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Corona Virus Containment and Emerging Challenges in Nigeria

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ABSTRACT

Making a debut in Wuhan China in December 2019, the new Corona Virus, now called COVID-19, rapidly transformed into a pandemic afflicting all continents and corners of the world by January 2020. The response in Nigeria has copied the blueprint of the West, namely: - lockdown, social (really, physical) distancing, regular hand washing, stay at home, and various levels of lockdown. Nigeria's response has so far made little impact in stemming the levels of infection. Within the month of May, the figure went up six-fold, and continues to rise. Recent high fatalities in some locations suggest that COVID-19-related deaths are being labelled as "mysterious deaths". The criteria for tests in the country are limited only to those with symptoms or under quarantine; and only about 60,000 have been tested by end of May. The national response has generated controversies, including militarization of enforcement, poor services in some isolation centres and continued lockdown with little palliatives. It is concluded that besides making little impact on the spread, the current strategy has imposed more burden on the people and is exacerbating existing privations.

Keywords

COVID-19, Nigeria, response and challenges, coronavirus, Africa.

Corona virus is sweeping over mankind, it is global pandemic we can never take for granted, everyone must be alert—Bobi Wine, Ugandan musician and member of parliament

Introduction

A new type of Corona virus, now referred to as COVID-19, was first identified in Wuhan China in December 2019; it rapidly transformed into a pandemic in March 2020 afflicting all continents and corners of the world [1,2]. However, there are also reports that coronavirus was already spreading in France by December 2019 [3]. By the end of May, the total number of infected was six million and over 370,000 lives have been lost. The pandemic is emerging as a global catastrophe which is turning the world upside down and inside out in terms of socio-economic existence. The first identified case in Nigeria was on 27th February, since then the infection has risen steadily; the total number of confirmed infections by end of May was 10,162, and over 287 have died.

Though Nigeria's Centre of Disease Control reported in April 2020 that it had 12 testing facilities with a capacity of 1,500 per day in Lagos and 1000 per day in other facilities; giving a testing capacity of 2,500 per day. The centres have consistently tested under its capacity [4]. The prevalence of infection is determined through tests, and by end of May, only about 60,000 have been tested in a country of 200 million. In addition, mass death events with symptoms attributable to the virus have been reported in Kano, Jigawa, Bauchi and Rivers states with no autopsies performed in most cases due to religious and cultural reasons, and these deaths have not been considered in the officially reported figures

[5-7]. In this way, the confirmed figures of infections and deaths may be only a fraction of the actual burden of the disease which remains unknown [8]. The numbers of infected in Nigeria with the new pandemic are developing; they are collated by various states through the Ministries of Health and Nigerian Centre for Disease Control, NCDC and announced in a daily briefing by the Presidential Task Force, PTF which coordinates the response. The tests are administered to people showing symptoms, those who have been in contract with positive test cases and/or who have been quarantined. Nigeria is yet to carry out mass tests, or even tests on demand.

The data for this essay are based on desk review from NCDC, the Presidential Task Force on COVID-19, and State and Federal Ministries of Health for the months of March to the end of May. The authors also engaged in direct monitoring of the pandemic with particular attention to statements made in daily briefings; number of tests and infections; announcements about lockdown and restrictions; the nature of enforcement and challenges attendant on the response.

The essay focuses on the spread of COVID-19 and the nature of the national response and the challenges emerging therefrom. These challenges include the militarization of enforcement; mass movement during restrictions, including of the *almajerai* (itinerant qur'anic youths who beg on the streets for food but return to their teachers for the night) and the internal displacement; and the controversy over importation of Chinese doctors purportedly to assist with the pandemic. There is also the issue of hospitals turning away non-COVID-19 patients. It is concluded that besides making little impact on the spread, the current strategy has imposed more burden on the people and is exacerbating existing privations.

The Pandemic in Nigeria

Through routine airport monitoring, health officials recorded an Italian arriving in Nigeria on February 27, 2020 as the first case of COVID-19. He was immediately quarantined in a treatment centre and has since been discharged. As shown in the tables below, the pandemic has risen, first slowly and now rapidly. Up till April 27, when the President made a third national speech on the pandemic, the total known number of recorded infections was 1270. Within a month, the number had risen over six-fold to 8068, on May 26 (Tables 1; Figure 1).

