Barriers to Accessing Medical Care in Sub-Saharan Africa (SSA) in Early Stages of COVID-19 Pandemic

Rachel Swindle, David Newhouse1

Eighty-two percent of respondents in a sample of Sub-Saharan African (SSA) countries were able to access medical care despite the COVID-19 pandemic. Of the remaining 18 percent, about one-third reported that the COVID-19 pandemic impaired their access, either due to lockdown restrictions, facility closures, or fear of contracting the virus. “Lack of money” was by far the most frequently reported barrier to accessing care across countries, especially for food-insecure households, two-thirds of which cited “lack of money” as the main healthcare access constraint. Continued monitoring can help shed light on who is most at risk of not being able to access healthcare during crises.

This note makes use of newly harmonized data to summarize reasons why respondents in 11 SSA countries were unable to access medical care during early COVID-19 stages. It draws on High-Frequency Phone Surveys (HFPS) fielded by National Statistics Offices with World Bank support. As of November 2020, 11 SSA countries had COVID HFPS harmonized datasets: Central African Republic (CAF)2, Ethiopia (ETH), Ghana (GHA), Kenya (KEN), Madagascar (MDG), Mali (MLI), Malawi (MWI), Nigeria (NGA), Senegal (SEN), South Sudan (SSD), and Zambia (ZMB). These HFPSs were fielded between April and July 2020 and contain multiple waves from several countries.3

Table 1: Variable Definitions

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>access_the_services</td>
<td>HH has been able to access medical services in the past 7 days when needed (Y/N) If response is “no”, interviewer proceeds with asking the respondent for the reason they were unable to access care.</td>
</tr>
<tr>
<td>acce_he_1</td>
<td>Reason: lack of money</td>
</tr>
<tr>
<td>acce_he_2</td>
<td>Reason: no medical personnel available</td>
</tr>
<tr>
<td>acce_he_3</td>
<td>Reason: medical facility was full</td>
</tr>
<tr>
<td>acce_he_4</td>
<td>Reason: medical facility was closed</td>
</tr>
<tr>
<td>acce_he_5</td>
<td>Reason: hospital/clinic did not have enough supplies or tests</td>
</tr>
<tr>
<td>acce_he_6</td>
<td>Reason: afraid/concerned about catching COVID19</td>
</tr>
<tr>
<td>acce_he_7</td>
<td>Reason: restrictions (stay-at-home, travel restrictions)</td>
</tr>
<tr>
<td>acce_he_8</td>
<td>Reason: lack of transportation</td>
</tr>
<tr>
<td>acce_he_9</td>
<td>Reason: OTHER</td>
</tr>
<tr>
<td>access_the_other</td>
<td>Description of reason HH was unable to access medical treatment.</td>
</tr>
</tbody>
</table>

1 The authors thank Johan Mistiaen, Benu Bidani, and Nobuo Yoshida for support and useful comments, and Jakub Kakietak, Julia Dayton, and Nick Stacey for useful comments and discussions.
2 Central African Republic (CAF) survey includes only Bangui (capital) and Bimbo.
3 All countries listed include the first wave of surveys, which were fielded predominantly in the months of April, May, and June (2020). Ethiopia (ETH) and Mali (MLI) also include a second wave of survey data from May, June, and July (2020). Nigeria (NGA) includes three waves of data with interviews conducted in April and May (wave 1), June (wave 2), and July (wave 3). Time periods between survey waves vary by country but on average there are about 4-6 weeks between interviews.
In most of SSA, the sample was drawn from the respondents of a previous nationally representative household survey. HFPS datasets are weighted by household, adjusted to correct for exclusion of households that lack phones from the sample. Phone survey respondents are largely heads of the households and their spouses.\(^4\)

Survey Findings

**Within the countries included in this analysis, the vast majority (82\%) of respondents in need of medical care were able to access appropriate facilities or personnel to obtain treatment.\(^5\)** Among the respondents who were unable to access care, “lack of money” was the most commonly cited obstacle.

