A Documentation of Nigeria's Response to the COVID-19 Pandemic

#COVID19NaijaResponse

CENTRE FOR COMMUNICATION AND SOCIAL IMPACT

COVID-19 RESPONSE

NIGERIA HEALTH WATCH

Informed commentary, intelligence and insights on the Nigerian health sector

#COVID19NaijaResponse

Contents

1 Background on COVID-19

The overall goal of the PTF is to stop further transmission of COVID-19 within Nigeria, ensure provision of basic treatment to those infected, and reduce the overall social and economic impact of the pandemic on the country and to ensure that the Federal Republic of Nigeria emerges from the COVID-19 pandemic with minimal negative impact to the population, health system and the economy.

On 30th January 2020, the World Health Organisation (WHO) declared the Chinese outbreak of the 2019 novel coronavirus (COVID-19) to be a Public Health Emergency of International Concern (PHEOIC), one which posed a high risk to countries with vulnerable health systems. According to the WHO COVID-19 dashboard, as of May 5th 2020, the outbreak had resulted in over 3.5 million confirmed cases and 250 deaths affecting 212 countries and territories around the world and two international conveyances.

The first case was identified in Wuhan, China, in December 2019. Since then, the spread of the coronavirus has challenged governments to create public policies to minimize the load of COVID-19 cases on health care systems, often described as "flattening the curve". The WHO Emergency Committee advised that the spread of the coronavirus may be interrupted by early detection, isolation, prompt treatment, and the implementation of a robust system to trace contacts. Other strategic objectives include a means of ascertaining how severe clinical cases

In light of the pandemic, the Africa Centre for Disease Control and Prevention (Africa CDC) is strengthening the capacities of member countries of the African Union in risk communications, preparedness, and enhancement of surveillance at points of entry. Africa CDC, which is modelled after the U.S. Centres for Disease Control and Prevention, was first devised in 2013 and was officially launched in January 2017 by the African Union after the 2014–2016 Ebola epidemic, to improve surveillance, response and prevention of infectious diseases. On 17 July 2020, the African Union Chairperson, President Ramaphosa of South Africa

Background on COVID-19

launched the Africa Medical Supplies Platform to coordinate bulk purchase of COVID-19 commodities and drugs by member states (Adepoju 2020; Janngo2020).

In Nigeria, the index COVID-19 case was reported on February 27th, 2020. Upon identifying the index case, National Emergency Operations Centre was immediately activated to trace his contacts. By March 9, 2020, 27 suspected cases had been identified across five states - Edo, Lagos, Ogun, Federal Capital Territory, and Kano - of which two were confirmed to be positive (i.e. the index case and a contact), with no deaths. A total of 1,216 contacts were linked to the index case. A week later, community transmission was established.

Since then, Nigeria has recorded above 55,000 confirmed cases, more than 43,000 recoveries and above 1000 deaths across all 36 states and the Federal Capital Territory (NCDC, 2020). On 9 March 2020, President Muhammadu Buhari, established a Presidential Task Force on COVID-19 (PTF), chaired by the Secretary to the Government of the Federation. The PTF is multi-sectoral, with membership beyond the health sector, and has led the country's response to the pandemic. The PTF announced closure of international borders and lockdown of cities across the country (PTF,2020). These have had severe consequences on livelihoods of Nigerians. Of note is the unprecedented private sector support to Nigeria's COVID-19 response through the Private Sector Coalition Against COVID-19 (CACOVID). Through this coalition, participating private sector organisations have raised more than NGN30 billion ($70 million) to support the response. This fund has been deployed to setting up isolation centres, improving laboratory diagnoses and providing palliatives across the country (CACOVID, 2020).

To strengthen health security capacities and ensure that Nigeria is prepared to prevent, detect, and respond to public health emergencies, in 2018, 19 federal agencies came together to develop the National Action Plan for Health Security (NAPHS). This process is coordinated by the Nigeria Centre for Disease Control (NCDC) as the country's International Health Regulations (IHR, 2005) national focal point, with support from the World Health Organisation (WHO) and other partners. In addition to this, the Nigeria Centre for Disease Control (NCDC) helped to set up Public Health Emergency Operations Centers (PHEOCs) in 23 out of the 36 states inside Nigeria prior to the COVID-19 pandemic.

#COVID19NaijaResponse

2 Desk Review Overview: Lessons learned from global responses to the COVID-19 Pandemic

The coronavirus disease (COVID-19) is the first truly global crisis in history, affecting virtually every person on the planet at approximately the same time. Dealing with the unforeseen challenges caused by the COVID-19 pandemic has taken a significant toll on nations across the world.

A desk review as conducted to present data and research from different country platforms and it is expected that these country-by-country response reports from Africa, Asia, Europe, North and South America and Oceania can help decision-makers and citizens in Nigeria understand the robustness of governmental responses in a consistent way, aiding efforts to fight the pandemic. Below are summaries of the key lessons and recommendations from the desk review.

1.1 KEY LESSONS

- Private sector involvement: From delivering critical supplies, to digital solutions and innovation, private sector input helped to meet the short-term needs in the COVID-19 response. It also demonstrates how all organisations, not just those in the health industry, are doing their part to address COVID 19 problems.
- Robust funding for epidemic preparedness: Funding committed so far by countries and international financing institutions will help government take national action and bolster economies. But urgent gaps remain especially in funding research and development of public health measures.
- Although COVID-19 is new, borrowing best practices from past response to health emergencies and applying them to this pandemic can help to curb the spread.
- Every country must design a comprehensive crisis package aimed at tackling the health emergency and supporting economic activity.
- Every country must have an emergency preparedness plan.
- Build strong health systems
- Political will is key
- Communicate clearly: A lot of effort must be put into informing and educating the people about COVID-19. Having credible and timely information creates the foundation for shared understanding of the nature of the problems and what needs to be done about them that is needed if mobilisation of collective effort is to occur – and helps build trust.
- Providing numbers and statistics on COVID 19, context, history, process of testing and procedure in a timely and straightforward fashion, which can help bolster trust.
- Telling people what they can do and how they can act to keep themselves and others safe.

1.2 RECOMMENDATIONS

- Communication is important. Communicating clearly, well and frequently will help build trust in the government.
- Primary healthcare is the foundation of every health system. Therefore, countries must strengthen their local health systems and primary health care which is paramount in stopping the spread of disease.
- Governments at different level must show commitment in fighting epidemics by prioritizing and increasing its investment for epidemic preparedness before the onset of any disease outbreak.
- The COVID-19 pandemic affects most people and hence must be taken seriously. The emergence of COVID-19 has led to the closure of businesses which has in turn taken a toll on the Global economy. This calls for the need for collaborations between the public and private sector for epidemic preparedness.
- To avoid the spread and effect of fake news, countries must adopt an effective communication model for disseminating information to its citizens.
- Strict adherence to preventive and safety guidelines by all governmental and private institutions/companies should be followed and a monitoring team should be established to monitor these various establishments at various regions within the country. Citizens also should be encouraged to adopt a good hygienic lifestyle and adherence to strict safety measures.
- It is vital to invest in national health and research systems to enhance laboratory capacity as well as the workforce. These are fundamental to a quick and effective national response to health emergencies and global health security.
- Countries must implement near-term readiness planning and large scale implementation of high-quality, non-pharmaceutical public health measures such as case detection and isolation, contact tracing, and monitoring/quarantining and community engagement by following blueprints of China.
- Artificial Intelligence played a large role in China's digital health strategies. Countries should leverage on technology to strengthen preparedness and response to public and other emergencies.

#COVID19NaijaResponse

3 Overview of Nigeria's response to COVID-19

Presidential Task Force on COVID-19 (PTF)

The overall goal of the PTF is to stop further transmission of COVID-19 within Nigeria, ensure provision of basic treatment to those infected, and reduce the overall social and economic impact of the pandemic on the country and to ensure that the Federal Republic of Nigeria emerges from the COVID-19 pandemic with minimal negative impact to the population, health system and the economy.

Introduction

On the 7th of March 2020, the Federal Government established the Presidential Task Force (PTF) for the Control of Coronavirus (COVID-19) Disease in Nigeria. The PTF is the national coordinating body for the COVID-19 pandemic response and had an initial mandate of six months. The overall goal of the PTF is to stop further transmission of COVID-19 within Nigeria, ensure provision of basic treatment to those infected, and reduce the overall social and economic impact of the pandemic on the country and to ensure that the Federal Republic of Nigeria emerges from the COVID-19 pandemic with minimal negative impact to the population, health system and the economy.

The responsibilities of the PTF include:

1. Develop guidelines and best practices for COVID-19 response
2. Establish a national budget and determine funding sources for Nigeria's response to COVID-19
3. Determine key nationwide policy and enforcement
4. Ensure national security throughout the response
5. Manage negative economic impact of the COVID-19 pandemic to the country

The PTF developed a National Pandemic Response Plan (PRP) with the following objectives:

1. Provide a coordinated and effective national and sub-national response to the COVID-19 pandemic
2. Reduce COVID-19 related morbidity and mortality
3. Mitigate pandemic-related impacts on critical, economic and health infrastructure
4. Facilitate post-pandemic recovery and rehabilitation operations

To effectively achieve the mandate of the PTF, a National COVID19 Response Centre (NCRC), was set up within the PTF to serve as secretariat. The NCRC, headed by the National Coordinator, serves as the operational arm of the PTF and provides leadership for the coordination and operations of the various health and non-health functional areas at the national level. The NCRC includes a secretariat, resource mobilization and government relations advisers, and an incident management system.

To drive the implementation of the Pandemic Response Plan, the PTF Secretariat established ten functional working groups with the goal of implementing the Incident Action Plan (IAP)determining policies and ensuring effective communication and collaboration towards the delivery of the PTF's mandate.

- **Case Management**
- **Epidemiology & Surveillance**
- **Infection, Prevention and Control (IPC)**
- **Laboratory**
- **Point of Entry (PoE)**
- **Resource Mobilisation**
- **Risk Communication and Community Engagement**
- **Security, Logistics and Mass Care (SLMC)**
- **State Coordination and Government Relations**
- **Sustainable Production Group**

Overview of Nigeria's response to COVID-19

Presidential Task Force on COVID-19 (PTF)

Through its different pillars, Ministries, Departments and Agencies (MDAs) and partners, the PTF successfully coordinated the nation's COVID-19 response in the following areas:

Coordination & Policy Formulation

Over fifty MDAs and partner organisations have been involved in the response and the PTF aligned all these organisations, improving linkages and partnerships between them.

Infrastructure & Services

Through the NCDC, FMOH and supporting partners, the PTF set up 39 labs across 25 states, 131 treatment centres with a total bed capacity of 7,040; 256 ICU beds and other key healthcare infrastructure

Partnerships & Resource Mobilisation

The PTF worked with development partners and the private sector, largely the United Nations and the Private Sector Coalition against COVID-19 (CACOVID), to support implementation of activities with technical and material output.

Capacity Building

The PTF through the NCDC and FMOH trained over 17,000 health care workers on Infection, Prevention and Control, Laboratory Operations and Case Management.

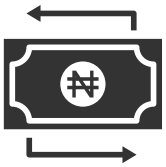
Risk Communication & Community Engagement

The PTF's daily televised briefings became the most credible source of information on the pandemic in the country. With leadership from the Federal Ministry of Information, communication and advocacy materials were produced and disseminated through traditional and digital media channels.

Humanitarian & Social Interventions

Through the Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development and NEMA, the PTF implemented social interventions aimed at cushioning the effect of the lockdown on individuals and small-scale businesses. These interventions were in 3 categories:

a) **Food** Between March and June 2020, a total of 30,876.3 metric tonnes of food items were distributed to 3,795,500 households.



b) **Cash Transfer** – 730,177 eligible household beneficiaries in 24 States received cash disbursements under the Conditional Cash Transfer Scheme, and other existing programs.

c) **Economic support** – These were in the form of the "Government Enterprise and Empowerment Programme", "Trader and Market Moni" loans, and a rapid expansion of the National Social Register.

Data from – Presidential Task Force on COVID-19: Mid-Term Report. July 2020

Overview of Nigeria's response to COVID-19

FEDERAL MINISTRY OF HEALTH

Federal Ministry of Health (FMoH)

The COVID-19 pandemic is a public health emergency, therefore, the public health response to the outbreak rests with the Federal Ministry of Health (FMoH) under the leadership of Dr Osagie Ehanire. However, the COVID-19 response has also required a multi-stakeholder, multi-agency collaboration as other relevant MDAs have been incorporated in to contribute their expertise to the response. The FMoH activated a National Emergency Operations Centre (EOC) for COVID-19, which is domiciled at the NCDC. The EOC is leading the national public health response to the COVID-19 outbreak in Nigeria, and is made up of different teams (pillars) responsible for different areas of the response, such as risk, communication, infection prevention and control and case management, with state EOCs leading the response at the state level. The National EOC includes representatives from the Federal Ministry of Health, other sister agencies and partners. The FMoH through the NCDC has led the risk communications, producing health promotion materials in different languages targeting various groups including religious and traditional leaders, as well as self-isolation guidelines for males and females.

