

Implications of COVID-19 on Healthcare Seeking Behaviour of the Rural-Poor in Ido-Ekiti and Environs. Nigeria

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Abstract

Background: Coronavirus disease of 2019 (COVID-19) in low- and middle-income countries (LMICs) is raising serious concerns about effective pandemic response and preparedness in the context of background fragile health systems and especially in developing countries like Nigeria with alarming poverty indices.

Aim: The study aimed to reveal the implication of the COVID-19 pandemic on the healthcare seeking behaviour of households experiencing (extreme) poverty and to also infer factors that influence the health-seeking behaviour in the area

Methods: A retrospective and comparative study using secondary data from the major tertiary healthcare centre which serves Ido-Ekiti; a town in southwestern Nigeria and its environs was utilized in this study; it comprises data before and during the pandemic.

Results: There was general decline across the clinics (90%) with some clinics having up to 55%, 33% reduction in visits during COVID-19. There was a total 13% drop across board from January to December of 2020 as compared with 2019.

Conclusion and Recommendation: The study suggests better enlightenment campaign and more investment in the healthcare sector especially in the rural areas. The conflict theory was adopted.

Introduction

The World Health organization's long standing definition of health as a "complete state of physical, social and mental wellbeing, not merely the absence of disease or infirmity" coupled with another definition referring to health as "an overall individual fitness for a fruitful creative living" by Agbeko (2010), portrays the principle state towards which all human societies strive to achieve for their members. This became imperative with the realization that only healthy people can fulfill their various obligations to the society and in the process ensure its survival and development. In a bid to realize this goal, each society or culture, irrespective of its level of development, evolves a health care system best suitable for its own peculiar circumstances and environment. Societies try to bring about a high status of healthcare for its members. Thus, in all parts of the world various kinds of healthcare systems evolved. These are known in many developing countries as traditional healthcare system.

For instance, the traditional medical system as found in Nigeria is a decentralized system in which community-based practitioners served clients from their compounds or the patients' homes. Easy access to the healer was one of its main assets. A variety of practitioners competed for clients including the herbalist, diviners, bone setters, psychiatrists, soothsayers, and birth attendants. It is imperative to note at this point that the traditional healthcare system was (and is still) adequate and relatively efficient for its

users for centuries past, hence its persistence to the present times in most parts of the world. Despite the fact that each culture evolves its own concepts of physical health and illness, much of what is now recognized as medicine derives from developments in the western society over the past two or three centuries, from where it spread to almost all parts of the world. The consequences are that in Nigeria today as in other parts of sub-Saharan Africa, there exists a dualism in the healthcare system. A situation where the traditional medical system, exists side by side with the modern medical system, with modern medical system being relatively dominant. The modern medical system is more centralized and organized.

In Nigeria, health system is structured into primary, secondary, and tertiary levels of care. The primary health care provides health care at the grassroots level mostly in the rural and sub-urban areas. Secondary health care focus health care to the semi-urban while tertiary facilities provides care for people in the urban city. Sources of healthcare in many developing countries such as Nigeria includes traditional/herbal, faith healers, Patent Medicine Vendors (PMVs) and orthodox health facilities. Often time, many people combined the use of this health sources in Nigeria. (Osamor, 2011) The private sector is highly active in Nigeria providing up to 60% of healthcare service in Nigeria (Agweye et al., 2019).

Health promotion programmes worldwide have long been premised on the idea that providing knowledge about causes of ill health and choices available will go a long way towards promoting a change in individual behaviour, towards more beneficial health seeking behaviour. However, there is growing recognition, in both developed and developing countries, that providing education and knowledge at the individual level is not sufficient in itself to promote a change in behaviour. An abundance of descriptive studies on health seeking behaviour, highlighting similar and unique factors, demonstrate the complexity of influences on an individual's behaviour at a given time and place. However, they focus almost exclusively on the individual as a purposive and decisive agent, and elsewhere there is a growing concern that factors promoting 'good' health seeking behaviours are not rooted solely in the individual, they also have a more dynamic, collective, interactive element. Academics have therefore started to explore the way in which the local dynamics of communities have an influence over the well-being of the inhabitants.

