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Module: **GLOBAL HEALTH SECURITY**
Theme: **PIRACY IN THE GULF OF GUINEA: ISSUES AND CHALLENGES FOR INTERNATIONAL TRADE, NATIONAL SECURITY AND SUSTAINABLE DEVELOPMENT OF MEMBER STATES**
Topic: **THE CORONAVIRUS PANDEMIC: HOW PREPARED WAS NIGERIA?**

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LECTURE

Participants: Military, Para-Military, Law Enforcement, Security and Intelligence, other federal government agencies strategic to the security infrastructure of the nation

PROTOCOL

I am delighted to have been invited here to the National Institute of Security Studies (NISS) to deliver this lecture, as part of the Global Health Security Module, on the topic: The Coronavirus Pandemic: How Prepared was Nigeria?

2. The answer to the rhetorical question "**how prepared was Nigeria?**" is simple; although Nigeria has a well written influence pandemic response plan, as will be discussed later, we were not prepared for the COVID-19 pandemic. However, no other country in the world was prepared for it, as global events have shown.

3. A Global Health Security Index study of October 2019 found that "National health security is fundamentally weak around the world. No nation is fully prepared to handle an epidemic or pandemic". The next question is of course: "**why were we not prepared?**" I will discuss why Nigeria was not, and indeed no country, was prepared for this COVID-19 pandemic. I shall speak about the course the pandemic took in Nigeria, what we have been doing and what we have planned, and I will conclude by asking and answering: "**how prepared *is* Nigeria?**"

4. First, I will briefly give some definitions to ensure understanding of terms that may come up in this lecture, which you have probably heard in discussions about COVID-19.

i. **Virus:** is a disease agent that enters and multiply only within living cells of a host. "Going viral" is a slang used to denote the fast spread of news, like of an infectious virus.

ii. **Novel:** means new or unusual.

iii. **The Coronavirus:** is a large family of viruses, some of which cause illness in humans, while others are only infectious to animals.

iv. **An Epidemic:** is a widespread occurrence of an infectious disease in a community at a particular time.

v. **A Pandemic:** is an epidemic, an infectious disease that has gone on such a scale that it has crossed international boundaries to other countries, usually affecting people on a large scale. it must result from spread and must also be infectious.

vi. **An Endemic:** disease is one regularly found among particular people or in a certain area.

vii. **Zoonosis:** is an infectious disease caused by a pathogen that normally resides only within an animal species but is transmitted to humans through the air like influenza, or by animal bites and saliva like in rabies, or from consumption of infected animals or products. Usually, the first infected human transmits the infection to at least one other human, and the spread starts from there.

Next question:

WHERE DID THIS NOVEL CORONAVIRUS COME FROM?

5. The reason these new virus transmissions cause pandemics is that, having never before been infected by these pathogens, human beings have no immunity to them and thus everybody can contract the infection and spread the virus.

6. Some zoonoses you have likely heard of are Ebola Virus Disease (EVD), Human Immunodeficiency Virus (HIV), bird flu and swine flu which have been known to cause pandemics such as the 1918 Spanish Flu and the 2009 Swine Flu.

7. Coronaviruses are the cause of common cold, and are implicated in serious diseases like asthma, pneumonia, and enteritis. In 2003 and 2011 respectively, 2 (two) coronaviruses, SARS-CoV and MERS-CoV of the same coronavirus family and also previously unknown in humans, caused epidemics. SARS-CoV-2 (2019) is the Novel Coronavirus responsible for this pandemic, suspected to have first infected humans in a live animal market in Wuhan, China.

WHEN DID THIS PANDEMIC START?

8. COVID-19 first broke out in China, in December 2019. It is reported that a young doctor who first drew public attention to its danger was prosecuted for spreading false alarm. He was vindicated when authorities finally comprehended the virulence of COVID-19 and reported the outbreak to the World Health Organization (WHO) at the end of 2019.