The Nigeria Centre for Disease Control (NCDC) is the Federal Ministry of Health (FMoH) agency tasked with responding to infectious disease outbreaks. Other agencies of the FMoH such as the National Institute for Medical Research (NIMR), National Institute for Pharmaceutical Research and Development (NIPRD), and National Agency for Food, Drug Administration and Control (NAFDAC) are also integral parts of the COVID-19 national response by developing and expediting processes for testing and validation of claims of pharmaceutical interventions for COVID-19. The National Primary Health Care Development Agency (NPHCDA) is also providing training and guidance to primary health care teams to ensure continuous provision of services by PHCs in communities during the pandemic.

DataFrom - https://nigeriahealthwatch.com/the-first-90-days-how-has-nigeria-responded-to-the-covid-19-outbreak-covid19naijaresponse/

The EOC is leading the national public health response to the COVID-19 outbreak in Nigeria, and is made up of different teams (pillars) responsible for different areas of the response, such as risk, communication, infection prevention and control and case management, with state EOCs leading the response at the state level.

NCDC
NIGERIA CENTRE FOR DISEASE CONTROL

Nigeria Centre for Disease Control (NCDC)

The Nigeria Centre for Disease Control (NCDC) is Nigeria's national public health institute, responsible for the health security of Nigeria through the prevention, detection and control of diseases of public health importance. As part of her mandate, the NCDC support States in responding to small outbreaks, and leads in the response to large disease outbreaks. Prior to the confirmation of the first COVID-19 case in Nigeria, the NCDC put the National Emergency Operation Centre (EOC), on high alert mode; monitoring the spread in other countries, carrying out risk assessments and strengthening Nigeria's preparedness.

The EOC is the central coordinating unit during public health emergencies like the Covid-19 pandemic and Lassa fever outbreak. It is usually multi-sectoral and multi-discipline; various subject matter experts across relevant MDAs are represented on the EOC, including the Armed Forces. The EOC operates at response levels depending on the severity of the outbreak, Level 1 being the lowest for outbreaks within localities in a State; where the outbreak affects multiple States or region, it is escalated to Level 2. The highest is Level 3 where all available resources at the State and national level is deployed to end the outbreak. To ensure a well-coordinated emergency response, NCDC activated a Level 3 response on the 27th of February 2020.

Data from -https://www.ncdc.gov.ng/news/253/100-days-of-nigeria-covid-19-response

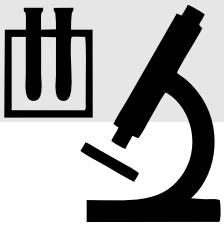
The EOC operates at response levels depending on the severity of the outbreak, Level 1 being the lowest for outbreaks within localities in a State; where the outbreak affects multiple States or region, it is escalated to Level 2. The highest is Level 3 where all available resources at the State and national level is deployed to end the outbreak.

Overview of Nigeria's response to COVID-19

The COVID-19 EOC has the following pillars:

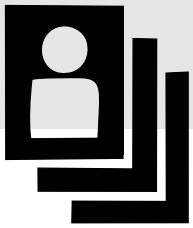
Surveillance & Epidemiology

Ensures prompt detection and reporting of suspected cases, builds states capacity for detailed case investigation, etc



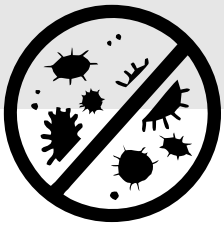
Laboratory Services

·Expands capacity for testing to ensure 100% geographic coverage, provides training and technical support to 36 + 1 states on specimen collection, packaging and transportation, etc.



Case Management

·Prompt isolation of suspected cases at health facilities, improved clinical outcomes of confirmed cases by reducing morbidity and mortality, etc.



Infection Prevention and Control (including safety)

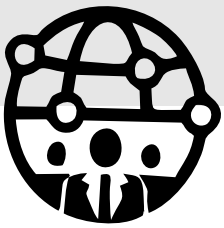
Prevents and limits community transmission, prevents amplification around healthcare facilities, etc.

Logistics

Ensures the availability of health products in the right quantity at the right location at the right time.

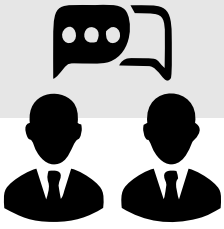
Research

Strengthens the EOC preparedness and response activities through the generation and/or synthesis of research evidence.



Liaison

Coordinates partner engagement, resource mobilization, requests for information.



Risk Communication

·Promotes rapid information sharing among in the public, provides timely and accurate information to the public about Government actions for containing COVID 19 outbreak, etc.

Point of Entry

Prevents, detects, assesses and responds to health events at points of entry (POE) for effective containment of COVID 19 in pursuit of national and global health security.

Data from "NCDC COVID-19 OUTBREAK RESPONSE STRUCTURE"

Overview of Nigeria's response to COVID-19

Expanding COVID-19 Testing Capacity

Since February 2020, Nigeria has significantly increased its molecular laboratory network for COVID-19 testing, from two as at February 27 to 71 fully functional laboratories in 35 states across the country and the FCT. The collaboration between NCDC and state governments, as well as private sector partners such as 54Gene, EHealth Africa, Shell Petroleum and Development Company of Nigeria (SPDC) and Dangote Foundation, amongst other partners, was instrumental to the expansion of the COVID-19 testing capacity. This resulted in better coordination that enabled better collection and a better, faster testing process.

The collaboration between NCDC and state governments, as well as private sector partners such as 54Gene, EHealth Africa, Shell Petroleum and Development Company of Nigeria (SPDC) and Dangote Foundation, amongst other partners, was instrumental to the expansion of the COVID-19 testing capacity.

Facilitating Training

The NCDC improved staff capacity in advanced diagnostics, disease surveillance and response. They also supported states to train public health workers, set up systems for efficient epidemiological data collection and sharing. The NCDC also trained health workers on infection prevention and control protocols, sample collection and effective management of COVID-19 patients. The NCDC risk communications teams also conducted training for military and paramilitary personnel.

Developing public health protocols

The NCDC established public health protocols with other agencies like the Ministry of Aviation, Nigeria Immigration Service, Nigeria Port Health Services, Nigerians in Diaspora Commission and Foreign Affairs. These protocols include mandatory completion of forms by travelers coming into the country to track their travel history. In order to limit the spread of the disease, the NCDC produced guidelines on public gatherings, management of pregnant women, the use of public transport, social distancing and wearing of non-medical face coverings, as well as guidelines for the safe burial of individuals who die from COVID-19.

Communication for public engagement and surveillance

Communication plays a significant role in COVID-19 surveillance by monitoring general conversations and engaging with the public. This is referred to as Event Based Surveillance and made possible by the NCDC Connect Centre. The centre manages the NCDC toll-free line, WhatsApp and SMS platforms.

The NCDC launched the **#TakeResponsibility** campaign which has formed the cornerstone of public health messaging. This is done by leveraging on social media, mainstream media and other avenues to encourage Nigerians to take responsibility for protecting themselves and loved ones and preventing the spread of COVID-19. Over 150 jingles currently air on radio and television, reaching communities across the country. With the support of Nigeria's telecommunication companies, over 100 million text messages have been sent out since February 2020 reminding Nigerians about measures that can be taken to protect themselves from COVID-19. The NCDC continues to work closely with the Federal Ministry of Information and Culture, as well as the National Orientation Agency to educate Nigerians on how to protect themselves.

Except where otherwise indicated, data from https://nigeriahealthwatch.com/the-first-90-days-how-has-nigeria-responded-to-the-covid-19-outbreak-covid19naijaresponse/

Over 150 jingles currently air on radio and television, reaching communities across the country. With the support of Nigeria's telecommunication companies, over 100 million text messages have been sent out since February 2020 reminding Nigerians about measures that can be taken to protect themselves from COVID-19.

As part of its mandate, NCDC has provided support to all states in Nigeria. The agency supported the establishment of State Public Health Emergency Operations Centres in 23 of the 30 states in Nigeria, without polio or public health EOCs. These EOCs have served as the coordination hub at state level since the first case was confirmed in Nigeria. The NCDC has deployed its highest number of rapid response teams - with 37 teams across 34 states and the FCT. The extent of this response has been supported by the deployment of additional surge teams from the Nigeria Field Epidemiology and Laboratory Training Programme (NFELTP), the World Health Organization (WHO) and Africa Centres for Disease Control (Africa CDC). NCDC continues to support every State with medical supplies, transportation of samples, training of health workers, risk communications and other response activities.

#COVID19NaijaResponse

4 State level coordination with NCDC

Across the country, states put in place measures to respond to the COVID-19 pandemic. States also received support, both financial and technical, from the Presidential Task Force on COVID19, the Federal Ministry of Health, the Nigeria Centre for Disease Control, and development partners.

Prior to the COVID-19 pandemic, NCDC had been supporting the surveillance activities for priority diseases through training and capacity building activities for infectious diseases response and provision of response materials for states.

State epidemiologists and state health promotion officers were tasked with leading the public health response in their states and communities. State Epidemiologists are tasked with coordinating the response to infectious disease outbreaks at the state level, including surveillance, investigation and contact tracing, while State Health Promotion Officers support risk communications activities at state level, including the dissemination of information, education and communication materials to local governments.

Qualitative In-Depth Interviews (IDIs) with state epidemiologists and state health promotion officers highlight the coordination process, successes and challenges of mounting a public health response to the COVID-19 pandemic at state level, and provide insights into the work that still needs to be done to improve infectious disease surveillance and risk communications at the state level. Requests for interviews were sent to state epidemiologists and health promotion officers through the NCDC. 14 state epidemiologists and 14 state health promotion officers responded to the requests for interviews. Respondents were interviewed between May and September 2020. The most central themes are highlighted below:

State Epidemiologists are tasked with coordinating the response toinfectious disease outbreaks at the state level, including surveillance, investigation and contact tracing, while State Health Promotion Officers support risk communications activities at state level, including the dissemination of information, education and communication materials to local governments.

Collaboration with NCDC before COVID-19 outbreak

Most of the state epidemiologists noted that their collaborations with NCDC prior to the COVID-19 pandemic were good. They mentioned that NCDC was already supporting surveillance activities or priority diseases through training and capacity building activities, through setting up emergency operations centres and providing supplies. NCDC was commended for its support during outbreaks of Lassa fever and Cholera.

"It has been very good. Before now, NCDC has been supporting the surveillance activities for priority diseases through training and capacity building activities for infectious diseases response and provision of response materials for the state." – Abia State Epidemiologist

"It has been good, because whenever there is a disease outbreak in the state, the first people we contact is the NCDC and they usually give us all the support that we need. During outbreaks like Cholera and Lassa fever, we had a lot of support from NCDC. Since the inception of NCDC, we have been collaborating." – Borno State Epidemiologist

State level coordination with NCDC

"The collaboration was smooth and cordial, especially the trainings and capacity building programmes. Whenever there is a need for response, we make a request and NCDC will support us as much as they can. We also reported to NCDC just as we reported to the state concerning any disease outbreaks, such as that of Lassa fever." – Cross River State Epidemiologist

"Before COVID-19, NCDC had already put certain structures in place for surveillance and response to some extent. The surveillance system practiced in the country before COVID-19 employs grassroot surveillance, such that we have health facilities at the community level, which consist of primary healthcare centers with surveillance focal persons that report to the local government DSLOs. There are also focal persons in the secondary and tertiary healthcare centres. These surveillance focal persons are trained by NCDC to report all cases of infectious diseases on a weekly or monthly basis. We also have community informants that report to the LGA DSLOs as well. All information is transmitted electronically from the LGAs to the state and national level. In a nutshell, I will say that NCDC has been relating very well with the state before COVID-19." – Gombe State Epidemiologist

Collaboration with NCDC during COVID-19 outbreak

NCDC provided technical support for states during the COVID-19 outbreak. States mentioned that collaborations with NCDC kicked up a notch when the pandemic hit Nigeria. They noted that NCDC took additional steps to provide personal protective equipment (PPE) and sample collection materials for health staff involved in the response, sent out personnel to support states, provided training for health workers, and supplied laboratory materials to improve testing. Some states noted however that their relationship with NCDC was strained during the response to the outbreak.