This reflects a growing interest across the social sciences in the contested concept of *social capital*. Attempts are now being made to develop this, as yet under-utilized idea, to incorporate knowledge about health seeking behaviour into health service delivery strategies in a way which is sensitive to the local dynamics of the community. This may be an extremely positive development. The whole area of knowledge around health seeking behaviour is rendered of little value if not incorporated into management and system developments. The fact that health seeking behaviour is 'not even mentioned' in widely used medical textbooks (Steen and Mazonde, 1999), perhaps reflects that many health seeking behaviour studies are presented in a manner which delivers no effective route forward. This results in an unfortunate loss for medical practice and health systems development programmes, as proper

understanding of health seeking behaviour could reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies in a variety of contexts.

Aim And Objectives

The study aims to assess the rate of utilization of health services at the chosen facility before and during the COVID 19 pandemic as well as to critically examine the various barriers and facilitators associated with accessing services during the COVID-19 pandemic in Nigeria. Specific objectives are to:

1. Ascertain the trend in the utilization of health services before and during COVID-19 pandemic.
2. Determine factors that influence the health-seeking behaviour in the area from previous studies.

Problem

The health and economic effects of COVID-19 are hitting Nigeria hard. The arrival of COVID-19 in Nigeria posed a public-health challenge for which the country was not fully ready for. On February 27, 2020, Nigeria reported its first confirmed case of COVID-19, making it one of the first countries in sub-Saharan Africa to be touched by the pandemic (NCDC, 2020). Since then, case numbers and deaths have steadily climbed, although they have not reached the figures witnessed in Europe and the Americas: as of October 7, 2020, Nigeria reported 59,583 confirmed cases of COVID-19 and 873 deaths (NCDC, 2020).

The healthcare indices of Nigeria has been very bad over the years as evident by records from the Federal Ministry of Health [FMoH] (2004) that nearly fifteen (15) percent of Nigerian children do not survive to their fifth birthday. The major causes being malnutrition that accounts for fifty-two (52) percent of the deaths, malaria thirty (30) percent and diarrhea twenty (20) percent. Maternal mortality has also been reported to be extremely high. (Obansa & Orimisan, 2013). In 2008, between 3million and 3.5million people were estimated to be living with HIV/AIDS. Nigeria was also the reported with the fourth highest number of tuberculosis cases in the world, with a 2004 estimate of 293 new cases per 100,000 population and 546 per 100,000 total cases (Obansa & Orimisan, 2013).

Even before the COVID-19 crisis, around 4 in 10 Nigerians were living in poverty according to the national poverty line, yet millions more had consumption levels only just above the poverty line, making them susceptible to falling into poverty when shocks occur (World Bank, 2020). Those with consumption levels between the poverty line and 1.5 times the poverty line may be defined as vulnerable (World Bank, 2016). Indeed, while 40.1 percent of Nigerians (82.9 million people) lived below the poverty line prior to the COVID-19 outbreak, a further 25.4 percent (52.6 million people) were vulnerable by this definition. In support of the foregoing, a study done by Omotosho (2010) on the health seeking behaviour among the

rural dwellers in the same Ekiti State revealed that the topmost factor that determines utilization is the affordability of the medical charges.

Staying healthy in the face of diseases or illness involve individual engaging in what is referred to as health-seeking behaviours when the need arises. According to Mboweni and Sumbane (2019), health-seeking behaviour or illness behaviour refer to the steps individual use in interpreting health challenges as well as measures taken to solve these problems. It also involves comprehensive strategy of health care use which inculcates activities that avert and cure health issues, maintain bodily state and well-being (Latunji & Akinyemi, 2008).

