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CHAPTER 25

PREPAREDNESS AND CONTAINMENT OF EBOLA VIRUS DURING FOOTBALL COMPETITIONS IN THE SOUTHWESTERN, NIGERIA.

Adisa Olawumi (Ph.D) ; Ayeni, Adeoti Adeyemi (Ph.D)
& Oyediran Babatunde Abideen

ABSTRACT

Objective: The Ebola virus disease, formerly called the Ebola haemorrhagic fever, was first identified in rural Zaire (now the Democratic Republic of Congo) in 1976, where it killed 280 people. The disease had mostly been confined to relatively small outbreaks in rural settings, until the 2014 outbreak, which hit urban areas in Liberia, Sierra Leone, and Guinea. Today, the African countries affected by the outbreak of Ebola in 2014 have been able to curtail it and have even come out strong out of its devastating effect. However, this disease has a tricky way of sneaking back, as it has demonstrated in the time past. So to what extent is our stadium equipped to screen, detect, prevent and contain Ebola spread during football competitions. This has been the major focus of this research.

Methods: Descriptive survey research design was used for the study. It was correlational type which explores the relationships that exists among variables on which predictions are made based on the relationships. A total of 75 (Seventy five) respondents were selected from among the Sport medical personnel, coaches, athletes, sport managers/administrators and sport journalist from each stadium to make a total of 150 (one hundred and fifty) respondents. A self-developed questionnaire which has reliability coefficient of 0.87 was used to collect data while the data were analysed using inferential statistics of chi-square at 0.05 level of significance.

Results: The findings of the study reveal that the selected stadia lack surveillance and detection capabilities for Ebola and other infectious diseases. It was also discovered that many personnel working in and around the stadia, athletes and spectators lack adequate knowledge about Ebola. The health facilities in around the complex too did not have functional diagnostic and containment capabilities for Ebola.

Conclusions: It was concluded among others that adequate laboratory service and active surveillance capacity for Ebola detection during football competition should always be made available by the authority concern.

Introduction

The Ebola virus disease, formerly called the Ebola haemorrhagic fever, was first identified in rural Zaire (now the Democratic Republic of Congo) in 1976, where it killed 280 people. The disease had mostly been confined to relatively small outbreaks in rural settings, until the 2014 outbreak, which hit urban areas in Liberia, Sierra Leone, and Guinea.

The World Health Organization (WHO) (2014), which was criticized for its slow response to the epidemic, called this 'the most severe, acute health emergency seen in modern times' .The virus is named after the Ebola River, in the Congolese region where it was first identified. The largest outbreak prior to 2014 was in Uganda in 2000: 425 were infected and 224 died. Though Ebola fatality rates vary from 25percent to 90 percent, the WHO placed the mortality rate in the 2014 West Africa outbreak at 70 percent.

The outbreak is believed to have started in December 2013 in a Guinean village near the Liberian and Sierra Leonean borders. According to New England Journal of Medicine (2014), the disease was traced to a two-year-old boy who died on December 6; he and his family were never tested for the disease, although their symptoms were consistent with Ebola (his mother, sister, and grandmother subsequently became sick and died). Researchers do not know how the family contracted the virus, which can be contracted from primates, bats, or contaminated food.

World Health Organisation (WHO) (2014) declared that, unlike past outbreaks, which were generally confined to remote villages in central Africa (most past outbreaks took place in the Democratic Republic of Congo, Sudan, Uganda, and Gabon, the current epidemic hit several communities before being identified as Ebola. By the time the diagnosis was made in early March, the virus had already struck multiple communities in Guinea, with suspected cases emerging in Liberia and Sierra Leone. Cases have also been reported in Nigeria, Senegal, and Mali, although the former two were declared Ebola-free in October, 2014. Mali declared its first case on October 23, 2014.