"I think the level of support has increased in terms of sending out personnel to support the emergency operations centres with supplies, equipment, case management and training of health workers." – Anambra State Epidemiologist

"The collaboration is a bit strained because of the issue of not sending collected samples out of the state for some time now due to the lockdown. However, we are trying to strengthen the collaboration as we really need the support of NCDC in the COVID-19 response." – Cross River State Epidemiologist

"They have been regularly supplying us with laboratory materials to improve our testing capacity even technical support. They also sent their rapid response team to the state to help us out in our response activities and train our staff thoroughly. They also helped us out in the management of COVID-19 cases." – Delta State Epidemiologist

"The collaboration has been superb. NCDC has been providing us with all the guidelines and materials required to carry out an effective response. They also sent a rapid response team from the national level made up of surveillance professionals that came to the state at the initial period and stayed for two months, helping us out and training our staff until they felt we were capable enough before leaving." – Enugu State Epidemiologist

"They have been regularly supplying us with laboratory materials to improve our testing capacity even technical support. They also sent their rapid response team to the state to help us out in our response activities and train our staff thoroughly. They also helped us out in the management of COVID-19 cases." – Delta State Epidemiologist

"The NCDC collaboration with the State Government on surveillance has been awesome. In fact, the Director General has made it a point of duty to make sure that the State Epidemiologists are included in all the activities concerning surveillance. They provided a platform where we had trainings and meetings to enhance our surveillance capacity and to keep ourselves updated. They also ensured that most states have emergency operation centers. Our own emergency operation center was stepped up in December 2019, which was before the COVID-19 pandemic. If we did not have a functional EOC, I do not know how we would have coped with the COVID-19 response. The relationship has been a wonderful and very promising one." – Rivers State Epidemiologist

State level coordination with NCDC

State Government Support for response activities

State support for response activities varied greatly from state to state. Some states commended their governments for their robust support, including the payment of weekly allowances, equipping labs with instruments and personnel, supporting risk communications, prepping treatment centres ahead of the outbreak, and training volunteers. Others noted that their state government provided support but it was not directed at where the needs were greatest, while some said funding from their state for response activities has been poor.

"Until we got funding from NCDC recently through the World Bank project, the State has been supporting us in all aspects of the response. All staff involved in the response, even cleaners receive weekly allowances from the State government. Also, our Labs for testing have been adequately equipped with instruments and personnel. The government responds quickly in regularly supplying us, even when we run out of stock. The government's response in risk communication is 100% and all radio stations, both public and private always invite people on air to raise awareness and educate the citizens." **– Abia State Epidemiologist**

"The challenge is that our state government releases the funds in little bits. The support has not been much, but it is better than nothing at all. The funding support has been poor compared to other states in the country." **– Bayelsa State Epidemiologist**

"Most of the State governments seemed not to be fully aware of what "outbreak response" actually meant, so the response was not very strong initially. The Benue State government made some resources available for the response, however, the resources should have been directed to the operations of the response such as training of staff, logistics, stipends and so on in order to motivate those working out in the field, but this was not the case. The areas which most of the funds went to was the production of face masks, sanitizers and renovation of the treatment center for the response. There is currently no borehole in the EOC, though boreholes were built in some Teaching hospitals and the Federal Medical Center, so the state government should pay attention to issues like this. Overall, I think the state did much better now than it has ever done in any other outbreak responses before COVID-19." **– Benue State Epidemiologist**

"The state government started preparing for the response even before we had our index cases by converting the Lassa fever treatment centre and other hospital centres into places for COVID-19 management. They have been providing some additional stipends to motivate the health workers to continue their duties. They have also made some mobile ambulances available for transporting infected individuals to the case management centers and also transporting collected samples to approved laboratories for testing. Various health workers were also trained by the state to improve their capacity in surveillance, contact tracing, testing and case management activities. In summary, the state government has been of tremendous help in the disease response." **– Delta State Epidemiologist**

"The state government is supporting us in all areas, including case management, building of a new infectious disease center and furnishing it with the required equipment. They have also improved the salary and insurance of COVID-19 health workers and has also ensured the decontamination of all hospitals and homes of confirmed cases. Response materials, PPE, medications and cloth face masks have all been provided, and the state government has also been supporting the risk communication activities at the grassroot levels through town union executives to sensitize the individuals in the community." **– Enugu State Epidemiologist**

"100% of what we do in the state is funded by the state government and they settled us with souvenirs for our COVID-19 response activities." **– Gombe State Epidemiologist**

State level coordination with NCDC

Partner Support for response activities

Partners, including development agencies, multinationals and private organisations, pitched in to support the national and state responses to the COVID-19 pandemic. States mentioned as partners the World Health Organisation (WHO), UNICEF, the World Bank, and UNFPA. Private organisations that provided support to states include Shell Petroleum Development Company (SPDC). Partners provided PPE, trained staff, and provided surveillance personnel and logistics.

Independent private organizations like Shell and Access Bank have been supporting us, coupled with some other individuals who have also provided PPE and cash. Concerning public partners, apart from NCDC, we have not received any support from other partners.

: Our main partner is WHO. They have supported us by providing surveillance personnel, risk communication, logistics (provided vehicles) and also organized surveillance trainings for a good number of our health workers. Recently, they provided us with data plans to enable us update our SORMAS and other records. The Nigerian Red Cross also provided us with a Land Cruiser to support logistics. The Nigerian Airforce base recently made their Laboratory available for our use in testing. Other partners like FHI360 and UNHCR were involved in Refugee camps to ensure that the refugees are safe and catered for. We still have some other partner groups that have contributed in different ways to help us out in the response. We know that other states have much stronger partnerships than us, which is why we need to improve our partnerships so we can get more help.

Some partners such as WHO and the National Primary Healthcare Agency have trained a number of our health workers at the primary healthcare level. UNICEF and UNFPA have also supported the state by furnishing the general hospitals and isolation centers. USAID has also provided a lot of equipment to augment those in the EOC and equip our call centers.

Our major support is from UNICEF, which has been supporting us in many areas such as prevention, control, surveillance and risk communication. We have also received technical assistance from WHO, which released their own staff to help us out with contact tracing. They also trained our Medical Laboratory Scientists, State surveillance officers and LGA surveillance officers, and also supported us with some refreshments while carrying out our activities. Also, the State Tuberculosis Program supported us by providing some PPE materials.

Collaborations with other government agencies

In addition to partners, collaborations with other state agencies were considered key to tackle the COVID-19 pandemic. Agencies included the National and State primary health agencies and the National Orientation Agency.

The NPHCDA staff have been helping us. The National Orientation Agency has also been helping us in risk communication.

State level coordination with NCDC

The NPHCDA and other arms of the State Ministry of Health have been overseeing the activities of the primary healthcare centers. Recently, the NPHCDA and State Primary Healthcare Agency collaborated to train health workers and community informants on various aspects of the COVID-19 response. Also, other partners like NOA and the Federal Ministry of Health have been collaborating with us and helping out in many ways.

We have good collaborations. The State Primary Healthcare Development Agency is part of our Emergency operations centre, and even the NPHCDA State Coordinator is available to help out in the EOC, so we collaborate together to decide on ways we can strengthen the EOC and the response.

We pay particular attention to primary healthcare in the rural areas because most patients visit the primary health facilities if they have any illnesses, so we are effecting our IPC program which will train the health workers in the rural areas to detect and report any cases to us, and also offer advice to the patient on the next step to take.

Collaborations with local communities, Disease Notification Officers (DSNOs) and health facilities:

Stakeholders were not limited to partners and other agencies. Getting the community involved in the response, as well as the notification channels from the ward level upwards, and collaborations with the health facilities, were all important parts of the state response. These collaborations allowed states to improve surveillance and reporting from the grass roots level up, as well as disseminate accurate information to communities through trusted channels.

Collaboration with local Communities:

What we are doing right now is that we have community informants that give us information from rural communities. When people fall ill, they visit these community informants for treatment advice, but if it is severe, then they will proceed to health facilities. So we liaise well with the community informants, CDC, the council of chiefs and other people in charge of health in the community.

At the community level, we once carried out an active case search in various communities to know if there are any other infectious diseases we did not take note of earlier on so we can give appropriate attention to them. However, we were met with resistance from the indigenes, who did not believe in the authenticity of our work and some believed that COVID-19 is not real. Some religious ones believe that they have divine immunity from the disease and cannot get infected no matter their level of contact with other people, so they see no need to adhere to the precautionary measures. The work of convincing people about the severity of the COVID-19 pandemic has not been easy, but we are doing our best and even thinking of more ways to improve the creation of awareness.

Collaborations with Disease Notification Officers (DSNOs)

There are about four LGAs in the state that are totally inaccessible and there are those that are partially accessible, though with no network connection. Thankfully, we have partners like WHO that offers us free Wi-Fi services to send and receive information on a daily basis to and from each of these LGAs. We also have virtual meetings on COVID-19 response once in a while.

State level coordination with NCDC

Benue: We have DSLOs in all the LGAs and State DSLOs. It is one of the strongest structures we have in our surveillance system and they have served as communication channels for reporting on infectious diseases long before COVID-19. Sometimes, they send us information through multiple sources such as the IDSR entries, SMS and Phone calls. In other instances, we directly move to the LGAs to make sure that the information being reported by the DSLOs is accurate

We make use of a general platform where they can input their reports and it will be accessible to me and other coordinators at the state level, as well as at the National level. Apart from this platform, there is also a weekly report that is sent in every Monday to us by the DSNOs.

We have monthly review meetings with all DSNOs during the first week of every month, where all the LGA DSNOs in the state come together and give their reports on all priority diseases, their challenges and also decide on the way forward. Once they submit their reports, the State collates everything and sends it to the national level. There is always feedback from the state to the lower levels and from the lower levels to the state in these meetings. There is also a state DSNO who is directly in charge of all the LGA DSNOs, gets updates from them and reports to me through daily phone calls and SMS. We also have a WhatsApp group where real-time information is shared concerning the surveillance activities and any challenges being faced. More importantly, we have the **Surveillance Outbreak Response Management and Analysis System**, called the **SORMAS** Platform, which is a real-time information transmission system for surveillance in the country, where anyone can access surveillance information anywhere in the country.

Collaborations with health facilities:

We have focal persons in some of the public and private healthcare facilities. The facilities with focal persons regularly communicate with the DSNOs, but for those facilities that do not have focal persons, we visit them once in a while to carry out active case research and sensitize them on how to report disease outbreaks properly. – Abia State Epidemiologist
For the Secondary health facilities, we have been able to engage them and train some of their staff to serve as sample collectors in the various LGAs across the state. All in all, we are working together with them to ensure adequate coverage in the COVID-19 response.

We have community informants and surveillance focal persons that are matched with each of the healthcare facilities in every community to ensure proper sensitization and monitoring of any suspected cases in any of these facilities. All their observations are reported to the DSNOs of the LGAs, who in turn communicate the information to the Epidemiology unit at the State level.

We can not get much data without the help of the healthcare facilities, so we collaborate with them and that is the essence of the trainings I talked about earlier on. We sensitize them on all these priority diseases so that they will be able to report any of their observations and regularly send us updates of the data they have gathered. We do not have any problem with the government healthcare facilities, where we have challenges is with the private healthcare facilities because some of them are not completely willing to share their information and data with us but we are still working towards that to ensure that all healthcare facilities regularly report back to the state.

State level coordination with NCDC

Surveillance and Contact Tracing:

States noted that surveillance and contact tracing activities for COVID-19 were successful, with state Rapid Response Teams deployed and increases in contact tracing kits. Yet they also largely pointed to challenges with the surveillance and contact tracing process, including logistics and funding gaps, inaccurate data collection, and reduced support for LGA surveillance systems. For other diseases besides COVID-19, states largely noted that surveillance had lagged behind as there was more focus on COVID-19. Still, especially in states where diseases such as Lassa Fever were endemic, efforts to maintain surveillance and contact tracing were made.

Surveillance and Contact Tracing for COVID-19

I would not say that is has been very successful, but we are trying our best. I believe Bayelsa has one of the best surveillance systems in the country, but we also have our challenges, such as the availability of transport vehicles, though this has been settled by NCDC's support. Concerning funding, there are still gaps but WHO has been supporting us with some funds. Surveillance in the state is a bit okay, but it is not so smooth in the LGAs because there is not enough support reaching the LGA surveillance systems. Overall, I would give our surveillance a rating of about 85%.

It has been successful, because we were well prepared even before we had our index case of COVID-19. As the number of cases started increasing, we immediately mobilized the State RRT and increased the number of our contact tracing kits. Our health workers were well trained and we had a contact tracing team for each case to ensure effective tracing. We also have a group of alert investigation teams consisting of DSLOs and Assistant DSLOs for each LGA to ensure maximal investigation of any case alerts from any of the LGAs. Summarily, our contact tracing and surveillance has been very successful so far.

It has been very successful, though with some challenges. We have been able to identify asymptomatic individuals from those that are COVID-19 positive, and also take note of any diseases or conditions that produce symptoms similar to COVID-19, so we can know how best to test for and manage these conditions. We have had some issues with inaccurate data collection and fear of contracting the disease while carrying out our field work. We have made sure to adhere to the precautionary measures and have improved our data collection strategies, so these challenges are being settled gradually.

We started with zero tests or cases, but now we have tested more than 14,000 samples and have recorded more than a thousand cases, of which 104 have been discharged. Now we are into mass community testing because the criteria for rating our level of performance with regards to the response and containment of COVID-19 is through the number of tests we have done on eligible individuals. The frequency of cases is gradually decreasing, which is a good sign, but we are not relenting as we have intensified our active case search and contact tracing in order to properly control the disease. Some companies have stepped in to provide palliatives for the people. The three components we are working on are preventive, creative and palliative measures, so we are trying as much as we can through the IPC and RCCE (risk communication and community engagement) pillars to curb the spread and ensure effective case management. We are also putting measures in place to ensure that people stay at home and adhere to the necessary precautions.

