



Molecular Detection and Sequencing of Rotavirus VP4 among Children Aged 0-5 Years with Gastroenteritis in 2 Selected Healthcare Centres in Keffi, Nigeria

I. Ibrahim¹, R. U. Usman², H. I. Mohammed^{3*}, D. Ishaleku³
and A. B. Shuaibu⁴

¹Medical Microbiology Unit, Medical Laboratory Department, Federal Medical Centre, P.M.B. 004, Keffi, Nasarawa State, Nigeria.

²Science Department, Brightway International Academy, Keffi, Nasarawa State, Nigeria.

³Department of Microbiology, Nasarawa State University, P.M.B. 1022, Keffi, Nasarawa State, Nigeria.

⁴Department of Veterinary Medicine, Usman Danfodio University, P.M.B. 2346, Sokoto, Nigeria.

Authors' contributions

This work was carried out in collaboration among all authors. Authors II and HIM designed the study, collected samples, performed laboratory and statistical analyses and wrote the first draft of the manuscript. Authors RUU, DI and ABS designed the study, managed literature searches, wrote the protocols and managed the analyses of the study. All authors read and approved the final manuscript.

Article Information

Editor(s):

(1) Dr. Wagner Loyola, Brazilian Agricultural Research Corporation, Brazil.

Reviewers:

(1) Nirmal Kumar Mohakud, KIIT University, India.

(2) Ahmed Samy El-Shafey, Tanta University, Egypt.

Complete Peer review History, details of the editor(s), Reviewers and additional Reviewers are available here:

<https://www.sdiarticle5.com/review-history/77674>

Original Research Article

Received 20 October 2021

Accepted 27 December 2021

Published 29 December 2021

ABSTRACT

Aims: This study was conducted to detect and sequence Rotavirus VP4 among children aged 0-5 years with gastroenteritis in 2 selected healthcare centres in Keffi, Nigeria.

Study Design: The study was a cross sectional study.

Place and Duration of Study: Keffi, Nasarawa State, between March and June 2019.

Methodology: Stool samples were collected from 303 (203 from FMC Keffi and 100 from PHC Angwan Waje, Keffi) children with gastroenteritis and information about them were obtained by

structured questionnaires. All collected samples were screened for the presence of Rotavirus antigen using Aria Rotavirus antigen detection test kit (CTK Biotech, Inc, San Diego, USA). VP4 was detected from Rotavirus positive samples by Reverse Transcriptase Polymerase Chain Reaction (RT-PCR) using specific primers. The sequences of the amplified VP4 genes were verified using MEGA software version 7 and Rotavirus strains were determined by pasting the FASTA (Text based format for representing nucleotide sequence) format into the Basic Local alignment Search Tool (BLAST) from the National Center for Biotechnology Information (NCBI). Data collected were analysed using Smith's Statistical Package (version 2.8, California, USA) and *P* value of ≤ 0.05 was considered statistically significant.

Results: Of the 303 children screened, 54(17.8%) were positive for Rotavirus infection. Highest prevalence of the viral infection was recorded among males (19.7%) aged 0-12 months (24.8%). Gender was found to be associated with rate of Rotavirus infection in this study ($P<0.05$). However, age was not significantly associated with the viral infection ($P>0.05$). Furthermore, based on the RT-PCR carried out, 3(5.6%) out of the 54 Rotavirus positive samples were positive for the VP4 gene and sequences of this gene were all found to be of type P [11] Strain N115.

Conclusion: This study reveals the presence of infection with type P [11] Strain N115 (5.6%) of Rotavirus in the study population. The detection of this rare rotavirus strain in this study is a cause for concern and hence there is an urgent need for the Nigerian health authorities to implement a nationwide surveillance system for monitoring rotavirus molecular epidemiology.

Keywords: VP4; rotavirus; gastroenteritis; children; Keffi; Nigeria.

1. INTRODUCTION

Rotavirus is the leading cause of severe gastroenteritis particularly among infants and young children worldwide with over 70% of cases occurring in Nigeria and other endemic sub-Saharan African countries [1-4]. It is believed that almost every child in the world is infected with rotavirus at least once by the age of five [5]. However, Immunity develops with each infection, so subsequent infections are less severe and hence adults are rarely affected [6].

Rotavirus belongs to the virus family *Reoviridae*, it is a non-enveloped and has an icosahedral nucleocapsid structure, enclosing a double stranded (ds) RNA genome segmented into 11 compartments. The genome codes for six structural proteins, (VP1 to VP4, VP6 and VP7) and five nonstructural proteins (NSP1 to NSP5) [7]. VP4 is on the surface of the virion that protrudes as a spike [8]. It binds to molecules on the surface of cells called receptors and drives the entry of the virus into the cell [9]. It has to be modified by the protease enzyme trypsin, which is found in the gut, into VP5 and VP8 before the virus is infectious [10]. It also determines how virulent the virus is and determines the P-type of the virus [11].

There are at least 10 distinct species/groups of Rotavirus (A- I, J), differentiated by their VP6 antigenic properties [12]. Groups A, B and C are found to cause infection in both humans and

animals, whereas groups D, E, F, G and I have been found only in animals [13]. There are 32 G (VP7) genotypes and 47 P (VP4) genotypes identified through molecular epidemiology [2].

Rotaviruses are transmitted by the faecal-oral route, via contact with contaminated hands, surfaces and objects, and possibly by the respiratory route [3,4,14]. The viral infection is usually associated with fever, nausea and vomiting, followed by abdominal cramps, frequent watery diarrhea, which may last for 3-8 days, cough and runny nose occurring mostly among infants [3,15].