According to 2014 report of the Centre for Disease Control, the Ebola outbreak in West Africa in 2014 was the largest of such epidemic in recorded history, with over 4,500 deaths attributed to the infection so far. In addition to the human toll, the 2014 outbreak became an international humanitarian crisis. In outbreak settings, Ebola virus is typically first spread to humans after contact with infected wildlife and is then spread person-to-person through direct contact with bodily fluids such as, but not limited to, blood, urine, sweat, semen, and breast milk. The incubation period is usually 8–10 days (ranges from 2–21 days). Asymptomatic individuals do not transmit Ebola Virus Disease. Ebola Virus Disease patients can transmit the virus while febrile and through later stages of disease, as well as post-mortem, when persons touch the body during funeral preparations. Ebola Virus Disease is characterized by sudden onset of fever and malaise, accompanied by other nonspecific signs and symptoms, such as myalgia, headache, vomiting, and diarrhoea. Patients with severe forms of the disease may develop haemorrhagic symptoms and multi-organ dysfunction, including hepatic damage, renal failure, and central nervous system involvement, leading to shock and death. The fatality rate can vary from 70-90 percent.

According to Uchendu and Anthony (2014), in Nigeria, there has been an unprecedented fear of Ebola virus disease (EVD or Ebola) since July 20, 2014 when, a man who was to become the country's index patient flew on commercial planes from Liberia, through Ghana, to Nigeria's largest city – Lagos. "In a matter of weeks some 19 people across two states were diagnosed with the disease (with one additional person presumed to have contracted it before dying)".

Football the "beautiful game" (aka soccer) has been bringing competition and fun to rural and underprivileged communities worldwide. Football was originally a recreational activity, but with the introduction of financial and material benefits and an attendant honour to it, the number of participants and the struggle for victory have introduced high level politics into it. Consequent upon the expected rewards, fraud, irregularities and injustices have overshadowed the system. However, a lot of people and groups are now interested in knowing about football events, fixtures, date, time and places of such events become matter of interest. They equally raise a question about past ones and even the plans for the future. Football is also a source of pride for many nations. According to the latest statistics, approximately 265 million persons (both male and female) play soccer (Philips, 2010).
About 4 percent of the world's Population is actively involved in the game, and there are 2,028 professional soccer teams in the world (Philips, 2010). La liga are extremely popular in Spain, Germany, Italy and Brazil. Worldwide, there are over 150,000 soccer teams. Soccer attracts more commercial and corporate cash than any other sport, but unfortunately it has also too often been victimized by corruption and scandals. Many of the short comings have already been identified (Philips, 2010).

However, football also retains a "brighter and more human" side. Not only has it help to develop and revitalize local economies, it has assisted in the rehabilitation of war victims, brought joy in the midst of suffering refugees camps, helped with reconciliation processes, redirected delinquent youth, and been part of awareness campaigns to help alleviate malaria, tuberculosis, HIV and AIDS.

In Nigeria and many parts of the world, through the game of football thousands if not millions have been exposed to life threatening diseases ranging from HIV AIDS, Zika virus and even Ebola. Ebola happens to be the most threatening disease as it spread fast between human and animals, in as much we know that the game of football involves different people from different countries coming together to participate hence, teams whose country is endemic to this disease happens to have the opportunity of spreading the disease to other team members and spectators therefore becoming a threat to the country of participation. So different measures need to be put in place to ensure that the spread of this deadly virus is equally prepared for, prevented and contained in case of suspected cases during football matches in Nigeria. However, football possesses enormous social Capitals which can help fuel the efforts to tackle one of the most devastating diseases in recent time-EBOLA. In, 2010 FIFA joined forces with the United Nations to stop the spread of Ebola epidemic in West Africa. More than 22,000 people have been infected with Ebola virus and over 8,800 have died making it the worst Ebola epidemic since the virus was identified in 1976 (Philips, 2010). FIFA'S tangible involvement with combating the disease led to the world health organization (WHO) in 2014 using the Antoinette Tubman stadium in Monrovia and Liberian football Association stadium for emergency large scale Ebola treatment centres. The WHO also Identified the stadium as the most suitable location in terms of effectiveness and safety to combat the effects of this devastating disease.