State level coordination with NCDC

Surveillance and Contact Tracing for Other Diseases

The truth is that other diseases have actually suffered a bit. Though we are trying to curb the spread of COVID-19, we are also trying as much as possible to continue surveillance for other diseases such as Lassa fever, Yellow fever and so on. The pressure from COVID-19 has reduced the available manpower required to make good progress in the surveillance for other infectious diseases.

To be honest, COVID-19 has affected the active surveillance of other diseases because more attention has been drawn to it. Recently, some focal persons from NCDC for other diseases like Yellow fever and Monkeypox have been contacting us to send in whatever data we have currently on other diseases aside COVID-19, so we are making efforts in that area too.

There are many of our surveillance teams out in the field surveying various communities for any suspected cases, be it COVID-19 or any other infectious diseases. Once we record any suspected cases of Measles, Yellow Fever and other epidemic-prone diseases, we immediately start sample collection, testing and contact tracing. So, our surveillance covers all other infectious diseases as well.

As much as COVID-19 is the center of attention globally at the moment, we are not entirely focused on COVID-19. There are other priority infectious diseases in Edo state, such as Measles, Guinea worm disease and Lassa fever. The Lassa fever disease is particularly endemic in our state, so we have two emergency operation centers, of which one is for COVID-19 and the other is for Lassa fever. Even though the number of Lassa fever cases has reduced, we are still surveying various communities that are endemic to the disease and wiping out all rodents that could serve as vectors for the Lassa fever virus. So, we are not relegating other diseases to the background and we are still carrying out surveillance for them.

We analyze weather and seasonal changes to get hints on the periods which certain diseases are likely to be prevalent. For example, rainy weather could give rise to floods, which could be suggestive of a cholera outbreak. We take note of these things and inform the people about the kind of diseases they should expect and the appropriate preventive measures to take. We also take certain measures to ensure that our health workers do not get overwhelmed by the COVID-19 response. Our health workers are given the necessary support and are trained to immediately report to us if they see signs of any infectious disease so we can respond quickly. Even during the heat of the pandemic, we were able to successfully treat a 4-month-old baby of Lassa fever. We also carry out other public health actions like community sensitization and immunization. We are aware of the fact that there could be other disease outbreaks, so we are unrelenting in our efforts to survey for other diseases aside COVID-19. We are also preparing ourselves for the possibility of living safely in the midst of COVID-19, because this pandemic does not seem like it will go any time soon.

We did not allow COVID-19 to affect the surveillance of other diseases. We have monthly virtual meetings with the DSLOs to discuss about all the disease cases observed without restricting ourselves to COVID-19.

State level coordination with NCDC

NCDC Communications Support:

The Nigeria Centre for Disease Control (NCDC) supported states with risk communications materials, training and awareness creation. States reflected that the information provided by the NCDC helped them better understand the symptoms to look for, pick out the nearest available laboratories, and also provide accurate information for their communities through its advisories and guidelines.

: It has been helping us in numerous ways. Just before the pandemic began, they sent information containing case definitions which we should watch out for. In the midst of the pandemic, the case definitions have been changing and NCDC has been regularly updating us in order to help us tackle the disease and strengthen our surveillance and response. They have also provided us with information regarding the laboratory network, so we were able to pick out the nearest available laboratories to send the collected samples for testing. Also, their management protocols have helped the case management team in their management of COVID-19 cases. They also regularly update us with priority areas we should focus on at each point in time during the pandemic. Summarily, we depend on NCDC heavily for insight on how best to carry out the response.

The information has been very useful to us. We usually receive daily updates and guidelines from NCDC on the COVID-19 response, which we use in our surveillance and response activities. The updates have improved our knowledge of the disease and has also helped us modify our approaches in contact tracing, testing, awareness campaigns and other activities.

The IPC (Infection Prevention and Control) pillar at the national level has worked with the state focal persons to conduct trainings. NCDC creates new guidelines when there are any changes and they update us with these guidelines, which we use in our surveillance activities. They taught us how to use all the tools we are currently using. Whatever they produce is what we use at the state level for surveillance. They also trained our healthcare workers and created WhatsApp groups for the case management officers at the state level where they can exchange ideas on new research discoveries in case management.

Challenges in responding to the COVID-19 pandemic

States pointed out several challenges faced while responding to the COVID-19 pandemic, ranging from contact tracing, stigma, funding constraints, lack of belief that the disease was real, logistics challenges, lack of manpower and inadequate renumeration for staff.

The major challenge is people's attitude. Most people are not willing to tell us about their contacts due to the stigma involved, so we have adopted the measure of convincing people that tested positive to come on radio and share their experiences in order to refine people's perception of the disease and reduce stigmatization. Some other issues include lack of manpower and the magnitude of activities, but all that is being settled because we are receiving proper funding to enable us tackle these issues. The State government has released funds and even vehicles for contact tracing activities.

Contact tracing has been difficult because people do not easily identify their contacts. Most of the contacts we eventually get may purposely switch off their phones and go into hiding, making it difficult for us to trace them. Also, the contact tracing process is not fully funded, so we usually have some trouble.

State level coordination with NCDC

Contact tracing right now is not easy because of lack of funding. For example, if we have to trace any contacts in the riverine communities, we would have to charter boats to get there. We usually follow up our contacts in the order of Day 0, Day 8 and Day 14, but for those in the riverine areas, we mostly resort to calling them, though it is important that we visit them to know how they are faring. So, for contact tracing and sample collection, it has not been easy for us.

We currently do not have a laboratory in the State for carrying out COVID-19 testing, which is very vital in the response. We usually collect samples from suspected individuals and send them to other testing laboratories outside the state, and we would have to wait for about a week or two before we receive the results. By the time the result arrives and the person tested positive, their contacts must have already mingled with so many other people and spread the disease further, making the work of contact tracing much difficult. Sometimes we even have to go after contacts based on assumptions. It has not been encouraging so far and it has weakened our response. We are also short on staff for contact tracing, which further makes the work slower. We also lack an adequately functional call center, and we recently witnessed an upsurge in the number of cases in the state.

Our major challenges are lack of a proper surveillance budget and absence of any programme vehicle. Some partners like WHO, Action Against Hunger and so on have been supporting us with funds, so the government is relaxed and has not done much to help out. Currently, there is no programme vehicle for me to use in conducting support supervision for all the LGAs. I was asked to write to NCDC concerning my complaints, but so far nothing has been done about it.

The biggest challenge in contact tracing is stigmatization. Some suspected or confirmed cases actually do not want us to come over to their residence and test them or pick them up for fear of the stigma associated with the disease, so they simply forward the names of their contacts to us and we have to resort to online contact tracing. Some other infected persons end up hiding it and do not make any effort to contact us at all. It would be easier if the contact tracing for COVID-19 is the same as that of other diseases, but the stigma associated is too much. For surveillance, we are okay, but we need more training and more helping hands.

Our other challenges have to do with the terrain. Delta state is marked by the presence of water bodies, so the cost and difficulty of transporting ourselves by water to reach our targets has been a major challenge, especially in the rural communities. The state government has made efforts to provide some ambulance boats we can use to reach these areas in order to carry out contact tracing, sample collection and other activities. The challenges I mentioned above are also included, so we are seeking ways to effectively overcome them.

Our major challenges center around the welfare of our surveillance officers in the field. They are faced with the challenges of inadequate support from the LGA authorities. Most of the LGAs are owing the workers' salaries for a number of months now and it has affected the work of the LGA surveillance officers as some of them have to make use of personal funds to carry out their work. Also, they face challenges in logistics, such as the lack of dedicated vehicles for their transportation while carrying out surveillance activities.

State level coordination with NCDC

At a point, we got to know that people do not really understand much about COVID-19. Some people do not believe that it is true, so we had some challenges in our contact tracing and surveillance activities. We solved this issue by involving the religious leaders to talk to those in the community, so people took heed and became more receptive to our activities. We also had problems with funding but we were able to get help from the state government, local government, WHO and other partners. We actually do not have much challenges.

Our major challenges are manpower, funding and poor response from people. Accommodation needs to be provided for our workers at the front lines in the LGAs and we also need vehicles for our outreach programs. The biggest challenge, however, is that most people think COVID-19 is not real.

Recommendations to improve disease surveillance

States made several recommendations to improve disease surveillance and response, including the need to improve contact tracing, focus on risk communications, increase funding for disease surveillance infrastructure, equipment and activities, strengthen the surveillance structures at LGA level, and improve data collection.

We still need to improve on our contact tracing. One of the things we are doing now is asking suspected individuals for their contacts while investigating cases, whether they have tested positive or not, so that if they test positive, we can trace their contacts right away. Also, we are now pushing the investigation to the LGA level, so that the DSLOs and surveillance focal persons will be involved and help us to trace contacts that are beyond our reach. Another measure we intend to use is that whenever we take samples from any contacts, we will also take note of their details so we can easily trace them and follow them up.

We need to focus more on risk communication because people need to be fully aware. The information needs to be passed down to the grassroot communities. If this is done, I think 80% of our problems will be solved, because people will be encouraged to own up and get themselves tested when suspicious of any symptoms. We also need to commit more resources to ensure that contact tracing is done effectively.

We need a lot of funding for proper disease surveillance, especially in the area of transporting ourselves for contact tracing and sample collection. We mainly need financial support.

The surveillance structures in the country are generally coming to life recently and COVID-19 has helped speed it up, however, the surveillance structures at the LGA level need to be strengthened by giving the DSNOs a ecrtain degree of responsibility and authority within their areas of jurisdiction to enable them function maximally. We also need to enhance our real-time online engagements because SORMAS is yet to be deployed, so it will help the DSNOs to make information available to all the structures across the state and country quickly. The capacity of the community informants needs to be enhanced by making them more relevant in the surveillance structure of the LGA and the state. If their roles are enhanced, they will be able to get information across much faster to all the various surveillance units. Adequate funds should also be provided in order to support all the pillars of surveillance and COVID-19 response.

State level coordination with NCDC

We need stronger collaborations with government agencies and adequate provision of funds and equipment to enable us carry out our surveillance activities more efficiently. We also need to have a national committee that will advocate for the creation of a proper surveillance budget to cover all our surveillance and response expenses in the state.

We need to get more trainings, equipment and data collection tools to improve our surveillance and other pillars of response. We need these supplies regularly so as to increase our effectiveness and output.

The main area we have to improve is our contact tracing, as far as COVID-19 is concerned. Some people give us wrong phone numbers or wrong addresses, making the work much more difficult. I would suggest that we should be looking at people's ID Cards and taking note of some of their record details which could be useful to us in the tracing process. Moreover, we need honesty from the community individuals and we can improve this by ensuring proper awareness of the citizens and quashing any misconceptions about COVID-19. We also need enough support to improve our surveillance activities in the riverine areas. We also need more volunteers in the response to make the workload lesser.

The major area we should improve on is strengthening the already existing surveillance network in the state, from the State Epidemiologist down to the Health facility focal persons. This can be done by regularly encouraging the workers, routinely following up on their activities, and the NCDC should reach out to the government at all levels in the state to ensure that they support the surveillance system fully. When the nationals intervene in such matters in the state, it is usually more effective.

There is no area that does not require improvement, though the main areas we need improvement are in funding, trainings and logistics supplies.

What we can do differently is to ensure that we move risk communication down to the grassroots by correcting any misconceptions and making people understand the importance of adhering to the precautionary measures. We also need to support the community informants and DSLOs by providing funds for them to enable them carry out their work effectively. Transport vehicles have to be provided so that we can properly supervise the surveillance activities going on in the LGAs and also carry out contact tracing.

We need to strengthen our surveillance system and give attention to case management, division of responsibility and provision of technical support from partners, especially NCDC. Stipends should be regularly given to encourage the health workers and accommodation should be provided for those at the front line.

State level coordination with NCDC

Communicating COVID-19 to the grassroots: Analysis of state level risk communications activities

Support from NCDC Risk Communications team

: Initially when the COVID-19 started, they came with few IEC materials, then EU WHO supported us with IEC materials. Now we can say we have enough because we just concluded step down training for COVID-19 for PHC workers. NPHCDA brought enough so in terms of IEC materials, we are not lacking again.

We only received posters from NCDC once, which were written in Hausa and English. That was some months ago in April. The posters were sent to WHO, who then sent it to the state EOC, then we in turn distributed them to the LGAs. For the COVID-19 updates and information, we regularly get them from NCDC through Email messages. The messages contained key priority information and virtual trainings. We use the key messages for creating awareness and we distribute the IEC materials to the LGAs through the state risk communication team.

Yes, we do. Immediately the IEC materials reached us, we started distributing them.
They were in the form of flyers, posters and roll up banners.

Design of IEC materials:

When NCDC sent the IEC materials to us, they gave us directives that we should translate it into our own local languages to aid comprehension by community indigenes, which we did. Since then, there has not been any need to design any other set of materials.