Rotaviruses are stable in the environment and can survive for long periods of time on toys and ordinary surfaces found in most homes. They also are relatively resistant to most soap and commonly used disinfectants, hence preventing a child from exposure can be difficult [3]. Therefore, vaccination still remains the best hope for preventing infection with Rotavirus especially in resource constraint nations such as Nigerian [1,16]. Additionally, most hospitals and diagnostic centres in such nations do not routinely diagnosed Rotavirus infection probably due to its high cost and may be because it share similar signs and symptoms with other infantile gastroenteritis [14,15,17]. This consequently usually leads to misdiagnosis and mistreatment of the viral infection.

Thus the aim of this study was to detect and sequence Rotavirus VP4 among children aged 0-5 years with gastroenteritis in 2 selected healthcare centres in Keffi, Nigeria.

2. MATERIALS AND METHODS

2.1 Study Area

This study was conducted at Federal Medical Centre (FMC) and Primary Healthcare Centre (PHC), Angwan Waje in Keffi Local Government Area, Nasarawa State, Nigeria. Keffi town, where the 2 centres are located is approximately 68 km from Abuja, Nigeria's Federal Capital Territory and 128 km from Lafia, the capital of Nasarawa State. It is located geographically between latitude 8°3'N of the equator and longitude 7°50'E and situated on an altitude of 850 m above sea level [18].

2.2 Study Population

The study participants were male and female children with gastroenteritis aged 0-5 years accessing health care in the 2 selected healthcare centres in Keffi, Nasarawa State, Nigeria. Their socio-demographic and other required information were obtained from their parents/guardians by the use of a designed questionnaire.

2.3 Sample Size Determination

To determine the sample size, the formula by Naing et al. [19] for sample size calculation at 0.05 level of precision was used;

$$n = \frac{Z^2pq}{d^2}$$

Where:

n = required sample size

Z = standard normal deviation at the required confidence interval (1.96) which corresponds to 95% confidence interval.

P = prevalence of Rotavirus infection from previous study (25.0%) (0.2) [20].

Q = 1 – p = 0.9

d = degree of precision expected (0.05)

$$n = \frac{(1.96)^2(0.2)(0.9)}{(0.05)^2} = \frac{0.76832 \times 0.9}{0.0025} = \frac{0.691488}{0.0025} = 276.6$$

$$n = 277$$

To ensure minimum error however, this was rounded up to 303 samples.

2.4 Sample Collection and Storage

A total of 303 stool samples (203 from FMC keffi and 100 from PHC Angwan Waje, Keffi) were collected from children with gastroenteritis aged 0-5 years. The samples were collected into sterile wide mouth universal containers, labeled accordingly and stored at -20°C until ready for use [21].

2.5 Laboratory Analysis

2.5.1 Detection of rotavirus antigen

All collected stool samples were screened for the presence of Rotavirus antigen using Aria Rotavirus antigen detection test kit (CTK Biotech, Inc, San Diego, USA). The tests procedure and results interpretation were done according to the instructions of the manufacturer.

2.5.2 Test procedure

The specimen was brought to room temperature and the test device was removed from the pouch and placed on a clean flat surface and labeled accordingly. Two drops of the watery stool was added into the labeled sample dilution vial followed by vigorous shaking to mix. Thereafter, 2 drops of the mixture was dispensed into the sample well of the test device and a timer was set up for 15 minutes after which the results were read and interpreted as positive, negative or invalid according to the manufacturer's instructions.

2.5.3 Molecular detection of rotavirus VP4

The VP4 was detected by a Reverse Transcriptase Polymerase Chain Reaction (RT-PCR) system previously described by Gentsch et al. [22] using specific primers (consensus primers VP4F/VP4R) adopted from the work of Simmonds et al. [23].

2.5.4 Rotavirus RNA extraction

Viral RNA was extracted and purified from 10% faecal suspensions in phosphate-buffered saline using the TRIzol method (Gibco BRL, Invitrogen, Burlington, Canada).

2.5.5 Rotavirus VP4 RT-PCR

The VP4 gene was reversely transcribed and amplified using the following primers as adopted from the work of Simmonds et al. [23]:

Con2 Forward (5'-ATTTCCGACCATTTATAACC-3')

Con3 Reverse (5'-TGGCTTCGCTCATTATAGACA-3')

The complementary DNA was generated by reverse transcription at 45°C for 30 minutes with initial denaturation at 95°C for 5 minutes followed by 35 cycles of denaturation at 95°C for 1 minute.

2.5.6 Agarose gel electrophoresis

The PCR products were analyzed by running a 1% agarose gel stained with ethidium bromide. The sizes of PCR products were estimated in relation to the migration pattern of a 100bp to 1000bp increments plus DNA molecular marker (BIONEER Daejeon, North Korea).

2.5.7 Rotavirus VP4 gene sequencing

The amplified VP4 genes obtained were sent to Inqaba Biotec, South Africa for sequencing. The method described by Sanger et al. [24] with modification was used. Briefly: 10µL of the amplified VP4 genes were cleaned by mixing with 2.5µL EXO/SAP master mix and incubated at 37°C for 15 minutes. The reaction was stopped by heating the mixture at 80°C for 15 minutes. Sequencing was then done on the mixture using Nimagen; Brilliant Dye™ terminator cycle sequencing kit version 3.1 BRD. The labelled products were then cleaned using ZR-96 DNA sequencing clean-up kit and analysed using Applied Biosystems ABI3500XL Genetic analyser yielding sequence chromatogram. Sequences were verified using MEGA software version 7. The strains were determined by pasting the FASTA (Text based format for representing nucleotide sequence) format into the Basic Local alignment Search Tool (BLAST) from the National Center for Biotechnology Information (NCBI).

