staff in some districts is worrying, and yet the reasons for the impact of the absence still need to be thoroughly understood and confirmed to guide managers to take appropriate action. Parallel to (Gaudine & Gregory, 2010), the absence of health workers in the Sylhet district affects all other health advantages in the study area. In Sylhet district, health workers are devoted to the disciplinary committee for absence (Davey, Cummings, and Newburn-Cook, 2009) in a few cases, not reported and confirmed. Although the perpetrators have come before the disciplinary committee, the district staff's absence continues (Kristensen, Jensen, Kreiner, and Mikkelsen, 2010).

The results of reduced workload, fatigue, and morale among some station staff, make the quality of service delivery effective (Garcia-Prado, Chawla, 2006). Providing quality healthcare services requires a vastly guided and available team in the workplace (Tweheyo Raymond, Reed, Campbell, Davies, and Daker, 2019). This persistent threat is ambiguous in the Sylhet district (Davey, Cummings and Newburn-Cook, 2009). Therefore, the results of this study are helpful for the administration of decentralized health organizations to acknowledge and address the reasons for the absence of health workers in the Ministry of Health (MOH) and the workplace. It can help provide health care and improve human health and quality of life in Sylhet district.

2 METHODOLOGY

A total of 186 respondents were included in the survey sample, where 150 were patients and 15 doctors, 11 nurses, three paramedics, one family welfare visitor, two lab technicians, and six pharmacists. Three Upazilas (sub-districts) were randomly chosen from the

Sylhet division. Each Upazila has just one health complex with one union family welfare facility from one Upazila (sub-district) was chosen randomly. Finally, 15 renovated Union Family Welfare Centers were selected randomly from the same region but only from Upazilas (sub-districts) with at least one facility. Primary data collected between ten and fifteen minutes spend for each interview. The Upazila (Sub-District) Health Complex Administrator and other medical personnel provided data for the missing doctors in the morning and afternoon. Primary data was collected through IMO mobile apps, WeChat, Messenger, and secondary data were collected from articles and newspapers. The survey data are analyzed mathematically as range and percentage. The analysis calculation was done by following this formula, Percentage = (Part of respondents /Total respondents) *100%, and using Microsoft excel. The data collection method was followed by observation and analyzed qualitatively. Some computer software, such as Microsoft Word and Microsoft Excel, was used to present this research and survey data.

3 LITERATURE REVIEW

The lack of government staff has been a barrier to public services. A tentative list of key informants among the research team members was produced and discussed to guarantee a comprehensive representation of important persons working in rural retention of Bangladesh's Human Resource for Health (HRH). Most publications addressing absence definitions have reported on further conversations with policymakers at the Ministry of Health and Family Welfare (MOHFW). Several classes were confined and abolished due to certain health conditions such as knee and back pain and stress. (Libet, 2001). Other definitions included broad and comprehensive examinations of Absenteeism, generally an upward salary review that included illness and other unimplemented causes for absence (Josephson, 2003). Although the exact definitions vary, the following categories of absences may create a typological structure: planned or unplanned, voluntary or involuntarily shown. Typically, these categories are based on reports of reasons for health professionals' absences, the validity of which is often unknown (Gaudine, Gregory, 2010).

One of the most prevalent types of corruption among front-line personnel is Absenteeism or unlawful worker absence from the geographical site (Davey, Cummings, and Newburn-Cook, 2009). It is a significant cause of labour shortages in the healthcare industry and has been shown to negatively influence the supply of high-quality management services (Tweheyo Raymond, Reed, Campbell, Davies, and Daker, 2019). On average, seven members of the tending employee's area unit reported missing at least one weekly workday. As a result, many rural African health clinics may only be open one or two days each week. (Tweheyo Raymond, Reed, Campbell, Davies, and Dake, 2019), In 2003, an associate degree all-India research found that over one-fourth of doctors and medical care professionals were absent from work on any given day (Agwu, Ogbozor, P.Odii, Orjiakor, Mbachu, Balabanova, Hutchinson, McKee, Onwujekwe, O. Obi and Roy, 2019).

Unexpected visits to health institutions revealed significant rates of absence in the People's Republic of Bangladesh (35 percent), African nations (37 percent), and Asian countries (40 percent) in a multi-country study of medical professionals' Absenteeism (Josephson, 2003). High Absenteeism is the fault of doctors and healthcare administration, which has led to more significant informal duties for front-line health workers and clinical responsibilities being shifted to nurses with less clinical experience (Davey, Cummings, Newburn-Cook, 2009). The suggested categorization is primarily based on the ideas presented in the literature review. There are two types of nurse absences planned and unexpected (Tweheyo Raymond, Reed, Campbell, Davies, and Daker, 2019). Gaudino and Gregory discovered that a qualitative study, physicians were missing from the general public sector while treating patients in the private sector. Patients from the public sector have even been referred to physicians.