Content of risk communications materials:

There have a lot of information, there have the key messages and even questions and answers for primary health care workers. We have the one addressing rumors about COVID 19. We have for the frequently asked questions. Some of them came in English language and some came in Igbo language. We have the one for the guideline for COVID 19 for PHC Health Workers, we have the one for when clients arrive, we also have infection control guide for COVID 19 for PHC Health Workers. The one EU WHO printed for us is in English but the pictorial is included so if you can't read English you can see the pictorial representation of what to do when coughing or sneezing.

When we had our first cases, we changed some of our posters and intensified our campaigns. Currently, most of our posters are now concentrated on preventing stigmatization of those that tested positive, persistent use of face masks, decreasing the fear of isolation centers and discouragement of concealing infected individuals.

They are materials containing information on preventive measures, signs and symptoms of COVID-19.

State level coordination with NCDC

Platforms for dissemination of risk communications at state level:

When they arrive, we call the LGA Health Information Officers, we have 21 LGAs in Anambra State. We give them a little orientation to explain who should get what material i.e. for the health worker and for the client. They need to be placed in strategic places like in our churches, markets and in our facilities. We also give them to our stakeholders, the gate keepers in our communities. We have our platforms, through phone calls and WhatsApp platforms that's how we disseminate our information.

We have the soft copies, which we send to the risk communication partners to distribute across the various LGAs with the help of health educators. We also have volunteers from UNICEF, so we use them as a tracking mechanism for the distribution of the materials, then they report back to us.

Once the materials got to us, we started distributing them the next day to all the parastatals, ministries and even pasted them at bus stops and major streets. We still intend to carry out motorized campaigns in other LGAs too. Before, we usually make use of media outlets such as TV and Radio stations, but now we are also passing the information physically by visiting LGAs to distribute the IEC materials and sensitize people on what the disease is all about. We are planning more strategies, but for now we are distributing and pasting the flyers at strategic places, and also carrying out motorized awareness campaigns in all the LGAs.

Usefulness of NCDC Communications materials

Yes, they are. These materials were sent to us at the beginning of the pandemic, so at a certain stage, we had to modify some of the key messages to suit the current trends of the pandemic. We have already exhausted the materials sent to us by NCDC, so our partners have helped us print new ones now containing information on the latest trends in the community.

Yes, they have. It is important that everyone is aware of the causes, symptoms, mode of transmission and preventive measures against COVID-19, so the IEC materials have helped achieve this, especially the posters and flyers containing frequently asked questions and myth busters about COVID-19. Some people do not have time or are unable to tune in and listen to radio news or watch TV, so those posters serve to easily pass the information to them.

Feedback to NCDC:

Weekly, we send our message, we give our risk communication report.

That is not our priority now. Most of the response materials used in the state are provided by the state governments and our partners, so our priority now is getting logistics to support the response. We do not just send reports back to them, we regularly forward our complaints as well. We do not report directly back to NCDC because we have to first send our reports to the state response coordination team, which then sends the report to NCDC.

NCDC have a Team Lead here in the state, so I usually give him weekly updates and reports on our activities so far.

State level coordination with NCDC

How NCDC Communications support has aided the state response

It has been helpful because we use the information to educate people on the importance of getting tested and treated for COVID-19. We have also assured people in need of other services like maternal and child health services to put aside their fears and visit the health centers. Many people are now fully aware of what the disease is all about and the necessary measures to be taken. We also interview those who have recovered from COVID-19 after treatment on media platforms like Radio and TV to air their views and inform others that COVID-19 is not a death sentence.

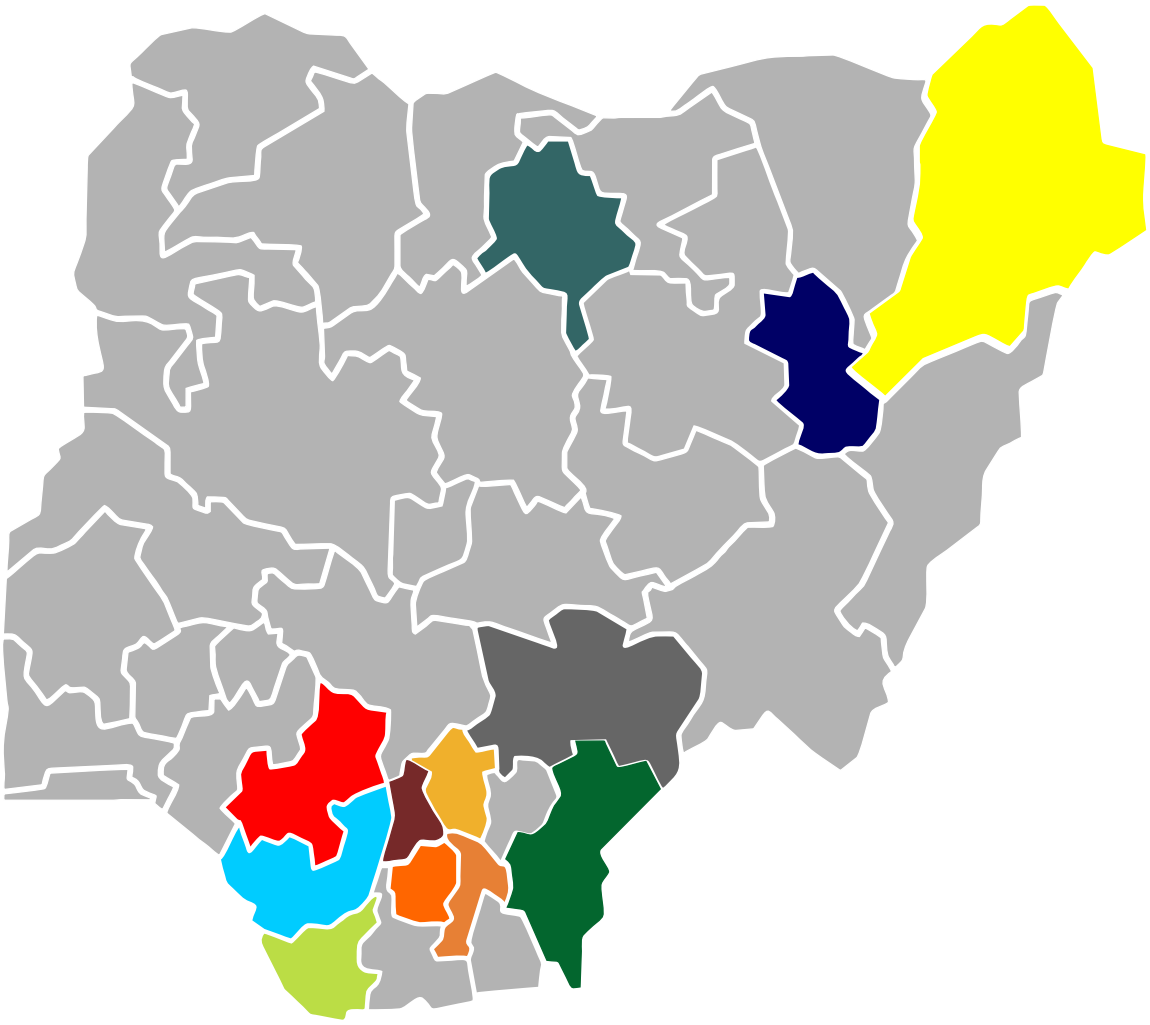
Recommendations (Areas for improvement)

There is a lot of rumors going on in social media. I told you about the media proposal I had put together, so if we can be appearing in different media every week. We need to do church sensitization our religious leaders need to come and we will sensitize them. The law enforcement officers should enforce the use of face masks, anybody who is not using face masks, should be penalized. But in the area of our religious leaders, something needs to be done. Let us do something quickly.

Because of the community transmission, house-to-house sensitization activities have been reduced to avoid transmission. The best thing to do now is to have motorized campaigns across the various communities and also get support to conduct surveys in the communities. There are a lot of misconceptions about COVID-19 and a lot of stigma associated with it, so people are scared of being declared positive. We need to improve people's awareness so as to erase those misconceptions and reduce stigmatization.

The main area that needs improvement is media coverage. We need more appearances, so we need to buy more slots at the media houses, because we currently make use of only one or two slots in a week due to lack of funds. Getting more slots of about three or four times a week will enable us create more awareness, such as the importance of using face masks and practicing social distancing. We have learnt that lack of compliance to the preventive measures from NCDC will keep increasing the rate of spread of the disease, thus, people have to comply to the guidelines and procedures in order to curb the spread. Even after the pandemic, we still have to keep educating people on the importance of using the precautionary measures in case of any other outbreaks, especially hygienic practices such as handwashing and ensuring proper sanitation of the environment.

State level coordination with NCDC



#COVID19NaijaResponse

4 Partner's Response

The COVID-19 pandemic has changed the way people work in Nigeria and the response has required a multi-sectoral approach with all arms of the government keyed into the response. This led to the setting up of the Presidential Task Force on COVID-19 which brought together the Ministers from different agencies to contribute to the response. Every aspect of Nigeria's public sector has had to get involved in some way in the fight against the pandemic and its resulting impact.

Partners continue to play a key role in Nigeria's COVID-19 response. Partners here mean organisations and associations working directly with the NCDC to provide evidence-based support as indicated by the PTF/FMoH/NCDC knowledge management system.

Partners supported in these specific areas; technical support, risk communications development and media support, community engagement, information dissemination, and financial support.

NATIONAL ORIENTATION AGENCY - RISK COMMUNICATIONS AND COMMUNITY ENGAGEMENT

The National Orientation Agency (NOA) has an established structure for sensitisation, with its 36 offices in every state of the federation. This gives it a broad platform for creating awareness and advocating for behavioral change throughout the country.

According to David Akoji, Special Advisor to the Director General at the NOA, the NOA contends that no other organ of government has the kind of spread and capacity for public enlightenment and sensitisation campaigns as it does. When the COVID-19 pandemic hit Nigeria, the NOA sprung into action, and to ensure that it is broadcasting the right information, the NOA received messaging from Nigeria Centre for Disease Control (NCDC).

They also received risk communications training from the NCDC on basic COVID-19 facts and preventive measures for their field staff in the 774 local governments areas of the federation and the Federal Capital Territory. These staff members then go on to disseminate the appropriate messaging on COVID-19 prevention to their communities.

David Akoji, Special Advisor to the Director General at the NOA said that working hand in hand with NCDC who provided risk communications content helped speed up the information dissemination process, given the need for emergency response that COVID-19 imposed on the country after the first case on February 27, 2020. "What we did was to go to NCDC to get the relevant prevention protocol messaging and build this into our traditional ways of couching our messages. We then sent them out to the field in various languages, to various communities, so that they know how to prevent themselves from contracting the virus," Akoji said.

Akoji explained that there was a bit of confusion at the beginning of the government's response, with the emergency set up of what seemed like parallel structures. However, it was not long before the NOA understood that they were included in the risk communications community engagement pillar of the Presidential Task Force (PTF).

Following this clarity at the early stage of the outbreak, NOA complemented their regular information

dissemination work with risk communications for COVID-19.

The PTF had committees in each state and the NOA embedded directors in each of these committees despite some push back around sharing control from some states at the beginning. As a result, the committees had instant access to the NOA's offices in the various local governments in each state. "We gave support in terms of putting at the disposal of these committees our expertise in relating at community level, and then our structures at that level," Akoji said.

In the initial stage, some states were reluctant to grant NOA access to activities of their task force committees. This delayed the dissemination of information as the NOA was unaware of state government activities.

"We gave support in terms of putting at the disposal of these committees our expertise in relating at community level, and then our structures at that level," Akoji said.

The pandemic is novel and so it has been challenging on many levels, including the fact that information about the virus has continued to evolve as more evidence is gathered. David Akoji agreed that the NOA has had to adjust its messaging and frequency of dissemination accordingly. He acknowledged that they have had challenges in adapting quickly due to funding constraints and inadequate financial and technical support by state government and local governments.

One key lesson Akoji says he's learning from COVID-19 pandemic is that risk communications and community engagement to combat this pandemic and any outbreak is not strictly a health sector affair. Relying on health promotion officers at the NOA alone to sensitise community members proved grossly insufficient. This led to what he referred to as widespread outcry from Nigerians who felt that the NOA could be more involved in the delivery of risk communications for COVID-19. The NOA must be mainstreamed into the frontline of the strategic planning and tactical implementation on the field, especially with regards to community engagement and sensitisation.

MEDICAL LABORATORY SCIENCE COUNCIL OF NIGERIA - LABORATORY SERVICES

Mandated by law to regulate the production, importation, sales and stocking of diagnostic laboratory reagents, kits, and chemicals for use in Nigeria, the MLSCN worked together with other government agencies to flatten the COVID-19 curve by contributing to the laboratory component of Nigeria's response strategy. The MLSCN also proceeded to validate the rapid diagnostic test kits for diagnosing COVID-19. This was done at the MLSCN owned Public Health In-vitro diagnostic Laboratory in Yaba, Lagos state.

