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COVID and Cities: Nigeria Case Study Report

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Authors: Chinyere Mbachu, Prince Agwu, Ifeyinwa Arize, Chinyere Okeke, Pamela Ogbozor, Charles Orjiakor, Aloysius Odii, Benjamin Uzochukwu and Obinna Onwujekwe

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List of Abbreviations

CACOVID	Private sector coalition against COVID-19
COVID	Coronavirus disease
CSO	Civil society organization
ESC	Economic sustainability plan
FMOH	Federal Ministry of Health
HMIS	Health management information systems
LGA	Local government area
MEACOC	Ministerial expert advisory committee on COVID
MDA	Ministries, departments and agencies
NCDC	National centre for disease control
NPHCDA	National primary health care development agency
PHC	Primary health care
PHEOC	Public health emergency operation centre
PTF	Presidential task force
WTF	Ward task force

Executive Summary

The impact of COVID-19 on the health and livelihoods of populations in low and middle income countries has been substantial. Some of the measures that have been put in place to reduce infection rates across the general population may exacerbate economic and social hardship. Although governments' responses to COVID-19 pandemic are intended to reduce the health impact on the population and the strain on the health system, they are likely to produce mixed effects across sub-groups of the population, with indirect or unintended consequences on the health and livelihood of the urban poor. This rapid review examined the scope of federal, state and local government responses to COVID-19 in Nigeria, in order to underscore how these have impacted on the health, wellbeing and livelihood of the urban poor in Enugu and Onitsha cities.

A case study approach was adopted in the rapid review. The time frame of the review was from 30 January to 31 August 2020. Data was collected through review of official documents, media reports and health information systems data. News reports were retrieved from the websites of media organizations. Official documents such as policies, strategies, guidelines, protocols, government orders, reports and minutes of meetings of expert committees were retrieved through intensive search on organizational websites. Published journal articles were retrieved through an electronic search on Google scholar, PubMed/Medline and Google. The microsite of the national center for disease control was reviewed to collect data on the evolution and trends of the pandemic and its response in the country and in Enugu and Anambra states. Data was extracted verbatim into excel spreadsheets and analyzed thematically drawing from the research questions and emerging themes.

Since Nigeria recorded its first case of coronavirus on 27 February 2020, cases have continued to rise on a daily basis, further straining an already fragile health system. Urban areas have contributed the most to the number of cases of COVID-19 in Nigeria. The multi-sector response to COVID-19 in Nigeria has been coordinated through the Presidential Task Force and state task force teams. However, there are no linkages between and across task force teams. Various stakeholders at national, state and local government levels have played (and indeed continue to play) complementary roles in the implementation of specific sectoral responses to COVID-19 in Nigeria. The expert and advisory committees at the federal and state levels appear to be working in their silos without any lines of communication to encourage information sharing and learning. Similarly, it is unclear whether and how the private sector are linked to other actors in the response strategy. Hence, the processes of coordination of actors and their actions are intricate and at the best fragmented. The coordination of COVID-19 response at all levels has been facilitated by the sense of responsibility and complementarity of the roles of stakeholders in resource mobilization and risk communication. However, coordination has been hampered by poor communication of policies among stakeholders, poor planning and contextualization of response strategies, lack of data for planning and implementation, and lack of accountability. The federal, state and city responses to COVID-19 have impacted on the livelihood of the urban poor, and some sub-groups of the urban poor have experienced the negative impacts more than the others. Safety net interventions have targeted poor and vulnerable households and small business owners. However, the measures used to determine poor households have been faulted. The negative impacts of COVID-19 response on the urban poor include, loss of jobs and income, increase in level of impoverishment, worsening access to healthcare, increase in domestic, sexual and gender-based violence, and brutality and extortion from security agencies.

The multi-sector approach and the unrelenting support of the private sector have contributed to the overall success of country and city response to the pandemic. However, there are some inadequacies in the COVID-19 response in

Nigeria. Expected linkages between stakeholders are missing, coordination of response is suboptimal and distribution of relief materials is ineffective due to poor data systems. Hence, the likelihood of duplication of efforts, inequitable resource allocation, wastage of resources and amplification of vulnerabilities in urban settings. Without a dedicated policy to address the plight of the urban poor and vulnerable groups, the aftermath of the pandemic response will translate to widened health inequity, income disparity and inequality in urban areas. As a matter of urgency, policymakers need to be more responsive and proactive in ameliorating the social and economic effects of the pandemic on the urban poor, and better prepare the country for future shocks and health emergencies.

Key messages:

Key findings and policy recommendations

1. The multi-sector approach and the unrelenting support of the private sector have contributed to the overall success of national, state and city response to COVID-19 pandemic in Nigeria.

2. The multi-sector, multi-level and multi-stakeholder nature of COVID-19 response in Nigeria, underlines the need for better coordination of actors and their actions. This will mitigate duplication of efforts and contribute to equitable and efficient resource allocation and use.

3. Interventions for the containment of COVID-19 outbreak and the risk communication strategies were poorly adapted to the Nigerian context, and this resulted in the lack of compliance to directives in urban areas. Therefore, future interventions should be adjusted to local realities of economic and social structures.

4. The COVID-19 response is marred with reports of irregularities and corruption in the procurement, distribution and use of resources. This is heightened by the lack of transparency and accountability by government. Appropriate models should be adopted or adapted for tracking COVID-19 resources at all levels, and data systems on resource tracking should be made public and accessible.

5. Urban vulnerabilities amplified by the COVID-19 pandemic presents an opportunity for a fresh consideration of urban planning approaches in Nigeria. Electronic data systems should be established for generating and continuously updating a comprehensive list of the poor and vulnerable individuals and households.

1. Introduction

1.1 Context/Why we need an assessment of COVID and Cities

The impact of COVID-19 on the health and livelihoods of populations in low- and middle-income countries has been substantial, placing already stressed and weak health systems under more strain. This impact is likely to be experienced differently by individuals and households depending on where they live and their socioeconomic groups. In addition to the upsurge in morbidity and mortality as a result of the pandemic, there has been massive disruptions to socio-economic activities as a result of some of the response measures instituted to control the epidemic. African countries already face numerous challenges, including a scarcity of public health human resources and logistics, poor public funding for health emergencies, and high burden of communicable diseases such as malaria, TB and HIV (Nkengasong & Mankoula, 2020; Reuben et al, 2020). Moreover, access to health care and other resources is skewed towards the more affluent groups, and the impact of COVID-19 on the livelihoods of the poorest is likely to increase these inequities.

In urban areas, the impact is likely to be highly variable across different socio-economic groups. Whilst middle and wealthier groups are often able to continue their employment from home, the lack of an adequate social safety-net and inflexibility of employment and reliance on the informal economy means that those in poorer economic groups will suffer potentially catastrophic loss of income and must continue to seek work in places that do not permit physical distancing. Furthermore, the same populations often live in cramped conditions close to other households, have high levels of other communicable and non-communicable disease to contend with, with limited access to hand-washing and sanitation facilities and often also close to livestock and outdoor markets.[1] In some communities, the measures that are designed to reduce infection rates across the general population may exacerbate economic and social hardship.

In recognition of the risks associated with the pandemic, the government of Nigeria put in place measures to control transmission, reduce morbidity and mortality, and protect and care for vulnerable populations. These measures include active surveillance and isolation of infected individuals, decentralized supplies and capacities for response, lockdowns and restrictions in social gathering. These interventions are being elaborated at primary health care (PHC) and community levels (NPHCDA, 2020) to ensure better service delivery and promote community engagement (NPHCDA, 2020; Amzat et al, 2020). Although the aim of these interventions is to reduce the health impact of COVID-19 on the population and the strain on the health system, it is likely that their effect across groups is mixed, and some interventions may have indirect or unintended consequences on the health and livelihood of the urban poor. The aim of this rapid review is to describe the scope of these polices and health system responses and begin to understand the differential impact on sub-groups of the urban population.

1.2 Background of the study metropolis /municipality /sub-metropolitan area

Nigeria is the most populous African country. Based on projections from the last census, Nigeria has an estimated population of 206 million people. Nigeria is a lower middle-income country with a gross national income per capita between $1,026 and $3,986 (World Bank, 2017). It ranks 158th in the Human Development Index (UNDP, 2019). Nigeria has achieved a stable democratic government since 1999. As at 29 September 2020, there were a total of 58,460 confirmed cases of COVID-19 (out of 509,555 samples tested), 1,111 deaths and 49,895 discharges. Consequently, there are 7,454 active cases of COVID-19 in the country. Nigeria has been described as the most COVID-19 impacted country in West Africa (NCDC, 2020).

Enugu city is located in Enugu state in the southeast of Nigeria. The city consists of three local government areas (LGAs) namely, Enugu South, Enugu North and Enugu East. It has a mix of residential, industrial and commercial areas and covers an area of 200 square kilometers. The projected population of the city in 2014 was 915,500 with population density of 6,400 inhabitants/km^2. About 22% of the population of Enugu State live in Enugu city. The **richest neighborhoods** in the city are found in (and around) Government Reserved Areas and Independence Layout. Settlements such as New Haven, Trans-Ekulu and Maryland are considered **mixed areas**, housing both high, middle and low-income households. Most of the **poorest neighborhoods** in the city are found in Ogui-Nike and Abakpa-Nike layouts. Enugu city has a considerable number of slums that can be found in the mixed-income and poorest neighborhoods. The Ogui slum settlement which is right at the heart of the city is located at the homesteads of the largest group of indigenous people of Ogui Nike. The squatter area extends from Obiagu, Ama-Awusa, Onu-Asata to Ogui road axis. This slum has been gradually expanding in land mass and population size since pre-independence (Nwachi et al, 2012). Other major slums in the city are Ugbo Odogwu, Iva valley, Ngenevu, Ugwu Paul, Artisan quarters slum 1 & 2, Nikenevu and Adazindube (Okeke et al, 2017).