A study by Omotoso (2010), opined that rural dwellers in Nigeria are the most neglected and the most deprived with respect to the provision of modern health care services. He added that they lack other basic infrastructural necessities that are essential to the maintenance and promotion of good health. This situation is very unfortunate. More so, as majority of the nation's population who produce the nation's food needs, including valuable export crops reside in the infrastructural underserved area. Even the few areas where medical facilities exist, such facilities are often short staffed, poorly maintained and are often inadequately supplied with drugs.

The outcomes of these results in the rural dwellers being subjected to high incidence of morbidity and mortality resulting from the prevalence of preventable parasitic and infectious disease. In most of the rural areas of Nigeria today, few people could have access to better medical treatment while few who are rich and in higher authorities do meet their health need abroad and consequently, leads to changes in health care delivery. The changes have led to very high cost medical treatment and no wonder, Nigeria has thus become a fertile ground for fake drug peddling. The health situation is further corresponded by the current AIDS epidemic (UNAIDS, 1997).

Many studies conducted on health-seeking behaviour and its associated factors with emphasis on ways people react to health issues, personal and socio-demographic factors, men's health-seeking behaviour, health-seeking behaviours of infants by their caregivers, communication experiences in accessing healthcare and factors influencing health-seeking behaviour among civil servants. (Olaigbe & Okunade, 2020; Agweye et al., 2019; Omotosho, 2010; Latunji & Akinyemi, 2008). Nevertheless, relative little or nothing has been done in terms of comparative study to investigate the impact of pandemics such as COVID-19 make on the rural-poor as it pertains to their health-seeking behaviour, this is a gap which this study intends to fill by adding to the existing knowledge.

Brief Literature Review

Coronavirus disease of 2019 (COVID-19) has become a public health emergency since its emergence in a city called Wuhan, a province of China on 17th November 2019 (*Live Science*, 2021). This led to the World Health Organization declaring it an international public health emergency in January 2020 with far reaching effects on the physical, mental, and social health of the public. The illness according to scientists is caused by the virus strain Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) and has affected people in more than 173 countries (Raluca et al., 2020).

According to Obansa and Orimisan (2013), the Nigerian healthcare system was already bedeviled with a few of the following challenges: Inadequate health facilities/structure, shortage of essential drugs and supplies, inadequate supervision of the healthcare system, poor human resources, management, remuneration and motivation, lack of fair and sustainable health care financing with very low per capita health spending, unequal economic and political relations, the neo-liberal economic policies of the Nigerian state and corruption, high out-of-pocket expenditure in health by citizens, absence of community-based integrated system for disease prevention, surveillance and treatment. So the COVID 19 pandemic therefore met a struggling and moribund healthcare system.

Furthermore, some barriers to health-care utilization on the other end, can be explained by several factors such as age, gender, self-rated health, perceived quality of care, lack of trust in the system, knowledge of need for care, access to care, socioeconomic status, lack of insurance coverage, and cultural beliefs (NASEM, 2018). It's an open secret that the rural dwellers suffer the greatest hit from an abysmal healthcare system, Orubuloye, et al., (1991) opined that while majority of the improved high grade and better – equipped medical facilities are located in the urban areas, few and poorly – maintained, shortage of equipment, drugs, buildings and personnel's are located in the rural areas. Little wonder, majority of the medical centres at the rural areas are usually described as mere consulting clinics.

Theoretical Framework

Conflict Theory

The conflict theorist approach was adopted as a theoretical orientation. The approach is anchored on the idea that emphasizes the social, political or material inequality of a social group; critiques the broad socio-political system. The conflict theory is derived from the writings of Karl Marx, and assumes that conflicts arise when resources (in this case access to healthcare), status, and power are unevenly distributed between groups in society. According to this theory, conflicts that arise because of inequality which in turn foster social change.

Furthermore, the approach assumes that society is constantly in conflict between two classes; the exploiter and the exploited, i.e. the “health haves” and the health “haves not” respectively. The focus here is on inequality, exploitation, class or social and economic status, agitation, struggle, conflict and social change. Conflict theory sees social life as a competition, and focuses on the distribution of resources, power, and inequality. It’s palpable and clear to all that the poor, the rural dwellers are usually the most disadvantaged when distribution and access to healthcare is critically reviewed.