While different strategies are being deployed to manage the outbreak, testing helps give a sense of the impact of these strategies by helping to understand the prevalence and spread of the virus. The reliability of results and a quick turn-around time therefore becomes very critical in testing. Rapid diagnostic kits help deliver results quickly, but they must meet minimum diagnostic accuracy requirements of sensitivity and specificity.. Validation therefore becomes very important.

Four of the test kits didn't meet the generally acceptable minimum sensitivity and specificity of 95% for in-vitro diagnostics and this means they are not approved for marketing or use in Nigeria.

Dr Tosan Erhabor who leads the MLSCN as Registrar/CEO explained that the MLSCN validation process started by placing an advert in four national dailies on March 30, 2020, requesting manufacturers or their sales representatives to submit their rapid test kits for validation. Out of the seven antibody-based rapid test kits submitted for validation, only four met the criteria for inclusion in the validation exercise.

Four of the test kits didn't meet the generally acceptable minimum sensitivity and specificity of 95% for in-vitro diagnostics and this means they are not approved for marketing or use in Nigeria.

The validation exercise had its share of challenges around sampling, paucity of funds, and logistics but the council continues to adjust their strategies as the outbreak evolves by scaling up test kit validation efforts in order to help increase testing capacity in Nigeria. They are currently validating another batch of rapid diagnostics test kits.

While reflecting on lessons learned from MLSCN's contributory response to the pandemic, Dr Erhabor noted that pandemics could emerge from time to time. Nigeria must ensure that the health system is prepared in a holistic sense. The current pandemic offers us the opportunity to also develop considerably robust templates that we could fall back on for future purposes.

CENTRE FOR COMMUNICATION AND SOCIAL IMPACT

CENTRE FOR COMMUNICATIONS AND SOCIAL IMPACT – RISK COMMUNICATIONS

CCSI is a core social and behavioural change organisation in Africa, innovatively empowering communities through partnerships and evidence-based strategies. CCSI leveraged on their expertise to develop and deliver coherent communication strategies that offer and support robust communication programs at national and even regional levels for the COVID-19 response.

CCSI's COVID-19 contributory response involved working with the federal government supporting the NCDC, also working with a local partner to catalyse and add value to the risk communications portfolio by adapting messages depending on what the data and the evidence was and at national level coordination meetings with other partners and stakeholders that are working in that space.

FinTech's response has been based on needs shared by NCDC. The organisation based its response around these questions: How do we support NCDC and increase technology contents so that they can provide better services to the people?

At sub national level, CCSI engaged volunteers who were already working on existing projects to serve as a group of front liners delivering critical infection prevention communication at the community levels. These volunteers are community members, known by the people and with established who have committed to providing their neighbours with accurate information about what is needed to protect oneself from COVID-19. According to Babafunke Fagbemi, Executive Director at CCSI, the impact of these volunteers' who have time and their resources to be part of the COVID-19 work force translates directly from the local government level, to the ward level, in states where CCSI has existing projects.

CCSI gets evidence from different levels particularly where the impact really matters which is at the individual level and community level. CCSI takes that feedback based on tools that have been developed by the NCDC and other partners and feed that into the process of message development and design.

Reflecting on lessons learnt from CCSI's support to the government's COVID-19 response, Babafunke was most impressed by the robustness of partnerships. For her, the most important lesson is to bring all the partners together to the table, map them, know where they work, know what their abilities are and see how they can work together so that we can actually have the best delivery on the long run. Going hand in hand with partnerships, is listening to the data. She believes that data could be from the audience, from policy makers, or from people that actually generate misconceptions, but it is important to let evidence drive the risk communications process. One of the main pillars in CCSI's strategy is addressing rumours and misconceptions. This for Babafunke is important because "I have learnt that when a cloud of rumours gather then the thunder of stigma strikes, then it could also be the other way around."

fintech 1000+

FINTECH – TECHNOLOGY

FinTech 1000 plus is a loose organisation with financial technology operators in the financial service industry, who are using technology to enable financial services across Africa. Members include regulators, telcos and central banks across Africa. The organisation is focused on making Africa a very veritable hub of financial technology and enable Nigerians and Africa in particular, to be able to access financial services through technology.

FinTech's response has been based on needs shared by NCDC. The organisation based its response around these questions: How do we support NCDC and increase technology contents so that they can provide better services to the people? Shola Fanopo, Coordinator of FinTech in answering that question, they always reached out to NCDC to ask how best FinTech can serve the Centre. Based on FinTech's core strengths, NCDC developed a list of challenges that the organisation could help solve.

FinTech's major work with NCDC has been to improve their call centre operations, Nigeria's first contact with NCDC. They have enhanced those platforms and made it easier for the NCDC officials to take complaints from the Nigerians, making it easier for Nigerians to lay those complaints and feedback as well.

FinTech provided core technological support in the critical area of contact tracing. Fanopo shared that manual contact tracing is very laborious and expensive and technology helped to ease the process a bit more.

ASSOCIATION OF PUBLIC HEALTH PHYSICIANS OF NIGERIA – TECHNICAL SUPPORT

The Association of Public Health Physicians of Nigeria (APHPN) is the largest body of public health physicians in Africa. APHPN consequently has strong human capacity to deal with epidemics and pandemics. With functional offices in all the states of the Federation and the Federal Capital Territory APHPN's comparative advantage to deal with pandemic enabled the association to quickly embed their members into different preventive arms and the pillars of the COVID-19 response.

According to its National Chairman, Professor Michael Asuzu, APHPN's response at the community level includes engagement, risk communication and in areas where the community structures are very fragile, the members work to reinvigorate them to ensure they are ready and responsive in dealing with the pandemic. Members at the community level were also involved in contact tracing. For APHPN, their response at the various levels is determined by the national response. Their skills and expertise are deployed based on the direction of the national response. In a cyclical pattern, the National response is determined to an extent on the evidence that APHPN members help generate.

RECKITT BENCKISER – RISK COMMUNICATIONS AND FINANCIAL SUPPORT

Reckitt Benckiser, a global consumer goods brand learned early on from the outbreak how to shift much of its operations from in-person to remote work. Dayanand T S, Managing Director, Reckitt Benckiser West Africa believes that this gave them a slight advantage to strategically reflect and work with the government in areas that best suited their strong capabilities.

Handwashing is an integral part of the government's risk communications response against COVID-19 Reckitt Benckiser invested in a lot of insights, materials and money behind digital messaging and TV, helping drive the awareness on the key role handwashing plays in preventing the spread of this coronavirus. By early February, the company had reached about 30,000 schoolchildren in about 10 LGs of Lagos State with in-person hand washing demonstrations. As the country went into a lockdown, RB shifted focus into digital knowledge creation, creating content about how to wash hands, the whole science behind handwashing and infection prevention and control. Dayanand understood that NCDC is Nigeria's apex public health body and as such were in very close touch with NCDC to align all their strategies with the country's national response. RB worked with NCDC to develop and disseminate key messages. For Dayanand and RB, this partnership was very crucial. As a company, RB also contributed in kind with donations of products like Dettol and Jik, which are household essential items for this pandemic period. They also had some personal protective equipment, imported like masks and gloves. Overall, both at the national and state level, RB's response is determined by RBs capability and what the need of the hour is. One key lesson learned for Dayanand and RB is the importance of collaboration. "Everybody has a role. And no single person might have all the might or the wisdom or knowledge to fix this"

TOLARAM GROUP – INFECTION PREVENTION AND CONTROL

Tolaram Group is a production company whose products range from

Indomie, Power Oil, Hypo, and several others.

Tolaram's engagement was simple but so crucial to the termed successes of Nigeria's COVID-19 response. They understood that a major point of entry for infection were the airports, so according to Opeyemi Awojobi, Product and Sponsorship Placement Manager at Tolaram, they donated thousands of litres of Hypo bleach to the Federal Airport Authorities to disinfect airports in Nigeria against the virus. Then Tolaram donated thousands of litres of Hypo bleach to NCDC to assist in disinfecting major offices, isolation centres and areas of concern. Where the company's support was called on beyond the scope of their products, they donated N1bn when the federal government needed the building of isolation centres, palliatives, and IEC materials.

The group engaged PECAN (Pest Control Association of Nigeria) to go into different communities in different locations to disinfect these communities. Locations like schools, markets and hospitals were fumigated.

UNICEF – TECHNICAL SUPPORT

A big component of UNICEF's COVID-19 response in Nigeria revolved around providing technical input to ensure that Nigeria is on par with global practices and evidence in relation to COVID-19 response strategies. UNICEF is also heavily supporting procurement.

The global pandemic has seen an unprecedented need for scaling up testing, protective personal protective equipment, increased need for case management. UNICEF has lead on procuring some of the equipment necessary to respond to the pandemic.

UNICEF's work at the state level involved collaborating with the state governments and the state EOCs, seeing how to contextualize the COVID-19 response at state, and making sure the state's preparedness and response activities are strengthened.

A critical area UNICEF is working is to strengthen other health services during a global pandemic which threatens to disrupt health services. For Dr Sanjana Bhardwaj, that's a very important area, and they continue to support the government to make sure that there is continued services for women and children. This includes immunisation services, Maternal Newborn Child Health Services, HIV services, and it means making sure that the services are available for women and children from community to primary health care, to secondary and tertiary level.

NIGERIA HEALTH WATCH – RISK COMMUNICATIONS AND COVID-19 RESPONSE TRACKING

Nigeria Health Watch, a communications and advocacy organisation has been at the fore front of the country's communications response to prevent the spread of COVID-19 since the first confirmed case of the virus in Nigeria in February 2020. Through various strategic projects implemented, Nigeria Health Watch provided critical and urgent technical, operational catalytic communications design support to the NCDC Risk Communications team; mined existing data for communications action in all stages of the pandemic including containment, treatment, care. Nigeria Health Watch was responsible for documenting, analysing and synthesising lessons learned from response to COVID-19, to improve Nigeria's future preparedness/response with epidemics and disasters.

Nigeria Health Watch's response also focused on countering misinformation in Nigeria by getting ahead of negative narratives around COVID-19, and fact-checking and debunking the misinformation. Rumours around COVID-19 in digital media was monitored to identify fake news. Nigeria Health Watch used a multi-media approach incorporating social media and traditional media to disseminate fact-checked health information.

With their expertise in health communications, Nigeria Health Watch supported NCDC with communications support and helped to develop COVID-19 guidelines for employers and businesses. Guidelines were also developed for schools, pregnant and nursing women, on social distancing and the wearing of face masks and advisory for vulnerable groups.

Nigeria Health Watch provided emergency risk communications support to NCDC with strategic communications where technical assistance was given to help set the weekly communication message priorities. Insights are gathered from weekly data gathered from the NCDC rumour log system, state health

promoters, NCDC social media platforms and perceptions surveys carried out by research organisations. The weekly message priorities are then sent out to the state health promoters, PTF Risk Communications pillar and NCDC risk communications team in order for them to craft messages that address the weekly message priorities. The support included providing and updating answers to the frequently asked questions on NCDC's COVID-19 microsite.

Nigeria Health Watch joined organisations such as Africa Check and Dubawa to support NCDC's rumour response to COVID-19. Nigeria Health Watch supported by:

- Detecting misinformation on social media and sending to the rumour response sub-group for debunking
- Collating rumours in the NCDC rumour log, analysing, and developing content to debunk them
- Producing infographics and doodles to debunk these detected rumours
- Disseminating debunked rumours on Nigeria Health Watch's social media platforms

Nigeria Health Watch's website, www.nigeriahealthwatch.com was selected by 9mobile, a telecommunications giant in Nigeria as one of the educational websites where users can access COVID-19 information for free. According to 9mobile, access to these websites would ensure that 9mobile customers and Nigerians remain connected and have more access to basic essential services, which they require.

#COVID19NaijaResponse

BMGF Response

BMGF has played a key role as a bridge between Nigeria and the rest of the region and the world. In a time when all countries were frantically sourcing for the same COVID-19 infection prevention control commodities at the same time, BMGF negotiating with regional and world influencers helped to make sure that developing countries including Nigeria got their fair share of commodities and were not unduly deprived.

In Nigeria, the Bill and Melinda Gates Foundation works with the government, the private sector, and civil society to help people lift themselves out of poverty. The belief that all lives have equal value and that everyone deserves to live a healthy, productive life is at the core of what they do.

The Bill and Melinda Gates Foundation with the face of its Nigeria office supported the COVID-19 response early on with strong technical and financial support for Nigeria's emergency preparedness. The foundation had a clear purpose from the start for its support. This was to strengthen public health emergency preparedness and response in the Nigeria in the context of the novel coronavirus.

Resource Mobilisation

Tijjani Mohammed, Interim Country Director for BMGF Nigeria Office shared that the foundation contributed to the UN basket funds to secure commodities and test kits for COVID-19 in Nigeria.

BMGF has played a key role as a bridge between Nigeria and the rest of the region and the world. In a time when all countries were frantically sourcing for the same COVID-19 infection prevention control commodities at the same time, BMGF negotiating with regional and world influencers helped to make sure that developing countries including Nigeria got their fair share of commodities and were not unduly deprived. They facilitated engagements at the regional Africa and global levels to ensure that Nigeria had access to the tools and technologies to manage the COVID-19 pandemic. This included test kits and reagents, the RDTs needed for research, as well as therapeutics. The engagement of the Foundation helped put Nigeria in the ongoing

discussion around vaccines.