FIFA has taken its self-declared mission "to build a better future" seriously by supporting the conversation of the Monrovia stadium into Ebola treatment units. Thanks to the continuous, fruitful, and fundamental collaboration between FIFA and the United Nations, today we can use the power of football to combat the Ebola epidemic, "says the then FIFA president Joseph Blatter. Blatter also promises to allay concerns regarding the impact of the treatment units on those installed pitch mentioned above. "FIFA proposed to cover the costs of any damage to the Stadia "says Blatter.

Wilfred lemke, special adviser to the secretary general of the United Nations on sports for development and peace, recognizes that the Ebola outbreak has affected the sport community in ways "ranging from the health threats to the athletes themselves and restrictions on travel affecting competitions and the development of sports" He, too, emphasized the need for national authorities, the UN and the world of sport to work closely together in order to halt the spread of the disease on November 17,2014,FIFA along the confederation of African football (CAF) dispatched a dream team "11" against Ebola, "featuring the then Real Madrid's Cristiano Ronaldo, Barcelona's Neymar Jr., Chelsea's Didier Drogba, and Bayern Munich's Philipp lahm among others, to promote 11 health messages recommended by medical specialists from Africa, the World Bank, and the WHO. Though, generally exemplars of good health, football players are hardly immune against Ebola. Therefore need arises to cater for the safety of players, and the spectators who throng the stadium across the globe to enjoy the "round leather" game. Football is also very popular in West Africa and this led to the FIFA' agreement with the CAF "to organized international matches of the countries that experienced [Ebola] intense transmission (Liberia, Sierra Leone and Guinea) on neutral ground." FIFA also recommends that soccer clubs "carry out a medical check -up" on players returning from "an international fixtures involving a high-risk country.

Who would have thought that football, a sport that is nearly 3,000 years old, would become so much more than kicking a ball to score goal? By looking closely, we can see in football, and in every sport that human will strive to overcome challenges that are sometime more than physical. Football and global sports in general, is no longer an activity solely associated with exercising the human body. It has transformed into global industry that captivates the attention of billions of people, employs millions, and is by some estimates worth $700 billion. The power and influence comes with social responsibilities, and the effort to impede Ebola might be one of the best examples of the shared obligation in contemporary sports. Through its global solidarity program, FIFA may assist the world in scoring the winning goal against Ebola (leszek, 2014).

According to the centre for disease control (CDS) (2014) Ebola ability to spread is largely due to stricken countries weak health care systems : Prior to the Ebola outbreak there were only fifty doctors in Liberia (a little more than one per 100,000):In the United States there are around 240 doctors for every 100,000 people. All affected countries reported dearth of doctors, treatment and prevention, supplies and beds for sick patients.
Ebola virus, as reported by CDS (2014) is classified as a level 4, which means that this virus can only be studied for research purposes in a level 4 biosafety Laboratory (BSLA). This level is required for work with dangerous or exotic agents that pose a high individual risk, cause severe to fatal disease or lack a vaccine or other treatment. A biological hazard at this level required the use of special personal equipment and clothing as well as segregated air supply among other precautions (Containment System for Infectious Diseases, 2014).

Ebola disease has been proven to be one of the most dangerous diseases in the world and as a result of this it has been discovered that it's detrimental effects on football competition and sport activities in general can never be over emphasised and hence every possible means in tackling the disease in football competition should be adopted since it has been discovered that one of the mode of transmission include contact from infected person to uninfected.
It is of note that Ebola epidemic had negative influence on Africa football competition

especially in Nigeria hence the need to speedily prevent and consequently eradicate the disease during football competition is highly essential. The danger that Ebola possess toward football competition is very alarming as it has forced football organizers to restructure and make adjustments towards organization of football competition as a result of Ebola outbreak. It is on record that football was badly affected due to the Ebola outbreak in West Africa. Liberia for example suspended all football activities or competition in 2014 in other to control the spread of the disease. Sierra Leone players were refused entry into seyduelles. Confederation of African football (CAF) also banned hosting of matches in Guinea, Liberia and Sierra Leone during the outbreak of the disease in 2014.