Onitsha city is located in Anambra state, south-eastern Nigeria. It occupies the eastern bank of the River Niger and is popularly called the 'waterside town" (Udo, 1981; Encyclopedia Britannica, 2019). The city consists basically of two local government areas (LGAs) namely, Onitsha South and Onitsha North. Over the years, the city has extended into parts of neighboring LGAs including Ogbaru, Oyi and Idemili; although they are not within the designated city limits. It has a mix of residential, industrial and commercial areas within a built-up area of 1,942 square kilometers. The projected population of the city in 2016 was 7,425,000 with population density of 3,824 inhabitants/km^2 (Demographia, 2016). Onitsha has a mix of wealthy, mixed and poor areas. The **richest neighborhoods** in the city are found in (and around) the planned new residential layouts. They are characterized by good housing plans and good access to basic amenities such as potable water, sanitation facilities and good asphalted roads. Settlements in and around Odoakpu, Woliwo, Fegge and Awada are considered **mixed areas**, housing both high, middle and low-income households. Most of the **poorest neighborhoods** in the city are found in Otu, within the Army Barracks, and at the outskirts of city within Prisons area and Okpoko industrial area (UN-Habitat, 2012; UN-Habitat 2009). Onitsha has large areas of slums in both old and new areas of the city that are located in mixed and poor neighborhoods. Four major slum areas in the poorest neighborhoods have been extensively studied and documented by UN Habitat. Two of these slum areas (Mammy market and Otu slums) are located within the legal limits of the city while Okpoko and Prison slums are located outside the city boundary (UN-Habitat, 2012).

Enugu and Onitsha have a large informal sector, and majority (over 90%) of the slum dwellers are informal sector workers (UN-Habitat, 2012; Uwadiegwu, 2013; Okoye et al, 2017). Access to public facilities and services is skewed to the disadvantage of the poorest neighborhoods in both cities. Basic urban services such as public health facilities, schools, water and sanitation facilities are lacking in the urban slums (UN-Habitat, 2012; Nwachi et al, 2012).

1.3 Study Questions and Research Objectives

Research Questions

1) How have city/local governments and national responses been coordinated? Are responses synergistic or have they undermined each other? What have been the facilitators and barriers to this?
2) What has the role of city governments been in the response and what are the facilitators and barriers to an effective short-term and long-term response by city government?
3) Have city governments played any role in coordinating or managing the responses of public, private, NGOs providing healthcare or other services (water, sanitation, phone networks, public transport etc) in the response in the short and long-term?
4) How has COVID-19 and the national/city response affected, or is likely to affect, the health, wellbeing and livelihoods of poor urban populations? Any difference for informal settlement and other urban poor? Short-term (weeks/one month) and long-term (months/years)?

General Objective

To examine the scope of federal, state and local government responses to COVID-19 in Nigeria, and underscore how these have impacted on the health, wellbeing and livelihood of the urban poor in Enugu and Onitsha cities

Specific Objectives

1) To describe the timeline of cases, events and policies for COVID-19 at the federal and state levels in Nigeria
2) To describe the processes of coordination and collaborations between federal, state and local governments in the response to COVID-19 in Nigeria
3) To identify the roles of federal, state and local governments in COVID-19 response, including their roles in coordinating and managing the responses of public and private service providers in the short and long-term
4) To identify the factors that have enabled or constrained effective response to COVID-19 by state and local governments
5) To describe the impact (or potential impact) of the COVID-19 response on the health, wellbeing and livelihoods of the urban poor.

2. Methods

2.1 Study design

A rapid review of government response to COVID-19 in Nigeria was performed. The review adopted a case study approach to describe federal, state and urban local government responses to COVID-19 in Nigeria.

2.2 Sampling, time frame and rationale

Time period: 30th January to 31st August 2020.
Rationale for time period: COVID-19 was announced a Public Health Emergency of International Concern on the 30th of January 2020. Following this announcement, Nigeria began implementing the WHO recommendations for infection prevention and control as well as other necessary actions outlined by the National Centre for Disease Control for pandemic preparedness and response.

2.3 Data collection methods

Data was collected through review of official documents, media reports and health information systems (HMIS) data. Desk review of official documents, journal articles and media reports that were written/published with the review time frame was performed by a team of independent reviewers. HMIS data on the timeline of COVID-19 cases and deaths at the federal and state levels were retrieved from the webpage of the National Centre for Disease Control (NCDC). Table 1 highlights the data collection methods used to explore research questions and their corresponding specific objectives.

Table 1: Summary of research questions, objectives and data collection methods

Research Question	Research Objectives	Data collection methods
1. How have city/local governments and national responses been coordinated? Are responses synergistic or have they undermined each other? What have been the facilitators and barriers to this?	1) To describe the timeline of cases, events and policies for COVID-19 at the federal and state levels 2) To describe the processes of coordination and collaborations between federal, state and local governments in COVID-19 response	Webpage of NCDC Document review Media review
2. What has the role of city governments been in the response and what are the facilitators and barriers to an effective short-term and long-term response by city government?	3) To identify the roles of federal, state and local governments in COVID-19 response, including their roles in coordinating and managing the responses of public and	Document review Media review

Research Question	Research Objectives	Data collection methods
3. Have city governments played any role in coordinating or managing the responses of public, private, NGOs providing healthcare or other services (water, sanitation, phone networks, public transport etc) in the response in the short and long-term?	private service providers in the short and long-term 4) To identify the factors that have enabled or constrained effective response to COVID-19 by state and local governments	
4. How has COVID-19 and the national/city response affected, or is likely to affect, the health, wellbeing and livelihoods of poor urban populations? Any difference for informal settlement and other urban poor?	5) To describe the impact (or potential impact) of the COVID-19 response on the health, wellbeing and livelihoods of the urban poor	Document review Media review

2.3.1 Media Content Analysis (including reports from tv/radio and online portals)

Description of Media search strategy: News reports were retrieved from the websites of government and private media organizations. The search was restricted to the websites of radio stations, television stations, daily news agencies and online news agencies that are reputable for reporting factual information from across the country and are influential or have large viewership or readership. The specific media sources and the rationale for their selection are summarized in table 2.

Table 2: Media sources and rationale for selection

Sources	Rationale
Daily news publication agencies – Vanguard, Punch, The Nation, Premium Times, Daily Trust, This Day, The Guardian, Daily Post, Sun, Business Day, Tribune, Independent	Reputable newspapers with large readership News articles (including archives) can be retrieved online from organizational websites Reports news from all over the country
Online news agencies – Sahara Reporters, Pulse Nigeria, Observer Research Foundation, Human Rights Watch, Nigeria Watch, Africa Times, Africa Newsroom, The Cable, Ripples, Devex	Large readership and followership Real-time reporting of factual information on COVID-19 response in Nigeria
Other online news – WHO-AFRO, All Africa, Save the Children	Real-time reporting of factual information on COVID-19 response in Nigeria
Radio station – Radio Nigeria	Large viewership (listeners) Real-time reporting of factual information on COVID-19 response in Nigeria

Media searches were performed using various combinations of the following keywords,

1) COVID-19 **OR** (COVID, coronavirus)
2) Nigeria **OR** (Enugu, Anambra, Onitsha)
3) Federal government **OR** (State government, Local government)
4) Response **OR** (policy, guideline, intervention, strategy, plan)
5) Urban areas **OR** (city, metropolis)

A search item comprised a minimum of five (5) keywords selected from numbers 1 to 5. A more comprehensive search item comprised a combination of all keywords written as,

((COVID-19 OR COVID OR coronavirus) AND (Nigeria OR Enugu OR Anambra OR Onitsha) AND ("federal government" OR "state government" OR "local government") AND (response OR policy OR guideline OR intervention OR strategy OR plan) AND ("urban areas" OR city OR metropolis))

Eligibility of media articles was determined by a quick scan of lead paragraphs to also determine if the focus is on issues related to urban areas, the role of authorities and other stakeholders in the COVID-19 response, and impact of COVID-19 interventions on urban dwellers.

2.3.2 Review of official documents and journal articles

Official document search strategy: Official documents such as policies, strategies, guidelines, protocols, government orders, reports and minutes of meetings of expert committees were retrieved through intensive search on organizational websites of government and non-government agencies involved in the COVID-19 response in Nigeria. The specific organizational websites and the rationale for their selection are summarized in table 3.

Journal articles search strategy: Published journal articles were retrieved through an electronic search on Google scholar, PubMed/Medline and Google for the same period as for the media search.

The search for official documents and journal article were performed using various combinations of the following keywords,

1) COVID-19 **OR** (COVID, coronavirus)
2) Nigeria **OR** (Enugu, Anambra, Onitsha)
3) Federal government **OR** (State government, Local government)
4) Response **OR** (policy, guideline, intervention, strategy, plan)
5) Urban areas **OR** (city, metropolis)

A search item comprised a minimum of five (5) keywords selected from numbers 1 to 5. A more comprehensive search item comprised a combination of all keywords written as,

((COVID-19 OR COVID OR coronavirus) AND (Nigeria OR Enugu OR Anambra OR Onitsha) AND ("federal government" OR "state government" OR "local government") AND (response OR policy OR guideline OR intervention OR strategy OR plan) AND ("urban areas" OR city OR metropolis))

Eligibility of official documents for inclusion was determined by a quick scan of summaries to determine if mention was made of issues related to urban areas, roles of state and local authorities and other stakeholders, processes of coordination and collaboration between federal, state and local authorities, or impact of COVID-19 interventions on urban dwellers. Eligibility of journal articles was determined by a quick scan of the abstracts to also determine if the focus is on issues related to urban areas, the role of authorities and other stakeholders in the COVID-19 response, or impact of COVID-19 interventions on urban dwellers.