Technical Support - National Pandemic Response Plan

Nigeria's COVID-19 response was defined by the National Pandemic Response Plan. BMGF helped the development of this plan by providing technical assistance to support the Presidential Task Force, the ministries, department and agencies as well as National Centre for Disease Control and Federal Ministry of Health. These efforts were led by the World Health Organization and helped to strengthen the NCDC's capacity to scale up comprehensive public health response. BMGF's technical support focused on this health response including contact tracing, public information and community mobilisation, case management, as well as infection prevention and control (IPC) coordination.

Risk Communication and Community Engagement

This was in the form of emergency communications support to both PTF and NCDC, emergency readiness for case management, data and logistics support, at the national level evidence to inform policy and unmitigated impact in Nigeria.

The Foundation supported PTF to produce strategic specific contextualized messages and materials that were also adapted to quickly be very responsive to the evolving epidemic context. Multiple pieces of messages and materials were developed in preparation and response to frequently changing scenarios.

The foundation is part of a network of other development partners providing NCDC with catalytic communication support by complementing evidence-based information with practical, locally targeted messages and materials.

BMGF's work to strengthen in-country response, planning, coordination, and management of the pandemic also had a community engagement component. The foundation has supported the coordination and mobilization of a multi-sector, civil society response, to mitigate community transmission, and minimize the health, nutrition, the social and economic impact of COVID-19. At sub-National and Community levels. Tijjani Mohammed reflects that this community engagement aspect of the response, though it came a little later, has achieved a great impact.

Logistic Support

The foundation is working with the Federal Ministry of Health under this bucket of support through NCDC to collect surveillance data and provide actionable analytics for informed decision making. The support strengthened in-country response, planning, coordination, and management of the pandemic.

BMGF Best Practices

For Tijjani Mohammed, one country with best practices that stood out is Senegal, who was ranked second in global pandemic response ratings. *"What stood out was the effectiveness of their national response. It was timely, it was cost-effective, and it was customized for an African country"*

By using mobile labs, the country was able to increase testing capacity, and many of the COVID-19 tests provided results within 24 hours.

Many African countries have taken strong early action. Some specific examples of COVID-19 innovations; Ghana started pulling tests, instead of testing people individually, this was aimed at conserving scarce resources, while still tracking the spread of the disease. This, for Tijjani, is a best practice for resource-constrained settings. In South Africa, they deployed, mobile testing units, and plan to produce 10,000, ventilators through a local manufacturing base. This was quite significant.

Kenya capitalized on radio and television to help improve access to education as a lot pupils were locked out of school, because of the lockdown. Kenya, in partnership with a telecom company, and Google outfit piloted, giant balloons over Kenyan air space, carrying 4G base stations which providing internet connectivity to rural and remote communities this. Through this innovation, Kenya was able to improve epidemic preparedness.

Despite the tremendous constraint that African countries have, they have continued to innovate, and to meet the corporate challenge of reducing community transmission of COVID-19 and to flatten the curve.

Lessons Learned (BMGF)

With the benefit of hindsight, the foundation emphasises that it would be crucial for governments to develop locally tailored, physical distance measures that work in that specific context. This proved to be a challenge at some point in the response, but the government kept adapting.

The key issues in the SDGs have suffered some form of recession due to the pandemic and measures taken to respond to it. For BMGF, these are some of the issues that we must keep front and centre if we were to ever experience that scale of the pandemic.

As a foundation, BMGF remains committed to helping to strengthen the health system in Nigeria and working with partners to develop innovative, locally tailored approaches to continue to contain the virus and minimize some of the social and economic challenges.

#COVID19NaijaResponse

6 Best practices from other countries





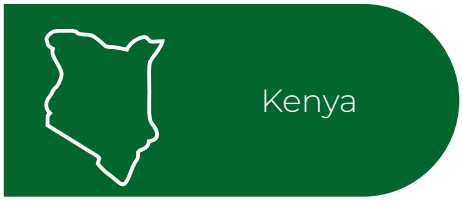

Africa

Nigeria

1. Constituting the Presidential Task Force (PTF) on COVID-19 with membership from various Ministries, Departments and Agencies (MDAs) to coordinate the national COVID-19 response.
2. Having the Federal Ministry of Health and the Nigeria Centre for Disease Control to lead the public health response.
3. Collaboration and support from the private sector to the Nigerian government and Nigeria Centre for Disease Control (NCDC) to help win the war against the COVID 19 in the country.
4. Allocation of funds to help address the increased vulnerability of people affected by both the pandemic and existing humanitarian crisis.

Ghana

1. Private sector involvement - church and football association support with isolation facilities.
2. Free provision of water, electricity and other essential amenities by the government.
3. Local manufacture of PPE and sanitizers.
4. Using the COVID 19 tracker app to track people and trace their contacts through telephone related data and link such people to health professionals for urgent action to be taken.



Kenya

1. A local factory that used to make clothing quickly pivoted its production and started producing locally made. Also, a community-owned company started making hand sanitizers, masks, and protective clothing for the community, other informal settlements, and the Kenyan national stockpile. The proceeds were ploughed back into the area to support contact tracing, isolation centers and treatment of patients in partnership with the Ministry of Health.
2. Doctors specialised in internal medicine, oncology, cardiology, renal, and pediatrics were involved in the COVID-19 response bringing the much-needed expertise to help effectively treat and manage the pandemic.
3. Three thousand of the area's most vulnerable families received direct cash transfers of $24 per month for 3 months to meet their basic needs, with financing coming from the local private sector and the Kenya Diaspora in North America.

Best practices from other countries

South Africa

1. The government applied best practices from past responses to health emergencies in South Africa and applied its experience from public health campaigns against tuberculosis and HIV/AIDS epidemics to curb the spread of the corona virus.
2. There were Public-Private Partnerships.
3. The procurement of mobile sampling and testing unit.

Egypt

1. To encourage people to rely on electronic payment methods and bank transfers instead of using cash, the Central Bank announced a series of new limits on cash withdrawals and deposits, while fees on electronic transactions were lifted for six months.
2. The government introduced a six-month extension for credit repayments targeting all individuals and businesses. The Ministry of Workforce also allocated EGP 50 million (USD 2.9 million) for workers, including women, who lost their job due to the coronavirus outbreak.
3. The authorities acted swiftly to allocate resources to the health sector, provide targeted support to the most severely impacted areas, and expanded social safety net programs to protect the most vulnerable.

ASIA

China

1. Over 70 fever clinics were set up to test patients with fevers immediately after index cases were recorded. The proactiveness of China is highly commendable in terms of infrastructure and the establishment of Isolation and treatment centers for cases at designated hospitals.
2. The Chinese government sent medical aid in the form of doctors and resources to other countries affected by the virus.
3. The government encouraged telecommuting, online learning and established a psychological hotline to provide mental health assistance to medical staff and the public.
4. The city of Wuhan in China completed a makeshift emergency hospital to treat patients infected with the coronavirus in just 10 days.

Iraq

1. UNICEF collaborated with the major telecommunication companies in Baghdad and Kurdistan Region (KRI) to distribute information on the prevention of COVID-19 to 14 million people via messaging services in both Arabic and Kurdish.
2. Assessments of the impact of the virus on vulnerable populations were done frequently.

EUROPE

United Kingdom

1. The UK government created an epidemic or pandemic plan using past epidemic or pandemic data proved useful for UK in fighting the current coronavirus pandemic.
2. Matt Hancock launched a scheme to recruit 250,000 volunteers to support the NHS through the pandemic, carrying out jobs like collecting and delivering shopping, medication or “other essential supplies” for people in isolation; transporting equipment and medication between NHS services; transporting medically fit patients and providing telephone support to people at risk of loneliness because of self-isolation.
3. Their communication and testing strategy which involved contact tracing helped slow down the spread of the virus, and the reemployment of retired NHS staffs, helped increase the

number of medical personnel's available to combat the virus.

Italy

1. Aid was provided for coronavirus-related research and development (R&D), for the construction and upscaling of facilities to develop and test coronavirus-relevant products, and to produce coronavirus-related products, such as vaccines treatments, medical products and devices.
2. Provision was made for wage subsidies for employees to avoid lay-offs during the coronavirus outbreak.

NORTH AMERICA

United States of America

1. The United States developed its testing approach by producing testing kits in the country. The American testing method was made public on January 28.
2. State Department facilitated the transportation of nearly 17.8 tons of medical supplies to China, including masks, gowns, gauze, respirators, and other vital materials.

Canada

1. The government launched a national public education campaign that provided Canadians with evidence-based information on COVID-19 and encouraged behaviors that protect individuals and communities. This campaign included advertising, partnerships, social marketing, social media posts, information resources, targeted outreach to at-risk populations, research, and technology.
2. Canadian researchers worked hard to support international efforts to fight the COVID-19 pandemic.
3. The government put effort into making employers of labour take responsibility for their employees. The government made sure they kept those with whom they worked aware of their current status as well as contingency plans to enhance relationships over the long term and to increase productivity even during the period of restriction.

SOUTH AMERICA

Brazil

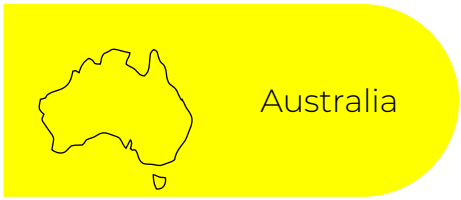
1. The communication adopted by the Brazilian federal and state governments helped create awareness regarding the virus both in urban and rural areas. For example, a System Usability Scale (SUS) App was created, which helped inform the population of the pandemic, bringing information on various topics such as symptoms, how to prevent it, what to do in case of suspected infection and a map indicating nearby health units.
2. The Ministry of Health created an image information bank to help support the care of cases and allow agility in the adoption of conduct by health professionals in the diagnosis of Covid-19.

Peru

1. The government, through the Ministry of Culture, disseminated guidelines and safety information in response to the coronavirus outbreak in 32 native languages. The informative material considers the cultural context of the people and represents more than 90% of the country's indigenous population.
2. An application, "Peru in your hands" was also launched. This provides information on infectious areas, and number of cases confirmed within regions and shares the location of nearby health care centres where care can be received in cases of an emergency.

Best practices from other countries

OCEANIA

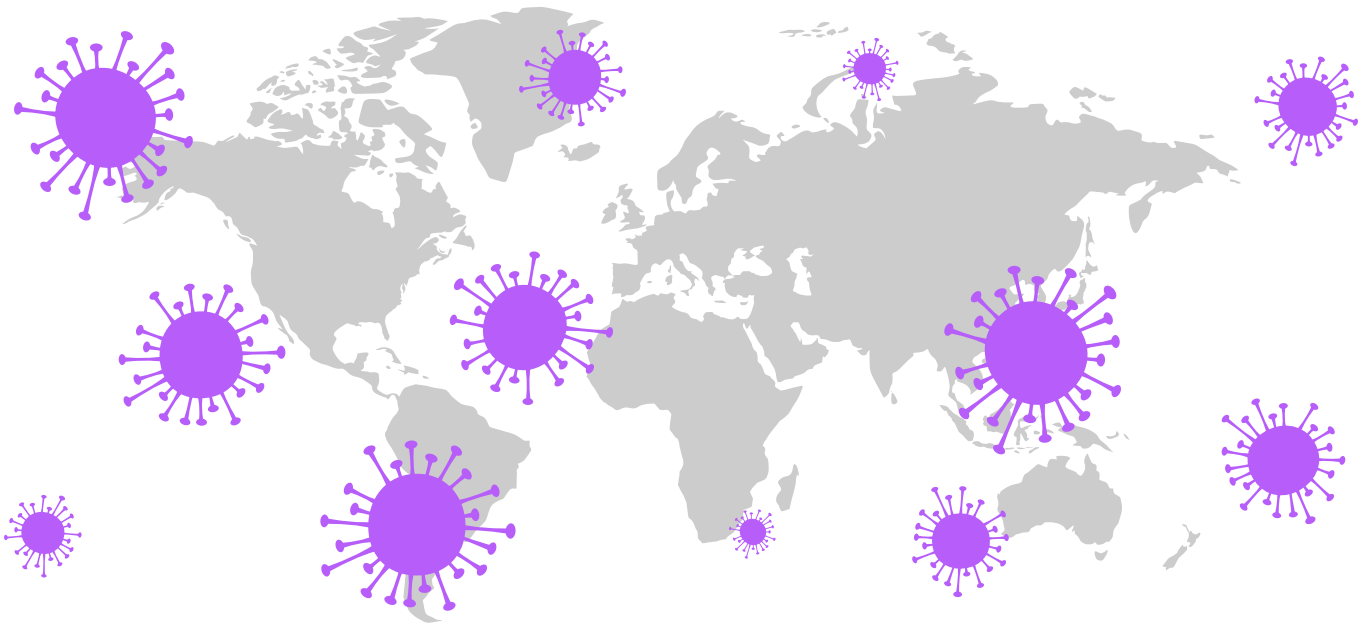


Australia

1. The coordinated response of Australian government officials across the political spectrum resulted in some of the best numbers in the world - 7,276 cases and just 102 deaths in a country of 25 million.
2. An economic stimulus towards wage subsidies, doubling unemployment benefits and free childcare for all also helped.
3. A national communication plan was developed to ensure that timely, factual and consistent information was provided to encourage the public to adopt behaviour that would help prevent and mitigate the impact of COVID-19.