Week	Total cases
week 1 (ending March 1)	1
week 2 (ending March 8)	1
week 3 (ending March 15)	2
week 4 (ending March 22)	30
week 5 (ending March 29)	111
week 6 (ending April 5)	232
week 7 (ending April 12)	323
week 8 (ending April 19)	627
week 9 (ending April 26)	1271
week 10 (ending May 3)	2556
week 11 (ending May 10)	4398
week 12 (ending May 17)	5959
week 13 (ending May 24)	7839
week 14 (ending May 31)	10162

Table 1: Weekly Confirmed Cases March-May, 2020.
Source: Nigeria Centre for Disease Control (https://covid19.ncdc.gov.ng/).

This phenomenal rise was through community transmission. An examination of the table shows that Lagos, the economic centre, has the highest prevalence with 4,963 people infected; followed by Kano, the most populous state in Nigeria according to the last census, and ancient centre of commerce with 954. Both are locations where huge numbers converge, Lagos is the economic hub where thousands flock in search of jobs and to engage in 'daily hustle' to make ends meet.

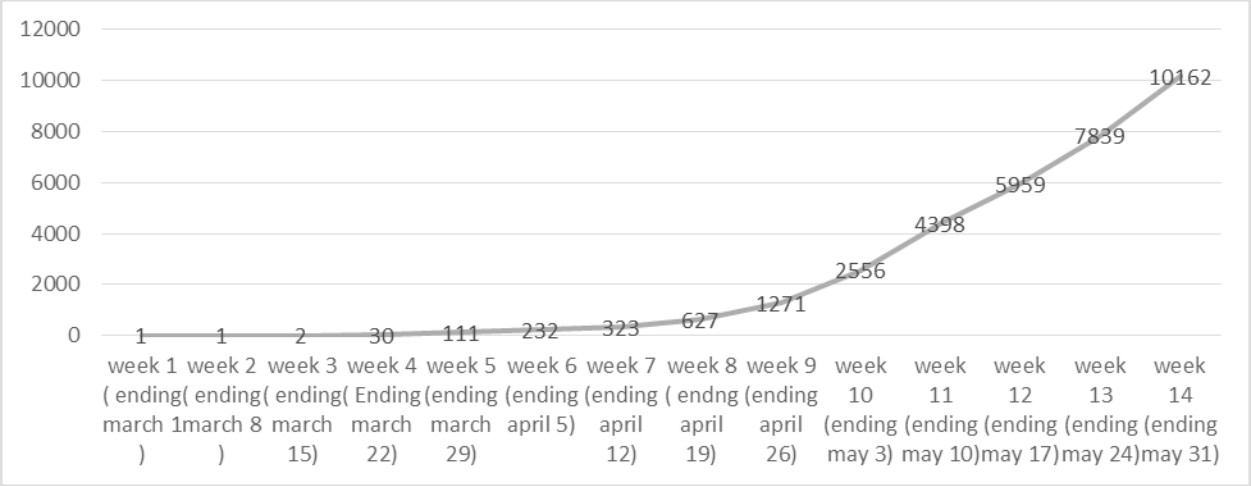

Figure 1: Number of Confirmed Cases, March- May, 2020
Source: Nigeria Centre for Disease Control (https://covid19.ncdc.gov.ng/).

State	Cases	Discharged	Deaths	Recovery rate %	Death rate %
Lagos	4943	825	54	16.69026907	1.09245398
kano	954	240	45	25.1572327	4.71698113
Abuja	660	182	19	27.57575758	2.87878788
Katsina	364	68	14	18.68131868	3.84615385
Oyo	292	97	6	33.21917808	2.05479452
Edo	284	69	13	24.29577465	4.57746479
Ogun	278	149	9	53.5971223	3.23741007
Borno	271	167	26	61.62361624	9.59409594
Jigawa	270	135	5	50	1.85185185
Kaduna	258	157	8	60.85271318	3.10077519

Table 2: States with the highest number of confirmed cases.
Source: Nigeria Centre for Disease Control (https://covid19.ncdc.gov.ng/)

The enormous difference in the numbers of those infected may be because Lagos is the only city testing close to capacity with decentralised testing, 26 sample collection centres in 20 local government areas and four (4) testing centres [9].

In addition, Lagos state recently increased its testing capacity to 2,000 tests per day. The third highest number of infections reported is in the Federal Capital Territory in Abuja with 660. Other locations of high prevalence are Katsina, Edo, Ogun, Borno, and Jigawa States in that order. The states with the highest prevalence are in all geopolitical zones except the South-east. This may be because there is only one testing centre in the entire zone by April 15 [8].