2.6 Data Analysis

The data obtained were analyzed using Smith's Statistical Package (version 2.8, California, USA). Chi-square test was conducted at 95% confidence interval and *P* values ≤ 0.05 were considered statistically significant.

3. RESULTS AND DISCUSSION

This present study was conducted to detect and sequence Rotavirus VP4 among children aged 0-

5 years with gastroenteritis in 2 selected healthcare centres in Keffi, Nigeria. A total of 303 children (203 from FMC Keffi and 100 from PHC Angwan Waje, Keffi) majority of which were males (157/303) aged 0-12 months (153/303) were recruited and screened for Rotavirus antigen. Overall, 54 (17.8%) children tested positive for Rotavirus infection giving a total prevalence of 17.8% (Table 1).

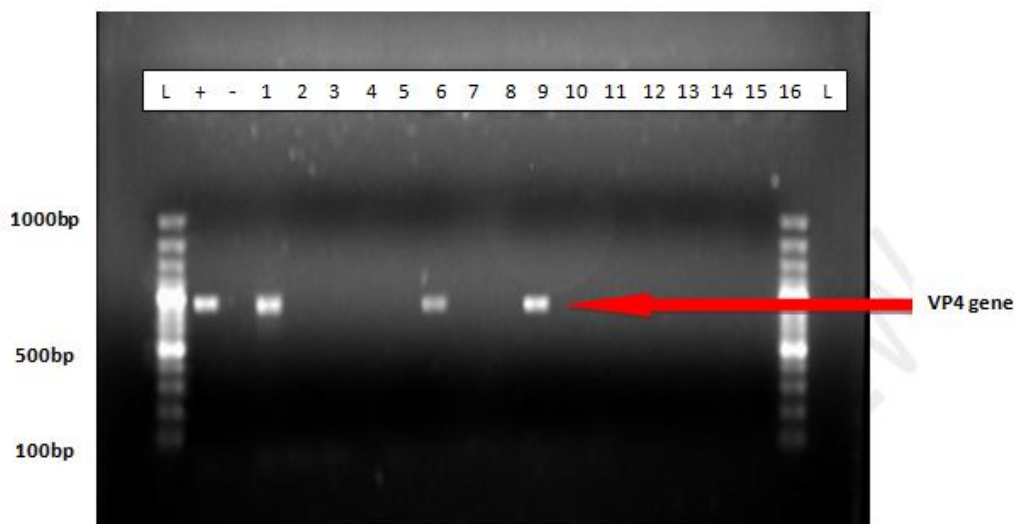
The 17.8% prevalence of Rotavirus infection recorded in this study was higher than the 6.0% reported among children in Kwara State [25], 7.4% among children with diarrhoea in Kano State [Suleiman et al., 2020] and 12.5% among infants in Calabar [26]. It was However lower than the 24.8% reported among children with gastroenteritis in Akure [27], 25.0% among children less than five years of age in Abuja satellite towns [28] and 56.0% among children with diarrhea in Enugu State [29]. Interestingly, researchers from other parts of Africa and the world also reported varying rates of the viral infection. For instance, it was 14.5% in Kenya [30], 16% in Sudan [31], 18% in India [32], 39.2% in Benin Republic [33], 44.8% in Indonesia [34] and 56% in Portugal [35]. The differences observed in the prevalence rates from different studies were possibly due to differences in testing methods used, location of the studies, time and season of sampling and study population types with different associated risk factors [2].

This study did not record significant association between Rotavirus infection and age of the participants (*P*>0.05). However, Most of the children infected were between the age group 0-12 months (24.8%), followed by 13-24 months (19.7%), 37-48 months (4.8%) and 25-36 months 1(2.9%) while none was detected in age group 49-60 months (Table 1). This observation agrees with the report of Theophilus et al. [20], Okebugwu et al. [27] and Dhital et al. [36] among children with gastroenteritis in Abuja, Akure and Eastern India respectively but disagrees with that of Mohammed et al. [37] and Aliyu et al. [38] who reported higher prevalence of the viral infection among Nigerian children within the age group 25-50 months. The higher prevalence of the infection recorded among younger children in this present study may be attributed to the absence of well-developed immune system among them as older children are expected to acquire protective immunity during repeated exposures to the virus and therefore, subsequent infections are mild or asymptomatic [39].

Table 1. Prevalence and distribution of rotavirus infection in relation to age and gender among children between ages 0-5 years with gastroenteritis in 2 selected healthcare centres in Keffi, Nigeria

| Parameter | No. Examined (N=303) | No. Positive (N=54) | Prevalence (%) (Overall=17.8) | p-value |
|--------------|-------------------------|------------------------|----------------------------------|---------|
| Age (months) | | | | |
| 0–12 | 153 | 38 | 24.8 | 0.7792 |
| 13–24 | 71 | 14 | 19.7 | |
| 25–36 | 37 | 1 | 2.9 | |
| 37–48 | 21 | 1 | 4.8 | |
| 49–60 | 21 | 0 | 0.0 | |
| Gender | | | | |
| Male | 157 | 31 | 19.7 | 0.0004* |
| Female | 146 | 23 | 15.8 | |

*Statistically significant

**Fig. 1. Agarose gel electrophoretogram of Rotavirus VP4 amplified gene. Samples 1, 6 and 9 were positive for Rotavirus VP4 gene while samples 2, 3, 4, 5, 7, 8, 10, 11, 12, 13, 14, 15 and 16 were negative. *L represents the molecular ladder, ‘-’ is the negative control while ‘+’ is the positive control**

There was significant association between gender and prevalence of Rotavirus infection in this study ($P < 0.05$) as males were more infected (19.7%) compared to their female counterparts (15.8%) (Table 1). This is consistent with the reports of most other previous studies conducted in Nigeria [3, 15, 18, 26, 28, 29, 37] and other parts of the world [30, 31, 34, 40]. The higher prevalence of the infection among male subjects in most previous studies may be connected to the fact that females mount stronger humoral and cellular immune responses to infection or antigenic stimulation than the males [41].