Consequently, most of the deaths and morbidities are traceable to these groups of people. Relating this theory to this study, residents and locals whose health-seeking behaviour was in one way or the other affected directly or indirectly owing to the COVID-19 pandemic suffered more losses. Not because of the pandemic but because of measures such as lockdown of health facilities, scarcity of means of transportation, closure of markets, to mention but a few. Unlike the rich and urban dwellers who relatively have more options and the financial resources and ‘connections’ to reduce these challenges.

According to Katung (2011), seeking professional health care in terms of type and source is influenced by factors such as educational status of an individual, economic status, severity of the symptoms of sickness, socio-cultural influences, distance, and quality of health care facilities. Also, cost of treatment, individual’s income, degree to which the individual is bothered about the symptoms and period of undergoing are also some of the signs and symptoms that one’s need to seek care. Most of these aforementioned factors affect the rural-poor the most.

Materials And Methods

Study design

The hospital was chosen by simple random sampling

Setting and population

Ekiti State with population of over two million people comprises the study area. It is located in the South/Western part of Nigeria and was carved out from old Ondo State in 1996 with twelve local government areas that makes up the Ekiti Zone of the old Ondo State.

However, additional four local governments were carved out of the old ones and today, the state is made up of sixteen local government areas with Ado-Ekiti, as the capital and Ido-Ekiti (location of the chosen hospital) being 35.5km away from the capital (Ekiti Government, 2004).

Data analysis

Secondary data from the Health Information Management (HIM) department of the hospital was utilized for the study.

Results

From the study, 59,006 patients visited the clinics in the year 2019 as against 51,325 patients in 2020. 29,848 and 26,750 children visited the COPD in 2019 and 2020 respectively. For the ward admissions, 4,229 and 3,279 patients were admitted into the wards in 2019 and 2020 respectively while 2,123 and 1,804 patients were admitted into the Accident and Emergency Wards.

TABLE 1: Showing the individual number of patients seen across the clinics over 12 months of the year 2019 & 2020.

S/N	Unit	2019	2020	2019:2020 % decrease
1.	COPD	29848	26750	10%
1.	CARDIAC	2176	1643	24%
1.	CHEST	444	408	8%
1.	ENDO	1083	769	55%
1.	GIT	570	566	1%
1.	SOPD	2354	1975	16%
1.	ANC	3076	2832	8%
1.	O & G	1664	1410	15%
1.	EYE	2794	2024	28%
1.	ENT	832	646	22%
1.	POPD	2493	2116	15%
1.	DERMA	381	342	10%
1.	NEURO	1383	1179	15%
1.	DENTAL	1936	1513	22%
1.	ORTHO	1478	986	33%
1.	URO	1401	1489	+6%
1.	RENAL	268	280	+4%
1.	HAEMA	208	200	4%
1.	DOTS	837	716	15%

1.	XYZ	3780	3481	8%
1.	PSOPD	376	271	30%
	TOTAL	59,006	51325	13%

Discussion

The COVID-19 pandemic has continued to ravage the world since the month of November in the year 2019 and this has created panic and fear to the citizen to the extent that it has affected the health seeking behaviour of residents. This study therefore examined the effect of COVID 19 on the health-seeking behaviour of residents during the COVID-19 pandemic in Ido-Ekiti, Ekiti state.