Nature of the Spread

The first cases were all people who recently travelled to locations which had the pandemic. As the President explained, infections in Lagos and the FCT were among "individuals with recent international travel history and/or those who came into contact with returnees from international trips" [10]. Following the closure of borders and 14-day mandatory quarantine of all arrivals, international sources of the infection have reduced. There is now community transmission from people who initially had contacts with returning travellers or even with infected fellow community members. This phase of the pandemic is challenging because of how many urban dwellers earn livelihood in crowded locations and markets. Many also live in crowded housing schemes such that the recommended physical distancing is virtually impossible.

This pattern of COVID-19 spread is similar to the experience with Spanish virus in Nigeria in 1918/1919 period. As Ohadike showed, the initial infection had foreign origins from ships which berthed in Lagos from Europe through Accra from where goods were offloaded and distributed to the hinterland. Many people in Lagos and along the western railway line which runs to northern Nigeria were the first to contract the virus. The pandemic penetrated further inland as far north as Kano, which itself became a "distribution centre" as goods were traded and transported to other places in the north.

An additional issue is that the figures provided only show total prevalence, without disaggregating this by rural and urban centres. Even as up to 65 percent of the population live in rural areas, test centres are only in urban areas. By April 15, there were 12 testing centres whose total capacity was 2,500 tests [10]; the number nudged up to 15 centres and by the last week of May, to 26 accredited and activated COVID-19 testing centres [4]. With a few testing centres and small numbers tested, the known figures of the infected could only be a tip of the proverbial iceberg.

Integrity of the numbers infected are further compromised by official denials by some state governments. Up to the last week in May, Kogi and Cross River state Governors deny that there are any infected people in their states; a situation unlikely to be true because of travel and contacts with neighbouring and other states. Governors of these states, along with others who point to mysterious diseases as cause of spike in deaths have been appropriately described as executive denialists [11]. In most of April, undertakers in cemeteries in Kano drew attention to an unusual number of corpses brought for burial. The causes of death were unknown, according to the state government, Islam has no provision for autopsies and health authorities had to rely on ''verbal autopsies'' provided by surviving relatives to determine the causes of death with no scientific evidence. The state government attributed the spike to "mysterious causes" and later to complications of malaria and meningitis, both of which are familiar experiences in the state [12]. However, since they conducted no actual autopsies, the situation shows the state government might be in denial; how else were malaria and meningitis identified as causes of death? To understand the situation, the federal government sent a special team from the NCDC. Their investigations showed that the deaths were COVID-19 related, but they provided no definite figures. The situation compelled the Federal government to impose special lockdown of 14 -days on the state; this was renewed for further 14 days.

The situation in Bauchi and Jigawa are similar. Undertakers reported unusual numbers of corpses for burial. As in Kano, the state first ascribed the deaths in Bauchi to "mysterious" causes. In Bauchi state the serving Governor was the first to be diagnosed with COVID-19, which he contracted from recent overseas travel. He went into isolation/treatment and recovered within a fortnight. The mysterious deaths in the state began after his recovery—possibly enough incubation time for those who may have been in contact with him or his travel companions. In Kano, Bauchi and other states with similar spikes, there is some obvious denial by blaming the deaths on mysterious causes [12]. In the last week in May, there were also 'mystery' deaths in Bonny local government of Rivers State. Relatives said the dead complained of loss of sense of smell, taste and shortness of breath, all symptoms of COVID-19, before they died [6,13]. As their deaths were labelled mysterious, they would not be recorded in COVID-19 fatalities.

The figures now show that from the first week in May, numbers have increased by an average of 200 daily. This increase is probably because many more people are presenting with the symptoms in treatment centres and there has been an ongoing increase in the

number of testing centres. Furthermore, based on the known total, the pandemic continues to spread, despite the national response (discussed below). The challenge of finding the true situation remains, there is no active case finding and tests, as discussed, are limited to a few locations.

National Response

Nigeria's response to the pandemic is coordinated at the national and state levels. Some of the measures intersect while others are unique to the states. At the national level, the response is coordinated by the NCDC and Presidential Task Force, PTF. There is also a Nigerian Private Sector Coalition Against COVID-19 [14]. These agencies work together, States supply figures to NCDC, while the PTF provides daily briefings of the situation. The summary of the briefing is condensed in periodic broadcasts by the President and there have been three broadcasts [10]. These broadcasts review efforts made and indicate priorities ahead and therefore make up major policy directions about the pandemic. There are regular updates by NCDC and the PTF, and states also update their situations.