9. Wuhan, China thus became the crucible for the incubation of this coronavirus pandemic. On further study, WHO declared it a Public Health Emergency of International Concern (PHEIC)on 30th January, by which time the health authorities of most countries began to draw on their pandemic preparedness plans for guidance. On 11th February, the Novel Coronavirus disease was named COVID-19 by the World Health Organization (WHO) and on 11th March, COVID-19 was declared a pandemic.

WHO IS RESPONSIBLE FOR PANDEMIC PREPAREDNESS?

10. The government of each country is accountable for the security of its citizenry. Indeed, all of you seated here are involved with national security infrastructure. The responsibility for health security in Nigeria, articulated in the Nigeria National Pandemic Preparedness and Response Plan, is domiciled in, and led by the Federal Ministry of Health (Health) and the National Emergency Management Agency (NEMA), and defines the roles and responsibilities of various government entities, including the armed forces.

11. Now, the next cogent question: "**why was Nigeria not prepared?**" Simply put: no one knew what to expect, despite the generic pandemic response plan, which is based on what was known of past virus epidemics. But as a virus previously not infectious to humans, little was known about COVID-19.

12. The peculiarities of COVID-19 caught all countries off guard. The ease of infection and the quick and rapid spread across the globe, has brought about an unprecedented pandemic. The dimensions and severity of the outbreak have never before been recorded.

13. As we can see from the raging infection that started in China and Asia, spread to Europe and the Americas; even countries with advanced, formidable, and resilient health systems succumbed to the pressure of COVID-19. It looked as if the strength of a health system did

not matter, the sheer volume of cases that arise has seen the collapse of even the most sophisticated health systems. No health system could withstand the impact as evidenced by the horrendous numbers of fatalities even in resource endowed countries. Thus, the impact of COVID-19 appears to be a factor of much more than the strength of the health system alone, and we shall come back to that.

DID NIGERIA HAVE A PANDEMIC PREPAREDNESS PLAN?

14. Even before this pandemic, Nigeria had a well-articulated Nigeria National Pandemic Influenza Preparedness and Response Plan developed in 2013, the National Health Act 2014, the 2016 National Health Policy and the 2nd National Strategic Health Development Plan (NSHDP II) 2018–2022, in which pillar 4 deals with reducing the incidence and impact of public health emergencies.

15. These plans, however, are generic and are based on lessons learnt from past and recent experience with smallpox, tuberculosis (TB), HIV, Ebola, Lassa fever, yellow fever, and seasonal influenza. As seen from the start of this pandemic, the impact of the unknown COVID-19 virus clearly overwhelmed the scope of these non-specific plans and called for extensive modification and specification for the response to COVID-19; a new virus whose behaviour and virulence were not known. It appears therefore, that all health systems were threatened and scrambling to restructure and adapt, starting from a common ground zero.

HOW DID NIGERIA RESPOND TO THE OUTBREAK?

Risk Assessment:

16. A risk assessment by the Federal Ministry of Health (FMoH), easily suggested that Nigeria had to guard itself against importation of the virus from China, which was then the global hotspot.

17. The common concern at the time, was about personnel of Chinese companies in Nigeria who were due to return from the Chinese New Year celebration which had just ended in China. Fortunately, the government of China extended the celebration and so delayed the return of these personnel from China. There was also concern about Nigerians resident in China, who might have embarked on homeward journey and possibly bring the virus to our country. In respect of this, the Federal Ministry of Health was in constant contact with the Nigerian Embassy in Beijing, which was monitoring the Nigerian community in China and giving advice on needs and issues around repatriation, as other developed countries had begun to do.

18. The Chinese Embassy in Abuja assured the Federal Ministry of Health that Nigerian citizens in Wuhan and across China, were being well taken care of and they also offered Nigeria technical and material support on COVID-19 response. The embassy reported that the government of China was particularly appreciative of the message of support and solidarity from His Excellency President Muhammadu Buhari.