Table 3: Sources of official documents and rationale for selection

List sources	Rationale
Websites of government agencies – Federal & State Ministries of Health; NCDC; Federal Ministry of Education; Presidential Task Force on COVID-19	Reliable sources for public documents Up to date situational reports of COVID-19 response
Websites of non-government agencies – UNDP, UNICEF, WHO-Nigeria, Plan Nigeria, KPMG, Christian Aid	Reliable sources for public documents Up to date situational reports of COVID-19 response
WhatsApp groups – Nigeria Health Economics Association; Network of Emerging Leaders in Health Policy and Systems	Access to unpublished official documents such as minutes of meetings and expert recommendations for COVID-19 response Access to electronic copies of policy documents that are otherwise available in print only

2.3.3 Review of HMIS data on COVID-19 cases, recovery and deaths

The microsite of the NCDC was reviewed to collect data on the evolution and trends of the pandemic in the country and in Enugu and Anambra states, in terms of tests performed, confirmed cases, recoveries, active cases and deaths over time, and disaggregated by sex/gender, age category and place of residence (urban or rural).

2.4 Data extraction and analysis methods

Table 4 shows a summary of the numbers of documents and media reports retrieved and included in the review, as well as the reasons for exclusion of those that were not eligible for review.

Table 4: Summary Table with number of documents and media reports found and included

Document review			**Media review**		
Documents found	Documents included	Summary of reasons for exclusions	Media reports found	Media reports included	Summary reasons for exclusions
83	Total = 51 (20 reports; 13 plans/guidelines; 13 journal articles; 5 opinion pieces)	Focus on other states (22) Duplicates (9)	184	Total = 122 (50 daily news publications; 35 online news; 37 blogs and commentaries)	Duplicates (42) Focus on other states (20)

Stage 1: Data extraction

Data extraction was performed by six (6) individual reviewers using excel spreadsheets. Two (2) separate spreadsheets were used to extract information from documents (official documents and journal articles) and media reports. Each spreadsheet contained sections for recording document or media report characteristics such as source/URL, authors, title and date, or full reference for journal articles. The spreadsheets also contained sections for recording information

on roles of city authorities, interventions/responses specific/sensitive/relevant to urban areas and their impact on the urban poor, as listed in table 5.

Table 5: Lists of sections under which data were recorded on the topics of interest

Characteristics/background of documents or media reports	Sections for recording information on topics of interest
Document name or media report title Lead organization/author Date published Source/URL Main purpose Target audience	Specific mention of urban areas Specific role/actions for national or state level stakeholders Other national or state-level actions and organizations mentioned Specific roles/actions of local governments/city council/municipality Other city level/local government actions or organizations mentioned Likely impact of roles/actions on the urban poor (including differences in men/women, older, disabled) Needs of the urban poor mentioned

Each document or media report was thoroughly read to retrieve relevant data on the topics of interest as previously listed. Reviewers applied a two-step approach in collecting and synthesizing information from each document or media report. At first, whole sentences or paragraphs were copied from documents or media reports and pasted into corresponding cells in the respective spreadsheets. This was followed by merging of all information recorded under each section by individual reviewers. Data from document and media review were merged for corresponding themes/sections in Word files. The Word files of these merged data from each reviewer were used as the transcripts for data analysis.

Stage 2: Methods of data analysis

A total of six transcripts of merged data were analysed. Thematic analysis was performed drawing on the research questions and themes that emerged from the transcripts. Table 6 highlights the themes in the coding framework.

The stakeholder analysis focused on identifying who is included (in what capacity) or excluded in the COVID-19 response at federal, state and local government levels, and the relationships and linkages that exist between government authorities at all levels, and between local governments and non-government agencies in the COVID-19 response in Nigeria, and specifically in Enugu and Anambra states.

Table 6: Coding framework used in thematic analysis of merged summaries of document and media review

Main themes	Sub-themes
Stakeholders and their roles in the COVID-19 response *(Synthesize key findings on the stakeholders involved at national and subnational levels, and their specific roles in planning, coordination, implementation, oversight etc. These findings are synthesized separately for each level/category of stakeholders as outlined, highlighting who is involved, their expected/assigned roles and their actual roles)*	National level stakeholders and their roles *(Including government ministries, departments, agencies, technical groups and committees, individual policymakers,)*
	State level stakeholders and their roles *(Focusing on Enugu and Anambra States)*
	Local government/city stakeholders and their roles *(Focusing on Enugu city or Onitsha city, as applicable)*
	Non-State actors and their roles

	(Including donors, development partners, NGOs, civil society organizations, private sector groups, professional organizations, community-based organizations, etc)
	Health providers and their roles *(Including public and private providers, registered formal and informal providers, etc)*
Relationships and linkages between stakeholders in COVID-19 response *(Highlight the linkages and relationships between the various levels and categories of stakeholders, and whether/how these relationships have contributed to strengthening or undermining response at the city levels)*	Types of linkages and relationships among stakeholders in COVID-19 response *(What relationships/linkages exist among stakeholders in planning, coordination, implementation, oversight etc.?)*
	Effects of stakeholder linkages and relationships on COVID-19 response at the city and national level *(Highlight how these linkages and relationships have impacted on the coordination of COVID-19 response at the city and national levels)*
Effects of COVID-19 and the national and city responses on the wellbeing and livelihoods of urban poor populations *(Highlight how COVID-19 and the response affect, or are likely to affect, the wellbeing and livelihoods of urban poor populations in the short term and in the long term. And any differential effects among categories of the urban poor)*	Effects of COVID-19 and response on the wellbeing and livelihoods of urban poor in the short and long term
	Potential effects of COVID-19 and response on the wellbeing and livelihoods of urban poor in the short and long term
	Differential effects of COVID-19 response on the wellbeing and livelihoods of vulnerable groups among the urban poor - *women, old, disabled, informal settlers, etc.*
Facilitators and barriers to effective city response to COVID-19	Facilitators and barriers to the implementation of stakeholders' roles and the response to COVID-19 in the short and long term *(Highlight the factors that have enabled or constrained effective response to COVID-19 by national, State and local/city governments in the short and long term. What has happened and to what effects?*
	Facilitators and barriers to the effective coordination of COVID-19 response at the city and national level (*What factors have enabled or constrained the effective coordination of COVID-19 response at the city and national levels? What has happened and to what effects)*

3. Results /Findings

Background information: Timeline of cases, events and policies in Nigeria

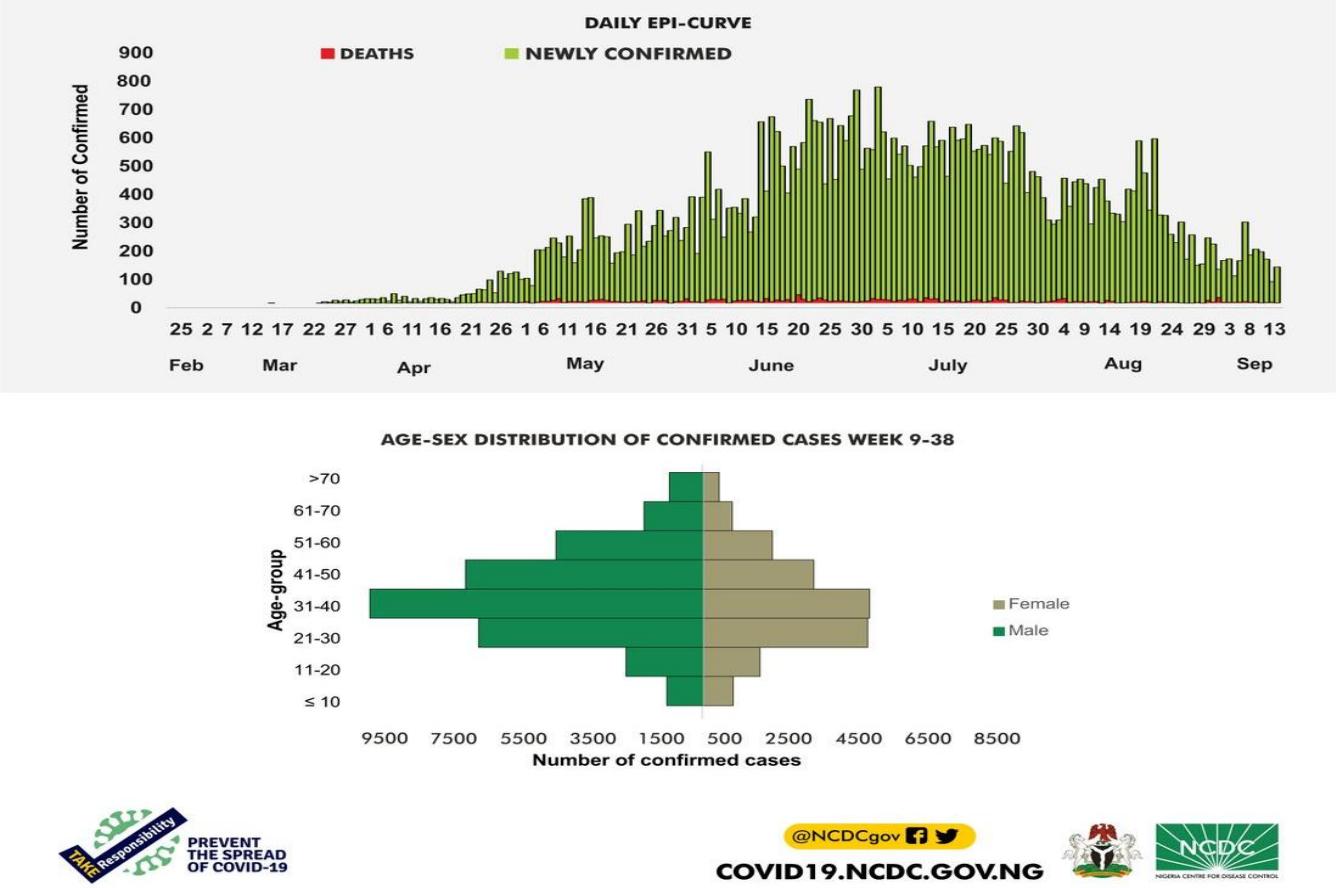

Figure 1: Timeline of COVID-19 cases and deaths as of 13 September 2020, and age and sex disaggregation of confirmed cases for weeks 9-38