By March 29, when Nigeria's President made the first broadcast, there were already complaints that this was late, one full month after the first case. According to the President, Nigeria has adopted "strategies used globally" but "implementation programs have been tailored to reflect our local realities". These strategies focus on containment, treatment and prevention. Many isolation/treatment centres were setup in hospitals which serve the purposes of quarantine for suspected cases as well as treatment for the confirmed. The prevention includes the standard WHO strategy, which in the President's word "tailored" to include:

- Regular hand washing, with soap and the use of sanitisers
- Keeping distance
- Use of masks, now compulsory
- Avoiding crowds, religious services are prohibited or limited to 50 people
- Suspension of funerals or limited to family members
- Ban on inter-state travel
- Dusk to dawn curfew on the country
- Marriages too are suspended or limited to family members
- Suspension of all schools [10]

The President imposed a lockdown on Abuja, Lagos and neighbouring Ogun State for an initial 14 days; this was extended twice by the same duration. The president described the lockdown as a containment measure "to identify, trace and isolate all individuals that have come in contact with confirmed cases". There is also a ban on inter-state movement, although trucks ferrying food stuff and petroleum products were exempt. Public isolation and treatment centres attend to all cases of COVID-19 and private medical facilities need special clearance to treat COVID-19 patients.

Part of the containment and prevention strategy includes the suspension of all passenger and private flights, suspension of work; however, some industries such oil, power generation and food processing are exempt. Health workers and journalists are also exempt from restrictions on movement. The President promised to provide relief materials to those whose livelihoods would be adversely affected; the palliative would include the continuation of school feeding programme even as schools are closed. He also announced that the internally displaced would receive two-month rations (at once). For the President, the objective is, besides 'flattening the curve', "to protect the lives of our fellow Nigerians and residents living here and preserve the livelihoods of workers and business owners to ensure their families get through this very difficult time in dignity and with hope and peace of mind".

States took their cues from the national programme and implemented their own measures, which the President warned must be consistent with federal policy [10]. Some, like Kaduna and Plateau states, had total lockdown in place for April and May; many of the states had no lockdown or only in the state capitals. Other states like Benue only implemented the ban on interstate movement and the curfew. Many states limited the numbers of passengers for minibuses and rickshaws as ways of ensuring distancing.

Many of the public isolation centres were hurriedly created in existing teaching and other hospitals; others were set up in football fields and event centres. The facilities differ from the more endowed, complete with high calibre personnel and ventilators, to some with few health staff and sparse equipment in dormitory-like accommodation. Characteristically, the isolation/treatment centres in the urban centres are better furnished than those in the semi urban.

Concurrent with the pandemic, is the emergence of "infodemic" as various tales and falsehoods about the pandemic have become known. Besides touting cocktails of various herbs and spices as cures, frequently mentioned is the preparation from Madagascar; none of which has been tested or certified either internationally or by Nigeria National Agency for Food and Drug Administration, NAFDAC. Some pastors have also emerged who claim they can cure COVID-19. This position reached an ironic turn when one of them who had laid hands to cure COVID-19 patients was himself infected and died within a week [15]. Some Nigerians deny the existence of COVID-19 or insist that "the disease no de kill Africa man". In addition, crowds protesting against lockdown in Kano were shouting "ba corona"; simply, Corona virus doesn't exist. As the public enlightenment messages reach more people, the numbers doubting the existence still exists may have reduced.

Nigeria's control measures continue to be implemented with varying level of dedication. Lockdown and restrictions on inter-statement were poorly implemented. Food carrying trucks exempt in the restrictions frequently smuggle passengers and even motor bikes and escape by bribing their way through security checks [16]. In many locations, COVID-19 restrictions were mostly observed in the state capitals. In other urban centres, implementation was

cosmetic. One of authors of this essay, visited two markets which had been sealed off and the traders moved to the surrounding streets where they congregated with their customers. As we now turn, there are challenges in the implementation and how to harness emergency preparedness in the pandemic [17].

Emerging Challenges

The national response has been attended by several challenges and controversies. The emergent challenges include the militarization of enforcement of the lockdown and other restrictions; the quality and service in treatment and isolation centres; availability of personal protective equipment; issue of Chinese doctors and mass movements of qur'anic pupils.