With all this one can vividly see that the issue of Ebola disease in football competition is not what one can wave off as it possesses a lot of health challenges to participants (al Jazeera, 2014). Already, it has caused catastrophic effects across West Africa. Soccer has long been a force to unite disparate factions of society across the region -- from its role in halting the civil war in Ivory Coast in 2005 to Nelson Mandela's culmination of healing South Africa's apartheid wounds with the 2010 World Cup. Yet it is exactly that power to bring people together, in strictly physical terms, which means soccer is also seen as such been threatened during the devastating Ebola outbreak.

Fear of the epidemic widening gripped countries, and Morocco in 2014 intimated that the risk from players and fans from across Africa descending on it for the continent's flagship soccer tournament, the 'Africa Cup of Nations', is one the country is not prepared to take. We are talking about the Africa Cup of Nations where we are expected between 200,000 to 400,000, even one million spectators to converge in Morocco," Mohamed Ouzzine, Morocco's youth and sports minister, said on Thursday. "I don't think there is any state or any country that has the necessary capabilities to monitor, check and control the current Ebola situation when faced with these numbers. This is our real problem. We don't have a problem with visiting teams; we have a problem with visitors."

Having already asked the Confederation of African Football (CAF) to postpone the 16-nation tournament set for January 2015. CAF then seek out alternate venues. Ghana revealed that it was contacted about the possibility of stepping in, while South Africa was sent a similar inquiry, according to BBC Sport.

The concentration of the virus, which took the lives of almost 4,500 people in the 2014 outbreak, was in Guinea, Liberia and Sierra Leone, none of which look likely to qualify for the Cup of Nations. Nigeria, the then defending champion, has better prospects, but, while the country had 20 cases of Ebola, it has since contained its outbreak. Although the scale of the impact on its most prestigious event remains unclear, African soccer was already hit hard by the effects of Ebola. Guinea, Liberia and Sierra Leone had bans from hosting games placed on them by CAF, with the latter suspending all matches in the country. During qualification for the Cup of Nations, Sierra Leone played back-to-back matches in Cameroon. The reaction the visitors encountered showed an ugly human side to the epidemic as fear of Ebola bred discrimination. The Sierra Leone team was subjected to opposition players hesitant to shake their hands and swap shirts, most painfully of all had "Ebola" chanted at them from the stands when facing Cameroon in the capital Yaoundé.

The players felt humiliated as exclaimed by John Tyre, Sierra Leone's backup goalkeeper. Those are far from isolated incidents, as African players had been targeted for abuse and baseless rumours from across the globe. One of Africa's most famous players, Michael Essien, who had play for AC Milan and previously starred with Chelsea and Real Madrid, felt

compelled to post rebuttals accompanied with pictorial evidence on social media in response to claims that his absence from a match was due to being diagnosed with Ebola. Tunde Popoola, Secretary-General, Nigeria Olympic Committee (NOC), who commented on the treatment of Nigerian athletes in Nanjing for Olympics in 2014, said the athletes were not allowed to train or associate with other athletes in China. "When our athletes got to China, they were checked but none of them tested positive to the virus, and they were kept in a separate part of the games village with athletes from Guinea. "They carry out tests on the athletes every morning and afternoon, even when they turned negative," Popoola said. He, however, noted that the NOC did not have any problems with the measures taken by the Chinese government, but that the athletes were affected psychologically. Popoola said that it was based on that, that the decision to come back was taken. " It is not as if the Chinese government was discriminatory against Nigeria; the issue is that the preventive measures affected our young athletes; we considered it unfair to subject our young athletes to this condition (vanguard 14,2014).