Our results, as depicted from *Table 1*, show an overwhelming decline in the utilization of the healthcare services across 90% of the entry points considered (19 out of 21). This in no small way reveals how the COVID-19 pandemic affected the locals that access care from the facility. Some decline in clinic visits was to the tune of 28%, 33%, and 55% below the attendance of the previous (2019) year. Across board, there was 7681 reduction in the number of hospital visit in the year 2020, a 13% fall when juxtaposed with the 2019 details. The severity of clinical presentation and usual fatality associated with the urology and renal clinic patients can explain the exemption noted in both clinics. Also worthy of note is the fact that there was a decline of over 3,000 visits in the Children Outpatient Department (COPD)

Figure 1, reveals a surprising findings; the Chest Clinic which supposedly should receive patients with majority of the COVID-19 symptoms such as cough, sore throat, difficulty in breathing, amongst others had no significant or expected increase in patients load. The question is where were those patients? The cardiac clinic, another major clinic that most COVID-19 patients were expected to visit either on follow-up or new referrals also had a reduced patient load.

Figure 2, summarizes the admission rates at the wards and at the Accident & Emergency points. There were reduced admissions in the year 2020 during the pandemic, still corroborating a decline in health-seeking behaviour of the patients relative to what was obtained in the year before the COVID-19 outbreak. There was 22% and 15% reduction respectively as regards the admissions at the wards and A & E respectively.

To determine factors that influence the healthcare seeking behaviour in the area, a few studies that addressed the subject were reviewed; according to Samuel (2020), people who have unmet social needs and the illiterates are more likely to not show up for medical appointments. Other factors include the type of ailment; availability of money at the time of illness, age, religious background educational background, severity of sickness, and household position among others determining the health seeking behaviour in the area.

According to Omotosho (2020) the major factors responsible for the choice of a particular establishment include: affordable cost, closeness, staff attitude, quality of service, knowledge of owners/staff, and neatness of the environment, availability of services required and availability of drugs required. The results from his study showed that 452 (32.9%) patrons claimed that they patronized a particular medical establishment because they could afford the medical charges. However, 395 (24.3%) indicated that patronage was due to the closeness of such medical establishment, 129 (10.3%) staff attitude, 210 (16.7%), quality of service, 16 (1.2%), knowledge of owner staff 66 (5.3%), neatness of the environment, 31 (2.5%), available of service, 31 (2.5%), drugs required and 11 (1.4%) are other factors.

Finally, Infectious disease outbreaks of large magnitude, such as COVID-19, need special attention beyond the routine in terms of resources and procedures, as they have tendency to significantly impact the nation's economy and health system. These impacts are usually more felt at the community level where the existing health resources are usually limited. Ajisegiri et al. (2020) suggest that Community Health Workers (CHWs) are able to fill in these gaps in the health system by extending health services to these vulnerable populations.

Recommendations

To improve medical condition and healthcare seeking behaviour in the rural areas, the following options will be made to have a great impact: provision of free healthcare services to the high-risk age groups such as children, pregnant women and the elderly, effective health insurance scheme for the masses, improvement of road condition, provision of more health personnel, adequate provision and equipping the medical facilities, quick attention services and others which may include making the environment tidier and provision of adequate scarcity around the medical facilities.

Conclusion

COVID-19 pandemic in no small way has affected the healthcare seeking behaviour of the rural-poor. In accordance with the conflict theory, the poor and the rural dwellers will continue to be cheated and exploited as far as access to free or at least affordable healthcare is concerned.

To further encourage utilization of healthcare facilities during any pandemic, adequate communication through verified channels like the Ministry of Health website, and radio/television should be employed to influence people's desire to seek healthcare services. Further research is needed to find out the healthcare seeking behaviour and factors influencing behaviour of the rural-poor who live in across the different states and socio-political zones.

Limitation And Suggestion For Further Studies

There authors believe that data from multiple sources might give a better picture of assessing the objectives of the study. Further research can also be done using the Tipping and Segall (1995) model of health seekers behavioural theory or the Health Belief Model by Sheeram and Abraham (1996).

Declarations

Acknowledgement

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Competing Interests

The authors declare that they have no known competing financial interests or personal relationships that have, or could be perceived to have, influenced the work reported in this article.