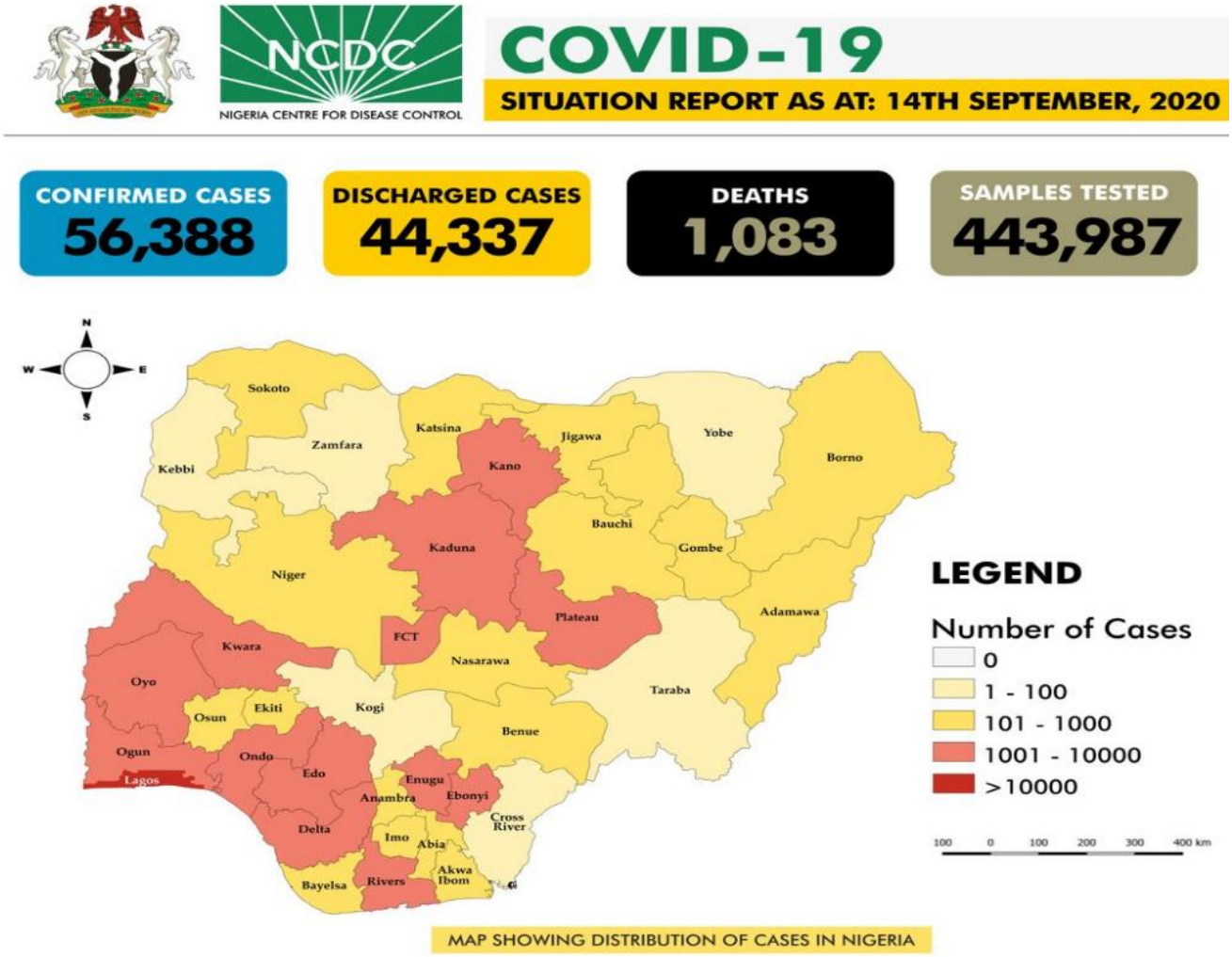

Figure 2: Situation report and geographic distribution of COVID-19 cases in Nigeria as at 14 September, 2020

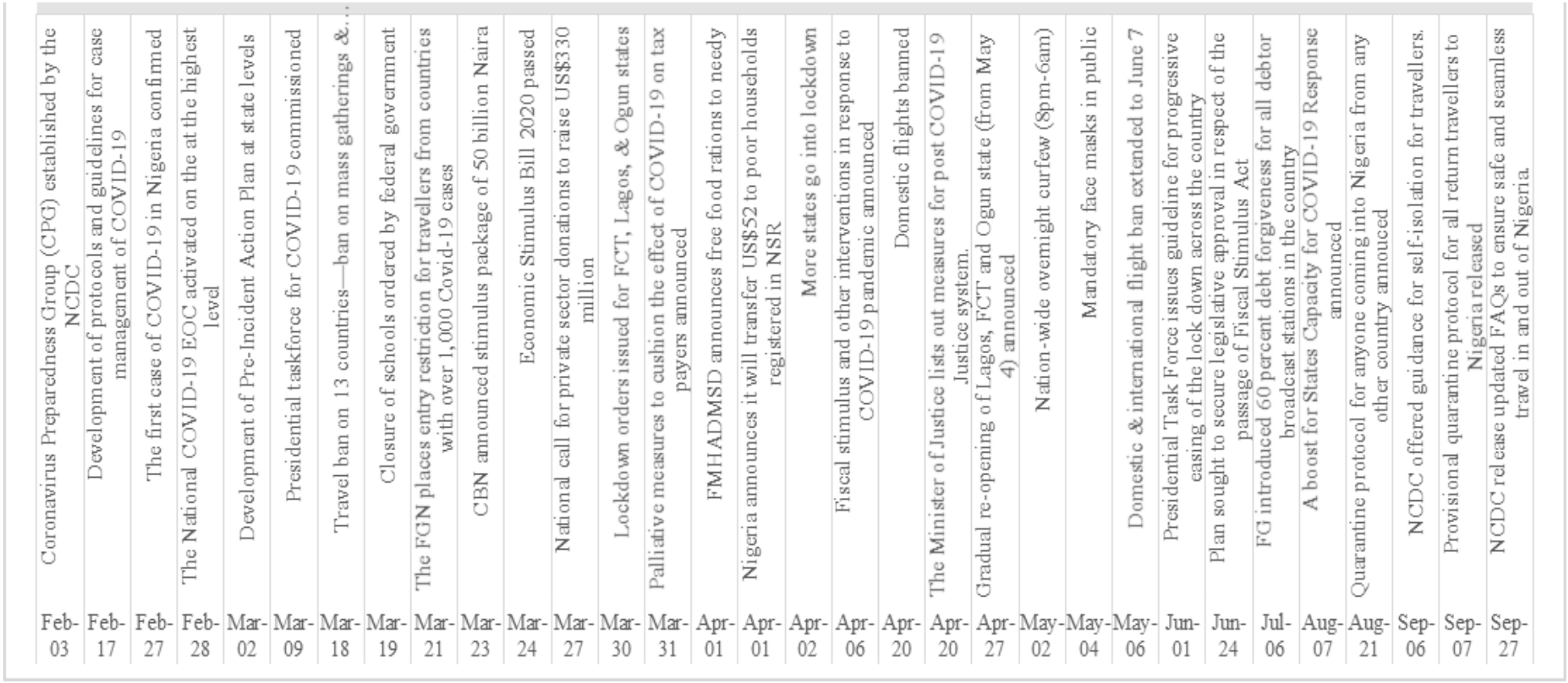

Figure 3: Timeline of COVID-19 policies and interventions in Nigeria

3.2 RQ1: Coordination and synergies (or not) between local and national government responses

In this section we highlight the specific responses and the roles of other stakeholders in coordinating the responses at national and state levels. We also present the facilitators and barriers to coordination of COVID-19 response at national and state levels.

The COVID-19 response in Nigeria has adopted both centralized and decentralized approaches. For instance, in order to contain the spread of the virus some interventions were defined and decided at the national level, for adoption or adaptation by states and local governments. Similarly, some policies and interventions designed to cushion the socioeconomic effects of the pandemic were made at the national level for implementation in states. However, some states have rolled out strategies and state-specific measures independent of the control and directives of the national government. Irrespective of the origin of the policies or interventions, they have been mostly synergistic.

Various stakeholders at national, state and local government levels have played (and indeed continue to play) complementary roles in the coordination and actual implementation of interventions for COVID-19 response in Nigeria. Figure 4 is a diagrammatic presentation of the coordination of COVID-19 response in Nigeria. It shows the relationships between the various stakeholders involved in coordination of response at federal, state and local government levels.