Militarization of lockdown enforcement

The enforcement of the restrictions on movement and curfew is very much a military affair. All across Nigeria, there are joint teams of armed military and police enforcers. In many situations, these armed personnel become agitated and shoot motorists and other violators of curfew hours or lockdown. In the immediate period after imposing lockdown on March 28, the number of people killed by security forces exceeded the number of deaths from COVID-19; the tally is 18 for the former and 12 for the latter [18]. The deaths are besides widespread torture and brutalization, such as instant punishments in the form of frog jumps. There are also allegations of extortion of motorists who contravene interstate or curfew restrictions. Enforcement took an additional dimension in Rivers State where the Governor ordered the demolition (which he personally supervised with fully armed guards) of two hotels for allegedly violating lockdown regulations [19,20]. Across the country, states established mobile courts which try violators, convict and impose fines of various sums of money.

In mid-May, the Nigerian Medical Association in Lagos, as reaction to repeated harassments, instructed its members to begin 'sit-at-home strike' to avoid encountering the security forces on the way to and from work. The harassment was despite instructions about lockdown which stipulate that all essential services, including health workers and journalists, are exempt [10,21]. These experiences of brutalization by security personnel also occurred in some other African countries [22].

Social consequences of lockdown.

Nigeria uses lockdown as part of the standard COVID-19 containment strategy but fails to attend to the consequences. Nigeria is the poverty capital of the world [23,24], and lockdown only aggravates the situation, especially for those who live from hand-to-mouth. This is more so when there is little social protection or safety nets. Thus, people who rely on daily income from activities such as food vending and shoe cobbling are pressed for food. In addition, the preventive regimen enumerated above, which remains the best safeguard, is near impossible for them. The recommended actions of social (physical)distancing and regular hand-washing are impracticable for the poor, who literally rub shoulders in overcrowded markets and have no access to clean water. They are packed like sardines in minibuses as standard transportation; accommodation is no different with sometimes up to six in a room in the slums where most live.

Lockdown is being relaxed in Lagos, Ogun states and Abuja; in other locations such as Kaduna and Plateau, people have two days a week to enable them to get food and other needs. This relaxation is even as the rates are going up, by June, all restrictions except the curfew from 10pm to 4.00am, have been lifted. This raises questions about whether the government is taking an easy way out in responding to growing privations from the lockdown. In addition, lockdown was also eased in many states for celebration of end of Ramadan. Religion, a sensitive issue in Nigeria [25], is influencing the containment efforts. Easter passed under lockdown and restrictions on church service; however, at the end of Ramadan on the weekend of May 22, some states lifted the lockdown. Kano state even announced that *eid* (open air prayers which brings hundreds of worshippers together) would be allowed and thus placing more importance on religious observance than prevention efforts.

Poor state of some isolation centres

Many of the isolation and treatment centres are sparsely staffed and equipped. Many have few beds, possibly why bunk beds were provided in Jigawa State. Some have only medical assistants who visit rather than stay with the detainees. There is also a lack of basic equipment such as oxygen supply and ventilators. In the country, ventilators which are now used in managing the condition are scarce. Also scarce are Personal Protective Equipment, PPE, for the 'frontline staff'. Nigeria has recorded two protests within a fortnight by COVID-19 patients and those in quarantine against the squalid conditions. The two protests, in Gombe and Kano states, were in semi-urban locations. In the first, the detainees took to the major road and were joined by others not under quarantine [18,26].

As the COVID-19 pandemic unfolds, it is further unearthing the poorly equipped nature of Nigeria's medical facilities. The shortage of medical facilities is why many isolation centres were hurriedly setup in football fields and event centres. The chairman of the PTF confessed during inspection of facilities for the Corona virus when he said, "I can tell you for sure, I never knew that the entire healthcare infrastructure was in the state in which it is, until I was appointed to do this work" [Chair of the Presidential Taskforce on Corona Virus-Covid-19] [10,27]. One explanation for the continuing shortages is the neo-liberal economic policy and its trademark prescription for cuts on welfare, including health services [28,29]. Implemented as health sector reforms, the new orientation redefined health care away from a welfare item it has been since inception of Western medicine in the country [30], to a commodity with a price tag [31,32].

Some patients were poorly treated, such as the suspected COVID-19 patient who has become known as Benue state index case. The woman had presented at a private hospital for pains and her specimen was obtained for COVID-19 test. While she

awaited the result, the state Governor called a press conference to gleefully announce Benue's first case. Beside mentioning her by name, unlike other COVID-patients, the test result was not disclosed to her. By the next day, a team of armed police cordoned off the hospital and moved her to a quarantine centre and then on to Abuja. They held her for 58 days despite protests that she did not have the virus [33]. There were no explanations why she was "incarcerated" for so long as COVID-19 would ordinarily not even last that long.