When an employee chooses not to come to work for reasons beyond the control of management, this is known as an involuntary absence. At the same time, voluntary absence occurs when an employee chooses not to work for reasons within the management's rule (Libet, 2001). It is common knowledge that distinguishing between voluntary and involuntary absence may be challenging. When an employer is notified that an employee is going to be away from work, they may make suitable preparations. This method has assessed various adequately scheduled absences as unexpected (Tweheyo Raymond, Reed, Campbell, Davies, and Daker, 2019). The most dominant example of this absence is studying the absence of disease. More subjectively, the lack might be because it has yet to be officially accepted or approved following the organization's policy. Permitted absences might encompass a variety of periods, such as yearly maternity leaves (Isah, Omorogbe, Orji, and Oyovwe, 2008). This study will be placed in Bangladesh's rural areas. This study will be one-of-a-kind in this situation.

4 RESULT AND DISCUSSION

4.1 Result

Table 4. Reasons for taking services from PHCs. Source: Field survey

Reason	Number Count n = 150	Percentage(%)
Nearer to home	20	13.33%
Doctors skilled	47	31.33%

Pleasant behavior of staff	8	05.33%
Inexpensive	54	36.00%
Suitable timings	5	03.33%
Free availability of drugs	16	10.67%

Source: Field survey. N=150

Comments: Regarding reasons for taking public health care system, 13.33% of respondents said for nearer to home, 31.33% of respondents said for doctor skilled, 5.33% of respondents said for pleasant behaviour of staff, 36.00% of respondents said for inexpensive, 3.33% of respondents said for suitable timings, 10.67% of respondents said for free availability of drugs.

Table 5. Patient satisfaction with doctors in rural areas PHCs.

Attribute related to doctors	Dissatisfied (%)	Relatively satisfied (%)	Delighted (%)
Relationship with patient	54.67	27.33	18.00
Attention to patient's complaints	62.00	21.32	16.68
Physicians advice	26.00	41.34	32.66
treatment skills	21.33	38.00	40.67
Time devoted to patients	28.67	23.33	48.00
Privacy during consultation	18.67	38.67	42.66

Source: Field survey. N=150

To get patient satisfaction with the doctors, this study's measurement scale as dissatisfied, relatively satisfied, and fully satisfied. According to Relationship with the patient, we can see that 54.67% of respondents were dissatisfied, 27.33% of respondents were relatively satisfied, and 18.00% of respondents were fully satisfied. We can see that most respondents (54.67%) were not satisfied. During this pandemic, the ratio between doctors and patients' relations was not good enough. Doctors want to avoid making close contact with patients frequently. According to Attention to patient complaints, we can see that 62.00% of respondents were dissatisfied, 21.32% of respondents were relatively satisfied, and 16.68% of respondents were fully satisfied. We can see that most of my respondents (62.00%) were not satisfied at all. According to Physicians' advice, we can see that 26.00% of respondents were dissatisfied, 41.34% of respondents were relatively satisfied, and 32.66% of respondents were fully satisfied. Here we can realize that most of my respondents were somewhat happy. According to Medical skills, we can see that 21.33% of respondents were dissatisfied, 38.00% were relatively satisfied, and 40.67% were fully satisfied. Here also, most of my respondents were somewhat happy. According to Time devoted to patients, we can see that 28.67% of respondents were dissatisfied, 23.33% were relatively satisfied, and 48.00% were fully satisfied. Here we can realize that most of the respondents were happy. According to Privacy, 18.67% of respondents were dissatisfied during the consultation, 38.67% were relatively satisfied, and 42.66% were fully satisfied. Here we realize that most of the respondents were happy.

Table 2. Reason behind the absenteeism of health worker in Bangladesh.

Reason behind the absenteeism of health worker	Percentage
An overly- centralized health system	28%
Weak governance structure and regulatory framework	39%
Income specifically additional sources of income	67%
Weak MoHFW	43%
Distance or transportation issues	26%
Sick days	28%
Lack of accountability	48%
Lack of equipment	52%
Lack of digitalization (Internet service and Biometric attendance)	39%

Source: WHO.int 2012

According to WHO, the percentage of health workers in rural regions is higher than in urban areas for various reasons, one of which is the transportation and the fact that lodging in rural locations is inadequate for female health professionals. On the other hand, the internet and digital equipment are not adequately accessible. A high rate of absence is considered a reliable sign of voluntary absence. According to (Allen, 1982), unplanned absences are usually brief and voluntary. In their research of nurses in Bangladesh, the

physicians discovered that two-day absence frequency as a measure of 'unavoidable' absence and linked to job satisfaction was of concern. As with maternity and annual absences, voluntary absences may be arranged. Even when group action records are available, scarcity is only sometimes characterized or monitored. Group activity records in LICs (Low-Income and Cost-Sharing Subsidy) may be limited and need more information or detail. As a result, determining the specific nature of the lack is challenging.