Points of Entry:

19. Murtala Muhammed International Airport, Lagos was identified as the most probable point of entry of the virus, followed by Nnamdi Azikiwe International Airport, Abuja. The public health authorities and FMoH surveillance personnel at these airports were put on highest alert, while land and sea points of entry were kept in view.

20. The Port Health Services of the FMoH was one of the first, globally, to implement temperature screening of passengers at international airports, and develop a compulsory health and travel history questionnaire for all arriving passengers.

Multi-Sectoral Collaboration:

21. A further response initiative was to set up a collaborative framework with immigration and customs officials, federal airport authorities and civil aviation departments, and to provide personal protective equipment (PPE) such as masks and gloves, to these frontline workers who were our designated first line of defence.

22. To secure this multisectoral collaboration, the Federal Ministry of Health, supported by the World Health Organization (WHO) and the United States Agency for International Development (USAID), convened 2 (two) inter-ministerial, multisectoral meetings, which were broadcast live, that brought the Ministries of Interior; Information and Culture; Aviation; Agriculture; Humanitarian Affairs, Disaster Management and Social Services; Environment and their agencies, together with the agencies of FMoH, to create a common front against COVID-19.

Nigeria Centre for Disease Control:

23. The second line of defence was the Nigeria Centre for Disease Control (NCDC), which had responsibility for identifying and testing for the virus, conducting surveillance, and providing risk communication. However, NCDC, at the onset, had no coronavirus test kits, although

the Nigerian health system had a network of polymerase chain reaction (PCR) machines, the specialised equipment required to test for COVID-19. Through the WHO, Nigeria reserved an option to send samples to South Africa for testing, however we were soon to get our own precious first few test kits, which were shared between Abuja and Lagos. WHO provided technical support for training laboratory technicians.

24. Nigeria started with 7 (seven) laboratories capable of confirming COVID-19 prior to the index case but has now expanded its capacity tremendously to 40 (forty) laboratories, which are better able to meet demand.

Information Management:

25. COVID-19 had, by now, become a subject of extremely high public interest and conversation, especially in the social media, where distortions, misinformation and disinformation had become rampant. The Federal Ministry of Health, at this point, began a series of press briefings to provide correct advisories and allay fears. On the advice of the then Chief of Staff, those briefings were scaled to daily interactive sessions with the media.

Tracing and Testing Strategy:

26. The first test of our response strategy came about in the middle of February when the Federal Ministry of Health received notice from the Nigerian Embassy in China, that a Nigerian student, against all advice, had left the COVID-19 epicentre of Wuhan, China, for Nigeria. The port health tracking system and state public health authorities were alerted, when it was revealed that the citizen was on a Kenya Airways flight with destination to Lagos. The passenger somehow slipped through the airport screening protocol but his identity and address in Lagos were quickly determined and the Lagos State health authorities set about tracing him. Thanks to the enormous experience of Lagos State in dealing with the Ebola crisis of 2014, the passenger was traced and tested, thankfully negative, and put on home quarantine. He remained symptom-free and was thus eliminated as an early source of COVID-19 importation.

Index Cases:

27. All these efforts geared towards forestalling virus importation were defeated when the first case of COVID-19 in Nigeria was confirmed in an Italian national, on 24th February, who arrived on a Turkish Airlines flight. The passenger, an engineer with an Ogun State-based

company, presented with symptoms of ill-health at a private hospital, from where, thanks to the high index of suspicion of the young attending physician, he was referred for testing in Lagos, found to be positive for COVID-19, and became Nigeria's index case on 27th February, 2020.

28. The experience of the Lagos State public health team, led to highly efficient contact tracing of the index case, and in which 179 contact persons were identified and placed in quarantine. Only 1 (one) turned out positive for COVID-19. Turkish Airlines was also alerted to do the needful with the flight crew. Public anxiety, by this time, increased with requests to prohibit flights from Asia to Nigeria, and airlines that flew these routes, as well as deny Asians entry to Nigeria.