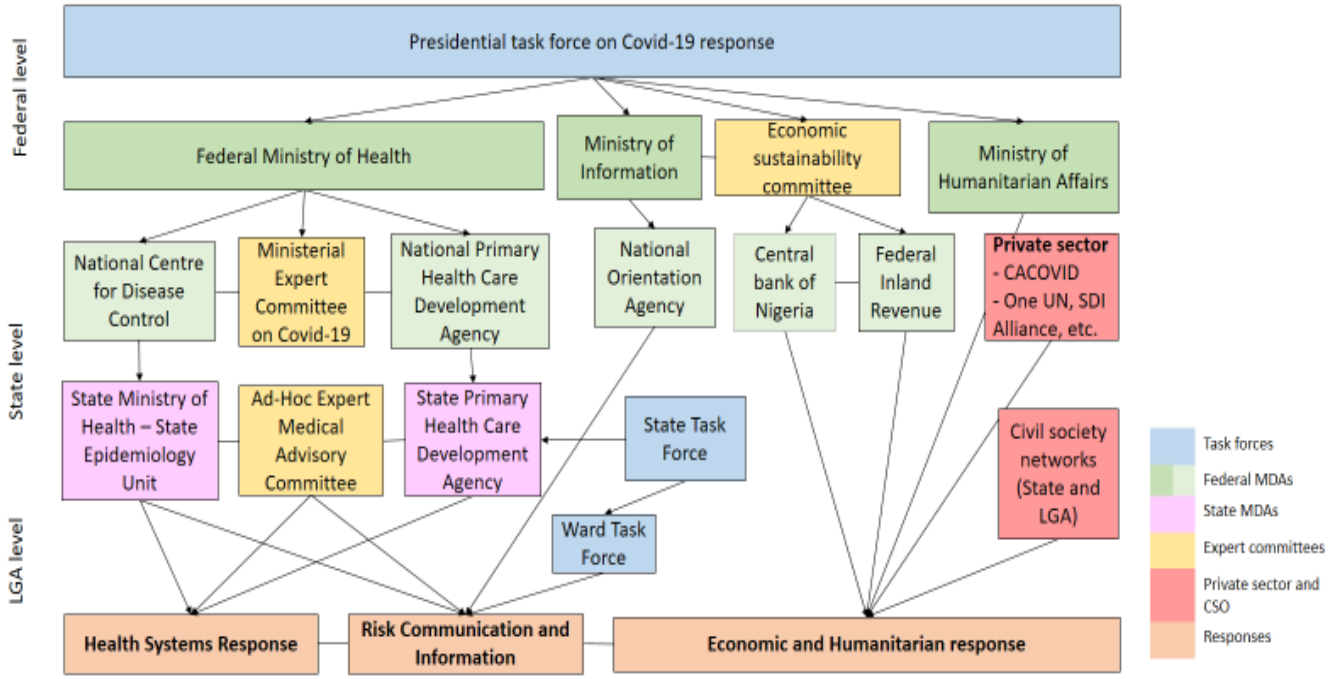

Figure 4: Key stakeholders involved in the coordination of COVID-19 response at Federal, State and Local government levels in Nigeria

3.2.1 Coordination of health systems response to COVID-19 in Nigeria

Upon confirmation of the first case of COVID-19 in Nigeria, the **Federal Ministry of Health** announced that a multi-sector coronavirus and pandemic preparedness group will be led by the National Centre for Disease Control (NCDC) (EIEWG, 2020). The FMOH subsequently outlined the policy directions and response strategy for containing the spread

of the coronavirus and set up the **Ministerial Expert Advisory Committee on COVID-19 (MEACOC)** to provide technical advice to the minister. A similar expert committee was replicated in Enugu state as an Ad-Hoc Expert Medical Advisory Committee tasked with de-escalation of the pandemic in the state (Okwor, 2020).

A Quarantine Act was elaborated by the federal government to contain the virus by regulating internal (inter-state) and international movement and travel. Furthermore, Port Health Authority employees stationed in Lagos and Abuja were deployed by the FMOH to key entry and exists points to restrict movement (FRN, 2020b).

The Federal Government has invested several millions of US dollars through the **National Centre for Disease Control (NCDC)** to improve laboratory testing, contact tracing and case detection, isolation of positive cases and treatment of COVID-19 patients (Andam et al, 2020). On the 28th of February 2020, a multi-sector Emergency Operations Centre (EOC) was activated at Level 3 – the highest emergency level in Nigeria – led by NCDC in close coordination with the State Public Health EOCs (PHEOC) (NCDC, 2020). NCDC has embarked on training of health workers to engage in active case search and contact tracing (NCDC, 2020). Moreover, personal protective equipment has been distributed in treatment centres, teaching hospitals and primary health care agencies in all 36 states and the FCT. There is also a dedicated portal for registering international travellers (returnees) to enable monitoring (through PCR tests) for a 2-week quarantine period following return from international travel (PTF, 2020b).

The coordination mechanisms at the state levels, to a large extent, mirror what obtains at the national level. In line with the national response, multi-sectoral Rapid Response Teams were established in states, comprising representatives of relevant Ministries, Departments and Agencies (MDA), and development partners such as WHO and UNICEF. In addition, Enugu State Government constituted the Ad-Hoc Expert Medical Advisory Committee, previously described, to come up with urgent and effective measures for de-escalation of the pandemic in the State.

Anambra state government provided 3 laboratories in Awka and Nnewi to improve testing and case detection (Adejoro, 2020), (Onyenucheya, 2020). The State procured Bsl2 or Bsl3 cabinet necessary for the upgrade and activation of the Gene expert platform (Ozumba, 2020). The **Enugu state government** released 330 million naira to revamp some hospitals as isolation and treatment centres and to fund the purchase of essential health consumables and resources (Mbamalu, 2020). These facilities were distributed to the three senatorial districts, and two of them are located in urban areas (Ezea, 2020). Enugu Medical Diagnostic Centre was also put in place to improve the turn-around time of COVID-19 test results which is very important for improving treatment and containing the virus generally. The sum of 100 million naira was set aside by the state government as a special health emergency fund, and life assurance packages were approved for health workers at the frontline (Mbamalu, 2020).

The **state epidemiologists** are in charge of contact listing after suspect cases have been moved from points of isolation (POI) to treatment facilities. They are also responsible for creating linkage with designated focal persons in referring facility and notifying relevant authorities at the state (Director of public health at SMOH) and national levels (director of surveillance at NCDC) (FMOH & NCDC, 2020a).

Health workers in primary care play the roles of case detection through laboratory testing, referrals, and treatment, and their contributions to controlling the pandemic have been recognized (FMOH & NCDC, 2020a; NCDC, 2020).

3.2.2 Coordination of economic response to COVID-19 in Nigeria

The **Federal Government** simultaneously established measures to contain the coronavirus and stimulate the economy by protecting businesses, creating jobs and protecting vulnerable groups from economic hardship (Federal Republic of Nigeria, [FRN], 2020a).

The federal government's economic response is led by the **Economic Sustainability Committee (ESC)**, which is chaired by the Vice President, while the **Minister of Finance** co-chairs the sub-committee on fiscal stimulus measures. The ESC developed the Economic Sustainability Plan that was published in June 2020 (Andam et al, 2020). The Plan which cuts across all sectors of the Nigerian economy seeks to, among others, cushion the effect of COVID-19 on small businesses through the implementation of a Micro, Small and Medium Enterprise (MSME) Survival Fund Program that comprises four schemes namely, (I) Payroll Support Scheme which targets 500,000 MSMEs with employees; (ii) Artisan and Transport Scheme which targets 300,000 artisans and transport businesses; (iii) CAC Formalization Scheme to support the free registration of 250,000 new businesses; and (iv) General MSME Scheme to provide grants to 100,000 MSMEs. Part of the economic plan is the announcement of fiscal and stimulus measures to shore up the economy. These measures include reducing government spending in anticipation of lower revenues from crude oil exports and providing up to 50 billion Naira to support households and small and medium-scale enterprises affected by COVID-19 (Andam et al, 2020). The Plan consolidates on existing safety net programmes such as cash transfers and N-power, and reviews loan repayment plans for micro-credit interventions (tradermoni) such that beneficiaries are given a three-month 'holiday' period before loan repayment begins (Federal Republic of Nigeria, [FRN], 2020a).

The **Central Bank of Nigeria** extended moratorium, and provided reduction of interest rate, credit support for the healthcare industry, regulatory forbearance and N50 billion targeted credit facility to reduce the impact of the virus and stimulate the economy (Deloitte, 2020). Similarly, the **Federal Inland Revenue Services** introduced some tax-exemption and extension measures and relaxed some audit requirements to reduce the impact of the pandemic on the economy of businesses and corporate organizations (Deloitte, 2020). Furthermore, FIRS granted various administrative concessions to taxpayers in response to cushion the effect of the pandemic on household and individual income (KPMG, 2020).

Private-sector Coalition against COVID-19 (CACOVID) has been heralded as a foremost contributor in the fight against coronavirus pandemic in Nigeria (Partners, 2020; CACOVID, 2020). CACOVID comprises 100 private organisations and individuals who have pooled resources to support government's efforts to contain the virus and cushion the socioeconomic effects on households and individuals in Nigeria. According to a report by Business Day (2020), CACOVID has raised over 27 billion Naira and supported the provision of treatment, testing, training and isolation facilities all over the country.

3.2.3 Coordination of risk communication and information dissemination about to COVID-19 in Nigeria

The epidemiologic profile/data of COVID-19 in Nigeria is coordinated by the **NCDC** at national level, and **epidemiologic units in the States' Ministry of Health** at the state level. Staff of NCDC are deployed to states to support in data management and collation, and to ensure that all cases and deaths from COVID-19 are reported from states to the NCDC.

The NCDC has been collaborating with the **Ministry of information** and the **National Orientation Agency** to ensure that citizens are properly sensitized about the virus and that risk communication is maintained at community levels. Various media platforms (including SMS, radio, television, social media) have been used to promote risk communication and COVID-19 prevention measures such as physical and social distancing, restrictions in social gathering, staying at home and hand hygiene practices (UNICEF, 2020).

The state governments also play critical roles in awareness creation and risk communication to citizens and high-risk groups (Bolashodun, 2020).

3.2.4 Coordination of other responses to COVID-19 in Nigeria

The **Ministry of Education** has been working closely with the PTF to ensure safety of students, teachers and other staff. After due assessment of the pandemic, approval for the closure of schools was granted with effect from Monday 23rd March 2020 (Nigeria Education in Emergencies Working Group, 2020). In collaboration with federal and state governments, and stakeholders in the education sector, a policy document which details guidelines for safe reopening of schools and learning centres was developed, and based on the recommendations, decisions about phased reopening of schools were made by various state governments.