"It creates a negative impression on their mind, which will go a long way to affect their psyche," Popoola said. On his part, Musa Nimrod, Chairman, Beach Volleyball Commission of the Nigeria Volleyball Federation (NVBF), said that withdrawal from the Youth Olympic Games, was a heavy blow to the career of the young athletes. The chairman said that the athletes had lost the opportunity of getting the needed exposure which would have enhanced Nigeria's future performance in sports. "It is unfortunate and very discouraging because the athletes have just lost a big opportunity to get exposed, especially for us as debutant in the beach volleyball event. "It is the dream of every child to feature at the Youth Olympic Games before the senior Olympics, it is discouraging, considering the kind of efforts the athletes put in during the preparations," Nimrod said.

Sports lovers want football administrators to make pragmatic efforts to ensure that sports development in Africa is not undermined by the outbreak of Ebola disease. If necessary measures are not put in place, sports development in West Africa may suffer great setback. It was also recalled that the 2014 ECOWAS Games scheduled to hold in Cote d'Ivoire was postponed because of the Ebola outbreak (Vanguard,2014). Nonetheless, Patrick Okeke, Secretary, Nigeria Basketball Federation (NBBF), opines that although the outbreak of the virus will cause a setback in the development of sports in Africa, the challenge will be temporary. "It is a wise decision to postpone the games because contacts cannot be avoided in sports; but the truth is that it will cause a setback for our sports in Africa. "However, I don't see the setback to be long because it is better to save lives; so, it is better everything is put on hold for now pending the time there will be solution to it," Okeke said. Tony Oghuma-Eghmai, NVBF Technical Director, corroborated Okeke's claim, insisting that it was a good decision to postpone sports events for some time to check the spread of the disease. "Although it will cause a setback for sports in Africa particularly Nigeria, a cure for the virus is worth waiting for. "This is a virus that spreads very fast and if we should continue holding sports events and feeling unconcerned, it will be disastrous (vanguard 14, 2014). Today, the African countries affected by the outbreak of Ebola in 2014 have been able to curtail it and have even come out strong out of its devastating effect. However, this disease has a tricky way of sneaking back, as it has demonstrated in the time past. So to what extent is our stadium equipped to screen, detect, prevent and contain Ebola spread during football competitions. This has been the major focus of this research.

Methodology

This study investigated the preparedness and preventive measures towards Ebola during Football competitions in Nigeria. Descriptive survey research design was used for the study. It was correlational type which explores the relationships that exists among variables on which predictions are made based on the relationships. This design was considered more appropriate as it helps to explain and interprets current issues and existing condition as well as identifying problems and prevailing practices; which is economical for independent research. The research work investigated two different National stadiums in Nigeria (The National Stadium, Lagos and Liberty Stadium, Ibadan) for the purpose of effectiveness.
A total of 75 (Seventy five) respondents were selected from among the Sport medical medicine personnel, coaches, athletes, sport managers/administrators and sport journalist were selected from each stadium to make a total of 150 (one hundred and fifty) respondents.

The research instrument for this study was a self-developed questionnaire developed in accordance with variable tested in the study. The questionnaire contains two sections "A" and "B". section 'A' dealt with the demographic data, while section "B" which is a four like type scale of partially agree, agree, partially disagree and disagree measures the attitude and behaviour of the respondents and also ascertain the level of the preparedness of the two stadium under study towards detection and prevention of Ebola outbreaks and spread during and after football competition. The instrument was pre-tested using 30 similar respondents in the Stadium in Ilorin, kwara state. The pre-test result indicated no ambiguity in the instrument and the reliability of 0.87 was obtained. Inferential statistics of chi-square was used to test the formulated hypothesis.