29. Multiple travellers, mostly Nigerian nationals, returning from various parts of Europe and the Americas, were the sources of large numbers of new COVID-19 importations to the country which soon overwhelmed the tracking, testing, tracing capabilities of the health system.

Community Transmission:

30. Inevitably, the COVID-19 importation became a deluge which, with multiple contacts of each infected person, transformed into the present community transmission phase. The matter was not helped by the intense stigma that attended persons who tested positive, and secondly by the nonchalant attitude of majority of the population who did not appreciate the severity of COVID-19. The disease was seen either as a ruse of some sort or as an alien problem of those could afford international travel, which they contracted abroad and which the man on the street thought would not affect him.

Presidential Task Force on COVID-19:

31. With the declaration of COVID-19 as a pandemic on 11th March by the WHO, His Excellency, following global best practices, set up a whole-of-government response system that brought stakeholders together in the Presidential Task Force (PTF) on COVID-19 Response, chaired by the Secretary to the Government of the Federation (SGF) with the secretariat led by the National Coordinator. The PTF members are:

Mr. Boss Mustapha (SGF)	Chair
Dr. Sani Aliyu	National Coordinator
Myself, Dr. Osagie Ehanire	Hon. Minister of Health
Ogbeni Rauf Aregbesola	Hon. Minister of Interior
Sen. Sirika Hadi	Hon. Minister of Aviation

Hajia Sadiya Umar Farouq	Hon. Minister of Humanitarian Affairs, Disaster Management and Social Services
Malam Adamu Adamu	Hon. Minister of Education
Alh. Lai Mohammed	Hon. Minister of Information and Culture
Dr. Mohammad M. Abubakar	Hon. Minister of Environment
Alhaji Yusuf Magaji Bichi	Director-General, State Services
Dr. Chikwe Ihekweazu	Director-General, Nigeria Centre for Disease Control (NCDC)
Dr. Fiona Braka	WHO Acting Country Representative

Support for the COVID-19 Outbreak Response:

32. As the PTF developed its strategy and workplan, support poured in from various sources, most significantly, from the United Nations (UN) agencies in Nigeria, who mobilised an initial USD 2 million, to procure essential commodities for Nigeria and created a single basket funding mechanism to support the government. The donors to the basket fund include the European Union (EU), and the governments of the United States (US) and the United Kingdom (UK). The Nigerian private sector established a Coalition Against COVID-19 (CACOVID) that also set up mechanisms to support building isolation and treatment centres. COVID-19 support funding mechanisms from the Central Bank of Nigeria (CBN) and Nigeria National Petroleum Corporation (NNPC) have also been implemented.

33. Many other groups and organisations have supported the federal government resource mobilisation for COVID-19, including private foreign foundations like Jack Ma Foundation and bilaterally from the government of China and regional organs like the West African Health Organisation (WAHO) who provided large quantities of test kits, personal protective equipment (PPE), disposables, ventilators and technical support to the health workforce, largely via video conferencing. The United States (US) government donated ventilators, and several indigenous organisations and even trade unions supported the Federal Ministry of Health, in ways big and small. The WHO has constantly been at our side with technical support and guidance.

NATIONAL RESPONSE MEASURES:

34. Following global patterns, Nigeria imposed lockdowns and travel restrictions to limit the rate of spread of COVID-19 in an attempt to "flatten the curve" and avoid overwhelming the health system. These measures were effective in curtailing disease spread but were socially disruptive and had negative effects on the economy and on livelihoods with serious consequences for populations who subsist on

daily wages. Despite spirited palliatives, things were difficult for the poor and vulnerable. Government had to navigate a thin line between taking measures that would save lives and measures that would protect livelihoods, a dilemma that all countries have had to face.

35. Countries with superior social services and coordination fared much better than those with less developed social support structures.

