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The Factors Associated with Lack of Access to Health Facilities Among Persons of Concern (PoC) During the COVID-19 Pandemic in Nigeria

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Abstract

Persons of Concern (PoC) are people displaced because of natural disasters or conflicts and violence, and they include refugees, asylum seekers, internally displaced persons (IDPs), and returnees. Nigeria is one of the major destinations of PoC in Africa. PoC should have the same rights in any sector, including health access in their destination. However, during the COVID-19 pandemic, about 19% of households faced a lack of access to health facilities in Nigeria. This study examined the factors related to the lack of access to health facilities among PoCs in Nigeria during the COVID-19 pandemic in 2020. Methods: Secondary data from the UNHCR survey, which was conducted in July 2020 among 3,222 households categorized as PoC, was used. Univariate, bivariate, and multivariate analyses were used to assess the factors with the aid of STATA 17 software. Results: Factors such as state of residence, population status, marital status, and gender of household heads were found to have a significant correlation with the lack of access to health facilities in Nigeria. Conclusion: The UNHCR, the Nigerian government, and other stakeholders must work together to ensure all PoCs can access health facilities easily, especially during outbreaks of pandemics and other disasters.

INTRODUCTION

The African continent consists of countries that are behind in many sectors over the years. Before the emergence of the COVID-19 pandemic, which has affected all sectors of the world, the health sector situation of the African continent was characterized by a shortage of facilities for isolation, intensive care, ventilators, and financial resources required to fight the COVID-19 pandemic(Dzinamarira et al., 2020). This became a source of concern about the ability of countries in the continent to deal with the COVID-19 pandemic (Dzinamarira et al., 2020). The infrastructure of the health sector is an important point for solving health issues, including pandemics such as COVID-19. Nigeria is one of the countries of Africa that faces challenges in its health sector, which the Covid-19 pandemic af-

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fected.

Nigeria is the third country in Africa with the highest cases of COVID-19 infections, behind Egypt and Algeria (Dan-Nwafor et al., 2020). At the beginning of the pandemic, Nigeria began recording and reporting cases two weeks after the announcement of the pandemic was made by the WHO (Ohia et al., 2020). To avoid transmission and control infection during the pandemic, the Nigerian government began to implement measures such as lockdowns, curfew restrictions, and closing of national and state borders (Eranga, 2020). These measures restricted people from accessing health facilities (Chukwuorji & Iorfa, 2020). and worsened routine health services because everyone's mobility changed drastically (Assefa et al., 2021). However, as evidenced by tracking the first cases of COVID-19 from Italian citizens who were infected in Lagos, the Nigerian government showed seriousness about tracking and isolating the citizens, including imposing the regulation of lockdown (Ebenso & Otu, 2020).

Persons of concern (PoC) are people displaced because of natural disasters or conflicts and violence, and they include refugees, asylum seekers, internally displaced persons (IDPs), and returnees (UNHCR, 2022). Nigeria is one of the major destinations of PoC in Africa. Nigeria is home to more than 85,000 refugees and asylum-seekers, most of them from Cameroon. Around 55,000 persons have been displaced, over 30,000 of whom arrived in Borno's capital Maiduguri (UNHCR, 2020). Maiduguri already hosts more than one million internally displaced persons (IDPs) due to prolonged insurgency in north-eastern Nigeria. These IDPs are already facing different health challenges, and the COVID-19 pandemic could worsen their condition. According to the United Nations Refugee Agency (UNHCR), PoC should have the same rights in any sector, including health access in their destination (UNHCR, 2022).

Compared to all the countries in Sub-Saharan Africa, Nigeria is the second country that lacks basic hand washing facilities (50 million people) after the Congo DRC (Okoi & Bwawa, 2020). This situation is worse for PoC such as asylum seekers, IDPs, IDPs returnees, refugees, and refugee returnees (Otoakhia & Aliu, 2021). This study, therefore, aimed to examine the factors related to the lack of access to health facilities among people of concern during the COVID-19 pandemic in Nigeria. Access to health facilities in this study is not only related to COVID-19 itself, but also to other services in the health facilities, including antenatal care, regular check-ups, contraception, and so on.