New Zealand

1. The country's strategy on speedy testing, contact tracing and isolation, and rigorously adhering to public health guidance enabled the country to control the spread of the virus.
2. Prime Minister Ardern displayed tremendous political will and was guided by science in her response. The idea of an extreme lockdown was not popular, but she persisted because she believed it to be the necessary thing to do.
3. New Zealand initiated lock down measures early and aimed for elimination of the virus from the country.
4. New Zealand combined strict physical distancing with strong testing, contact tracing, clinical management of those infected, and clear and regular public health communication. The country also took steps to cushion the economic blow.
5. A lot of effort was put into informing and educating the people about COVID-19. Having credible and timely information created the foundation for shared understanding of the nature of the problems and what needed to be done by them.



#COVID19NaijaResponse

7 Perception Survey

Qualitative Perception Survey of Health Workers and the Public on Nigeria's Response to COVID-19

Healthcare workers are at the frontline of the COVID- 19 pandemic response and are exposed to, not only infection with COVID-19 due to their frequent exposure to infected individuals, but also psychological distress, long working hours, fatigue, occupational stigma and physical violence.

The transmission of the disease among healthcare workers is exaggerated by overcrowding, absence of isolation facilities, contaminated environment and is likely enhanced by insufficient knowledge and awareness of infection control practices among. That inadequate knowledge and the incorrect attitudes among HCWs can directly influence practices and lead to delayed diagnosis, poor infection control practice, and spread of disease.

This perception survey was carried out in July 2020 and the goal was to explore the perception of Nigerian health workers and the general public on the response to COVID-19 in Nigeria and propose recommendations for improving epidemic preparedness and response to future pandemic outbreaks in Nigeria.

The survey objectives were as follows:

A

To understand the perception of the different cadres of health workers on the way COVID-19 has been managed in Nigeria

B

To explore the perception of the different groups of Nigerians (Social, ethnic and religious variations) on the way COVID-19 has been managed in Nigeria.

C

To understand the diversity in impact between high burden and low burden state in Nigeria

D

To understand myths and misconceptions around COVID-19

Perception Survey

In-depth telephone interviews and Focus Group Discussions were conducted with key stakeholders at the State, LGA and community levels, in states randomly selected from each geo-political zone – Bauchi, Bayelsa, Kebbi, Lagos, Niger, Ebonyi States and the FCT. A total of 48 respondents representing Health Workers, Religious and Community Leaders, Women and Youth Groups, Traders, Farmers, Artisans and Taxi/Keke Riders answered questions administered to them via telephone interviews, video conferencing and in person.

The qualitative data gathered was passed through a thematic analysis process that produced key themes. These themes were regarded as vital in determining the perception of all the participants. These themes were broken down into broader sub-themes and key quotes were grouped under these sub-themes that helped explain the different objectives of this survey.

1. **Epidemic Preparedness**
   - Lack of Understanding about COVID-19
   - Nigeria was not prepared
   - Nigeria is not well equipped
   - What we can do differently
2. **Epidemic Response**
   - Information Dissemination
   - Level of Confidence in Health System
   - Palliatives
   - Political Response/ Low Political Will
   - Price Hikes and Social Distancing

1. Epidemic Preparedness

Infectious disease outbreaks are inevitable and the best time to prepare for these outbreaks is before they occur. We can reduce the impact of epidemics by making sure we are prepared to respond. To do this we must learn from what happens when an epidemic is taking place, as well as just before it takes hold and after it has died down. Nigeria is not a stranger to infectious disease outbreaks, from annual outbreaks of Cholera, Yellow Fever, Lassa Fever, etc. to the 2014 Ebola Outbreak, the country has dealt with its share of disease outbreaks. Respondents shared their opinions about how prepared Nigeria was to respond to the COVID-19 outbreak.

"I can say that Nigeria has no plan for epidemic outbreak like in the case of this Covid-19 there were no personal protective equipment which were supposed to have been in various hospitals and health centres before now for all the health workers." **Health Worker, Bayelsa State.**

"The preparedness, the awareness and all others, it's not something to write home about, all the same, I don't still think we are prepared, if I go by the statistics of what we get day by day, it's not up to date...we are not testing enough, they will just come to an environment like this, test like 5-10 people and the testing is meant to be done house by house as recommended by WHO but we are not doing it like that." **Health Worker, Ebonyi State.**

a. Lack of Understanding about COVID-19:

Before the first case was identified in Nigeria, relevant authorities, CSOs, private organisations, etc., had started to sensitise people about the outbreak. Some people believe that there was too much information being put out and it was often hard to separate the real information from fake news. Seeking to understand respondent's level of understanding and perception of the COVID-19 pandemic, they were asked to describe what COVID-19 was in their own words.

"Covid-19 is a dangerous disease that came from China because they eat some kind of nonsense animals. I don't know, but what I know is it is a deadly virus that one can contact at any time." Youth, Ebonyi State.

"Corona Virus is a disease that has a trace in every part of the world. Based on my understanding, it originated from China. According to reports, it started from there, then gradually to every part of the world." Artisan, Bauchi State.

b. Nigeria was not prepared:

The perception among respondents appears to be that the government was not prepared to tackle the outbreak. Further probing revealed that this perception was borne out of how they feel their local and state governments may have responded to the outbreaks in their respective states.

"Nigerian wasn't prepared, there wasn't any isolation centres, there wasn't enough knowledge regarding epidemic diseases, infact Nigerian hasn't invested well in the health sector, so we were not prepared, we were not ready." **Health Worker, Lagos State.**

"Nigeria is always not prepared for epidemics; epidemics always take us by surprise, we don't budget for it, so when the epidemics arise, that is when we would start looking for solution, we are never anticipating. For instance, when Ebola came, we were taken by surprise. When Lassa fever came, the same." **Health Worker, Bayelsa State.**

c. Nigeria is not well equipped:

Respondents also believed that Nigeria was not well equipped to respond to the COVID-19 pandemic,

"I can say that Nigeria has no plan for epidemic outbreaks like in the case of this Covid-19, they ran helter-skelter to get personal protective equipment which should have been in various hospitals and health centres before now." **Health Worker, Niger State.**

"I am not a medical personnel, but I think if provided with the right working tools, I am sure they'll be able to execute their duties, but without proper working equipment they can't carry out their duties effectively even if they want to. Our doctors are capable of handling the pandemic if provided with all that they require." **Religious Leader, Kebbi State.**

d. What we can do differently/ Recommendations

Respondents proffered recommendations on what the government ought to do to be prepared for the next epidemic.

"Financial support, laboratory equipment and drugs. They should also be able to research about other disease and their prevention before they occur". **Health Worker, Kebbi State.**

"To be well prepared, education is the key. People should be well educated concerning their health so that we will be well prepared for anything in case of another outbreak". **Health Worker, FCT.**

"I encourage states and federal government to build more hospitals and equip the with the vital equipment." **Health Worker, Niger State.**

"Nigeria needs to increase her political will in terms of the healthcare system, result in adequate budgetary funding of the healthcare system. Nigeria should increase its political will and the healthcare budget appropriately." **Health Worker, FCT.**

2 Epidemic Response:

On the government's response to the COVID-19 pandemic, respondents agree that in some areas the government did well while in others there was room for improvement.

a. Information Dissemination

I would say they have been awareness and community mobilization through, television, radio, town carriers and the social media, so there is awareness that Covid-19 is real, and I would rate the level of information circulated 80-90%." **Health Worker, Lagos State.**

"Honestly, I will have to rate it high because if you look at the various channels that are available; TV, radio, online, social media platforms, a lot of work have been done to develop the communication materials and also keep people informed and be updated about it." **Health Worker, FCT.**

"It's not like Covid-19 is not real but the way the message is being passed across, it's like they are using it just to acquire more wealth for themselves. I think there is a problem with the medium of information." **Youth, Niger State.**

b. Level of Confidence in Health System:

I think they are trying; we have confidence in them, but the health facilities lack the necessary equipment needed." **Women Group, Niger State.**

"People are not confident in them. Especially, you know when you get to a hospital, normally they won't attend to you even before covid-19. Now, they are afraid of treating you because they don't want to contact the disease. So, how will people have confidence in that kind of system?" **Community Leader, FCT.**

c. Palliatives

"In my own opinion, the palliative aspect is not encouraging, looking at other countries they were at home self-isolating, government was helping them in some things both financial and other things. But in Nigeria it was kind of a mirage, we keep hearing and seeing nothing." **Health Worker, Bauchi State.**

"The palliatives are not reaching the people that need it, so you still see people dying of hunger, frustration and other hunger induced illnesses." **Youth, Ebonyi State.**

"On the palliatives, we only heard that some people were given while others were not, some were given money others were not." **Farmer, Kebbi State.**

d. Political Response/ Low Political Will

"In my ward, in the local government I'm from, I called the person representing the area in the house of representatives of the state, that this outbreak would be a very good point for us to go and enlighten the people. I volunteered, just show the political will, hire a boat, let us go and inform the people, enlighten them, low and behold, he said he would think about it, that was how it ended." **Health Worker, Bayelsa.**

"I think some other agencies and then the average Nigerian and political leaders as well as state, local government level are not doing as much as I think they can do a lot, wearing masks is still an issue, you will walk out now and see out of only ten people, you are the only one wearing a mask and you wonder why." **Health Worker, FCT.**

"In the area of palliatives, the government tried, but then if they cannot give palliative to everyone, they should try and subsidize price of things, the government can do it, there should be price control in times of crisis." **Youth Leader, Niger State.**

"People have used the situation to increase the price of goods and blame it on the lockdown, even food is not affordable. You might have a little money, but you can't afford to buy food." **Artisan, Bauchi State.**

"Here in my locality there is no social distancing, so it didn't affect me, people don't observe social distancing here, even wearing of facemask." **Women Group, Niger State.**

#COVID19NaijaResponse

8 Lessons Learnt

1

Governments must develop locally tailored measures that meet the needs of different communities in Nigeria. This proved to be a challenge at some point in the response, but the government kept adapting as new evidence emerged. Working with partners, government should continue to develop innovative, locally targeted approaches to contain the virus and minimize some of the social and economic challenges faced by citizens.

2

There is a critical need to strengthen surveillance structures at the community level, to ensure that early detection of outbreaks. Having a clear reporting system from the local government to state to national helped with rapid reporting of outbreaks. Having a data collection platform that is real time, such as SORMAS, made it easier to compile data that was quickly analysed and used in decision making for the response.

3

The capacity of community informants needs to be enhanced by making them more relevant in the surveillance structure of the LGA and the state. If their roles are enhanced, they will be able to get information across much faster to all the various surveillance units. Adequate funds should also be provided in order to support all the pillars of surveillance and COVID-19 response.

4

The importance of risk communications to support outbreak response efforts cannot be overestimated. There is need to get accurate and timely information to the grassroots at the onset of any outbreak, because people need to be fully aware of what is happening and how they can protect themselves.

5

There needs to be early community sensitization at the grassroots in order to build trust and ensure the buy-in of communities at the onset of potential outbreaks. Getting the proper information to the grassroots early will also help dispel myths and rumours about outbreaks.

6

Funding at the onset of the outbreak was a challenge; epidemic preparedness must be prioritised with a sustained and stable provision of fund for disease surveillance, logistics, for contact tracing, for community mobilization. Preparedness for potential outbreaks means that adequate funding needs to be put aside in budgets to fund epidemic preparedness activities, but also during an active response, funding must be released for critical response activities such as disease surveillance and active case searches. One suggestion was to create a national committee that will advocate for the creation of a proper surveillance budget to cover surveillance and response expenses in the state.

Lessons Learnt

7

Stronger collaborations between government agencies will help strengthen responses to outbreaks. The multi-sectoral nature of the response both at the national and sub-national levels were positives that should not be ignored. It is important in responding to an epidemic or pandemic that all partners are brought together, understanding their abilities and deploying them accordingly to have the best response and outcome in the long run.

8

Training should be a continuous process during outbreak response, to adapt to the response as new evidence emerges. Training of health workers at all levels of healthcare delivery is critical. Training of Disease Notification Officers (DSNOs) is important ahead of and during outbreak response.

9

It's important to listen to the data, and let evidence drive the decision-making processes.

10

National agencies should function in a supportive role to the states, but the states should take greater ownership of the response in their different communities with rapid training and capacity development of community leaders.








#COVID19NaijaResponse

CENTRE FOR COMMUNICATION AND SOCIAL IMPACT

COVID-19 RESPONSE

NIGERIA HEALTH WATCH

Informed commentary, intelligence and insights on the Nigerian health sector