SOCIOECONOMIC IMPACT of COVID-19:

36. The socioeconomic impact and burden of the COVID-19 outbreak and the fallout of measures to curb it included border closure and movement restrictions and border closures severely impacted commerce and economic performance and created a wave of unemployment and security concerns. Palliatives were offered by federal and state governments in a first-of-a-kind initiative to relieve pressure on households with regard to food supplies. Much has been learned from these exercises and the flow of social services has since improved.

THE HEALTH SECTOR:

Case Management:

37. At the start of the response, parallel to the containment strategy, the Federal Ministry of Health (FMOH) began inventory of isolation facilities and intensive care unit (ICU) equipment, particularly ventilators, intensive care specialists and laboratory diagnostic capabilities; and stockpiling of relevant commodities. NCDC began intensive infection prevention and control (IPC) training across the country and states were urged to expand and equip isolation and treatment facilities.

38. In the meantime, bed spaces for infectious diseases have increased to 7,040 with 60% occupancy, and ICU beds to 256 ICU beds with less than 6% occupancy. The PTF recommendation is for each state to have a 300-bed minimum isolation and treatment centre with a 10-bed ICU, with the necessary trained personnel to staff the facilities around the clock. This amounts to a minimum total of 11,100 accredited COVID-19 treatment bed spaces and 370 ICU beds across the country; the response is still a work in progress.

39. The health sector in Nigeria can be described as fragile and in need of better funding. However, the COVID-19 challenge has not turned out to be a test of health system fragility in the classical sense. COVID-19 does not respect health systems and ours has withstood the

pressure so far, although we have not yet seen the worst of COVID-19. In the barely 7 months since the outbreak of COVID-19, more knowledge has emerged about the virus and its pathology. Treatment protocols and options have arisen, been discarded, and replaced with other tentatively more promising regimens.

40. Nigeria benefits from intensely following the latest developments and WHO recommendations. We are also participating in research and development to generate new knowledge and treatment alternatives. The initial focus on ventilators based on the experience of Italy, Spain, the United Kingdom (UK) and New York City in the United States, has turned out to be different so far in Nigeria, since less than 2% of COVID-19 cases have required ventilators and do well with oxygen supplementation. This places a higher priority on the need for oxygen concentrators.

Essential Services:

41. The fear and focus on COVID-19 infection resulted in rejection of patients, even for routine treatment, in both public and private treatment facilities. This created an upsurge in avoidable morbidity and mortality, that threatened and threatened to upset gains in health indices which have been made at great cost. These challenges led FMoH to take measures to redirect attention to essential routine health services and emergency medical services by engaging the governor's forum and state and FCT health authorities.

42. The opportunity offered by the COVID-19 outbreak to reset the health system cannot be missed. Through the National Primary Health Care Development Agency (NPHCDA), plans are underway to upgrade the network of primary health care centres (PHCs) to a new model design, in every political ward. The revitalisation aims to revamp the hitherto largely comatose secondary health network and reorganise the tertiary and specialty hospital systems, using a mix of public and private funding streams and relieve the federal government of much of the burden of governance and micro-management.

Research:

43. The Nigeria Institute of Medical Research (NIMR) successfully conducted the first ribonucleic acid (RNA) genetic sequencing of the COVID-19 virus in Africa and determined it to be identical with the virus sequenced in China and Italy. Nigeria received commendation for its responses from both the Director-General of the World Health

Organization (WHO), Dr. Tedros Ghebreyesus, and the Secretary-General of the United Nations, António Guterres.

44. Research and development (R & D) in our research institutions is being supported to evaluate all aspects of the COVID-19 response, including the safety and efficacy of all treatment options. As a novel virus, the answer for the management of COVID-19 can come from anywhere. The National Institute for Pharmaceutical Research and Development (NIPRD) is constantly evaluating local remedies and has submitted an interim report on the evaluation of the "COVID Organics" herbal tincture from Madagascar.

45. Nigeria is also participating in the international clinical trial called the WHO Global Solidarity Trial launched by WHO and partners, to generate robust data from around the world to find the most effective treatments for COVID-19.