Furthermore, based on the RT-PCR carried out in this study, 3(5.6%) out of the 54 samples that

tested positive with the lateral flow immunoassay kit were positive for the VP4 gene (Fig. 1). The low rate of rotavirus VP4 gene detected by RT-PCR in this present study could possibly be as a result of PCR inhibitors in the faeces that were carried over into the RNA extracts [42]. It could also be attributed to prolonged storage of the stool samples, method of RNA extraction and effects of freezing and thawing [43].

The 3 amplified VP4 genes were sequenced and were found to be of type P [11] Strain N115 (Figs 2A and 2B). This strain showed 88.08% nucleotide identity to human rotavirus A strain G12 P [11] with accession number MH559158.1

in the GenBank. The nucleotide sequence of the N155 strain detected in this study has been deposited in the GeneBank under the accession number: EU200796.1 (Figs 3 and 4).

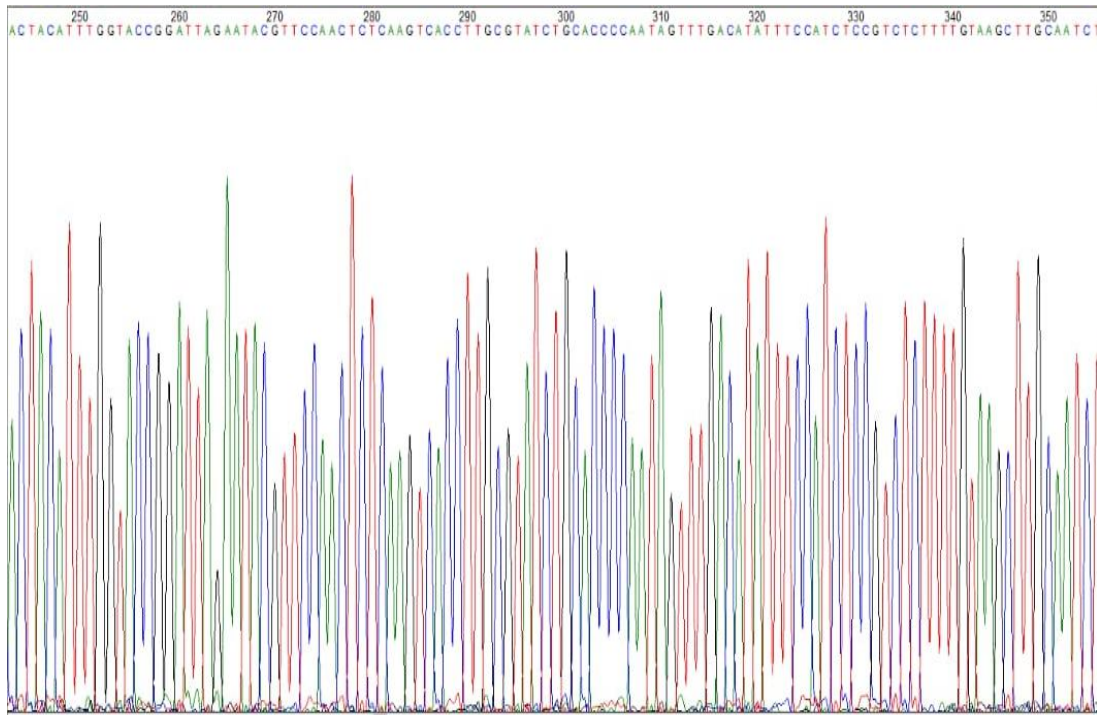


Fig. 2A. Chromatogram of the Sequenced RotavirusVP4 Genes (Forward Primer)