The issue of lack of access to health facilities during COVID-19 has been reported by many studies. For instance, the antenatal care services in the public health centers had a limited number of visitors, and the number of children under five years who attend the immunization decreased a lot (Núñez et al., 2021; Tuczyńska et al., 2021). That might be due to the restricted physical interaction that does not allow people to visit public areas without masks and ensure people vacinnated.

The several reasons for the limited number of visitors to health facilities also affect PoC in Nigeria. The study in Bangladesh, Nigeria, Kenya, and Pakistan reported low participation in health services, including preventive services, because people were afraid of being diagnosed with COVID-19 (Ahmed et al., 2020). They faced difficulties accessing health facilities during the COVID-19 pandemic., For instance, the study among IDPs in Lagos, Nigeria, found that they did not receive any support from the state during the pandemic, and to visit health facilities, they were required to receive at least the first dose of COVID-19 (Adejoh et al., 2022). Other studies in Nigeria revealed the difficulties in accessing sexual and reproductive health services during the pandemic, including health care for mothers and newborns (Adelekan et al., 2021; Adetutu et al., 2023; Balogun et al., 2015). This study focused on the factors that mostly influenced the lack of access to health facilities among PoCs in Nigeria during the COVID-19 pandemic in 2020.

METHOD

Study Design

This cross-sectional study utilized secondary data from the survey by the UNHCR on the "Socio-economic impact assessment of COVID-19 pandemic among persons of concern in Nigeria (July 2020)" which was conducted from June to July 2020. The PoC in this study are asylum seekers, internally displaced people (IDPs), IDP returnees, refugees, and refugee returnees. The unit of analysis in this study was the household.

Data Collection Techniques and Data Sources

The sample consists of 3,222 households spread across nine states covering the six geo-political zones of Nigeria (North-east, South-South, South-east, South-west, and North-central) including the Federal Capital Territory, Abuja. The survey covered the aspects of health and nutrition, health, protection, food security, livelihood and social cohesion, and basic needs. It examin-

ed the impact of the COVID-19 pandemic on the situations of economic, social, cultural, civil, and political rights. The survey used a sociocultural value and age-gender diversity lens to provide information about the potential economic impact of COVID-19.

The original survey utilized the minimum sample size technique by taking the UNHCR database, and then choosing the respondents randomly. The sampling method used was disproportionate stratified random sampling. The data was collected using computer-assisted telephone interviews with the aid of smartphones and tablets (via the Kobo Collect App). This was due to the restriction and the regulation against physical movement during the pandemic. This current study used total sampling to select the households that fully answered the questionnaire. The study merely focuses on access to health facilities. All the information about the households was reported by the heads of households. The dataset was accessed from the UNHCR website: https://microdata.unhcr.org/index.php/catalog/284 after obtaining approval.

Method of Data Analysis

The outcome variable of this study is the lack of access to health facilities during the COVID-19 pandemic by households. The variable was dichotomized into two: "No" for those who had access and "Yes" for those who lacked access. The sociodemographic, economic, and level of awareness variables were the independent variables. The variables were selected based on availability in the dataset and they included the age of the head of household [<19; 19-59; >59], sex of head of household [female; male], marital status [Married; Divorced; Engaged; Separated; Widowed; Single], occupation [paid job; Artisans and others; Business; Farming; Remittances and students], income during Covid-19 [<20,000; 21,000-40,000; 41,000-60,000; 61,000-80,000; >80,000], COVID-19 awareness [High; Moderate; Low], state of residence [FCT; Adamawa; Benue; Borno; Cross River; Lagos; Ogun; Taraba; Yobe], and population sub-group [IDPs; IDP returnees; Refugee; Refugee returnees; Asylum seekers].

The analyses covered 3,222 households selected after data cleaning. The data analysis has been done using univariate, bivariate (Chi-Square test), and multivariate (binary logistic regression) analyses. The results of this study were analyzed using STATA version 17 (Mahidol University license).

