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The "New Normal": The Nigerian COVID-19 Response and What Our Post-Lockdown Society Should Look Like

The unprecedented global COVID-19 pandemic is changing the face of human society and its systems, from healthcare to education, consumption patterns, the world of work, value systems, political regimes and legal systems. The condition was first reported in Nigeria in February 2020, and within a few weeks of its onset, we had entered the community transmission phase. Today, there are more than 16,000 confirmed cases of COVID-19 across 35 States and the FCT, and over 400 deaths and counting. How Nigeria recovers from the effects of the infection will depend on the innovations we are willing to introduce and the reforms we are committed to implementing in the various sectors of our society.

Our considerations:

A. Assessing the initial national response and the transition to intelligent lockdowns

As the infection started to take its toll and the number of new cases and deaths increased globally and across the country, the Federal Government and several States implemented total lockdown policies in order to isolate people from the virus, as was the practice in most other countries at the beginning of the pandemic. This essentially entailed closing our national borders to international travellers, closing all government offices, schools, businesses, religious and worship centres and suspending large social gatherings. Only a few essential services were exempted. This was accompanied by testing of symptomatic patients; isolation and treatment of confirmed cases; tracing and

Facts about the new reality:

- COVID-19 is caused by an RNA virus called SAR-Cov-2, in the family of Corona viruses that were responsible for the SARS and MERS epidemics in 2003 and 2012 respectively;
- Not all infected people will exhibit symptoms; some infected people (asymptomatic) will go through the infection without ever exhibiting symptoms;
- Both symptomatic and asymptomatic people can shed the virus and transmit it, and that makes it particularly difficult to control in the absence of an effective vaccine;
- Even for symptomatic people, research shows that in almost 50% of all cases, the peak period of infectivity and viral shedding is 2-3 days before the onset of symptoms, when patients are largely undiagnosed;
- There is presently no proven cure or vaccine for the condition, and patients are treated symptomatically, with supportive therapies only;
- A myriad of drug therapies and combinations of therapies are being reported by various interest groups in different settings as possible preventive and treatment options for the condition. However, there are no completed randomised trials of sufficiently large samples that have upheld the efficacy or otherwise of any of these therapies to date;
- The WHO is presently supporting a multi-country SOLIDARITY trial of at least 4 therapy regimens in which Nigeria is participating, among over 100 other countries. Until there is sufficient evidence, WHO cautions against recommending or administering any of these unproven treatments to patients with COVID-19. Of course, self-medication must be discouraged because it can lead to serious harm;
- Infection rates are higher indoors than outdoors.

quarantining of suspected cases. There was also enhanced public education on the need for social distancing and the adoption of good hygiene practices by all citizens using a variety of traditional, electronic, print and social media channels.

The lockdown policy went on for weeks across the country, despite challenges and breaches and with several extensions of the initially announced duration. However, as the pain of a national lockdown grew intolerable, especially on the part of the least well-off, and coupled with rising insecurity of lives and property occasioned by the activities of miscreants who could not earn a daily living, a new consensus gradually emerged which held that managing, rather than defeating the disease would be a more realistic option. This heralded the era of intelligent/partial/eased lockdowns. In the first phase of the partial lockdown that lasted 4 weeks, several sectors of the economy were advised to reopen under strict guidelines (use of cloth face coverings in public, physical distancing, frequent hand washing/use of alcohol-based hand sanitisers, cough etiquette promotion, enforcement of overnight curfews and ban of interstate travel), with a view to holding all the gains of the periods of prolonged lockdowns. These included the banking sector, small and medium scale businesses, public transportation, some government offices and local/neighbourhood markets. Business hours were restricted, and overnight curfews were enforced between the hours of 8pm and 6am. However, schools at all levels, places of worship, night clubs, cinemas, party arenas and large markets remain closed.

Despite a daily announcement of new cases by NCDC and a rising death toll from COVID-19, in early June 2020, the Federal Government introduced the second phase of the national containment strategy. This would involve a cautious and progressive easing of the lockdown across the Federation over another 4 weeks, with a stronger focus on high-burdened local government areas within identified States. The goal of this phase was to gradually restore economic activities across the country to protect livelihoods, whilst balancing public health considerations. A nationwide set of minimum safety guidelines were provided for States to build upon to strengthen their local prevention strategies against community transmission.

In this second phase, several other public and private sector institutions are expected to have a re-opening plan that is safe and practicable, in full compliance with NCDC safety advisories and containment guidelines, with clearly spelt out codes of conduct and rules of engagement that will define the "New Normal" society. Some relief has been given or promised to labour and industry, domestic air transportation and the faith communities. However, there is still a nationwide travel ban across State borders except for the most essential services. Similarly, all categories of schools, cinemas, clubhouses, gyms and bars are to remain closed. The nationwide overnight curfew also remains in place, but the effective hours have been revised to between 10pm and 4am to allow for more daytime business hours, thus reducing overcrowding which the ill-advised shorter business days and the more stringent curfew caused.

