

Nigeria Multi-Hazard Risk Communication

Guideline



August 2023

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Foreword

Given the volatility, uncertainty, complexity, and ambiguity that the world continues to experience, most recently demonstrated by the COVID-19 pandemic, in addition to insecurity and international conflicts, it is essential that we remain prepared for public health emergencies. When it comes to protecting the health of Nigerians, one of our priorities is communication with the people we aim to safeguard. Whether it is chemical emergencies, infectious disease outbreaks, war, or another crisis causing public health emergencies, it is imperative to establish trust between Nigerians, the health ministry, departments, and agencies, and, of course, the national public health institute.

In line with the International Health Regulations (IHR, 2005) that Nigeria is a signatory to, and as the IHR National Focal Point, we have the responsibility to ensure that Nigeria can prevent, detect, and respond to public health threats. Fortunately, we live in an age in which technology can easily be harnessed to reach people to communicate public health emergency safety measures to avert diseases such as Lassa fever, cholera, cerebrospinal meningitis, and yellow fever. These risk communication efforts may be through short messaging services (SMS), social media, television, and other platforms. However, efforts are not limited to technological means, and risk communication also capitalises on community sensitization by word of mouth, posters, and community leaders using their voices.

As you read these guidelines, you can expect to quickly realise the importance of multi-hazard risk communication, our drive to strengthen health security, and the global framework of IHR and tools such as the Joint External Evaluation, risk analysis methods, risk communication strategies, and monitoring and evaluation plans.

I want to express my appreciation to my predecessor, Dr Chikwe Ihekweazu, for his efforts towards the development of this document from its inception to the time it was being finalised when I took over as Director General of the Nigeria Centre for Disease Control and Prevention (NCDC).

On behalf of the NCDC, I extend our gratitude to the Federal Ministry of Health, other ministries, Departments, and Agencies; States, Local Government Areas, and local and international partners; and last, but certainly not least, the staff of the NCDC who have contributed to the preparation of this document. It will surely contribute to protecting Nigerians and, of course, the global community.



Dr Ifedayo Adetifa
Director General, NCDC

Message

Responding to the COVID-19 pandemic while managing concurrent outbreaks of Lassa fever and cholera has highlighted the need for strategies to better prevent, detect, and respond to multiple disease outbreaks through efficient risk communication. The Nigeria Centre for Disease Control and Prevention (NCDC), with the support of Ministries, Departments, and Agencies, as well as many partners, has developed and implemented several strategies to guide effective risk communication and community engagement across the country.

These strategies were put to the test in February 2020, when Nigeria recorded its first case of COVID-19. NCDC launched a national communication campaign with the theme “Take Responsibility” to promote behaviours to prevent the spread of COVID-19 in Nigeria. The campaign called for all Nigerians to take a part in protecting their health and that of those around them.

This Multi-Hazard Risk Communication Guideline contains strategies for keeping the public informed and engaged in the prevention, detection, and response to health emergencies. Risk communication when misinformation is present and widespread requires knowledge of audiences, engagement with target communities, and collaboration with multi-level stakeholders to achieve maximum impact and reach the most vulnerable people. The NCDC continues to strive for excellence in risk communication backed by research and informed by best practices and leveraging on lessons learnt as we continue to review and improve on our strategies.

As the NCDC works with State Ministries of Health and relevant stakeholders to develop sub-national capacity for risk communication, we call on public and private agencies to invest in sustaining the successes achieved so far. Effective multi-hazard risk communication is essential to health emergency preparedness and to mitigate the economic and social impact of infectious disease outbreaks.



Dr Chinwe Ochu

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Acknowledgement

The Multi-Hazard Risk Communication Guideline is a document that focuses on using a multisectoral, multistakeholder, One Health approach to guide risk communication and community engagement for complex health emergencies. The development of this document brought together many colleagues, partners, Ministries, Departments, and Agencies, as well as colleagues from States and Local Government Areas who contributed immensely and to whom we are especially grateful.

We are also thankful to the members of the National Risk Communication Technical Working Group. They continually participated in meetings to provide expert insights and conducted an in-depth review of the document. These members include but are not limited to participants from the Federal Ministry of Health, Federal Ministry of Agriculture and Rural Development, Federal Ministry of Environment, Federal Ministry of Information and Culture, Nigeria Centre for Disease Control and Prevention, National Primary Health Care Development Agency, Federal Road Safety Commission, National Emergency Management Agency, National Orientation Agency, National Youth Service Corps, Nigeria Civil Aviation Authority, Nigeria Meteorological Agency, Society of Public Health Physicians of Nigeria, National Assembly, National Agency for Food and Drug Administration and Control, National Agency for the Control of AIDS, Federal Ministry of Women Affairs and Social Development, Nigeria Security and Civil Defense Corps, Nigeria Police Force, Ministry of Defense, National Biosafety Management Agency, Federal Ministry of Education, Office of the National Security Adviser, Ahmadu Bello University Zaria, University of Nigeria Nsukka, University of Ibadan, World Health Organization, United Nations Children's Fund, United States Agency for International Development (USAID), Breakthrough ACTION Nigeria, African Field Epidemiology Network, Red Cross, US Centers for Disease Control and Prevention (USCDC), Centre for Communication and Social Impact, Nigeria Health Watch, Corona Management System, Lafiya project, Nigerian Guild of Editors, National Commission for Persons with Disability, Federation of Muslim Women Association, and CORE Group Polio Project.