Results

Hypothesis 1: Nigeria sport stadia will not lack significant surveillance capacity for Ebola detection during football competition

Table 1: Chi-square (X2) analysis on lack surveillance capacity for Ebola detection during football competition

Question items	Laboratory service				Total	X^2 Cal.	X^2 Crit.	Df	Sig.
	SA	A	D	SD					
Q1	50 33.3%	43 28.7%	35 23.3%	22 14.7%	150 100.0%	50.533	1.635	6	.000
Q2	31 20.7%	71 47.3%	37 24.7%	11 7.3%	150 100.0%				
Q3	49 32.7%	52 34.7%	28 18.7%	21 14.0%	150 100.0%				

Table 1 shows that the calculated X2 value of 50.533 is greater than the X^2 table value of 1.635 at df 6; while the p value of 0.000 is less than 0.05 (X^2 cal.= 50.533, X^2 crit.= 1.635, df=7, p<.05). The indication is that Nigeria sport stadia lack significant surveillance capacity for Ebola detection during football competitions. Hence, the null hypothesis was rejected.

This findings further corroborate the of view Isere, Fatiregun, and Ajayi (2015) that in Nigeria, surveillance and notification of diseases involve the immediate notification of epidemic prone diseases, diseases targeted for elimination and eradication and monthly notification of other diseases of public health importance. For a disease surveillance and notification system at the district/LGA level to be functional and effective in early detection of epidemic-prone diseases, clinicians remain indispensable to effective reporting because they can detect unusual disease manifestations and conditions that rely on clinical signs not related to laboratory testing, clusters of illnesses through patient interview and clinical judgments. They stated further that presently in Nigeria, the collection, collation, analysis and interpretation of disease-related data in public health institutions are often incomplete and untimely partly because of poor awareness among clinicians of the importance of their role in disease surveillance and notification activities for the prevention of infectious disease outbreaks. Many outbreaks which have occurred in Nigeria over the years have been attributed to clinicians either not reporting or reporting late when the index cases of epidemic prone diseases present in the various health institutions across the country. From previous studies on disease surveillance and notification, it is pertinent to note that failure in mandatory reporting of notifiable diseases among clinicians have been attributed to lack of awareness of the existence of a surveillance network for notifiable diseases including the requirement for reporting, which diseases are notifiable, how, when and to whom reporting should be done.
It was this lack of surveillance capacity that led to Nigeria recording it first Ebola case when the American – Liberian man named Patrick Sawyer travelled by plane from Monrovia, Liberia, via Ghana and Togo to Nigeria while visibly suffering from symptoms of Ebola and died of the virus in a hospital in Lagos a few days later. Sawyer was not quarantined immediately on arrival and some medical workers who came into contact with him and people he met died (Shuaiberal, 2014).

Hypothesis 2: Nigeria sport stadia will not significantly lack adequate laboratory services capacity for Ebola detection during football competition

Table 2: Chi-square (X2) analysis on lack adequate laboratory services capacity for Ebola detection during football competition

Question items	Active surveillance capacity				Total	X^2 Cal.	X^2 Crit.	Df	Sig.
	SA	A	D	SD					
Q1	53 35.3%	49 32.7%	40 26.7%	8 5.3%	150 100.0%	58.960	1.635	6	.000
Q2	40 26.7%	54 36.0%	37 24.7%	19 12.7%	150 100.0%				
Q3	43 28.7%	64 42.7%	31 20.7%	12 8.0%	150 100.0%				

Table 2 shows that the calculated X2 value of 58.960 is greater than the X2 table value of 1.635 at df 6; while the p value of 0.000 is less than 0.05 (X2 cal.= 58.960, X2 crit.= 1.635, df=7, p<.05). The indication is that Nigeria sport stadia significantly lack adequate laboratory services capacity for Ebola detection during football competition. Hence, the null hypothesis was rejected.

Thiam e.tal (2015) also observed in their study that access to functional diagnostic services is also a major factor in the spread of Ebola. Health facilities lack adequate trained staff. The health personnel have not been adequately trained on Ebola. One or two staff were identified per facility and invited to attend training for two or three days on Ebola. Afterward the trained staff was supposed to replicate the training in their respective structures, however no additional budget or material support was provided to facilitate that feedback, and no follow up was made to ensure this took place. Although the staff of the health centres acknowledged having received enough gloves, they complained that the protective equipment against the Ebola virus (coats/gowns, individual masks, bibs and boots) and sanitation products, in particular, chlorine, were not enough at all peripheral health facilities.

