

Self-quarantine in responding to COVID-19 outbreak in Lagos, Nigeria: A case report

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Introduction

Coronavirus disease 2019 (COVID-19) has spread across the globe as rapidly as imagined. COVID-19 was named a pandemic disease and now has a significantly rising mortality rate. Yet in the battle to curtail it, contact tracing and monitoring is a very key approach just like many other diseases of similar virulent nature.[1,2] Achieving control through this strategy will depend on characteristics of the pathogen and response[1]and most likely on the socioeconomic status of the individual. Housing in Nigeria is unarguably one of the very basic requirements of families just as food and clothing [3].

Despite the challenges of inadequate good and affordable accommodation for the populace, self-quarantine of asymptomatic contacts is one of the main strategies for curtailment and monitoring[1]. Permitting subclinical cases freedom of movement when they could transmit the disease prior to the onset of symptoms is worrisome [4]. Certain countries have adopted quarantine or self-quarantine policy for passengers (Passengers of Interest) from countries with confirmed COVID-19 transmission [3] or people who had close contact with cases. However, the proficiency of self-quarantining of contacts that lives in slums and the associated impending factors such as crowd, illiteracy, and poverty could be devastating. It is important to note that the Federal Government of Nigeria through her Presidential Task Force has commenced facility supervised-quarantine for evacuees from European, American, and Asia countries. Hopefully, it was not medicine after death.

Case 1

For this report, one highlight is a 32-year-old male, House-keeper who works in a hotel. He lives in a crowded urban-slum area of Lagos in a 'face-me and face you apartment and was a close contact of a COVID-19 index case where he works. Contact was placed on self-quarantine for the first 14 days and daily follow up instituted. He developed a headache on day 9 and a fever (Temperature 38.2°C) on day 10 the follow-up period. No cough, no rhinorrhea, no chest

tightness, and no sore throat. He was being monitored from home by a group of public health personnel (Contact tracers). The contact tracers consequently made a follow-up visit to his house and discovered he was absent. He went to the market to buy groceries. Thereafter he reported a normal temperature reading throughout the rest of the follow-up days and had claimed the reported fever was an error on the said day.

Case 2

The second concern was a 10-year-old female who lives in another urban-slum area of Lagos, in a densely populated community of interest. She was identified for COVID-19 case investigation and sample collection. She was noticed during an active case search and she presented with a dry cough of one-month duration prior to investigation. No fever, no sore throat, no headaches, no vomiting, and no diarrhea. Incidentally, this was during the lockdown period, where people were expected to stay in their individual homes to enhance social distancing to reduce the spread of COVID-19. On our visit to the community, we noticed that social distancing evidently might not yield the expected result in such an environment. The houses or make-shift homes are well closely parked and fully parked with all age groups of individuals who were obviously overwhelming the facilities of concern – homes. This was farfetched from an ideal home situation. Apparently for this group of people staying at home poses more danger for COVID-19 exposure than mitigating it.

The two scenarios above push for the following questions: 1. could modifications to self-quarantine and imposition of monitored quarantine help in certain socioeconomic conditions where crowd is a bane? 2. Could there be variation to the model of contact tracing and monitoring during matters of Public Health importance? This report highlights the risk of housing style and location in facilitating adherence to public health regulations.

Discussion

About one billion people worldwide who live in urban slums or informal settlements are highly prone to COVID-19 infection since essentials such as portable water, toilets, sewers, drainage, waste collection, security, and acceptable accommodation are unlikely [5,6,7,8]. Inadequate spacing, probable viciousness, and overpopulation in slums seriously constraints idea of physical distancing and made self-quarantine unrealistic, and swift transmission of infection possible [9,10,11,12]

The novelty nature of COVID-19, case definitions kept changing. There were modifications based on the country's specificities and WHO advice. It was apparent for the peculiarity of Lagos, divided based on the size and slums population that the 'one-cap-fit-all' approach would not suffice for quarantine processes for contacts of confirmed cases or returnees from high-risk countries. It is almost certain that quarantines and travel bans are usually the first line of action to stop the spread of highly contagious diseases.[13]It was almost inevitable that such a uniform approach of self-quarantine in a State like Lagos was going to be difficult. Over 70% of Lagosians live in the slum and controlling COVID-19 spread in the face of community transmission must require a different approach from the usual. More so if the processes are enforced or implemented in chaotic manners, it could boomerang. In a state with an estimated population of about 15 milion [14] where an average of 7-10 people lives in a typical size room in the slums and are expected to self-quarantine in such rooms. This was not possible especially with the highly contagious COVID-19 infection.[15] Obviously residents living in these informal settlements are cautiously helpless economically before and even during COVID-19 responses.[16] Contrary to this is the highbrow areas of Lagos where people live conveniently within their compound and have access to their

individual rooms with little or no interference if they want. Self-quarantine can be grossly convenient with expected high yield results. It could be seamless because of the manageable population, level of educational attainment, and other socio-economic factors that are different from those in the slums.

In view of this, the ideal thing would be facility quarantine for the slums populace in a situation like COVID-19, where the spread of the highly contagious disease is inimical. This entails enormous public health funds no doubt and is not a popular approach ever [3]. Unfortunately, knowledge gained in recent epidemics has not been well harnessed and our 'fire brigade' approach to issues of public health concerns is evidently palpable. Individuals that are adjudged to be comfortable with self-quarantine should be encouraged with routine education and adequate follow-up to monitor new symptoms and deteriorating ones. It is also worthy to appreciate that the poor and the rich are not as far away as they used to be. The common factors unfortunately are diseases of public health interest. Government should come to the aid of her populace, build habitable houses, provide education and encourage job creation for the masses. All of which could help reduce our poverty index, promote better living, and reduce informal population settings to a bearable proportion.

Conclusion

In conclusion, a self-quarantine approach to curtailing the spread of infectious diseases like COVID-19 should not be a 'what is good for the Goose is also good for the Gander' rather it should be prioritized to cater for the different socio-economic backgrounds while preparing the approach.

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