We are greatly indebted to Mrs. Babafunke Fagbemi, Dr. Olayinka Umar-Farouk and their respective organizations Centre for Communication and Social Impact and USAID funded Breakthrough ACTION Nigeria that worked on the finalisation and copy-edit of this document, We specially thank the members of NRCTWG secretariat who worked hard with other colleagues to support finalisation of this document.

We appreciate expert contributors and reviewers who helped with the finalisation of the document including Dr. Chinwe Ochu (NCDC), Mrs. Babafunke Fagbemi (CCSI), Mr Halilu Usman (USCDC), Dr Olayinka Umar-Farouk, Omolara Oyinlola, Meyiwa Ede, Munkail Titilola and Smart Joseph (Breakthrough ACTION Nigeria), Stephanie Clayton (Johns Hopkins Center for Communication Programs), Sandra Chipanta (Johns Hopkins Center for Communication Programs), and Marcela Aguilar (Johns Hopkins Center for Communication Programs).

Finally, immense appreciation goes to the leadership of the NCDC. The former Director General, Dr Chikwe Ihekweazu, recognized the importance of the document and provided the opportunity to work on it, bringing different stakeholders together to develop the document. We acknowledge the support of the Director General, Dr Ifedayo Adetifa, for the continued support, guidance, and push for the completion of the document.



Dr Yahya Disu

Chairman, National Risk Communication Technical Working Group

Acronyms

ACSM	Advocacy, Communication, and Social Mobilization
AFPAC	Armed Forces Programmes on AIDS Control
APHPN	Association of Public Health Physicians of Nigeria
BA Nigeria	Breakthrough ACTION Nigeria
C4D	Communication for Development
C4E	Communication for Education
CBO	Community-Based Organisation
CCSI	Centre for Communication and Social Impact
CGPP	Core Group Partners Project
CHIPS	Community Health Influencers Promoters and Services
COMBI	Communication for Behavioural Impact
COMO	Community Orientation and Mobilisation Officer
COVID-19	Coronavirus Disease 2019
CSM	Cerebrospinal Meningitis
CSR	Corporate Social Responsibility
CUG	Close User Group
DRU	Disaster Response Unit
DSNO	Disease Surveillance and Notification Officer
DSS	Department of State Services
EOC	Emergency Operation Centre
FAQ	Frequently Asked Question
FBO	Faith-Based Organisation
FCT	Federal Capital Territory
FGD	Focus Group Discussion
FMAFS	Federal Ministry of Agriculture and Food Security
FME	Federal Ministry of Education
FMEnv	Federal Ministry of Environment
FMHADSD	Federal Ministry of Humanitarian Affairs and Poverty Alleviation
FMIC	Federal Ministry of Information and National Orientation
FMHSW	Federal Ministry of Health and Social Welfare
FMWA	Federal Ministry of Women Affairs
FOMWAN	Federation of Muslim Women's Associations in Nigeria
FRSC	Federal Road Safety Corps
GIS	Geographic Information system
HPO	Health Promotion Officer

ICT	Information Communication Technology
IDP	Internally Displaced Person
IEC	Information, Education and communication
IHR	International Health Regulation
IPC	Infection Prevention and Control
JEE	Joint External Evaluation
LEEMP	Local Empowerment and Environmental Management Project
LEMA	Local Government Emergency Management Agency
LGA	Local Government Area
LIO	Local Government Immunization Officer
M&E	Monitoring and Evaluation
MAS	Mobile Authentication Service
MCC	Mission Control Centre
MDAs	Ministries, Departments, and Agencies
MHRC	Multi-Hazard Risk Communication
MoD	Ministry of Defence
MODHIP	Ministry of Defence Health Implementation Programme
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NANNM	National Association of Nigeria Nurses & Midwives
NAN	News Agency of Nigeria
NAQS	National Agricultural and Quarantine Services
NASCP	National AIDS & Sexually Transmitted Infection Control Program
NASS	National Assembly
NBMA	National Biosafety Management Agency
NCAA	Nigerian Civil Aviation Authority
NCC	Nigerian Communications Commission
NCDC	Nigeria Centre for Disease Control and Prevention
NCPWD	National Commission for Person with Disability
NEMA	National Emergency Management Agency
NGO	Non Governmental Organisations
NHPF	National Health Promotion Forum
NIMET	Nigerian Meteorological Agency
NIS	Nigeria Immigration Service
NNRA	Nigerian Nuclear Regulatory Authority
NOA	National Orientation Agency
NOSDRA	National Oil Spill Detection and Response Agency
NPF	Nigeria Police Force
NPHCDA	National Primary Health Care Development Agency
NRCS	Nigerian Red Cross Society

NRCTWG	National Risk Communication Technical Working Group
NSA	National Security Agency
NSC	National Security Council
NSCDC	Nigeria Security and Civil Defence Corps
NYSC	National Youth Service Corps
ONSA	Office of the National Security Adviser
PC4	Presidential Crisis Communication Command Centre
PHEIC	Public Health Emergency of International Concern
PHEOC	Public Health Emergency Operation Centre
PHS	Port Health Services
PoE	Point of Entry
PPP	Public, Private Participation
PPR	Peste Des Petits Ruminants
PRASCOR	Pharmacovigilance Rapid Alert System for Consumer Reporting
RAEF	Rock of Ages Empowerment Foundation
RC	Risk Communication
RCC	Rescue Coordinating Centre
RCCE	Risk Communication and Community Engagement
RCCE TWG	Risk Communication and Community Engagement Technical Working Group
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health plus Nutrition
SBCC	Social and Behaviour Change Communication
SBCTWG	Social and Behaviour Change Technical Working Group
SEMA	State Emergency Management Agency
SMS	Short Message System
SOP	Standard Operating Procedure
SPHPN	Society for Public Health Professionals of Nigeria
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TOR	Terms of Reference
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
USAMRD	United States Army Medical Research Directorate
USCDC	United States Centers for Disease Control and Prevention
VCM	Volunteer Community Mobilizers
WHO	World Health Organization

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How to use this document

This document is intended to guide risk communication and community engagement strategy development, planning, and implementation at the national, state, and local government area levels. It cites other existing documents to provide further guidance where necessary.