Ethical Clearance

The ethical clearance to use the secondary data was obtained from the UNHCR Microdata Library on June 22, 2022. Based on the COVID-19 Socio-Economic Impact Assessment Report on Persons of Concern, the original survey was organized by the UNHCR together with partners in Nigeria. The collection of the data was done by the UNHCR together with government and community leaders. To ease proper awareness and ensure the validity of the study, UNHCR and partners were informed of community susceptibility.

RESULT AND DISCUSSION

Table 1 below presents the general characteristics of the sample. Almost one-fourth of the persons of concern (PoC) in Nigeria lacked access to health facilities during the COVID-19 pandemic (22%). The heads of households, who were the persons interviewed for this survey, were mostly aged 19 to 59 years (89%), while about 10% were above 59 years old. More than half of the households were headed by females (56%) while 44% were headed by males. About two-thirds of the respondents were married. The main occupations of the heads of household were farming (48%) and business (26%). The majority of them earned less than 20,000 Naira (43 USD) per month (75%). Concerning awareness about the COVID-19 pandemic, 34% had high awareness while 38% were moderately aware. Adamawa (26%), Benue (19%), and Cross River (36%) States had the highest prevalence of PoC. In terms of the population status, most of them were refugees (55%) and IDPs (28%).

Table 1. Characteristics of households of persons of concern

Variables (N = 3,222)	Frequency	Percentages
Lack of access to the health facility		
No	2,512	77.96
Yes	710	22.04
The age group of the head of household		
<19	39	1.21
19-59	2,873	89.17
>59	310	9.62

Variables (N = 3,222)	Frequency	Percentages
Sex of the Head of Household		
Female	1,815	56.33
Male	1,407	43.67
Marital Status of the Head of Household		
Married	2,153	66.82
Divorced	68	2.11
Engaged	10	0.31
Separated	97	3.01
Single	567	17.60
Widowed	327	10.15
The Main Occupation of the Head of Household		
Paid job	406	12.60
Artisans, not fully paid, and others.	205	6.36
Business	829	25.73
Farming	1,532	47.55
Remittances and students	250	7.76
Current Monthly Income in Naira (During the COVID-19 Pandemic)		
<20,000	2,413	74.89
21,000 – 40,000	578	17.94
41,000 – 60,000	181	5.62
61,000 – 80,000	36	1.12
>80,000	14	0.43
Level of Awareness of COVID-19		
High	1,099	34.11
Moderate	1,232	38.24
Low	891	27.65
State		
Adamawa	835	25.92
Benue	596	18.50
Cross River	846	26.26
Federal Capital Territory	12	0.37
Lagos	105	3.26
Ogun	32	0.99
Taraba	323	10.02
Yobe	260	8.07
Borno	213	6.61
Population Group/Status (Persons of Concern)		
IDPs Returnees	394	12.23
Asylum Seekers	46	1.43
IDPs	917	28.46
Refugee	1,787	55.46
Refugee Returnee	78	2.42

The bivariate analysis examined the association between each independent variable and the lack of access to health facilities among PoC using the Chi-Square test. Table 2 below shows the results of the test, which indicated that the associated factors were the age of the head of household, sex, marital status, level of awareness of COVID-19, state, and population status of the persons of concern in Nigeria. For the strength of the associated predictors, marital status, state, and population status had the strongest association with the study outcome (p-value <0.000), followed by the level of awareness about COVID-19, sex, and age group (p-value 0.015, 0,017, and 0.049, respectively). On the other hand, the main occupation and the monthly income had no association with the lack of access to health facilities.

Table 2. Factors Associated with the Lack of Access to Health Facilities among PoC in Nigeria