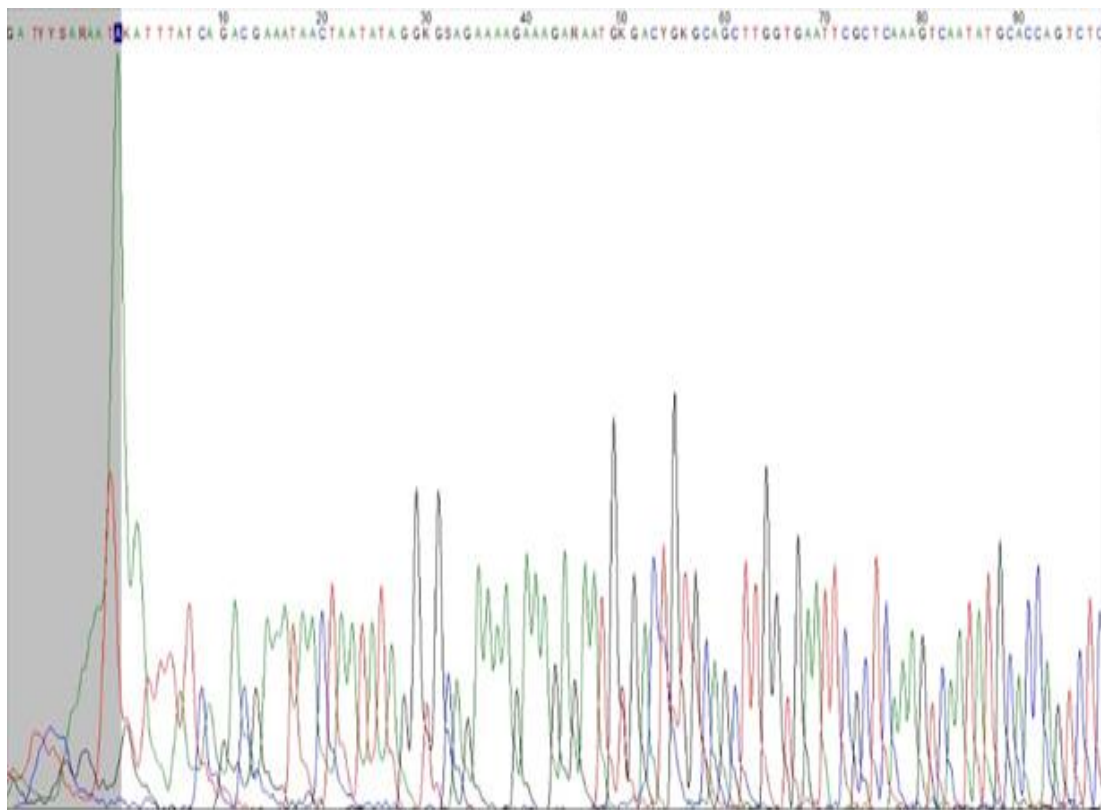


Fig. 2B. Chromatogram of the Sequenced Rotavirus VP4 Gene (Reverse Primer)

| Description | Max Score | Total Score | Query Cover | E value | Per. Ident | Accession |
|---|-----------|-------------|-------------|---------|------------|------------|
| Human rotavirus A isolate N155 VP4 gene complete cds | 882 | 882 | 97% | 0.0 | 88.08% | EU200796.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/168710/2016/G12P11 VP4 (VP4) gene partial cds | 689 | 689 | 95% | 0.0 | 85.39% | MH559158.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1731557/2017/G12P11 VP4 (VP4) gene partial cds | 673 | 673 | 95% | 0.0 | 85.14% | MH559165.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/168239/2016/G12P11 VP4 (VP4) gene partial cds | 673 | 673 | 95% | 0.0 | 85.14% | MH559161.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/165460/2016/G12P11 VP4 (VP4) gene partial cds | 665 | 665 | 95% | 0.0 | 85.02% | MH559160.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1617178/2016/G12P11 VP4 (VP4) gene partial cds | 665 | 665 | 95% | 0.0 | 85.02% | MH559159.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/169046/2016/G12P11 VP4 (VP4) gene partial cds | 665 | 665 | 95% | 0.0 | 85.02% | MH559153.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1617421/2016/G12P11 VP4 (VP4) gene partial cds | 657 | 657 | 95% | 0.0 | 84.89% | MH559154.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1720697/2017/G12P11 VP4 (VP4) gene partial cds | 641 | 641 | 95% | 0.0 | 84.64% | MH559156.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1615595/2016/G12P11 VP4 (VP4) gene partial cds | 641 | 641 | 95% | 0.0 | 84.64% | MH559155.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1842605/2018/G12P11 VP4 (VP4) gene partial cds | 633 | 633 | 95% | 0.0 | 84.52% | MH559171.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1842602/2018/G12P11 VP4 (VP4) gene partial cds | 633 | 633 | 95% | 0.0 | 84.52% | MH559170.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1725114/2017/G12P11 VP4 (VP4) gene partial cds | 633 | 633 | 95% | 0.0 | 84.52% | MH559157.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/164567/2016/G12P11 VP4 (VP4) gene partial cds | 633 | 633 | 95% | 0.0 | 84.52% | MH559152.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/173950/2017/G12P11 VP4 (VP4) gene partial cds | 625 | 625 | 95% | 1e-178 | 84.39% | MH559169.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1722032/2017/G12P11 VP4 (VP4) gene partial cds | 625 | 625 | 95% | 1e-178 | 84.39% | MH559164.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1720706/2017/G12P11 VP4 (VP4) gene partial cds | 625 | 625 | 95% | 1e-178 | 84.39% | MH559163.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1720702/2017/G12P11 VP4 (VP4) gene partial cds | 625 | 625 | 95% | 1e-178 | 84.39% | MH559162.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1739626/2017/G12P11 VP4 (VP4) gene partial cds | 601 | 601 | 95% | 2e-171 | 84.02% | MH559168.1 |
| Human rotavirus A strain RVA/Hu-wt/IND/1739394/2017/G12P11 VP4 (VP4) gene partial cds | 601 | 601 | 95% | 2e-171 | 84.02% | MH559167.1 |

Fig. 3. Image of BLAST of sample showing sequence with significant alignment with that in the Gen Bank