Section 1 provides a background of the multi-hazard situation in Nigeria, defines the term multi-hazard risk communication, and describes the goal of this communication in the context of a multi-hazard situation. This section also explains the strategic focus of this document and presents Joint External Evaluation scores for risk communication, which indicate progress towards fulfilling International Health Regulation requirements. Finally, this section presents findings on risk, vulnerability, and capacity analysis of disasters, conflicts, and epidemics as of the time of the development of this document.

Section 2 describes the evolution of a hazard with the accompanying emotional reactions during public health emergencies, and it presents relevant strategies for different phases of the hazards. It explains the components of an integrated model for risk communication and various risk communication strategies for addressing different situations during crises.

Section 3 emphasizes the importance of leveraging the existing guidelines across sectors and embracing a multi-disciplinary approach to multi-hazard risk communication. It lists the guiding documents for the development of risk communication strategies and plans in Nigeria. It justifies the use of social science theories, methods, and experts for addressing risk communication issues.

Section 4 describes institutional governance and coordination mechanisms for multi-hazard risk communication in Nigeria. It also describes the interrelationships and the responsibilities of stakeholders—including ministries, departments, agencies; partners; and communities—in the development, planning, and implementation of multi-hazard risk communication at all levels.

Section 5 explains the framework for monitoring and evaluation of multi-hazard risk communication interventions at all levels for different phases of a hazard. It also guides selecting techniques for the evaluation of interventions.

Executive Summary

The world is increasingly plagued by multiple hazards occurring concurrently and consecutively, with a recent example being the COVID-19 pandemic and the steadily rising number of disasters caused by climate change. Multi-hazards, whether natural or related to human activity, can have social, economic, health, and environmental consequences with devastating impacts on lives and livelihoods. Therefore, it is imperative to heighten awareness of policymakers and the public regarding the risks posed by multi-hazards. This goal can be achieved through a robust risk communication strategy designed to enhance preparedness and response to public health emergencies.

This guideline outlines hazards in the context of Nigeria, and it addresses the complexity of outbreak preparedness and response over time due to factors such as conflict. It also assesses the current capacity of Nigeria for risk communication with reference to the Joint External Evaluation, it elucidates the strategies and tools for multi-hazard risk communication, emphasising the role of lead agencies and the need for a multi-disciplinary and multi-sectoral approach that leverages existing structures at the national, sub-national, and local government area levels.

The document concludes with a general framework for the monitoring and evaluation of multi-hazard risk communication. The process of monitoring and evaluation should be implemented at all phases of disaster cycles (preparedness, mitigation, response, and recovery), and it is critical to the success, sustainability, and scalability of interventions.

A whole-of-society approach and the contribution of a variety of stakeholders including ministries, departments, agencies, and other partners in the development of this document, have helped to define a clear pathway for multi-hazard risk communication in Nigeria.



Section 1: Introduction and Background

1.1 Background and Rationale

A hazard is any incident or event that affects health, and the probability of the occurrence of such events is known as risk. Hazards in this context are classified into the following categories: disaster, public health emergency of international concern (PHEIC), pandemic, epidemic, and conflict. In Nigeria, some prevalent hazards that result in public health emergencies include flooding, epidemic disease, PHEIC, desertification, militancy, banditry, building collapse, windstorm, fire, air crash (at the point of entry and in-country), gully erosion, oil spillage, pipeline vandalization, drought, communal and religious conflicts, pest infestation, road accidents, and chemical poisoning.

A multi-hazard situation exists when more than one type of hazard occurs at the same time in a geographical location, either independently or relatedly, resulting in a complex public health emergency.

For example, Nigeria experiences outbreaks of infectious diseases yearly. In recent years, the public health response to these outbreaks (including risk communication) in many parts of the country has become complex because the outbreaks are occurring in conflict-prone areas. Public health authorities and workers are not equipped to address conflict-related hazards; however, response efforts have been more successful where security agencies and other critical stakeholders were involved in planning and implementation.

Such situations underscore the need for a multi-hazard approach to risk communication during complex public health emergencies.

Risk Communication and Community Engagement (RCCE) for multi-hazards means communicating about risks associated with public health emergencies involving more than one type of hazard.

Multi-hazard risk communication involves working with risk-affected communities that are experiencing complex public health emergencies. It requires tailoring scientific language to meet their needs, improving the understanding of societies at risk, and effecting action or behavioural change.

This document guides conducting or developing strategic plans for risk communication in any outbreak situation or when an outbreak occurs amid civil conflicts or disasters. Its application is adaptable to the level of response (national or subnational), the complexity of the emergency (involving multiple hazards), and the size of the public health emergency (number of people or communities affected). Depending on the type of hazard and context, the agency primarily responsible for the hazard control takes the lead and shares information with other relevant agencies and stakeholders to facilitate their meaningful involvement and support for effective response.

