

THE COVID-19 ERA: THE VIEW FROM NIGERIA

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Abstract

If we were told that one day the entire world would take its guidance for managing a health crisis from empirical thought, nobody would have believed it. However, with the December 2019 arrival of COVID-19 in China, the world subsequently went into a frenzied state that resulted in widespread adoption of untested strategies or potential cures; circumstantial evidence provided without randomized control trials (RCTs) was published rapidly and widely considered the gold standard in medical research and therapeutics. Nigeria and much of the rest of the world blindly adopted treatments like chloroquine or hydroxychloroquine and various prevention strategies, often without monitoring the efficacy of these treatment and social control strategies. COVID-19 provided Nigeria a critical opportunity to create or strengthen its national laboratory system by building up its Level 3 laboratories in all parts of the country with the capability to perform PCR tests and viral isolation. There was also an opportunity to establish hospitals in every region of a sufficient standard to reduce the numbers of Nigerians travelling abroad to seek medical treatment; to invest in building capacity to develop antiviral medications and vaccines in Nigeria, and to ensure better international health policies. Rather, Nigerian leaders, government, and health managers decided (like most other nations of the world) to shut down society using isolationist policies that were not necessarily tailored to local needs. Despite adopting these methods, COVID-19 cases continued to skyrocket in Nigeria. In the future, before adopting such broad sweeping policies, there should be local tailoring to assess their effectiveness in different communities. Given that the country has much experience in controlling Lassa and Marburg Fever outbreaks, Nigeria should lead by developing new strategies, new protocols, and new local guidelines, based on validated and reproducible studies to ensure that the public health authorities are not caught unaware by any new outbreaks of emerging or reemerging diseases.

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When the world proclaimed social distancing, consistent use of face masks, and hand washing as the way out of the COVID-19 crisis, nations adopted the policies without question.¹⁻⁵ There was not a single case review, cross-sectional, case control, or cohort study to test the efficacy of any of these purported solutions in Nigeria or elsewhere in Africa. The entire world copied, adopted, legislated and implemented. Randomized control trials (RCTs) were never mentioned in COVID-19 policy and practice implementation, even though RCTs have long been the gold standard in medical research and therapeutics. What made the situation worse was the complete absence of monitoring of the efficacy of social control strategies across many of the world's nations.

When chloroquine and hydroxychloroquine were mentioned as having the capacity to improve the quality of care, reduce the length of hospital stays and mortality rate, people in many countries adopted chloroquine for both treatment and as a prophylactic.⁶⁻⁹ Before long, all chloroquine and hydroxychloroquine tablets on hospital and pharmacy shelves were exhausted in Nigeria, and chloroquine became an essential drug sold at exorbitantly high prices.

When reports started coming out that chloroquine and hydroxychloroquine were not efficacious in treating COVID-19 as people had hoped, it became difficult to re-educate people, have them stop misusing the medications, and get them to accept the new situation. Several conspiracy theories arose around hydroxychloroquine and its use, and even the US president was said to have placed himself on hydroxychloroquine.

When local healers claimed to have cures or treatment for the virus in Nigeria, their claims were discounted, and their solutions never put to the test as they were not taken seriously and seen as mere African solutions. Thus, rather than capitalizing on the opportunity to investigate local herbal remedies with purported antiviral effects (given that most Western drugs are plant based), research pharmacists in African research institutions followed US and European guidelines instead.

When reports began to emerge from UNICEF and other humanitarian organizations that more people in Nigeria were dying from hunger and starvation, homebound diseases, gender-based violence, and intimate gender violence from the isolationist policies, they were completely ignored.¹⁰⁻¹² When it was reported that people who stayed at home were no longer comfortable staying in the same location, this was dismissed until the COVID-19 became widespread in the community and among the self-isolated groups.

When it was learnt that a COVID-19 vaccine study was being conducted to prevent viral infection, people readily volunteered in Nigeria, although some volunteers died in the study.¹³⁻¹⁴ This sparked panic and the Federal Government shut down schools, churches and prayer houses, markets, and companies, and commanded everyone to continue to stay at home. When reports emerged that people who judiciously abided by social distancing recommendations, wore masks consistently, and washed their hands regularly accounted for a large proportion of new cases, people cried foul. No study was done to verify this claim or to change the current policies guiding the COVID-19 epidemic control in Nigeria.

While people were locked down at home, COVID-19 cases skyrocketed across Nigeria. The Federal Government stayed busy counting the number of people tracked, isolated, tested, and confirmed to have COVID-19 and those who died from it, but little was done to educate and provide effective social isolation policies.¹⁵⁻¹⁶ The medical authorities watched as the disease moved in Nigeria from single digit infections to over 15,000 cases.

While the population was on lockdown, the Federal Government and health service managers set up isolation centers, where COVID-19 infected patients were effectively left without care or support of any kind and refused any form of social services, unlike the previous much-praised management of Lassa and Marburg Fevers in the country. These treatment centers housed COVID-19 patients who were asked to wait out the infection without any psychosocial support, therapeutics, or other services. The powerful elite who were affected could stay in their homes, but the poor were hauled into centers as if they had committed a crime by testing positive for COVID-19, thus stigmatizing the infected and leading to symptom denial. While some contacts of travellers were traced

and isolated, their test results were never given to them by the regulatory bodies, even after several samples were taken for testing.

The USA was at variance with WHO guidelines and withdrew from the organization. Meanwhile, Madagascar became the first country to claim a cure for the virus. Yet, many African leaders refused to think, plan, and develop systems that would make a difference in the continent.

The COVID-19 era has been a global period of suspended mental thought across the nations of the world. However, many people who were infected and died in Nigeria were children, despite the fact that schools were all closed down. While schools, research centers, and churches were closed, markets and banks kept open to transact business. Yet, the COVID-19 cases continued to rise.

COVID-19 saw governments across the world panic and in Nigeria there was huge Governmental anxiety with an undefined vision, despite good success in previous viral haemorrhagic fever management. While banks, companies, and individuals donated billions of naira to the Federal Government of Nigeria to help fund the control program, they withheld salaries, reduced salaries, or even sacked their employees.

The question of whether evidence-based policies can be used once more, rather than empirical thought needs to be asked. The Nigerian Center for Disease Control (NCDC) does publish basic detailed statistics on those who were infected in order to review what has been done, to monitor and evaluate previous strategies, and if possible, to conduct planned studies to evaluate the output, outcome, and benefits of various governmental strategies.

Given that Nigeria is a country used to looking after epidemics, such as Lassa and Ebola, next time, we should evaluate before rushing into new strategies which may not be socially enforceable. Before broad sweeping policies are adopted, we should assess their effectiveness. Finally, before we close down public and private organisations, we should look at the cost effectiveness and benefits. Moreover, before the next epidemic, we should develop new strategies, new protocols, and new guidelines, based on validated and reproducible studies to ensure that we are not caught unaware.

Acknowledgements: SDTR is supported by the Wellcome Trust Institutional Strategic Support Fund at Imperial College London.

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