Variables (n = 3,222)	Lack of Access to Health Facilities			p-value
	No	Yes	Total	
Age group of the head of household				0.049
<19	25 (1.00%)	14 (1.97%)	39 (1.21%)	
19-59	2,236 (89.01%)	637 (89.72%)	2,873 (89.17%)	
>59	251 (9.99%)	59 (8.31%)	310 (9.62%)	
Sex of the head of household				
Female	1,443 (57.44%)	372 (52.39)	1,815 (56.33%)	0.017
Male	1,069 (42.56%)	338 (47.61%)	1,407 (43.67%)	
Marital status of the head of household				<0.001
Married	1,706 (67.91%)	447 (62.96%)	2,153 (66.82%)	
Divorced	60 (2.39%)	8 (1.13%)	68 (2.11%)	
Engaged	7 (0.28%)	3 (0.42%)	10 (0.31%)	
Separated	83 (3.30%)	14 (1.97%)	97 (3.01%)	
Single	396 (15.76%)	171 (24.08%)	567 (17.60%)	
Widowed	260 (10.35%)	67 (9.44%)	327 (10.15%)	
Main occupation of head of household				0.083
Paid job	317 (12.62%)	89 (12.54%)	406 (12.60%)	
Artisans, not fully paid, and others	164 (6.53%)	41 (5.77%)	205 (6.36%)	
Business	620 (24.68%)	209 (29.44%)	829 (25.73%)	
Farming	1,206 (48.01%)	326 (45.92%)	1,532 (47.55%)	
Remittances and students	205 (8.16%)	45 (6.34%)	250 (7.76%)	
Current monthly income in naira (during the COVID-19 pandemic)				0.157
<20,000	1,863 (74.16%)	550 (77.46%)	2,413 (74.89%)	
21,000 – 40,000	470 (18.71%)	108 (15.21%)	578 (17.94%)	
41,000 – 60,000	138 (5.49%)	43 (6.06%)	181 (5.62%)	
61,000 – 80,000	31 (1.23%)	5 (0.70%)	36 (1.12%)	
>80,000	10 (0.40%)	4 (0.56%)	14 (0.43%)	
Level of awareness on COVID-19				0.015
High	831 (33.08%)	268 (37.75%)	1,099 (34.11%)	
Moderate	959 (38.18%)	273 (38.45%)	1,232 (38.24%)	
Low	722 (28.74%)	169 (23.80%)	891 (27.65%)	
State				<0.001
Adamawa	724 (28.82%)	111 (15.63%)	835 (25.92%)	
Benue	400 (15.92%)	196 (27.61%)	596 (18.50%)	
Cross River	688 (26.59%)	178 (25.07%)	846 (26.26%)	
Federal capital territory	4 (0.16%)	8 (1.13%)	12 (0.37%)	
Lagos	66 (2.63%)	39 (5.49%)	105 (3.26%)	
Ogun	17 (0.68%)	15 (2.11%)	32 (0.99%)	
Taraba	266 (10.59%)	57 (8.03%)	323 (10.02%)	
Yobe	176 (7.01%)	84 (11.83%)	260 (8.07%)	
Borno	191 (7.60%)	22 (3.10%)	213 (6.61%)	
Population group/status				<0.001
IDPs returnees	344 (13.69%)	50 (7.04%)	394 (12.23%)	
Asylum seekers	34 (1.35%)	12 (1.69%)	46 (1.43%)	

Variables (n = 3,222)	Lack of Access to Health Facilities			p-value
	No	Yes	Total	
IDPs	86 (27.31%)	231 (32.54%)	917 (28.46%)	
Refugee	1,407 (56.01%)	380 (53.52%)	1,787 (55.46%)	
Refugee returnee	41 (1.63%)	37 (5.21%)	78 (2.42%)	
Total	2,512 (100%)	710 (100%)	3,222 (100%)	

The result from the multivariate analysis to examine the predictors of the outcome is shown in Table 3. It was found that among all the predictors, some had a correlation that contributed to the lack of access to health facilities, including sex of the head of household, marital status, main occupation, level of awareness of COVID-19, state, and population status. In detail, female-headed households. Being a single PoC had a strong correlation to predict the lack of access to health facilities when compared to being married;, the single was 1.81 times more likely to lack access to health facilities. Compared to those with paid jobs, being recipients of remittances and students decreased the risk of lacking access to health facilities by 41%. Moreover, compared to those with high awareness of COVID-19, those with low awareness had decreased risk of lacking access to health facilities by 25%. For the state of residence of PoC, compared to those residing in Adamawa, those that were living in Benue, Cross River, Federal Capital Territory, Lagos, Ogun, Taraba, and Yobe had higher odds of lacking access to health facilities with odds of 6.09, 5.68, 24.01, 10.28, 14.06, 4.95, and 2.54 respectively. In terms of population status, compared to IDP returnees, those categorized as IDPs, refugees, and refugee returnees correlated with lack of access to health facilities. In detail, those who were IDPs were 1.58 times more likely to face the lack of access to health facilities, those who were refugees had a decreased probability of lacking access to health facilities by 61%, and those who were returneesrefugee-returnees were 4.81 times more likely to face the lack of access to health facilities. The age of heads of household and monthly income did not have any correlation with the lack of access to health facilities among PoC in Nigeria during the COVID-19 pandemic.