The officials and stakeholders responsible for risk communication during public health emergencies at national and subnational levels should refer to this document to plan, implement, and evaluate risk communication interventions and strategies.

1.2 Strategy Statements

The strategy statements that guide the workings of this Multi-Hazard Risk Communication Guideline are those of the National Risk Communication Technical Working Group (NRCTWG)

1.2.1 Vision and Mission of the Multi-Hazard Risk Communication Strategy



Vision

To build informed and resilient individuals and communities empowered to prevent, respond and mitigate the impact of multi-hazard public health emergencies through coordinated, consistent, and context-specific communication response.



Mission

Establish a clearly defined mechanism for integration of roles and activities for achieving effective and efficient communication response in the context of a multi-hazard communication plan.



1.2.2 Goal and Objectives



Goal

To provide a framework for the development and management of risk communication for public health emergencies in Nigeria



Objectives

- Define operational structures and coordination mechanisms with roles and responsibilities for risk communication at all levels
- Establish a mechanism for information sharing and Provide guidance for development, scalability, and adaptability of communication strategies to public health emergencies

1.2.3 Scope

The scope of this document encompasses providing guidance to stakeholders on how to plan and implement risk communication responses for addressing public health emergencies, including infectious disease outbreaks occurring during disasters, conflicts, or both.



1.3 Strategy Statements

1.3.1 Risk Communication

Risk communication is the real-time exchange of information, advice, and opinion between experts or officials and people who face a threat (hazard) to their survival, health, or economic or social well-being. Its ultimate purpose is to enable everyone at risk to make informed decisions to mitigate the effect of the threats and to take protective and preventive actions.

1.3.2 Multi-hazard Risk Communication

Multi-hazard risk communication focuses on the real-time exchange of information between officials from different agencies, experts, and those affected by any type of hazard, including disasters, conflicts, or infectious diseases, that can result in a public health emergency.

1.3.3 Guiding Principles of Risk Communication

Public health emergencies are characterised by the public's need for accurate, credible, and timely information to protect their health and well-being. As information changes rapidly and involves emerging or novel threats, potentially against the backdrop of conflict or other ongoing concerns, the event may be complicated by confusion, panic, and misinformation. These factors may influence how quickly the emergency can be brought under control. Therefore, risk communication must employ the guiding principles that would enable it to maintain public trust and confidence in the response and promote the uptake and utilisation of preventive messages. The guiding principles (WHO 2017) are the following:

- I. Create and maintain trust
- II. Acknowledge and communicate even in uncertainty
- III. Coordinate communication among stakeholders

- IV. Be transparent and fast with the first and all (subsequent) communication
- V. Be proactive in public communication
- VI. Involve and engage those affected
- VII. Use integrated approaches
- VIII. Build national capacity and support national ownership

Types of Crises

Table 1-1. Examples of Potential Crises

National Multi-state Disease Outbreak Investigation or Environmental Crisis	Site specific Events/Crises.	Terrorism	
		Bio	Chemical
<ul style="list-style-type: none"> • Foodborne • Airborne • Waterborne • Vector-borne • Unknown infectious agent • Chemical • Natural disaster • Toxic materials • Radiologic materials • Large-scale environmental crisis • War related 	<ul style="list-style-type: none"> • Laboratory incident with the release of material into a community • Death of employee, contractor, or visitor on campus • Hostage event involving an employee or contractor on campus • Bomb threat • Explosion or fire causing the destruction of property • The violent death of an employee or contractor or visitor on campus • Laboratory incident with laboratory worker 	<ul style="list-style-type: none"> • Suspected • Declared 	

The Risk of Hazard

Disasters are the ultimate test of emergency response capability. The ability to deal effectively with disasters is becoming more relevant as the factors that tend to increase the risk are also growing. Some of these factors include the following (Auf, der Heide E. 1996):

- Increasing population density. As areas become more densely populated, the number of potential victims is higher when a disaster occurs.
- Increasing population in new areas. As people move into new areas, land use patterns may change, bringing animals and people into different relationships and causing environmental changes due to deforestation, intensive farming, or climate change-related events.
- Increased settlement in high-risk areas. An increase in population density is occurring in disaster-prone areas. There is a substantial settlement in areas at high risk of natural disasters, such as

flooding, earthquakes, hurricanes, and landslides, and areas susceptible to human-related disasters, including land adjacent to hazardous waste landfills, airports, and nuclear power plants.

- Increased threat from technological tools. New technology is adding to the list of disaster agents at an ever-increasing rate, for example, through improper disposal of used equipment such as household appliances, televisions, phones, and other ‘techno trash’ that can release toxic or radioactive compounds.
- Emerging infectious diseases and antimicrobial resistance. Infectious diseases are a continuing danger to all people, no matter their age, gender, lifestyle, ethnic background, or economic status. Diseases remain among the most common causes of suffering and death, and they impose an enormous financial burden on society. Because new diseases can arise without warning, we must always be prepared to meet the threat.

Throughout history, humanity has fallen victim to pandemics of cholera, plague, influenza, typhoid, tuberculosis, and other infectious diseases that were once so widespread. In the years following World War II, a widespread belief was that humans were winning the millennia-long war against infectious microbes. Antibiotics could treat such life-threatening bacterial diseases as tuberculosis and typhoid fever. Dread diseases of childhood, such as polio, whooping cough, and diphtheria, could be conquered through vaccination. Coupled with earlier improvements in urban sanitation and water quality, vaccines and antibiotics dramatically lowered the incidence of infectious diseases. Thus, it became possible to imagine a world in which contagious pathogens would no longer prey upon humanity.