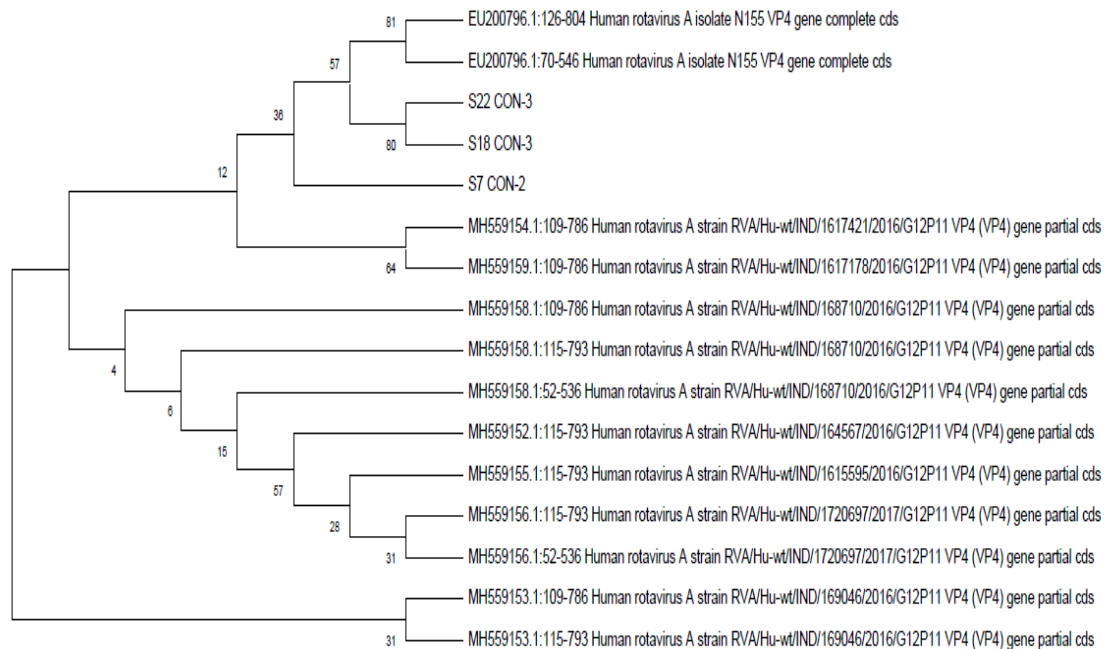


Fig. 4. Phylogeny of rotavirus VP4 gene

This strain of Rotavirus detected in this present study has not been reported in Nigeria. In contrast however, other genotype combinations have been reported in Nigeria and other African countries. For instance, genotype G12 was detected in Asaba, Delta State [44], Ibadan, Oyo State, Nigeria [45], Nairobi, Kenya [46], Dakar,

Senegal [47], Democratic Republic of Congo [48] and in Tunisia [49].

Furthermore, in India, Giri et al. [50] identified genotype G12 P [11] while Ray et al. [51] and Ramani et al. [52] reported the detection of strain N155 with a difference in the G-type (G10)

among neonates with gastroenteritis in India. Additionally, Libonati et al. [53] also reported the detection of G10 P [11] type in India. These strains of group A rotavirus are believed to be from bovine origin as a result of bovine-human gene re-assortment [50].

4. CONCLUSION

This study recorded 17.8% prevalence of infection with type P [11] Strain N115 (5.6%) of Rotavirus among children aged 0-5 years with gastroenteritis in 2 selected healthcare centres in Keffi, Nigeria. The detection of this rare rotavirus strain in this study is a cause for concern and hence there is an urgent need for the Nigerian health authorities to implement a nationwide surveillance system for monitoring rotavirus molecular epidemiology, before considering introduction of rotavirus vaccination into the expanded program on immunization (EPI). This will help to give necessary information on current genotypes and novel introductions as well as evolution of mutant strains to help augment current rotavirus prevention and control.

CONSENT

All parents/guardians of the children included in this study completed and signed an informed consent form.

ETHICAL APPROVAL

Formal ethical approval to conduct this study was obtained from the Research Ethics Committee of Federal Medical Centre, Keffi (FMC/KF/HREC/207/17). Permission was also obtained from the management of Primary Healthcare Center Angwan Waje, Keffi.

ACKNOWLEDGEMENT

The study team would like to thank the management of Federal Medical Centre and Primary Healthcare Centre, Angwan Waje, Keffi, Nigeria for their kind permission to conduct the research work. We are also grateful to all parents/guardians of the children who voluntarily participated in the study. However, this research did not receive any form of grant from governmental or non-governmental organizations.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Troeger C, Khalil IA, Rao PC, Cao S, Blacker BF, Ahmed T, et al. Rotavirus vaccination and the global burden of rotavirus diarrhea among children younger than 5 years. *JAMA Pediatrics*. 2018; 172(10):958-965.
2. Motayo BO, Faneye AO, Adeniji JA. Epidemiology of rotavirus A in Nigeria: Molecular diversity and current insights. *Journal of Pathogen*. 2018;2:1-7.
3. Ojobor CD, Olovo CV, Onah LO, Ike AC. Prevalence and associated factors to rotavirus infection in children less than 5 years in Enugu State, Nigeria. *Virus Disease*. 2020;31(3):316–322.
4. Ibrahim I, Usman RU, Mohammed HI, Ishaleku D. Prevalence and predictors of Rotavirus infection among children aged 0-5 years with gastroenteritis in 2 selected healthcare centers in Keffi, Nigeria. *Asian Journal of Research and Report in Gastroenterology*. 2021;5(1):1-9.
5. Bernstein DI. Rotavirus overview. *The Pediatric Infectious Disease Journal*. 2009;28: S50-S53.
6. Grimwood K, Lambert SB. Rotavirus vaccines: opportunities and challenges. *Human Vaccines*. 2009;5:57-69.
7. Estes MK, Greenberg HB. *Astroviridae*. In: Knipe DM, Howley PM, editors. *Fields Virology*. vol. 6, Lippincott Williams and Wilkins; 2013.
8. Gardet A, Breton M, Fontanges P, Trugnan G, Chwetzoff S. Rotavirus spike protein VP4 binds to and remodels actin bundles of the epithelial brush border into actin bodies. *Journal of Virology*. 2006;80(8):3947–3956.
9. Arias CF, Isa P, Guerrero CA, Méndez E, Zárate S, López T, et al. Molecular biology of rotavirus cell entry. *Archives of Medical Research*. 2002;33(4):356–361.
10. Jayaram H, Estes MK, Prasad BV. Emerging themes in rotavirus cell entry, genome organization, transcription and replication. *Virus Research*. 2004;101(1): 67–81.
11. Hoshino Y, Jones RW, Kapikian AZ. Characterization of neutralization specificities of outer capsid spike protein VP4 of selected murine, lapine, and human rotavirus strains. *Virology*. 2002;299(1):64–71
12. Bányai K, Kemenesi G, Budinski I, Földes F, Zana B, Marton S, et al. Candidate new