The COVID-19 pandemic affected Nigeria, just like other countries of the world, including healthcare access to the people due to the imposition of lockdown and movement restrictions. Nigeria is one of the destination countries

Table 3. Multivariate Analysis of Predictors of Lack of Access to Health Facilities among PoC in Nigeria

Independent Variables	AOR	p-value (CI)
The age group of the head of household		
<19	Ref	
19-59	0.51	0.063 (0.25 – 1.03)
>59	0.45	0.048 (0.21 – 0.99)
Sex of the head of household		
Female	Ref	
Male	1.29	0.012 (1.06 – 1.58) **
Marital status of the head of household		
Married	Ref	
Divorced	0.74	0.441 (0.34 –1.59)
Engaged	1.82	0.396 (0.46 – 7.22)
Separated	0.98	0.941 (0.54 – 1.77)
Single	1.81	<0.001 (1.42 – 2.31) ***
Widowed	1.12	0.510 (0.80 – 1.56)
Main occupation of the head of household		
Paid job	Ref	
Artisans, not fully paid, and others	0.69	0.098 (0.44 – 1.07)
Business	1.04	0.779 (0.77 – 1.42)
Farming	0.90	0.511 (0.67 – 1.22)
Remittances and students	0.59	0.020 (0.38 – 0.92) *

Independent Variables	AOR	*p-value* (CI)
Level of awareness on COVID-19		
High	Ref	
Moderate	0.97	0.777 (0.78 – 1.20)
Low	0.75	0.026 (0.59 – 0.97) *
State		
Adamawa	Ref	
Benue	6.09	<0.001 (4.27 – 8.70) ***
Cross River	5.68	<0.001 (3.58 – 9.02) ***
Federal Capital Territory	24.01	<0.001 (6.46 – 89.22) ***
Lagos	10.28	<0.001 (5.66 – 18.67) ***
Ogun	14.06	<0.001 (5.96 – 33.15) ***
Taraba	4.95	<0.001 (2.93 – 8.37) ***
Yobe	2.54	<0.001 (1.78 – 3.64) ***
Borno	1.19	0.550 (0.67 – 2.14)
Population group/status		
IDPs returnees	Ref	
Asylum seekers	1.52	0.404 (0.57 – 4.08)
IDPs	1.58	0.016 (1.09 – 2.30) *
Refugee	0.39	<0.001 (0.23 – 0.66) ***
Refugee-returnee	4.81	<0.001 (2.67 – 8.64) ***

Note: *p-value <0.05, **p-value <0.01, ***p-value <0.001
LR chi2= 288.61; prob >chi2 0.000; pseudo R2=0.0849; log likelihood= - 1554.8583

for persons of concern (PoC) in Western Africa, such as refugees and asylum seekers, and the country also has a large number of internally displaced persons and returnees due to numerous natural disasters and violence. The United Nations refugee agency, UNHCR, conducted a survey in 2020 with PoC to assess the impact of Covid-19 on them. The data from that survey was used for this study. This study was undertaken to examine the impact of the COVID-19 pandemic on access to health services among PoCs. The findings revealed that about one-fourth of all the PoCs in the states covered by the survey lacked access to health services during the COVID-19 pandemic. The sex of the household head, being single, being the recipient of remittances and student, having low awareness of COVID-19, state of residence, and population status were found to be the significant predictors of lack of access to health facilities among the PoC in Nigeria. A study in Lagos State of Nigeria during the COVID-19 pandemic in 2020 has also reported that IDPs faced difficulties accessing healthcare such as distance to public health facilities, the quality of care, and fear of the coronavirus (Adejoh et al., 2022).