However, this optimism was premature. As early as the 1950s, penicillin began to lose its power to cure infections caused by *Staphylococcus aureus*, a common bacterium that can cause serious illness. In 1957 and 1968, new strains of influenza emerged in China and spread rapidly around the globe, and in the 1970s, there was a resurgence of sexually transmitted diseases. Also, during the 1970s, several new diseases were identified in the United States and elsewhere, including Legionnaires’ disease, Lyme disease, toxic shock syndrome, and Ebola hemorrhagic fever. Antibiotic-resistant bacteria are now becoming more common in hospitals, among patients, and in communities.

Looming over the yearly routine of preparing for each flu season is the threat that a pandemic strain might emerge—a virulent new type of influenza that can span the globe in months and decimate the world’s population, similar to the strain that killed more than 20 million people in 1918-1919. Such a lethal virus can sweep the world without warning. The recent avian influenza scare in Hong Kong in 1997 raised the spectre of a possible global pandemic and jolted the world from any renewed complacency about infectious diseases. The COVID-19 pandemic affecting more than 200 countries has also demonstrated devastating socioeconomic and health impacts globally.

- **Increased international travel.** International travel and trade play a role in the development of microbial resistance. A microbe originating in Africa or Southeast Asia can arrive on North American shores within 24 hours. In the United States, published reports show that the majority of multidrug-resistant typhoid cases originated in six developing countries.
- **Megacities.** By all indications, the world will have as many as 20 cities with populations above 20

million within the next 25 years. Most of these cities will be in developing countries where poverty, population density, and lack of sanitation will allow microorganisms to incubate and spread rapidly. With the modern speed of travel, the global threat is obvious.

The rapid geographic movement of products and populations, changes in lifestyles and behaviors, the emergence of new infectious diseases, and the deliberate use of microorganisms and toxins as terrorist weapons add to the current public health risks. In addition, unforeseen interactions, such as those that may allow disease agents to cross species' barriers, also add to the unpredictability of public health risks.

- **Increased terrorism.** The threat from terrorism is real, it is immediate, and it is evolving. State-sponsored terrorism appears to have declined over the past five years, but transnational groups—with decentralized leadership that makes them harder to identify and disrupt—are emerging. The world is seeing fewer centrally controlled operations and more acts initiated and executed at lower levels.

Terrorists are also becoming more operationally adept and more technically sophisticated in order to defeat counterterrorism measures. For example, as security around government and military facilities has been strengthened, terrorists seek out “softer” targets that provide opportunities for mass casualties. Employing increasingly advanced devices and using such strategies as simultaneous attacks, the number of people killed or injured in international terrorist attacks rose dramatically in the 1990s, despite a general decline in the number of incidents. Approximately one-third of these incidents involved US interests.

An act of biological or chemical terrorism may range from the dissemination of aerosolized anthrax to contamination, and predicting when and how such an attack may occur is impossible. The probability of biological or chemical terrorism cannot be ignored, especially in light of the events of the past 10 years. (Biological and Chemical Terrorism: Strategic Plan for Preparedness and Response, 2000)

1.4 Overview of Risk Communication in Hazard Situation in Nigeria

Nigeria periodically experiences different categories of hazards which are can be natural (physical and biological), accidental (biological, chemical, and radiological), or human-related (technological, mechanical, chemical, radiological, terrorism, war, and conflicts). Examples of hazards experienced in Nigeria are epidemics (e.g., cholera, Lassa fever, yellow fever, measles, mpox, and cerebrospinal meningitis); infectious diseases of international concern, pandemics, and other related public health events at the points of entry (e.g., yellow fever, Lassa fever, cerebrospinal meningitis, mpox, Ebola, Marburg virus, COVID-19, and so on); disasters (drought, desertification, flooding, coastal erosion, dam failure, building collapse, oil spillage, maritime collision or accident, bomb explosion, fire, air and road crashes, and boat mishap); and conflicts (e.g., ethnic, political, and religious violent conflicts; communal clashes; and insurgency).

Communicating risks during public health emergencies can become complex and ineffective when more than one hazard occurs at the same time, such as infectious diseases, conflicts, and disasters at the

same time in a location, or when there is an outbreak of infectious diseases in a disaster-prone or conflict-ridden area. Therefore, risk communication needs to be tailored to the context of public health emergencies by using approaches that address the multi-hazard nature of the emergency.

Multi-hazard risk communication considers the types of hazards, risk perception, the vulnerability of the people, and resources available for good planning and effective implementation. The goal of multi-hazard risk communication is to mitigate the impact of the hazards whenever or wherever they occur.

1.5 International Health Regulations

The International Health Regulations (IHR, 2005) is an international agreement that is legally binding on 196 countries (States Parties), including Nigeria as a signatory. The IHR aims to protect the global community from public health risks and emergencies that cross international borders.

The IHR (2005) recognizes risk communication as a critical pillar for a response using multi-level, multi-sectoral, and multifaceted risk communications capacity for public health emergencies. Such communication needs to be carefully planned, implemented, and integrated adequately with emergency management activities and operations, especially for the outbreak-prone diseases, national disasters, and diseases indicated in Annex 2 of IHR 2005.