B. Assessing possible exit strategies out of lockdowns

Epidemiological and evidence-based exit strategies out of lockdowns include the following:

i) Wait for herd immunity to take hold, whereby 60 -80 % of the population becomes infected, and so natural transmission of infection will cease. This is still far-fetched, as no country, not even the

worst hit on the globe, has achieved this yet;

ii) Wait for the R naught (R_0), i.e. the possible number of new infections from an infected patient, to fall to 1 or less than 1. This will not happen until the infection has peaked, the curve flattened and transmission risk tremendously reduced in the population through a combination of strategies. Nigeria is yet to achieve this milestone;

iii) Introduce massive antibody testing that can serve as *immune passports* for the re-entry of individuals into work and society. Antibody testing, although relatively inexpensive, compared with molecular PCR testing, is fraught with limitations as an exit strategy, because this testing modality is more accurate in locales where disease prevalence is above a certain threshold and could generate false negatives in locales where the disease prevalence is low. Furthermore, the degree of immunity conferred by antibody presence in COVID-19 is not yet understood. The WHO has therefore warned against using rapid antibody tests as *immunity passports* towards reopening the economy in order to avoid a *false sense of security*;

iv) Wait for a widely available vaccine. Despite optimistic projections to the contrary, the prospects for this could take up to 1 to 2 years. Lockdowns are simply not sustainable for the amount of time it will take to develop a vaccine; and

v) Follow the 5-component WHO exit lockdown guidelines:

    a. COVID-19 transmission must be under control;

    b. The capacity of the health system must be sufficiently built to detect, test, trace and isolate cases;

    c. Spread must be minimised in hot-spot areas;

    d. Preventive measures must be in place in schools, workplaces and other places of interest;

    e. The community must be sufficiently disciplined to comply with social distancing and personal hygiene guidelines.

The WHO-recommended intelligent lockdown appears to be the most plausible strategy towards our lockdown exit in Nigeria today.

C. Situational assessment and intelligent lockdown risk mitigation scenarios

An intelligent lockdown is appropriate for countries where the combined risk of spiralling economic decay and resultant social unrest supersede the intended benefits of a continuous lockdown. In order to strike a balance between lives and livelihoods, a policy of intelligent lockdown is already in place countrywide. But Nigeria has not met the 5 components of the WHO "exit lockdown guidelines" enumerated above (B v). Our epidemic is not under control as is, and is yet to peak. The capacity of our health system is not yet sufficiently strengthened to detect, test, trace and isolate all cases of COVID-19, nor are our stockpiles of PPE sufficient for the use of all frontline health workers.

There are also competing political pressures that mitigate the transparent reporting of COVID-19 infection rates. This under-reporting has been observed in Asia, Europe and the Americas and albeit less evident in Africa, is most certainly at play here. Therefore, we must accept that the infection rate is grossly underestimated in Africa in general, and in Nigeria in particular where a couple of states

have vehemently opposed testing and where the exact cause of death is hardly ever determined. As such, our risk mitigation approaches should be calibrated to this understanding, to avoid complacency, driven by a false sense of security, cognisant that the infection in Africa appears to have been moderated by a combination of epidemiological, ecological and demographic variables.

Community spread of a pandemic infection in an intelligent lockdown scenario is dependent on a number of risk mitigation correlates: the degree of a country's public health policy enactment; governance and performance accountability; the degree of collective discipline or indiscipline of a citizenry, community education of diligence around personal hygiene, effective social distancing and utilisation of PPE as deemed appropriate; the efficiency and agility of the prevailing in-country public health infrastructure to implement effective "identify, track, trace and respond processes"; and the access of most of the citizenry to healthcare facilities and resources.

Nigeria must be prepared for the infection to run its "natural history" of disease progression. While eased locked downs will reduce economic, social and political pressures in the absence of significant economic palliatives at scale, there will inevitably be collateral damage by way of increased infection among the general population, increased disability within some 20% of the infected population and death within, at current best-guess estimates, around 3 - 5% of the infected population. This wider community harm should be anticipated, accepted and considered as uncontrollable collateral damage under the prevailing local circumstances of an intelligent lockdown.

Our recommendations:
Key options should focus on messaging for prevention, risk mitigation and behaviour change; these must be our "vaccine" for now. This will entail:

- Government at all levels, civil society and all relevant partners/stakeholders investing heavily in **Behaviour Change Communication (BCC)** interventions to bring the public to a shared understanding of the risks and repercussions of COVID-19 infection. This will involve greater investments in time, money and professional expertise of behaviour change scientists to lead the campaign. Government must also lead by example; by practicing what they preach.