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Figures

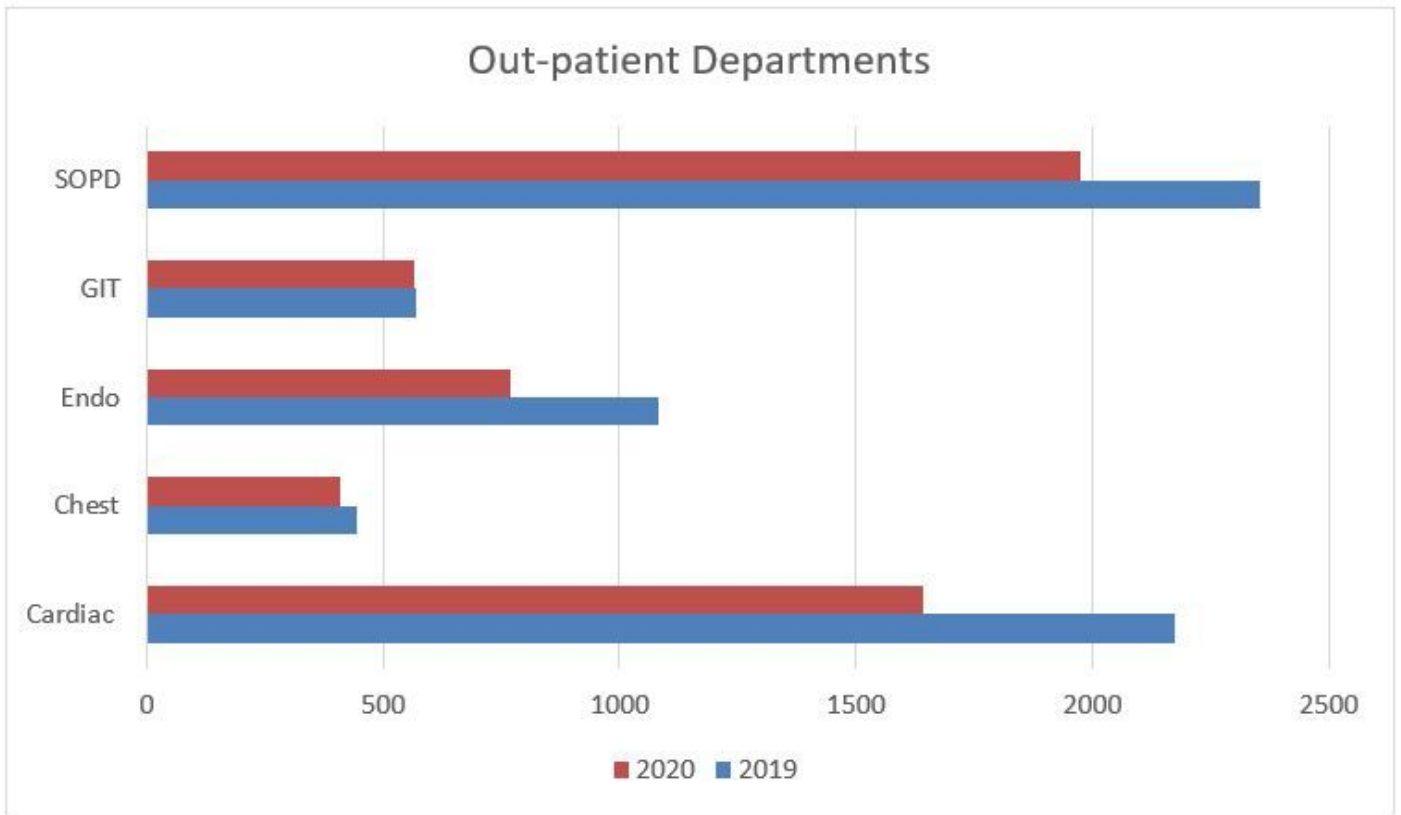


Figure 1

Bar chart showing the differences in the number of patients seen across selected few clinics at the out-patient department over the years 2019 & 2020.