1.5.1 Joint External Evaluation

The Joint External Evaluation (JEE) is a process for assessing the fulfilment of IHR requirements for countries. The gaps identified during the process guide the development of a national action plan for health security. The assessment is performed in 19 technical areas, including risk communication. It allocates scores for each of the criteria as follows: 1 = no capacity; 2 = limited capacity; 3 = developed capacity; 4 = demonstrated capacity; and 5 = sustainable capacity.



The first JEE provides the baseline of the IHR requirements, while subsequent evaluations reflect progress towards fulfilment of the requirements. IHR emphasises the vital role of risk communication in mitigating the adverse impacts of a public health emergency. Still, recent events have shown that risk communication is not easy to manage in Nigeria.

1.5.2 JEE Targets for Risk Communication

Voluntary JEE is one of the technical frameworks in support of IHR (2005) Monitoring & Evaluation. The technical areas covered in this voluntary component of the technical framework are grouped into four core areas: prevent, detect, respond, and IHR-related hazards and points of entry.

The JEE in this respect considers:

- **Preventing** and reducing the likelihood of outbreaks and other public health hazards and events defined by IHR is essential.
- **Detecting** threats early can save lives.
- Rapid and effective **response** requires multisectoral, national and international coordination and communication.

Each indicator in the JEE tool has attributes that reflect various levels of capacity. These are identified with scores ranging from 1 (indicating that implementation has not occurred) to 5 (indicating that implementation has occurred and is tested, reviewed, and exercised and that the country has a sustainable level of capability for the indicator). For each indicator, a country receives a single score based on its current capacity. The “technical area questions” help the evaluators determine the appropriate score. A country can advance to the next adjacent level only when it has achieved all the attributes of its current capacity levels.

For example, to be rated as having demonstrated capacity, a country has to meet all the attributes of developed and demonstrated capacity. All responses must be supported by documentable evidence.

The JEE scoring system emphasises

1. Use of multilevel, multisectoral, and multifaceted risk communication capacity for public health emergencies
2. Real-time exchange of information, advice, and opinions during unusual and unexpected events and emergencies so that informed decisions can be made to mitigate the effects of threats and to support protective and preventive action
3. Use of a mix of communication and engagement strategies, such as media and social media communications, mass awareness campaigns, health promotion, social mobilization, stakeholder engagement, and community engagement

The 2017 JEE report by the World Health Organisation (WHO) showed an aggregate JEE score of 2.0 for risk communication. The report also identified the need for National Multi-Hazards Risk Communication guidelines for Nigeria to continuously improve the JEE score. Subsequently, a mid-term internal evaluation was conducted in 2019 with an aggregate score of 3.0 (see Table 1). On this premise, developing a multi-sectoral and multi-hazard risk communication guideline and an emergency plan was inevitable. Therefore, the multi-hazard risk communication plan is a subcomponent of the National Multi-Hazard Public Health Emergency Plan.

Table 1:

JEE Score 2017 (Original Tool) (Aggregate score = 2.0)		JEE Score 2019 (2.0 Tool) (Aggregate score = 3.0)	
R.5.1 Risk communication systems (plans, mechanisms, etc.)	1	R.5.1 Risk communication systems for unusual/unexpected events and emergencies	2
R.5.2 Internal and partner communication and coordination	3	R.5.2 Internal and partner coordination for emergency risk communication	3
R.5.3 Public communication	2	R.5.3 Public communication for emergencies	3
R.5.4 Communication engagement with affected communities	2	R.5.4 Communication engagement with affected communities	3
R.5.5 Dynamic listening and rumour management	2	R.5.5 Addressing perceptions, risky behaviours, and misinformation	4



1.6 Risk Analysis (Disaster, Epidemics, Conflict)

Risk analysis identifies hazards that can affect the health and safety of people and property through risk assessment, development of strategies to reduce the risk, and strategies for containing the hazards.

Hazard is any incident or event that affects health, and the probability of the occurrence of such events is known as risk. Hazards in this context are classified as disasters, epidemics, and conflicts.

Nigeria continues to experience a wide range of hazards, including epidemics, disasters, and conflicts or security situations. The hazards have either rapid or slow onset, resulting in catastrophic situations with loss of lives and property and degradation of the environment that threatens the health of plants and animals. Many communities in Nigeria have experienced at least one type of hazard, but some have experienced more the occurrence of multiple hazards at different times or simultaneously.



1.6.1 Vulnerability

Vulnerability is the degree to which a hazard or a threat event will likely exert or negatively affect a population or community.

The vulnerability of Nigerians to hazards is a function of several factors, including poverty, gender inequality, gender-based violence, human rights abuse, population density, urban slums, the human condition, and infrastructure. Other factors include environmental degradation, literacy, level of public awareness and compliance, the dynamics of public policy, and environment on disaster management. It is important to note that people with disability are disproportionately affected by hazards and that stigma and discrimination worsen the impact of hazards on people with disability.

As vulnerability could influence the scale, severity, or duration of an event, as well as the speed of recovery, it must be considered in all communication interventions in a disaster cycle. Therefore, a vulnerability assessment (the process of identifying, quantifying, and prioritising the vulnerabilities in a system) is necessary to inform adequate and effective risk communication plans and implementation.

1.6.2 SWOT Analysis (Capacity)

An analysis of the risk communication capacity examines the strengths, weaknesses, opportunities, and threats (SWOT) regarding the ability to deliver effective multi-hazard risk communication for public health emergencies by the system at all levels. The 2017 JEE report showed that Nigeria's risk communication core capacity was limited (below-average level) with various human capacities at the national and sub-national levels. The mid-JEE report of 2019 showed demonstrated capacity (above average level).