Controversy over Chinese Doctors

Another emerging issue is the 15 Chinese doctors who came to Nigeria supposedly to assist with the pandemic. As the Health Minister explained, the purpose was "to share their experiences in fighting the COVID-19 pandemic" [34]. China, the origin of the pandemic seemed to have it under control and hence doctors from there could bring their experiences to bear. The Nigerian Medical Association and other groups opposed their arrival, but the government insisted there was something to gain. On arrival in Abuja, they were received with full protocol and, on insistence by civil society organizations, were quarantined for the usual 14 days. They emerged from quarantine, but rather than deployments to various centres, the Health Minister announced later that he did not know their whereabouts [35]. He also said he could not vouch that all 15 were doctors, and some were technicians. Many came to assist a Chinese construction company [36]. However, the Minister of the Interior explained that the government works with the China Civil Engineering Construction Corporation (CCECC); it is "doing some work for us in several places and in conjunction with some Nigerian companies agree to support us in the effort to respond to the Pandemic. At Idu in Abuja, they participated in retrofitting and equipping the isolation there" [37]. There is an obvious question of trust: were the Chinese "doctors" invited by government to lend a hand in COVID-19 or did they use the pandemic as cover to gain entry for work with CCECC? Some controversy was also raised over the duration of their visa [34]. In any case, if they came to assist with the pandemic, then because coronavirus patients are only managed in government health facilities and not by private practitioners without a special authorisation, they should be guests of the federal government and there would be no questions of their whereabouts.

Mass Movement of *Almajerai*

During the period, the northern governors decided to repatriate *almajirai*, who were in all northern states begging on the streets, to their states of origin. Empowered by the order, they were herded into trucks in a manner which compromised distancing. Because there was no testing prior to repatriation, this may have contributed to dissemination of the disease.

This also connoted the problem of State of origin in Nigeria, which refers to where one's parents originated and is huge political issue which entitles or denies many advantages [25]. In related situation, civil strife and Boko Haram war in the Northeast continue to trigger internal displacement. As villages are attacked, residents move to Internally Displaced People, IDP, camps where distancing is not observed.

Covid-19 phobia and hospital treatment for other conditions

Nigeria has always had some regular diseases among which are malaria and typhoid, with periodic outbreaks of meningitis and other epidemics. These ailments are treated in medical care facilities which have primary, secondary and tertiary levels [38]. Besides competing for personnel, equipment, and to some extent space, COVID-19 is beginning to adversely affect hospitals attendance. There are fears both from the side of the patients that they might catch the virus in hospitals, and from hospital personnel who fear that patients might bring the virus. There are reports by the PTF that the entire range of hospitals now turn patients away [39]. It has cautioned hospitals to desist from doing so and continue to receive non-COVID-19 patients. The fresh fears are leading to a decline in hospital attendance. The emerging situation is a further barrier to access to medical care which in ordinary times reaches only 54 percent of the population [40]. This is an emerging double whammy; the pandemic is both taking away valuable staff and now instilling fears into would-be patients and medical facilities to restrict access.

Conclusion

Fighting COVID-19 in Nigeria shows some containment efforts are being made, but emerging outcomes do not reflect the efforts. As shown, in the first six weeks increases in the number of infections were slow; thereafter the graph rose rapidly and remains high. Some of this is because heavy death toll which point to COVID-19 in some states are denied, or ascribed to malaria and meningitis or mysterious causes. Acceptance would show the magnitude of the problem and what help they need. There is also the lacklustre implementation of restrictions which in many cases are limited to urban centres. The response "used globally" which Nigeria claims to adopt has not exactly been tailored to suit local conditions. For the majority who live from hand-to-mouth, sustenance, provided more generously elsewhere, is not available in Nigeria.

The palliatives do not reach many of the vulnerable, and other measures like school feeding even raised controversies. The more disquieting are the killings and brutalization by security services which suggest that more appropriate enforcement mechanisms are not canvassed. Similarly, life in some treatment centres has led to two protests and this can only provide conditions for further spread. The containment efforts have provided little grounds for optimism; the strategy might be appropriate, but implementation has been less thorough. In the final analysis, the situation suggests that Nigeria is yet to have a firm handle on the pandemic. The experiences so far provide a learning curve, but only time will tell whether and what has been learnt by PTF, NCDC and States and the Nigerian people.

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