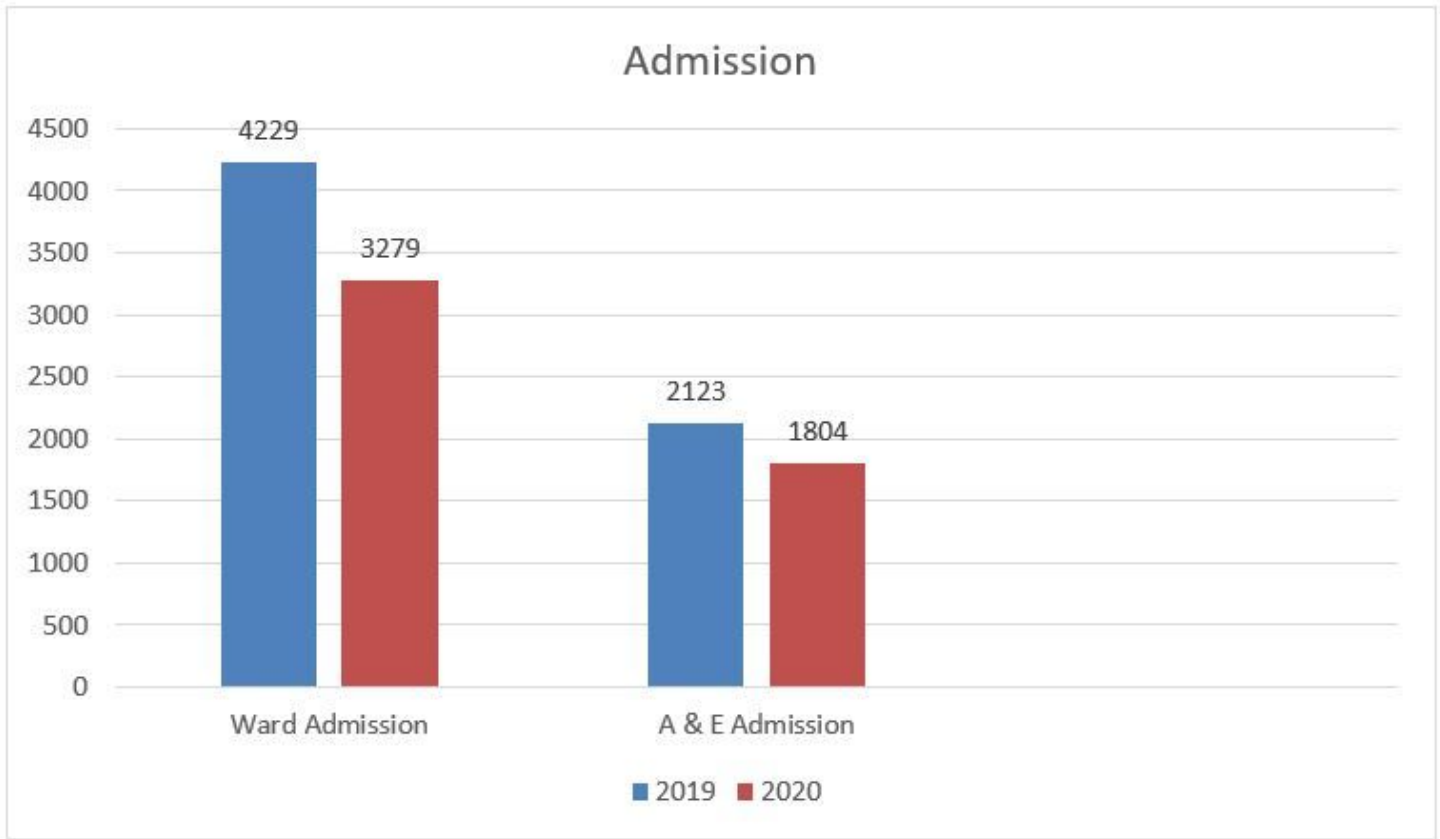


Figure 2

Bar chart showing the drop in admission at both the ward and Accident & Emergency, the chart depicts a 22% and 15% decline respectively.