The table below shows the SWOT analysis of the national capacity for risk communication as of 2021

Strengths	Opportunities
<ul style="list-style-type: none"> • Collaboration between established government agencies working in various areas of multi-hazards risk communication, e.g., ONSA, NCDC, PHS, FMOH, NEMA, FMHAPA, FMEEnv, and FMAFS • Existing structures to implement multi-hazard risk communication across all tiers of government • National coordination for risk communication • Availability of robust traditional and social media environments • Regular press releases during disease outbreaks targeted on key national media which will ensure appropriate reach across the country in multiple languages • Proactive outreach to communities prior to potential outbreaks of Lassa fever, yellow fever, CSM, cholera, monkeypox, measles, COVID-19, and influenza • Gender sensitivity • Utilizing weather forecast for early warning • Engagement of donor partners to fund activities • Established structures in communities • Sustainability framework • Capacity for media engagement • Unity in teamwork • Capacity for high-level advocacy to legislators, the presidency, governors' wives, religious bodies, traditional leaders, etc. • Public and private participation • Inter-agency collaboration and network • Trained members of the NRCTWG on risk communication • Available human capacity and resources for risk communication • Capacity to support vulnerable groups in IDPs, prisons, and Almajiri • Capacity for effective community mobilization 	<ul style="list-style-type: none"> • Existing personnel for risk communication (more than 200,000 in the National Youth Service Corps) can help transmit information to affected communities. • Wide reach and influence of key public national media exist under the government-owned Ministry of Information. • Capacity building of health workers by collaborating partners and stakeholders • Funding opportunities from donors • Use of different social media platforms • Leveraging on the use of ICT for dissemination of information • The One Health approach gives room for an improved multi-hazard risk communication • inter-agency, inter-partner collaborations • External funding opportunities through CSR, donors, etc • Leveraging on the gains achieved during this pandemic • Availability of community volunteers • Strong community structures in existence • Availability of risk communication documents on the websites • Availability of policy document • Existence of vibrant media and social media landscape for information dissemination • Strengthened risk communication at points of entry • Using various languages to disseminate risk communication • Strong collaboration among partners and media • Adequate and competent human resource in most MDAs and partners • Active partners supporting government structures • Existing programs for the training of NYSC members on risk communication and data collection • Key public and private media organisations exist

Weaknesses	Threats
<ul style="list-style-type: none"> • Inadequate coordination among government agencies • Unavailability of documented strategies and plans of operations at all levels • Inadequate documentation of response activities and case studies • Limited funding; most plans have not been implemented, and this continues to call into question the acceptability of assumptions of the overall system • Inadequate monitoring and evaluation of risk communication activities • Lack of continuity of participation on the team from MDAs and partners • Limited capacity building • Reliance on NGOs and private organizations for funds • Lack of proactive attitude towards issues • Not carrying other agencies along when it comes to implementation • Inadequate supply chain logistics • No effective template for M&E • Low involvement of the private sector • Poor funding for risk communication activities • Duplication of efforts by government agencies • Poor utilisation of funds for planned activities • Poor data management for risk communication • Inadequate vulnerability capacity assistance for risk communication • Lack of trust between agencies to share policy documents • Inadequate data generation and use from risk communication activities • Duplication of duty between risk communication officers and other responders • Structures not fully developed within the TWG to cater to the different technical areas • Inadequate supply of IEC materials • Unavailability of documented strategies and plans for operations at a sub-national level • Poor role clarification among partners • Lack of SOPs • Lack of continuity of staff to risk communication TWG 	<ul style="list-style-type: none"> • Rumours, unverifiable information, and misconception in the media, especially social media. • Poor reporting by the media • Inadequate funds • Insecurity • Lack of political will at all levels of government to support risk communication • Poor community engagement • Poverty • Illiteracy and ignorance • Religious and ethnic divide • Multiple languages • Inadequate sensitization and awareness creation • Duplication of efforts by different MDAs • Bureaucracy • Bottom-up approach not applied • Inter-agency rivalry • Professional and cadre rivalry • Poor infrastructure • Weak legislation • Poor community engagement • Overlapping funding • Lack of synergy • Stigmatisation • Infodemics • Lack of government backup policy establishing the RCCE TWG • Lack of central communication coordination mechanism • Policy disconnects • Lack of proper regulation of social media making fake news and rumours to fly easily • Reliance on donor funding • Lack of institutional memory in agencies • Inconsistency of information between security agencies and the media • Non-prioritisation of risk communication in disaster response

1.6.3 Coordination Structure Assessment

The existing coordination structure for risk communication at the national level (NRCTWG) is multi-disciplinary, multi-sectoral, and multi-partner, using a multi-hazard approach including One Health, which involves collaboration between the human, animal, and environmental health sectors to optimise health outcomes, for planning and implementation. The existing structures at the sub-national level include state and LGA social mobilization committees similar to national risk communication TWG, but they need capacity strengthening to apply multi-hazard and One Health approaches.

In January 2021, a rapid assessment was conducted to identify the coordination structures available in the 36 states and Federal Capital Territory (FCT) that can be leveraged for risk communication activities, including preparedness and response to any public health event or emergency.