FMoH Priority Focus:

46. COVID-19 is still an unfolding global challenge; world news channels reveal the difficulties that advanced economies are facing and the difficulties in dealing with them. Nigeria is learning lessons and adapting new knowledge to its strategy. The overall strategy of the Federal Ministry of Health (FMoH) has been to strive for the best outcomes while preparing for the worst.

47. Our focus is:

i. **Contact Tracing:**

to slow the rate of spread by contact tracing, to reduce infections of this easily transmissible disease. This is achieved largely through behaviour change communication and non-pharmaceutical measures and advisories that require, more than anything else, the cooperation and collaboration of the citizenry. Wearing a mask is the simplest of them, but unfortunately, this has proven difficult since compliance and adherence are extremely poor, a problem being experienced in many countries, especially those with liberal social order.

ii. **Isolation and Treatment:**

to continue expanding capacity for isolation and treatment of COVID-19 cases. This also proves difficult because the extreme ease of transmission yields cohorts of new positive cases, which constantly outstrips the holding capacities of states. This problem that experienced by all countries with major outbreaks. Nigeria has deployed a strategy to utilise its primary health care network as community support centres for observation of the up to 80% asymptomatic persons with COVID-19,

who are highly infectious. Strategies have also been developed for home-based care for those who meet the criteria.

iii. Prioritisation of At-Risk Persons:

better care and earlier intervention to avoid complications, by prioritisation of hospital admission for persons with pre-existing diseases such as diabetes, hypertension, HIV, TB, cancer and other chronic conditions, with the knowledge that COVID-19 fatality is highest among this category of COVID-19 cases.

iv. National Emergency Medical Service and Ambulance System (NEMSAS):

to create an effective National Emergency Medical Service and Ambulance System (NEMSAS) that supports early and professional response to medical emergencies and public health needs, working with both private and public health delivery systems as well as related response stakeholders and communications agencies.

v. Testing:

expanding testing volume and related logistics, to improve case-finding.

vi. Data:

improving data collection and application to improve strategy.

48. **CHALLENGES:**

i. Stigmatisation:

this has led to a large proportion of COVID-19 cases evading authorised treatment centres.

ii. Heath Sector Stratification:

The stratification of health care services, including even public health response, which can limit collaboration and cooperation between federal and state health authorities, even among states.

iii. Funding Limitations:

these could affect procurement of commodities, PPE and hospitality and medical services to persons in isolation and treatment centres.

iv. Unaccredited COVID-19 Treatment:

Engagement of unauthorised and unaccredited hospitals in treatment of COVID-19, leading to increase in community transmission and increase in health worker infections.

HOW PREPARED *IS* NIGERIA?

49. This now brings us to the next important question: "**how prepared is Nigeria?**" Nigeria is much better prepared for this pandemic and is still preparing. The present situation is not out of hand.

50. COVID-19 is still an unfolding global pandemic and Nigeria has not reached its peak of transmission. Our high population and population density, along with previous mentioned conditions and challenges, give reason for apprehension but also make accurate predictions difficult.

51. However, we continue to closely monitor global and especially national, regional, and even cluster developments and prepare corresponding responses. These could include precision lockdowns of hotspots for targeted implementation of response measures and strategic deployment of material resources such as Gene Xpert machines to high volume treatment centres.

52. Risk communication and community engagement are also being increased and improved in collaboration other ministries, departments, and agencies (MDAs).

CONCLUSION:

53. In conclusion, COVID-19 reveals that collaboration and cooperation between the governed and governing is vital and has never been so important and desirable as with this outbreak. It appears that there is a relationship between infection and fatality rates on the one hand, and the level of collaboration between state and population on the other hand, looking at the global picture. Therefore, we need to intensify this relationship so that the population takes ownership of the response.

54. I must not fail to express appreciation to partners, especially multilateral organisations of the UN group and bilateral organisations who, even faced with dire situations in their own countries, offered -and still offer- Nigeria a helping hand and contribute to stabilisation of the situation so far.

Thank you.