The **Ministry of humanitarian affairs, disaster management and social development** has the responsibility of protecting and providing humanitarian and social assistance to people in conflict or disaster-affected areas in the country. The Ministry was mandated to sustain the school feeding programme during the pandemic in order to reduce the potential nutritional and social effects of the pandemic on children and vulnerable households (FRN, 2020b). 70,000 metric tons of food were to be released from the national grain reserve for distribution to poor and vulnerable households and internally displaced persons were granted two months' worth of food rations (Deloitte, 2020). An additional one million poor and vulnerable households were added to the list of 2.6 million households eligible for assistance within two weeks (Andam et al, 2020).

The **Organized Private Sector for WASH** in Nigeria (POSWASH) installed hands-free hand washing facilities at target locations without hand washing facilities in order to promote hand hygiene for vulnerable groups, especially those in Internally Displaced Persons (IDPs) camps (Sanitation, 2020).

The **Nigeria One UN COVID-19 response** reflects the United Nation's support for an inclusive and nationally owned COVID-19 response through a shared vision and a common strategy. Its purpose is to coordinate and align UN's efforts and leverage partnerships with the government, development partners, foundations, CSOs and the private sector to increase the availability, accessibility, affordability, adaptability and acceptability of COVID-19 response interventions in Nigeria (UNDP, 2020).

The Nigerian **Slum/Shack Dwellers International (SDI) Alliance**, comprised of Justice & Empowerment Initiatives – Nigeria (JEI), the Nigerian Slum/Informal Settlement Federation (the Federation), and the Physically Challenged Empowerment Initiative (PCEI) launched a community awareness campaign through peer-to-peer, door-to-door education and distribution of flyers, facemasks, hand sanitizers, and hand-washing stations across 144 slums and informal settlements in Nigeria (SDI, 2020).

3.2.5 Interactions between national and state level stakeholders in COVID-19 response in Nigeria

The whole response to COVID-19 in Nigeria has been the result of collaborations between various government and non-government stakeholders at national, state and local government levels. Some of the notable responses to highlight these interactions are,

Training of health workers: The training of laboratory technicians on testing for COVID-19 was jointly undertaken by the State ministry of health, NCDC and WHO (Osibe, 2020). Likewise, the National Primary Healthcare Development Agency (NPHCDA) complemented the efforts of State governments by training PHC workers on preparedness and response to coronavirus.

Policymaking (e.g. lockdown restrictions, reopening of schools**):** the decision to reopen school is a joint decision between Federal and State Ministries of Education and the PTF (Federal Ministry of Education, 2020). Other stakeholders involved were local government, development partners, donors, civil society, and the private sector. They are expected to provide all resources needed by school communities for safe reopening. Moreover,

parents/guardians, parent teachers' association, school-based management committees, unions, communities, and education service providers were also consulted for safe reopening of school.

Procurement of essential services and funding: The response to COVID-19 comes with huge financial costs. Therefore, the government at the national and state level have been working closely with the United Nations to procure essential health equipment for testing, quarantine and medical care. Also, the government, have been making concerted efforts to mobilise internal and external resources from private sectors, UN, and World Monetary Fund (IMF)/ World Bank (UNDP, 2020). Furthermore, UNICEF continues to provide support to the state's EOCs on COVID-19 responses, and technical assistance to federal ministry of education and state governments to deliver home based learning through radio and television for school age children (UNICEF, 2020). Meanwhile, WHO (2020) reported that it would provide support for local authorities, leaders and policy-makers in cities and urban settlements to effectively handle the situation of COVID-19 and at the same time consider vulnerable groups like the urban poor (WHO, 2020). IOM has also been working with government and relevant partners to i) stem the impact of the disease ii) support the Government of Nigeria to safeguard development gains made so far, mitigate the pandemic's socio-economic impacts and iii) continuity of life-saving assistance and services in emergency settings (International Organisation for Migration, 2020). The IOM has shown enough commitment to this by engaging with different working and technical groups coordinated by the UN in Nigeria to co-lead the World Food Programme, collaborate on the socioeconomic response pillar and support to the PTF and National Laboratory system pillars.

Resource mobilization and allocation: Financial and material resources have been mobilized from philanthropists, private sector organizations and donor agencies (Mbamalu, 2020). The largest coalition of donors is the CACOVID, as previously described. Similarly, the COVID-19 Response Steering Committee in Onitsha city has successfully lobbied the government to ensure that personal protective equipment (PPE) is adequately mobilized and equitably allocated to health workers in the COVID 19 Isolation Centres get. Moreover, the Obi of Onitsha, through the Onitsha COVID 19 Response Program, is collaborating with the committee to ensure humanitarian support is equitably distributed to those in need (World Stroke Organisation, 2020).

3.2.6 Facilitators to the coordination of COVID-19 response at national and state levels

Multiple funding: Federal and State governments generated their resources to contain the spread of the virus, while providing as much support to the people as the economy would permit (Civil society in Nigeria, 2020). Funding from donors, private individuals and private establishments has been quite useful. Through pooled resources, government have been able to start up test centres in many states and increased the test capacity of many laboratories.

Joint Information Dissemination: Government's intervention covers the spectrum from information dissemination and sensitization on preventive measures (Civil Society of Nigeria, 2020), but the task is not left to the government alone. Civil society groups as well as local partners at the community level have been helping to disseminate information regarding the virus. This has proved useful in ensuring that people learn about the virus and as well learn ways to reduce the risk of exposure.

Private sector involvement: To further assist the government, the organized private sector and some non-state actors at national and state levels joined in the enforcement of lockdowns, provision of health resources and food palliatives, and advocacy for efficient and transparent utilization of resources by the governments throughout the period and beyond (Qualitative Magazine, 2020; United Nations, 2020; Uzor, 2020).

3.2.7 Barriers to the coordination of COVID-19 response at national and state levels

Poor communication of policies between state governments was a serious challenge to the effective coordination and synergy of some responses. For instance, the installation of a gate at the Onitsha (Niger) head bridge created misunderstanding between Anambra and neighbouring Delta state government (Gwamnishu, 2020). For several days and weeks, trucks conveying food items and fuel were stranded despite being categorized as essential services. Eventually, the blockade was lifted and the tension between the two states was resolved.

Weak enforcement of control measures by security agencies: The ban on interstate travel was violated by many citizens because security forces were compromised in their enforcement of the bans. Non-essential workers were granted access to travel in-between states if they were willing to pay their way through security check points (CLEEN Foundation, 2020; Eleke, 2020). This resulted in some state governors making occasional visits to inter-state boundaries to supervise and enforce the travel restrictions (Ezea, 2020). Similarly, there were breaches in social gatherings that necessitated the crackdown undertaken by some state governors (Okwor, 2020).

Poor planning and poor contextualization of control measures: Implementation of lockdowns and curfews across the country, particularly in urban areas was constrained by a lack of adequate preparation and adaptation to the country's context of an economy that is largely driven by the informal sector. Hence, coordination of the response was almost impossible as citizens found it difficult to adjust to the economic implications of a lockdown (Nwaubani, 2020).

Poor city planning: The poor city agenda hindered coordination of responses particularly in slum areas. Slum residents lacked the capacity and the resources to implement control measures (Dixit et al, 2020). A lack of urban housing plan especially for the densely populated regions like slums and sprawls made it difficult for persons in those areas to observe physical distancing and other safety measures against COVID-19 (Uzochukwu et al, 2020). Such places also lacked access to good water and sanitation facilities required to maintain good hygiene (Nwaubani, 2020; The Sun, 2020a).

Lack of data or inappropriate use of data: The absence of data on socioeconomic status of urban residents affected disbursement of palliatives, since it was difficult to determine who was poor (Dixit et al, 2020). The measures of poverty used in the National Social Register to compile the list of those to received conditional cash transfer were inadequate. The ability to recharge a mobile phone with more than 100 naira, and a bank balance of more than 5,000 naira are not standard parameters for measuring poverty and vulnerability. Rather, poverty is a composite measure of income level, consumption pattern, literacy level, employment status, nutritional status, and levels of access to healthcare, safe drinking water and sanitation (Njoku, 2020).

Corruption and lack of accountability: Health workers have complained that there are structural and facility-level corruption and accountability issues that compromise their efforts as healthcare providers to contain the COVID-19 pandemic and limit its health and social impacts (Onwujekwe et al, 2020)

3.3 Role of local (city) government in response and facilitators and barriers

Local governments are expected to drive the state's policies and strategies at the city and community levels. They have a critical role to play in bridging the gap in risk communication at the community levels and ensuring that pandemic prevention guidelines are strictly adhered to in public places.

In Anambra state specifically, **Ward Task Force (WTF)** were established in all 21 local government areas. Hence, there are a total of 326 WTFs who monitor community compliance with directives on public gathering and opening of business premises, and who assist with contact tracing and case detection based on travel history and/or presence of

symptoms (Egbuna, 2020; Osibe, 2020). In addition to the WTF, community leaders, civil society, trade unions, professional groups and organized private sector are engaged to promote hand hygiene and compliance to use of face masks in public places (Adinuba, 2020).

Anambra COVID-19 Network, a conglomerate of civil society organizations, media and other professionals, have toured 21 LGAs of Anambra state monitoring, documenting, reporting, engaging and distributing palliatives to rural communities. The **Civil Society Organization network** also produced risk communication materials to aid the sensitization processes in the communities (Pactcheck, 2020)

The **Onitsha COVID-19 Response Team** was involved in training community volunteers selected from 20 villages in the city on community sensitization and contact tracing, and in the production and distribution of personal protective materials (Onwuka, 2020; Ejechi, 2020). Similarly, the **Onitsha Advancement Foundation** have contributed to the success of sustainable economic interventions being implemented in the city, such as technological skill acquisition, business learning and financial intermediation as outlined in the Economic Sustainability Plan (Olatunji, 2020).