The findings revealed that PoC in the Federal Capital Territory (FCT) experienced the most difficulty accessing health facilities during the COVID-19 pandemic. This might be because the FCT is the capital city of Nigeria and the implementation of the lockdown and movement restrictions was more pronounced in the capital , hence making it difficult for the PoC to access health facilities. Also, the PoC may not be original inhabitants of the FCT hence, may not have been familiar with avenues for accessing health facilities with ease since the lockdown and restriction of movement did not apply to persons requiring healthcare. Other States that faced similar difficulties were Ogun, Lagos, Benue, Cross-River, Taraba, Yobe, and Borno, which are all located around the international borders of Nigeria, except for Benue State. Moreover, considering their condition as PoC, which means they were already in a vulnerable and disadvantaged position, they should have been given extra attention by the governments of the respective States and other stakeholders, in line with the UNHCR's requirement that PoC should have equal rights to access health services like their host communities. However, there is a general lack of access to health services not only for the PoC but for all citizens as well, with the PoC facing more challenges (Kolawole et al., 2015).

Our findings also reveal that compared with IDP returnees, that is, persons returning to their original place of residence after being displaced, other PoCs, such as refugee returnees and IDPs, were more likely to lack access to health facilities.

A previous study in Nigeria found that refugees faced challenges in accessing reproductive health services, even in the refugee camp (Okanlawon et al., 2010). Another study has reported that IDPs in the North-Eastern part of Nigeria face health challenges, including acute malnutrition and inadequate healthcare services (Abbani, 2021). A study reported that the limited number and type of drugs, contraceptive tools, and medical treatment is another challenge faced by refugees (Oyekale, 2017). Others have found cultural barriers, resource-related barriers, and physical confounders as barriers (Adedini et al., 2014). In Nigeria though, the government, the UNHCR, and third parties provide services to the PoC by focusing on protection, provision of shelter, and blankets. Others include self-reliance, cash assistance, water, sanitation, and health (Ogolla, 2023).

Elsewhere, a study in the UK that interviewed asylum seekers and refugees to understand the barriers to health facilities access found language barriers, inadequate interpretation service, lack of awareness, and discrimination related to race, religion, and immigration to be the major barriers (Kang et al., 2019). The issue of the language barrier was also reported by a study that made refugees not visit health facilities regularly (Morris et al., 2009). Another study of refugee women in South Australia also found the main barrier to accessing primary healthcare to be language (Clark et al., 2014). Accessibility to maternal and child health services by refugees also faced challenges such as access, language, and promoting continued engagement (Riggs et al., 2012). One study found the factors that affect refugee women's participation in healthcare services to include shame or fear about the family's condition, being judged by the provider, fear of hospitalization, and facing logistic difficulties (Drummond et al., 2011). A recent previous scoping review of the literature found that language barriers, legal status, and resource constraints influence PoC access to healthcare (El Arab et al., 2023).

Our findings also reveal that PoC who were single or already engaged to be married had more risk of lacking access to health facilities. A previous study has reported that those who were single had low participation in healthcare and outpatient services (Robles, 2014). Also, compared to the female-headed households, the male ones tend to lack access to health facilities more. The other potential independent variables found no association with the lack of access to health services.

CONCLUSION

The persons of concern (PoC) in Nigeria consisted of refugees, internally displaced persons (IDPs), IDP returnees, asylum seekers, and refugee- returnees. During the COVID-19 pandemic, the utilization of health facilities was low among PoC, and about one-quarter of households lacked access to health facilities. The predictors of lack of access to health facilities were male as head of household, single marital status, being a receiver of remittances and student, having low awareness of Covid-19, residence in Benue, Cross River, Federal Capital Territory, Lagos, Ogun, Taraba, and Yobe State, and being an IDP and refugee returnee. The UNHCR, the Nigerian government, and other stakeholders need to work together to ensure all PoCs can access health facilities easily during times of emergencies such as the COVID-19 pandemic. Future studies could include a qualitative approach to provide in-depth information through the PoC to understand more about the factors that were responsible for the lack of access to health facilities.

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