4.2 Discussion

Most respondents (54%) thought the seating arrangement was sufficient. However, in the current study, 100% thought it was adequate. The responders in this survey were happy with basic facilities such as seats, cleanliness, illumination, and fans, among other things. Perhaps as people's literacy levels rise, so does their awareness of personal cleanliness. The ideal classification system is simple to use. More study in this area might lead to a new classification approach that considers whether the absence was officially sanctioned (unsanctioned). It's conceivable that some absences, for example, are unplanned, involuntary, and unofficial. This kind of absence might occur if health personnel skip their scheduled shift to cover for a sick colleague. Despite definitional challenges and a lack of research, certain absenteeism types seem to be a more significant concern in LICs, which is particularly important to patients. One sort of deliberate absence is attendance at courses that take health professionals away from their work areas.

Presentism, the concept of being officially present at work but distracted with non-work-related activities, is a similar issue that may be more prominent in LICs and that our search may not have identified. However, measuring health professional absenteeism has proved difficult in both high- and low-resource settings. Absence data in some form are often accessible in PHCs. Some LICs claim to have sick leave records. However, these are often inadequate or erroneous. Even when documents are available, verifying reasons for absence is difficult because false reporting and recall bias may limit effective interpretation. They are mostly self-certified or self-reported. Interestingly, a substantial positive association and a solid infraclass correlation were identified for self-reported and administratively recorded absence in one research of nurses in Bangladesh (Allen 1982),

Although most nurses exaggerated their lack of knowledge, most absenteeism studies have been conducted in PHCs, with most participants being nurses. It's unclear why scientists choose to concentrate on nurses. However, we may argue that nurses are often the most significant single health professional group in terms of numbers, that nurse absence records are better kept, or that investigators are less comfortable questioning the traditionally more powerful group of physicians. Nursing jobs tend to cluster around sick leave, owing to the high cost of sick leave to patients, governments, taxpayers, and even insurance companies. Sickness insurance schemes and other kinds of social insurance may significantly influence sick leave.

On the other hand, sick leave might be a quick solution to escape unpleasant work conditions or experiences in certain instances. It may sometimes be the only way to take time from work to deal with personal matters. Because distinguishing between actual sickness and shirking may be challenging, frequency of absence has been used to indicate voluntary absence. And it is influenced by factors like work dedication. On the other hand, long absences are often seen as a symptom of poor health and may be anticipated by variables such as burnout and musculoskeletal disorders. The absence rates of higher-ranking cadres are lower. They are also said to have a greater absenteeism rate than other cadres. Because there is so little research, it's essential to be cautious when interpreting the results.

Professional values that require them to be physically present, as well as a scarcity of personnel to fill in for them (due to their limited number), may reduce absenteeism. According to studies, they may be absent from the public sector while providing services in the private sector, mainly when the laws are more permissive. Physical work pressure, as well as a lack of autonomy and enjoyment, may cause absenteeism at all levels of the hierarchy. There are few studies on how to reduce health professional absenteeism. Only one research focused on reducing absenteeism was found in a Cochrane review on the impact of preventative staff assistance. It revealed that the intervention had no meaningful effect. Indeed, strategies to reduce absenteeism have sometimes increased absenteeism by eroding employee commitment or having unanticipated consequences for management or employee behavior.

5 RECOMMENDATIONS AND CONCLUSION

5.1 Recommendations

There are some recommendations for the study area's PHCs based on this survey:

- The monitoring system should be more effective in rural areas PHCs.
- Should take action immediately who had submitted false documents for leave
- Should make a more complex leave of absence policy.
- Investigators of the leave grantor should investigate everything carefully before granting permission.

5.2 Conclusion

Absenteeism may be a helpful indicator of healthcare professionals' psychological and physical well-being and a measure of system performance in the rural area of Bangladesh. That might help people understand how diverse variables such as the workplace, nature of employment, individual traits, and environment impact different absenteeism types and justify efforts to combat it. Working in

the public sector, practicing in rural, and traveling rural in Bangladesh are all significant career possibilities for Bangladeshi health professionals. This study found a common issue in labor economics, better job qualities must closely relate to healthcare employees' preferences. Provisions such as free transportation and training for people taking up a remote position, for example, might go a long way toward luring new health providers to rural regions. Second, the employment market, which connects demand and supply for healthcare jobs, have to be better structured in various steps, ranging from better organizing market data to making the market more transparent so that demand and supply can meet. According to the discussions, monitoring may successfully affect health worker behavior when paired with incentives and workplace standards. On two levels at the same time, there's plenty of room. In the beginning, quantitative research should explicitly examine some assumptions this study suggests, such as the relative strength of extrinsic incentive structures and monitoring devices to elicit high performance. Second, a complete impact analysis would be very beneficial to suggest new incentives or monitoring systems and planned program changes. Recent work in Rwanda demonstrates how this may aid in the identification of innovative ideas as well as give solid inputs to a more successful human resource policy. This research's outcomes may be used to establish new human resource policy initiatives.

DECLARATIONS

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