In Enugu state, city governments facilitated the decontamination of streets with chlorinated sprays, while market leaders supervised enforcement of safety protocols in market places (The Sun, 2020). The **Association of Tricycle Riders Transport Union,** Enugu also assisted the city government in enforcing safety measures and penalizing offenders or non-complain members of the union (Nwanosike, 2020).

Several community groups and non-government organizations in Anambra and Enugu have provided relief and food items to poor and vulnerable groups (women and children) but there is no clear mechanism of coordination for these groups (Osadebe, 2020; Raphael, 2020; Pactcheck, 2020). Apparently, these philanthropy groups decide and mobilize what they want to give, whom they want to assist and where they will find such people, without the guidance of city governments. Hence, the process is largely uncoordinated.

3.3.1 Facilitators to the city government response to COVID-19

The facilitators to city government response to COVID-19 somewhat mirror the facilitators at federal level, and they include **availability of funding**, **multi-stakeholder involvement**, and **private sector support.**

Although the tasks of screening, contact tracing and testing, and isolation and care have been primarily the responsibilities of federal and state governments, the processes have been facilitated by the **actions of city level (ward) task force** (Civil Society of Nigeria, 2020).

Moreover, the **involvement of communities and volunteers in monitoring** strict compliance with government directives have contributed to stimulating city level coordination of the response.

3.3.2 Barriers to the city government response to COVID-19

In addition to the barriers to federal and state government response (previously presented), city governments face major challenge of **overcrowding in urban slums**, which make it impossible to institute physical and social distancing control measures for COVID-19.

There is also a **lack of basic amenities** like water and sanitation facilities in urban slums, which constrain implementation of hygiene practices to reduce the spread of the virus (UNDP, 2020).

3.4 Coordination of cross-sector responses

The multi-sector response to COVID-19 in Nigeria has been coordinated through the PTF and state task force teams. The **Presidential Task Force on COVID-19** was established on the 9th of March 2020 to coordinate and oversee the multi-sector and inter-governmental response to COVID-19 in Nigeria (WHO, 2020). The committee was tasked with the responsibility of providing overall policy direction, guidance and support to the National and State Emergency Operations Centres (EOC), and other ministries and government agencies involved in the response. Other mandates include delivering national and state level pandemic control priorities such as establishment of treatment centres, defining containment measures and promoting dissemination and management of information. The PTF has also steered decision making around safe reopening of schools and learning centres, international travel and immigration policies (FRN, 2020a; PTF, 2020b; Andam et al, 2020).

Similarly, **State task forces** have been established in Anambra and Enugu states (as in all states in Nigeria) to contextualize and adopt/adapt national policies and guidelines on COVID-19 to the State front. The composition of the State task force varies from State to State. However, it comprises policymakers, political office holders, heads of relevant ministries and agencies (including health, information and security), heads of referral hospitals and laboratories and civil society organizations.

3.5 Socio-economic effects /effects on livelihoods of the urban poor

The federal, state and city responses to COVID-19 response have had both positive and negative effects on the livelihood of the urban poor in Nigeria. Some sub-groups of the urban poor have experienced the negative effects more than the others.

3.5.1 Positive effects on the livelihoods of the urban poor

On a positive note, the economic and humanitarian responses have targeted poor and vulnerable households and small business owners. Poor households have received either **cash transfers or pre-paid debit cards**, and some have received **food rations**.

Small business owners have benefited from the MSME Survival Fund Program of the Federal government. Although an independent evaluation of the impact of the intervention is yet to be publicized, reports show that the various schemes have made significant progress towards achieving their target numbers of beneficiaries across the country. As at 1st September, 2021, the Payroll Support Scheme had reached 91.9% of target beneficiaries (459,334 MSMEs) comprising 43% female-owned businesses and 3% special needs; the Artisan and Transport Scheme had reached 97.8% of its target (293,336 artisans and transport businesses); the CAC Formalization Scheme had provided free registration to 244,162 small and growing businesses (97.7% of target beneficiaries); while the General MSME Scheme had provided grants to 82,491 MSMEs (82.5% of target beneficiaries) (Fadare, 2021).

Empowerment of the urban poor: Justice and Empowerment Initiatives (2020) provided coronadiaries for the urban poor, comprising audiovisuals and visuals to help them document their daily experiences at survival.

3.5.2 Negative effects on the livelihoods of the urban poor

Increase in level of impoverishment: The number of impoverished people in urban areas increased as a result of the pandemic and its response in Nigeria (Pactcheck, 2020). Household income for the informal sector workers was most negatively impacted due to lockdown measures (KPMG, 2020). Considering that majority (65%) of Nigerians work in

the informal sector (Civil society of Nigeria, 2020), the economic impacts of the lockdown was a 14-percentage point temporary increase in the poverty headcount rate for Nigeria, implying that 27 million additional people fell below the poverty line during lockdown (Andam et al, 2020).

Loss of jobs and income: It is estimated that households lost on average of 33 percent of their incomes with the heaviest losses occurring for urban households and rural non-farmers (Resnick, 2020). Loss of jobs, especially for the informal and private sector employees, was a key socio-economic consequence of the pandemic on the urban poor (Christopher, 2020; Uroko, 2020). In another report, 79% of households experienced massive decrease in household income, while 59% reported inability to purchase staple food items for household consumption (Siwatu et al., 2020). The poor who equally rely on social networks for survival, also had difficulties because the lockdown had also affected their income (Olajide, 2020).

Inequitable access to educational resources: The closure of schools affected close to 46 million students throughout the country, and the most affected groups of children were those from poorer homes who were enrolled in public schools and had no access to online educational resources (Nigeria Education in Emergencies Working Group, 2020). Private schools and some state governments introduced various distant learning programmes through online platforms. However, this was only beneficial to children from more wealthy households who could afford to purchase electronic equipment (android phones, tablets or computers) and frequent data bundles. Hence, children form urban poor households and rural areas with limited or no internet access were disenfranchised, and existing inequities were exacerbated (TEP & NESG, 2020).

Worsening access to healthcare: Poor urban households experienced even more difficulties accessing healthcare from public and private health facilities (Nwaubani, 2020; Ogunpolu, 2020). Siwatu et al (2020) reported that up to 26% of households could not access medical care.

Brutality and extortion from security agencies: Owing to the immediate effects of the lockdown restrictions on the informal economy, urban residents who relied on a daily income resisted the lockdown measures and this was met with police brutality and extortions from security agencies (Campbell & McCaslin, 2020; Siwatu et al, 2020). In April, the National Human Rights Commission (NHRC) reported 33 incidents of inhuman treatments, 27 incidents of unlawful arrest and detention, and 18 cases of civilian deaths in the hands of the Nigerian Police (ACAPS, 2020). In Enugu State, specifically, the CLEEN Foundation (2020) mentioned that the State COVID-19 taskforce in the urban area intimidated and extorted money from the urban poor who broke the rules in search of livelihood. There were also reports that the sources of livelihood of some of such urban dwellers were impounded/confiscated (Justice and Empowerment Initiatives, 2020).

Unfit control measures: Informal settlements (slums) are side-lined in the distribution of urban resources and are therefore at highest risk of health hazards. Whereas recommended physical distancing and hygiene measures are convenient for people in gated communities, it is practically impossible for people in informal settlements that are overcrowded and lacking in sanitation facilities (Lawanson, 2020).

Effects on vulnerable groups: Women and children from urban households whose livelihood were dependent on daily earnings experienced various forms starvation. Women and girls, particularly, have been disproportionately affected since the lockdown, with pregnant women highly vulnerable because of already existing inequality (Civil Society of Nigeria, 2020). Another major fallout during the lockdown was an increase in domestic violence against children and women, who were forced to stay indoors with the persons that molest them. The Women's Aid Collective in Enugu State reported 25 cases of rape between April and May 2020 and handled 156 cases of sexual and gender violence (Obisike, 2020). As a result, there was a protest in Enugu State by CSOs, demanding for proper implementation of the Violence Against Persons Prohibition Law.

4. Discussion

Since February 27 2020 when Nigeria recorded its first case of coronavirus, cases have continued to rise on a daily basis, further straining an already fragile health system (Dixit et al, 2020). Urban areas have contributed the most to the number of cases of COVID-19 in Nigeria (ACAPS, 2020). This is probably due to high urban population density and the associated socioeconomic activities of the informal sector (Nwaubani, 2020). Although data on COVID-19 cases are unavailable for Enugu and Onitsha cities, the host states (Enugu and Anambra) have recorded some of the lowest figures for COVID-19 cases and fatalities in Nigeria, and this is irrespective of the high socioeconomic activities in both states (Onyenucheya, 2020). In response to the COVID-19 pandemic, Nigeria has elaborated many policies, strategies and plans at national, state local government levels. Evidence-based approaches such as social distancing and "test, trace and treat" have been implemented in all states in Nigeria. However, these have been implemented on the foundation of a weak health system with slow emergency response, weak accountability, fragmented data and poor surveillance and information monitoring. These weaknesses have led to implementation gaps.

Moreover, most of the pandemic containment measures in the country were copied from dissimilar (more developed) contexts/countries without due consideration of the fit for Nigeria's urban population and economy. Nigeria's urban economy is an informal sector-driven economy, and majority of the urban poor rely on daily earnings from small businesses, unskilled labour and semi-skilled labour for their livelihood. Government's directive for a state-wide lockdown in Nigeria was issued without any plans to sustain the urban economy or provide palliatives to motivate compliance from informal sector workers. Consequently, the enforcement of lockdown measures had harsh socioeconomic impacts on the urban poor, and this became an even bigger problem for the government than the pandemic itself (Michaelowa & Michaelowa, 2020). Similarly, directives for social distancing, hand hygiene, personal protection and sanitation were issued without recourse to the living conditions of the urban poor, the lack of basic amenities such as water supply, and the loss of income that accompanied the lockdown response. Hence, it was an uphill task to implement the pandemic containment measures in hard hit urban areas, or to secure compliance from the urban dwellers (particularly the urban poor).