- Building a high level of trust among the people, and between the people and government institutions to aid adherence to official recommendations and guidelines for COVID-19 prevention. Trust is the currency of public health. We must motivate people to take personal responsibility for their health and wellbeing and dispel the myth of resilience against COVID-19 circulating in certain segments of the society.

- Educating and empowering the citizenry to strike a balance between remaining at home where possible and venturing out where necessary.

- A review of our national containment guidelines, particularly with regard to religious and large indoor social gatherings. It is our opinion that lifting the suspension on these (as recently announced by PTF) was premature; without the successful buy-in of the entire community for physical distancing, wearing of mouth and nose cloth coverings and general hygiene etiquette, there has already been a significant uptick in the daily number of recorded cases of infection.

- Establishing and maintaining nationwide community-led public health monitoring to support continued adherence to guidelines for social distancing and personal hygiene across sectors, even beyond the present outbreak and COVID-19 becomes yet another endemic communicable disease. We note there is an army of existing but under-utilised community health workers and local government workers across the country that can be gainfully deployed in this regard.

- Decentralising the national response in favour of streamlined partnerships between the State governments, private health sector, national and international NGOs and development partners in various components of the response. (To include partnering for testing, contact tracing, isolation, treatment, surveillance, training of health staff, and community mobilisation and empowerment.)

- Ramping up testing and contact tracing which are essentially the main technical tools left available to us as we have neither treatment nor vaccine for now. We must improve on our testing numbers and our result turnaround time in all 36 States of the Federation and so Cross River and Kogi States must take steps to catch up with the rest of the Country.

- Establishing testing and contact-tracing protocols, leveraging all the support of local and international partners that we can.

Conclusion

The present system of centralised response led by the NCDC only is often attended by late response to calls/citizen requests and a lot of dissatisfaction and citizen distrust of the system. The NCDC will be overwhelmed as the number of confirmed cases rises daily. The few dedicated NCDC and/or Government isolation facilities are also getting filled. There is equally a concentration of untapped expertise and human capital across the various teaching and specialist hospitals and private hospitals in the country that is largely uninvolved in the current national response because their health facilities have no specified roles—even when routine services are put on hold in many of them—due to the lack of adequate supplies of PPE and standard precaution facilities. There is a generalised concern that patients who need these routine services might be experiencing more complications at home, and mortality figures from their non-Covid health conditions might surpass those from COVID-19 at the end of the pandemic, if nothing is urgently done about this.

The Federal Government should therefore be more preoccupied with funding and standards setting, training and supplies and demonstrating best practices, and enacting appropriate new protocols for different sectors, whilst leaving much of the day-to-day implementation in the hands of the other relevant stakeholders who have traditionally played such roles effectively for other pandemics, notably HIV and AIDS. This will shorten response time, improve accountability and help to build trust in the national response.

It is the considered opinion of the Anap Foundation COVID-19 Think Tank that establishing a COVID-ready state in Nigeria requires:

1) the full and willing participation of the people;

2) a high level of organisation within communities;

3) strong and decentralised public health services which include an efficient testing, tracing and isolation capacity;

4) continuing to limit large religious, sporting and social gatherings of all kinds – especially indoor gatherings;

5) **Behaviour Change Communication (BCC)** strategies customised to local languages and cultures;

6) implementation of new and safer protocols across most economic activities instead of simply attempting to shut them down for several months, as PTF and some State Governors currently advise, because the latter is unsustainable and directly threatens livelihoods, thereby also indirectly threatening life; and

7) COVID-ready hospitals, health care facilities and isolation centres in all 36 States of the Federation.

The survival of many of us will depend on both our individual conduct and that of the collective.

KEY TO ABBREVIATIONS

1) AIDS – Acquired Immune Deficiency Syndrome.

2) FCT – Federal Capital Territory

3) HIV – Human Immunodeficiency Virus

4) MERS – Middle East Respiratory Syndrome

5) NCDC – Nigeria Centre for Disease Control

6) NGO – Non-Governmental Organization

7) PCR – Polymerase Chain Reaction

8) PPE – Personal Protective Equipment

9) PTF – Presidential Task Force on COVID-19

10) RNA – Ribonucleic Acid

11) SARS – Severe Acute Respiratory Syndrome.

12) WHO – World Health Organization

A Publication of the Anap Foundation COVID-19 Think Tank.

The Anap Foundation COVID-19 Think Tank was established on 22 March, 2020, to help Nigeria respond to the Coronavirus Disease 2019 ("COVID-19") pandemic. The Think Tank is comprised of 18 members drawn from across the 6 geopolitical zones and the diaspora (USA & Germany). Collectively, the Think Tank comprised of volunteers, has decades of expertise in medicine, logistics, e-commerce, economics, finance, law, communications, religious knowledge, academia, mobilization, advocacy, sustainability, governance, grant making, accountancy, actuarial science, health management and international disaster management.

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For more information on the Anap Foundation COVID-19 Think Tank, please visit www.anapfoundation.com