- rotavirus species in Schreiber's bats, Serbia. *Infection, Genetics and Evolution*. 2017;48:19-26.
13. Lanzieri TM, Linhares AC, Costa I, Kolhe DA, Cunha MH, Ortega-Barria E. Impact of rotavirus vaccination on childhood deaths from diarrhea in Brazil. *International Journal of Infectious Diseases*. 2011;15(3):206-210.
 14. Dennehy PH. Transmission of rotavirus and other enteric pathogens in home. *Pediatric Infectious Diseases*. 2000;19(10):03-105.
 15. Junaid SA, Umeh C, Olabode AO, Banda JM. Incidence of rotavirus in children with gastroenteritis attending Jos University Teaching Hospital, Nigeria. *Virology Journal*. 2011;8(1):233-238
 16. Madhi S A, Cunliffe NA, Steele D, Witte D, Kirsten M, Louw C. Et al. Effect of human rotavirus vaccine on severe diarrhea in African infants. *New England Journal of Medicine*. 2010;362:289–298.
 17. Suleiman KO, Usman AD. Incidence of Rotavirus among children with diarrhoea attending Hasiya Bayero Pediatric Hospital, Kano State, Nigeria. *Acta Scientific Microbiology*. 2020;3(3):01-08.
 18. Akwa VL, Binbol NL, Samaila KL, Marcus ND. Geographical perspective of Nasarawa State, Onaive Printing and Publishing Company Ltd, Keffi, 2007;p 503.
 19. Naing L, Winn T, Rusli BN. Practical issues in calculating the sample size for prevalence studies. *Archives of Orofacial Sciences*. 2006;1:9-14.
 20. Theophilus KU, Uzoamaka CO, Okechukwu SO, Chukwubike C. Prevalence and genotypes of Rotavirus infection among children with gastroenteritis in Abuja, Nigeria. *Research Journal of Microbiology*. 2018;13(2):84-92.
 21. Cheesbrough M. District laboratory practice in tropical countries. Low price edition. Cambridge University press, USA. 2010;297.
 22. Gentsch J R, Glass R I, Woods P, Gouvea V, Gorziglia M, Flores J, et al. Identification of group A rotavirus gene 4 types by polymerase chain reaction. *Journal of Clinical Microbiology*. 1992;30:1365–1373.
 23. Simmonds MK, Armah G, Asmah R, Banerjee I, Damanka S, Esona M, et al.. New oligonucleotide primers for P-typing of rotavirus strains: strategies for typing previously untypeable strains. *Journal of Clinical Virology*. 2008;42:368–373.
 24. Sanger F, Nicklen S, Coulson AR. DNA sequencing with chain-terminating inhibitors. *Proceedings of the National Academy of Sciences of the United States of America*. 1977;74(12):5463-5467.
 25. Kuta FA, Uba A, Nimzing L, Damisa D. Molecular identification of Rotavirus strains Associated with diarrhea among children in Kwara State Nigeria. *Bayero Journal of Pure and Applied Sciences*. 2013;6(2):23-26.
 26. Nnukwu SE, Utsalo SJ, Oyero OG, Ntemgwa M, Ayukekbong J.A. Point-of-care diagnosis and risk factors of infantile, rotavirus-associated diarrhoea in Calabar, Nigeria. *African Journal of Laboratory Medicine*. 2017;6(1):1-5.
 27. Okebugwu QC, Adebolu TT, Ojo BA. Incidence of Rotavirus infection in children with gastroenteritis in Akure, Ondo State, Nigeria. *Futa Journal of Research in Sciences*. 2017;13(1):122-128.
 28. Chukwuma OU, Itohan EB. Prevalence and risk factors of Rotavirus infection among children less than five years of age in Abuja Satellite Towns, Nigeria. *Journal of Advances in Microbiology*. 2018;9(1): 1-8.
 29. Tagbo BN, Mwenda JM, Armah G. Epidemiology of Rotavirus diarrhea among children younger than 5 years in Enugu, South East Nigeria. *Pediatric Infectious Disease Journal*. 2014;33:19-22.
 30. Muendo C, Ahmed L, Rashmi K, Boniface O, Thaddaeus E, Pamela N. Prevalence of rotavirus infection among children with acute diarrhoea after rotavirus vaccine introduction in Kenya, a hospital cross-sectional study. *BioMedical Central Pediatrics*. 2018;323(18):1-9.
 31. Magzoub AM, Naser EB, Jalal AB, Omran FO. Rotavirus infection among Sudanese children younger than 5 years of age: A Cross sectional hospital-based Study. *Pan African Medical Journal*. 2018;16:88-93.
 32. Dass SM, Snigdha P, Amulya K. A study on Prevalence of Rotavirus infection in children below 5 years, with acute gastroenteritis. *International Journal of Community Medicine and Public Health*. 2018;5(8):3358-3361.
 33. Jijoho MMA, Annick C, Alid'ehou JA, Tam'egnon VD, Anges HB. Epidemiological survey of Rotaviruses responsible for infantile diarrhea by the