Hypothesis 3: Nigeria sport stadia will not have inadequate functioning health system for containment of Ebola contact persons during football competition

Table 3: Chi-square (X2) analysis on adequate functioning health system for containment of Ebola contact persons during football competition

Question items	Functioning health system				Total	X^2 Cal.	X^2 Crit.	Df	Sig.
	SA	A	D	SD					
Q1	46 30.7%	45 30.0%	42 28.0%	17 11.3%	150 100.0%	61.333	1.635	6	.000
Q2	49 32.7%	55 36.7%	26 17.3%	20 13.3%	150 100.0%				
Q3	48 32.0%	56 37.3%	30 20.0%	16 10.7%	150 100.0%				

Table 3 shows that the calculated X^2 value of 61.333 is greater than the X^2 table value of 1.635 at df 6; while the p value of 0.000 is less than 0.05 (X^2 cal.= 61.333, X^2 crit.= 1.635, df=9, $p<.05$). The indication is that Nigeria sport stadia had inadequate functioning health system for containment of Ebola contact persons during football competition. Hence, the null hypothesis was rejected. According to Centre For Disease Control (CDC) (2014) reported that the disease's ability to spread as it is, largely due to the stricken countries' weak health-care systems: Prior to the Ebola outbreak there were only fifty doctors in Liberia (a little more than one per 100,000); in the United States there are around 240 doctors for every 100,000 people. All affected countries have reported a dearth of doctors, treatment and prevention supplies, and beds for sick patients. This findings also corroborate Thiam e.tal (2015) study which find out that the isolation rooms for the Ebola suspected cases in the health facilities were inadequate and might have put the health staff and other patients at risk. The maintenance staff in the hospitals and health centres recognised that training was inadequate in infection prevention measures for Ebola. Health care workers and health managers also confirmed that the epidemic has had a direct impact on priority health programmes with a drastic drop in number of consultations, reduction of the immunization coverage, greater numbers of home deliveries, increase of cases of severe malaria among children and pregnant women, delays in reporting and a decrease in revenue. Logistical issues affected the timely management of suspected cases or dead bodies. Communities and health staff accused organisations in charge of transportation and referral of not responding in time to collect suspected cases.

Hypothesis 4: Nigeria sport stadia will not significantly have inadequate trained human resources for Ebola detection during football competition

Table 4: Chi-square (X2) analysis on adequate trained human resources for Ebola detection during football competition

Question items	Trained human resources				Total	X^2 Cal.	X^2 Crit.	Df	Sig.
	SA	A	D	SD					
Q1	48 32.0%	41 27.3%	44 29.3%	17 11.3%	150 100.0%	66.600	1.635	6	.000
Q2	48 32.0%	73 48.7%	10 6.7%	19 12.7%	150 100.0%				
Q3	58 38.7%	44 29.3%	40 26.7%	8 5.3%	150 100.0%				

Table 4 shows that the calculated X^2 value of 66.600 is greater than the X^2 table value of 1.635 at df 6; while the p value of 0.000 is less than 0.05 (X^2 cal.= 66.600, X^2 crit.= 1.635, df=6, p<.05). The indication is that Nigeria sport stadia had inadequate functioning health system for containment of Ebola contact persons during football competition. Hence, the null hypothesis was rejected.