**Almost one-third of survey respondents reported COVID-related reasons for not accessing care (9\% cited lockdowns, 6\% cited facility closures, 14\% cited fear of COVID-19).** Figure 1 displays an overview of reasons for not accessing care in the region, while Figure 2 describes findings by country and survey wave. All estimates represent simple averages of survey-weighted means, where each country mean (and wave if applicable) is calculated using weights provided by the national statistics office. Note that because some surveys allow respondents to cite more than one reason for inability to access care, the sum of the reasons cited is greater than “100”.

**Figure 1: Health Care Inaccessibility in SSA Region, Estimates are raw averages of survey-weighted country means.**

**Figure 2: Breakdown of Inaccessibility Reasons by Country and Survey Wave**

\(^4\) More information about the high frequency phone surveys can be found in Khamis et. al., 2021.

\(^5\) Survey weights used in all calculations.
Respondents in urban areas were much more likely to cite “fear of catching COVID-19” as a reason to not seek care (Figure 3). Overall, rural survey respondents tend to report slightly higher rates of ability to access care (85%) than urban respondents (84%). While lack of financial resources remains a dominate barrier to seeking care, people in urban areas cite fears of contracting COVID-19, facility closures, and stay-at-home orders more often than rural inhabitants. Rural households are also more likely to report transportation limitations as a reason for not obtaining care.

Figure 3: Health Care Access and Urban/Rural Dwelling Location, Raw averages of survey-weighted country means

In Ghana, Senegal, Ethiopia, and Malawi, “fear of contracting COVID-19” was also more frequently cited as a reason for not seeking medical care. These countries are slightly more urban than others in this sample, which might help to explain this finding. Compared to those residing in rural areas, urban-dwellers more often report concerns over catching COVID-19 as obstacles to seeking medical care. More densely populated areas might be predisposed to having higher numbers of confirmed COVID-19 cases, but further research could explore the trends between confirmed cases in a given area and propensity to cite fear of disease as a prohibitive factor in the ability to satisfy medical needs.

Households who reported food insecurity were far more likely to cite resource constraints as barriers to access. The COVID HFPPs do not measure consumption or welfare status, but they do ask a series of questions to measure incidence of food insecurity. Data on whether an adult member of a household skipped a meal in the 30 days preceding the survey provides a proxy measure of welfare. Households that did not report skipped meals were more likely to be able to access care (91%) compared to households where adults did skip meals (84%). Figure 4 shows that when they were unable to access care, households without skipped meals were more likely to cite stay-at-home orders or lack of medical personnel as reasons to not seek care. Households with adults skipping meals, meanwhile, were more likely to report they did not seek care because of insufficient financial resources. These households were also more likely to report that they could not access care because the facility was closed. These findings highlight disparities in service accessibility between families experiencing one measure of food insecurity (adults skipping meals) and households where adults did not have to skip meals.

Figure 4: Health Care Access and Food Insecurity, Raw averages of survey-weighted country means
Implications Going Forward

As the COVID-19 pandemic progresses, these preliminary findings highlight the importance of monitoring both (a) people’s ability to access needed medical care, and (b) the nature of constraints to accessing care. Monitoring changes in self-reported reasons for service inaccessibility over the course of the pandemic and the aftermath of this public health crisis can shed light on who is most at risk of experiencing reduced access to medical care during a shock. Profiling the characteristics of higher-risk people and communities enables policymakers and aid organizations to better target cash and in-kind relief measures for both the ongoing COVID as well as future crises.

One possible uses of this data include exploring the connection between perceptions and behaviors; such as perceptions about how “fear of catching COVID” influence “accessing care”, for instance, and how these perceptions and preferences change in response to factors like mobility restrictions, public information campaigns, and frustration with restrictions.

Further research could also explore the long-term consequences of being unable to access medical treatment. Inability to access healthcare can negatively impact health indicators, such as increased disability rates and lower life expectancies, as well as have economic impacts, including depleted assets and a decline in labor force participation.

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