- Immunomolecular Technique in Cotonou. *International Journal of Microbiology*. 2018;5:1-7.
34. Prasetyo D, Iesje M, Sabaroedin Y, Setiati E, Yati S. Association between severe dehydration in Rotavirus diarrhea and exclusive breastfeeding among Infants at Dr. Hasan Sadikin General Hospital, Bandung, Indonesia. *Journal of Tropical Medicine*. 2015;5:1-4.
 35. Ribeiro A, Elmano R, Ângela C, Newton CMG, Adelaide A. Incidence of Rotavirus and Adenovirus: detection by molecular and immunological methods in human Faeces *Journal of Pure and Applied Microbiology*. 2013;7(3):1-9.
 36. Dhital S, Jeevan BS, Bharat MP, Keshab P, Basistha R. Molecular epidemiology of Rotavirus causing diarrhea among children less than five years of age visiting national level children hospitals, Nepal. *BioMed Central Pediatrics*. 2017;17(101): 1-7.
 37. Mohammed AA, Aminu M, Ado SA, Jatau ED, Esona M.D. Prevalence of rotavirus among children under five years of age with diarrhea in Kaduna State Nigeria. *Nigerian Journal of Paeditrics*. 2016;43(4):264-268.
 38. Aliyu AM, Aminu M, Ado SA, Jatau ED. Epidemiological studies on Rotavirus associated with diarrhea among calves and children in Kaduna State, Nigeria. *Bayero Journal of Pure and Applied Sciences*. 2018;11(1):101-105.
 39. Crawford SE, Sasirekha R, Tate JE, Umesh DP, Lennart S, Mary KE. Rotavirus infection. *Nature Reviews Disease Primers*. 2018;3(17083):1-39.
 40. Jain D, Manmohan S, Sandeep B, Bansidhar T, Sukanya G. Incidence of Rotavirus in the National Capital Region, India: A retrospective study based on multicentric diagnostic laboratory. *International Journal of Medical Laboratory Research*. 2019;4(1):1-7.
 41. Fish EN. The X-files in immunity: sex-based differences predispose immuneresponses. *Nature Reviews Immunology*. 2008;8:737–744.
 42. Tate JE, Mijatovic-Rustempasic S, Tam KI, Lyde FC, Payne DC, Szilagyi P. Et al. Comparison of 2 Assays for Diagnosing Rotavirus and Evaluating Vaccine Effectiveness in Children with Gastroenteritis. *Emerging Infectious Diseases*. 2013;19(8):1245-1252.
 43. Lewandowski K, Bell A, Miles R, Carne S, Wooldridge D, Manso C, et al. The Effect of Nucleic Acid Extraction Platforms and Sample Storage on the Integrity of Viral RNA for Use in Whole Genome Sequencing. *The Journal of Molecular Diagnostics*. 2017;19(2):303-312
 44. Uzoma EB, Chukwubikem C, Omoyibo E, Tagbo O. Rotavirus genotypes and the clinical severity of diarrhoea among children under 5 years of age. *Nigerian Postgraduate Medical Journal*. 2016;23:1-5.
 45. Babatunde OM, Adedayo OF, Johnson AA. Epidemiology of Rotavirus A in Nigeria: Molecular Diversity and Current Insights. *Journal of Pathogens*. 2018:1-7
 46. Agutu M, Ongus J, Kombich J, Kamenwa R, Nyangao J, Kagira J, et al. Prevalence and genetic diversity of rotavirus infection in children with acute gastroenteritis in a hospital setting, Nairobi Kenya in post vaccination era: a cross-sectional study. *The Pan African Medical Journal*. 2017;26:38-49.
 47. Dia ML, Diop A, Sonko MA, Bâ M, Cissé MF. First report of gastroenteritis by genotype G12 rotavirus in Dakar, Senegal. *New Microbes and New Infections*. 2015;(6):30–32.
 48. Heylen E, Batoko BL, Zeller M, Stevens S, De Coster S, Conceicao-Neto N, et al. Rotavirus surveillance in Kisangani, the Democratic Republic of the Congo, reveals a high number of unusual genotypes and gene segments of animal origin in non-vaccinated symptomatic children. *PLoS ONE*. 2014;9(6):e100953.
 49. Moussa A, Ben Hadj Fredj M, Fodha I, Ben Hamida-Rebaï M, Kacem S, Argoubi A. Distribution of rotavirus VP7 and VP4 genotypes circulating in Tunisia from 2009 to 2014: Emergence of the genotype G12. *Journal of Medical Microbiology*. 2016;65(9):1028–1037.
 50. Giri S, Nayana PN, Ann M, Manohar B, Simon A, Singh T, et al. Rotavirus gastroenteritis in Indian children < 5 years hospitalized for diarrhoea, 2012 to 2016. *BioMed Central Public Health*. 2019;19:69-79.
 51. Ray P, Sharma S, Agarwal RK, Longmei J R, Gentsch VK, Paul RI, Glass MK. First Detection of Rotaviruses in Newborns with neonatal Rotavirus infection at all India Institute of Medical Sciences, New Delhi,

- India. Journal of Clinical Microbiology. 2007;45(11):3824-3827.
52. Ramani S, Nicolas WC, Liya H, Sue EC, Czako R, Smith DF, et al. The VP8* domain of neonatal Rotavirus strain G10P[11] binds to type II precursor glycans. Journal of Clinical Virology. 2013;87(13):7255-7264.
53. Libonati MH, Dennis AF, Ramani S, McDonald SM, Akopov A, Kirkness EF, et al. Absence of genetic differences among G10P[11] rotaviruses associated with asymptomatic and symptomatic neonatal infections in Vellore, India. Journal of Virology. 2014;88(16):9060-9071.

© 2021 Ibrahim et al.; This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Peer-review history:

The peer review history for this paper can be accessed here:
<https://www.sdiarticle5.com/review-history/77674>