Kennedy e.tal (2016) observed that the status of the existing laboratory structure and service delivery system in Liberia is characterised by numerous challenges, which were uncovered during the EVD outbreak in Liberia that became a major public health problem in the country and the sub-region. Poor health infrastructure, lack of logistics during the beginning of the outbreak, and an inadequate number of trained staff in public health disease surveillance and laboratory diagnostic response in emergency situations, were key factors leading to the delay in surveillance, response and containment to the outbreak.
Hypothesis 5: Personnel working within the stadia will not have inadequate knowledge about Ebola infection and spread during football competition

Table 5: Chi-square (X^2) analysis on adequate knowledge about Ebola infection and spread during football competition

Question items	Inadequate knowledge about Ebola infection				Total	X^2 Cal.	X^2 Crit.	Df	Sig.
	SA	A	D	SD					
Q1	72 48.0%	44 29.3%	18 12.0%	16 10.7%	150 100.0%	112.800	1.635	6	.000
Q2	54 36.0%	56 37.3%	22 14.7%	18 12.0%	150 100.0%				
Q3	70 46.7%	43 28.7%	29 19.3%	8 5.3%	150 100.0%				

Table 4.5 shows that the calculated X^2 value of 112.800 is greater than the X^2 table value of 1.635 at df 6; while the p value of 0.000 is less than 0.05 (X^2 cal.= 112.800, X^2 crit.= 1.635, df=6, p<.05). The indication is that personnel working within the stadia had inadequate knowledge about Ebola infection and spread during football competition. Hence, the null

hypothesis was rejected.

Thiam e.tal (2015) in their study discovered that almost one year after the beginning of the Ebola virus disease outbreak in West Africa, the perceptions of stakeholders and the observed reality were that the level of preparedness in the health districts was low. The study identified poor coordination mechanisms, inadequate training of human resources and lack of equipment and supplies to field teams and health facilities as key elements that affected the response. The situation was worsened by the inadequate communication strategy, misconceptions around the disease, ignorance of local culture and customs and lack of involvement of local communities in the control strategies, within the context of poor socioeconomic development. As a result distrust developed between communities and those seeking to control the epidemic and largely contributed to the reluctance of the communities to participate and contribute to the effort.

Olayinka (2015) postulated that perhaps the biggest challenge was improving public awareness of the disease, and trust and confidence in the medical response. Good communication, transparency, and community engagement will be central to success. Community chiefs should be involved in ensuring the support of their community members. The members of the community are the only one who can have easy access to the community. Community awareness needs to continue until the communities are seen playing their expected roles. The most successful public health programs and initiatives are based on an understanding of health behaviours and the context of its occurrence. Therefore, relevant theories of behaviour change and the ability to use them skillfully should be the premise on which interventions to improve health behaviour can best be designed. Information about factors like customs, cultural mores, habits, beliefs, and superstition are important for any health changing behavior to be accepted. This factors need to be worked on for the community to accept change.

Conclusion

Evidence from the study revealed that the selected stadia for this study are not prepared for detection, surveillance and containment of Ebola disease during football competition due to the fact that the stadia did not have:

1) adequate laboratory service for Ebola detection during football competition
2) active surveillance capacity for Ebola detection during football competition.
3) adequate functioning health system for containment of Ebola contact persons during football competition.
4) adequate trained human resources for Ebola detection during football competition.
5) personnel working within the stadia that have adequate knowledge about Ebola infection and spread during football competition.

Recommendation

Based on the findings of the study following recommendations were made:

1) Since it has been shown that the sport stadia had no adequate laboratory Service for Ebola and other highly communicable diseases detection during football competition, then sport administrators should ensure that they constantly made available standard diagnostic Centre within the stadium and ensure that the lab is well equipped.
2) The sport administrators should ensure that well trained medical personnel are employed to constantly handle the health systems within the stadium complex in other to ensure its efficient functionality.
3) The Surveillance capacity of the health system within the stadia should be ensure in

line with WHO standard.

4) Since it was discovered that sport stadia did not have adequately trained human resources for Ebola and other infectious diseases detection during football competition then the sport administrators should ensure that the services of well-trained medical personnel are employed. They should also be exposed to constant training on the detection and management of infectious diseases among highly mobile large population.

5) Lack of knowledge is a major factor in the spread and inability to detect Ebola. Intensive effort and programmes must be put in place to educate stadium personnel, athletes and spectators alike for them to be more aware of this potential killer.

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