The vulnerability of the poor to economic booms and busts is the premise on which demands for the provision of robust social safety net are made. This will contribute to ensuring financial risk protection for those at the lowest rung of the income scale. Therefore, in response to the socioeconomic consequences of the COVID-19 pandemic and its containment measures, federal and state governments in Nigeria developed and began to implement some safety net interventions, including distribution of food rations, cash transfers to households and microcredit facilities to small business owners. Although these economic responses were well-intended, the desired outcomes were not achieved for various reasons, including lack of or poor use of data on poverty and vulnerability in urban areas, and corruption and lack of accountability. Furthermore, social welfare schemes—such as food assistance and cash transfers—have been inadequately and inefficiently distributed. Hence, federal and state governments are yet to develop a sustainable cash transfer policy to support the vulnerable groups in the population.

There have been reports of embezzlement of COVID-19 relief funds by government officials, particularly at the federal level. Hence, fueling the existing public mistrust of government and political office holders. Besides, the approach deployed by government to determine vulnerable (poor) households that will quality for relief materials was also faulty and non-transparent. Leveraging data used for the Social Investment Programme to determine potential beneficiaries of the COVID-19 palliative was faulted as lacking in transparency. Considering that poverty measurement

is multi-dimensional, it was also inappropriate to use the amount spent on airtime recharge to determine poor households.

Data is a critical requirement to ensure that project planning and implementation are effective and successful. The consequences of unavailability of a comprehensive and SES disaggregated register of urban dwellers became very apparent in the distribution of palliatives and cash transfers to vulnerable households. It significantly hampered equitable distribution of palliatives in the cities and increased citizens' mistrust of the government. Recently, Nigeria was on the news for the mass looting of COVID-19 palliatives that were discovered in warehouses in some major cities. The delay in distribution of palliatives was once more attributed to a lack of data on the vulnerable and poor. Therefore, the urban poor are increasingly at risk of not benefitting from interventions designed to mitigate the economic effects of the pandemic on poor and vulnerable groups. Governments should leverage the lessons of COVID-19 to generate a comprehensive database of urban dwellers and establish systems to ensure this database is regularly updated.

The implementation of COVID-19 response in Nigeria has involved multiple stakeholders including government departments and agencies, expert and advisory committees, organized private sector, development partners, civil society coalitions, and community leaders and gatekeepers. These stakeholders operate at various levels – federal, state, local government and community – and the scope of their responses vary depending on their capacities. The key facilitators of the health system response are the NCDC, federal and state ministries of health, and the national and state primary healthcare development agencies. Whereas the economic and humanitarian responses are facilitated by the ministry of humanitarian affairs and the central bank. The multiplicity of stakeholders in the COVID-19 response underscore the genuine interest of groups and individuals to control the outbreak and mitigate the potential social and economic consequences. Having multiple stakeholders could also be beneficial to the response when there are multiple sources of funding and material resources. However, if the responses and contributions of the multiple stakeholders are not well coordinated, the greatest consequence would be inequitable allocation of resources.

Although we have attempted to organize the response to COVID-19 into three main categories and an 'others', this review uncovered that there is some form of structure in the process of coordination of responses, albeit intricate. At the apex of the coordination is the PTF, but considering that health is on the concurrent legislative list in Nigeria (so a responsibility of both Federal and State government), state and local governments have replicated their task forces (State task force – STF and Ward task force WTF) to coordinate responses at respective levels. The task force oversees and coordinates the multi-sector inter-governmental efforts at respective levels. However, it is not apparent whether and how the PTF controls or communicates with its state and local government counterparts, and whether there are horizontal linkages across state task force teams. Similarly, there is the replication of expert advisory committee at federal and state levels, but the linkage between and across these committees is unclear. In addition, the private sector and development partners appear to be floating in the coordination structure. These weak (or absent) linkages between stakeholders is problematic because it fosters working in silos and its attendant inefficiency in resource utilization. Moreover, stakeholders stand to benefit from one another when linkages exist because in addition to providing an opportunity for pooling resources together, it also enables sharing of vital information and leveraging others' experiences in designing and implementing interventions. Therefore, attention should be given to the coordination of stakeholders and their actions in the COVID-19 response.

The civil society organisations and private sector have contributed significantly to building an effective community response to COVID-19. However, there are concerns about duplication of interventions, inefficient utilization of resources and skewing of beneficiaries of these interventions due to poor coordination of private sector response (Civil Society of Nigeria, 2020). In an attempt to mitigate wastage and inefficiency, some civil society organizations have formed coalitions in some states and are collaborating with state governments to appropriately target vulnerable groups. For instance, the advocates for disabled people in Enugu state are working with the government to provide palliative to people living with disabilities inside and outside of the city (Qualitative Magazine, 2020). This will inadvertently contribute to effective and equitable distribution of palliatives to these group of people.

With regards to the differential impacts of COVID-19 response on the urban poor, our findings showed that women and children were disproportionately affected by the negative consequences of the response strategies. In the medium-term, the global spotlight on the rise of gender-based violence during the COVID-19 crisis provides an opportunity to strengthen legislation protecting women and girls from violence. A gender-responsive strategy must be underscored by the government and all stakeholders in dealing with the fall-out of the COVID-19 crisis. This includes the prioritization of gender-based violence centres as essential services, as well as the inclusion of women in decision-making to ensure that valid gender concerns are adequately captured. Now more than ever, policymakers must be responsive to lessen the effects of the impending social and economic crises and better prepare Nigeria for the future.

5. Conclusions and Policy Recommendations

The socio-economic impact of the pandemic is a huge test on the organisation and functioning of government at the national, state and local level. The multi-sector preparedness approach by the government and the unrelenting support of the private sector have contributed to the overall country response to the pandemic. However, there are missing linkages between stakeholders, coordination of response is suboptimal and distribution of relief materials is ineffective due to poor data systems. Hence, the likelihood of duplication of efforts, inequitable resource allocation, wastage of resources and amplification of vulnerabilities in urban settings. Without a dedicated policy to address the plight of the urban poor and vulnerable groups, the aftermath of the pandemic response will translate to widened health inequity, income disparity and inequality in urban areas. As a matter of urgency, policymakers need to be more responsive and proactive in ameliorating the social and economic effects of the pandemic on the urban poor, and better prepare the country for future shocks and health emergencies.

In line with these, the following recommendations are made:

1. Establish (vertical and horizontal) linkages between stakeholders (actor groups) at all levels

Government should establish linkages between the various task forces, starting from the presidential task force at the national level to the ward task force at the local government level. Linkages should also be established between expert and advisory committees at all levels. These linkages should also cut across the advisory committees of various states as well as the task forces of these states. This will enable sharing of information and experiences, and adoption of best practices.

2. Strengthen the coordination of actors and their actions in the COVID-19 response

The multi-sector, multi-level and multi-stakeholder nature of COVID-19 response in Nigeria, underlines the need for better coordination of actors and their actions. This will mitigate duplication of efforts and contribute to equitable and efficient resource allocation and use. A better coordinated response will ensure that no one is left behind, particularly vulnerable women and children in underserved urban areas.

3. Contextual adaptation of disease outbreak containment and preventive measures

Interventions for the containment of COVID-19 outbreak and the risk communication strategies were poorly adapted to the Nigerian context, and this resulted in the lack of compliance that is being observed in urban areas. Moreover, a one-size-fits-all response will not be effective in a diverse and dynamic context such as is found in Nigeria. Therefore, interventions should be adjusted to local realities, taking into consideration the economic, social and cultural factors. Active and meaningful community engagement will contribute to better adaptation and will ensure community ownership, trust and acceptability of interventions on risk communication and personal protection.

4. Strengthen accountability and transparency in the management of COVID-19 resources

The COVID-19 response is marred with reports of irregularities and corruption in the procurement, distribution and use of resources. This is heightened by the lack of transparency and accountability by government. The processes outlined in the national public procurement policy should be strictly adhered to in the procurement of COVID-19 resources. Appropriate models should be adopted or adapted for tracking COVID-19 resources at all levels, and data systems on resource tracking should be made public and accessible. Heightened vigilance from civil society organizations and the mass media could contribute to better public accountability for resources.

5. Improve urban planning and urban data systems

Urban vulnerabilities amplified by the COVID-19 presents an opportunity for a fresh consideration of urban planning approaches in Nigeria. In the immediate term, there is need to transit from generalist top-down planning to more grounded localized planning. This can be achieved through the resuscitation of the local planning authorities and empowering them to prepare lower order plans to guide the development of local communities. Furthermore, electronic data systems should be established for generating and continuously updating a comprehensive list of the poor and vulnerable individuals and households.

6. Address the needs of the urban poor and other vulnerable groups through better targeting

The COVID-19 response should include interventions that are specifically designed to ameliorate the impact of the pandemic on the urban poor and other vulnerable groups. Strategies that are gender-responsive and vulnerability-sensitive should be underscored by the government and all stakeholders in addressing the needs of the urban poor. This includes the prioritization of gender-based violence (GBV) centres as essential services, as well as the inclusion of women in decision-making to ensure that valid gender concerns are adequately captured.

7. Mainstreaming health in all policies, strategies and plans

The multi-sector COVID-19 pandemic response should move beyond a one-off emergency action. Rather, the government should use this as an opportunity to mainstream health in all sectors, particularly in the environmental sector to address water and sanitation issues, and the private sector to enhance domestic resource mobilization for health. The government should also increase the efficiency of its response to the pandemic, making sure that regular health programs remain well-funded to forestall potential long-term impacts of a COVID-19 related crowding out.

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