Key findings include

- I. Varying coordination structures (e.g., social mobilization committee, health promotion forum/committee, advocacy communication and social mobilization core group, advocacy core group, social and behaviour change communication committee, demand generation committee, and ward health committee) exist at State and/or LGA levels.
- II. Documented terms of reference do not appear to exist for some of these structures, especially the social mobilization committee predominant in 32 states.
- III. Membership of these committees does not include representatives of organizations that allow for multi-sectoral collaboration, for example, Ministry of Agriculture, Ministry of Environment, National Emergency Management Agency, civil society organizations, security agencies, or the private sector.
- IV. Implementing partners and donors provide support for the coordinating structure meetings in two-thirds of the states.
- V. Main activities conducted include community sensitization, awareness, advocacy, and campaigns focused on COVID-19, immunization, yellow fever, family planning, and malaria.
- VI. A mix of communication channels (emails, SMS, WhatsApp, official letters, and face-to-face interaction) can be used to engage the coordination structures.
- VII. The change in nomenclature from health education officers to health promotion officers at state and LGA levels has not been fully implemented.

Recommendations

- I. The nomenclature of the coordination structure and the responsible people across states and LGAs should be standardized in line with the National Health Promotion Policy. In addition, the coordination structure at the LGA level should be domiciled within the Primary Health Care department. This step will require buy-in and coordination by the health MDAs at the national level.
- II. The coordination structure should have vast membership that allows for a multi-sectoral response during public health events or emergencies.
- III. A cross-cutting term of reference should be developed.

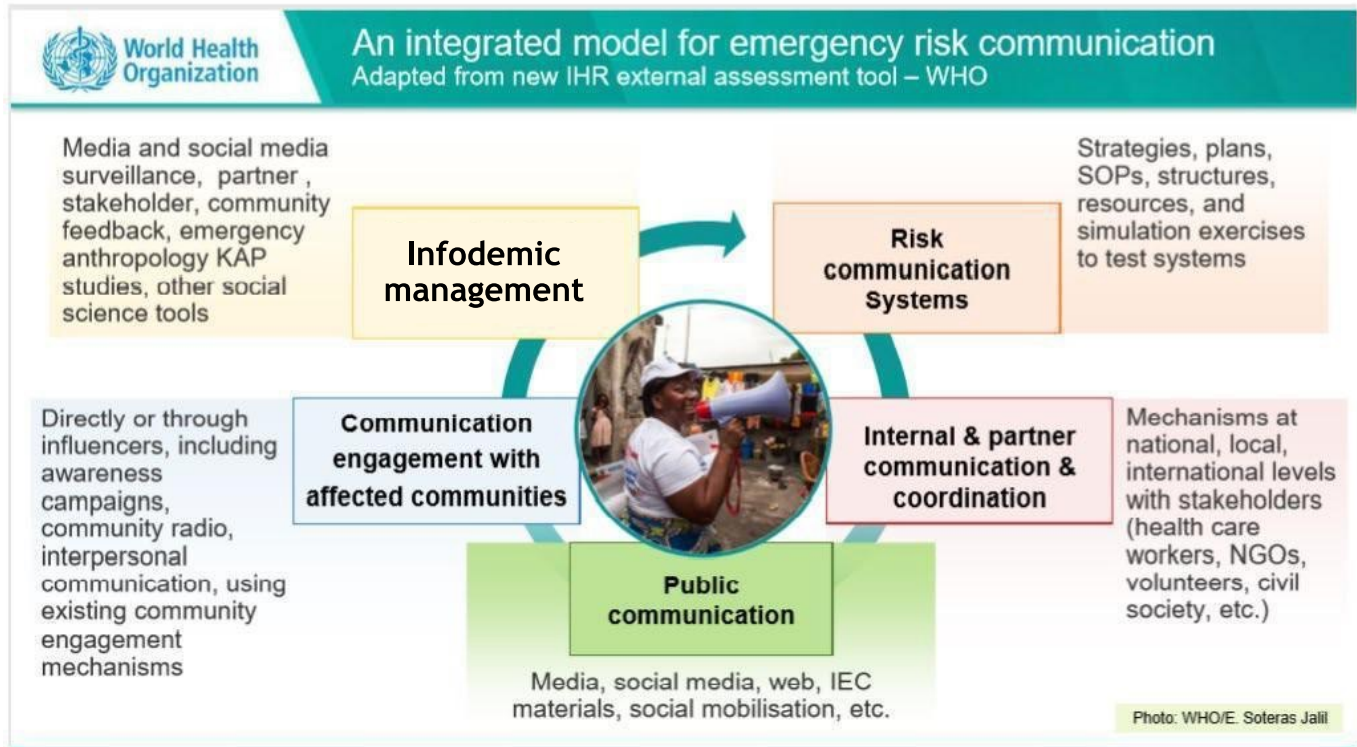


Section 2: Framework and Approaches to Multi-Hazard Risk Communication

2.1 Framework

Nigeria adopted the recommended integrated model for risk communication as the framework for developing, planning, and implementing risk communication and community engagement (RCCE) in the country. The five components of this model have been adapted to the Nigerian context for the RCCE system at all levels: risk communication system, stakeholders’ coordination and communication, public communication, community engagement, and infodemic management.

The WHO algorithm as shown below is adopted:



2.1.1 Risk Communication Systems

- I. **Preparedness phase:** A risk communication system provides a framework for risk communication development and management at all levels. It includes developing or adapting toolkits such as guides, procedures, processes, and strategies for risk communication. In addition, planning, budgeting, and resource mobilization are critical activities of the risk communication system. It also includes building staff and stakeholders' structures, systems, and capacity in risk communication and conducting simulation exercises to test systems and capacities.
- II. **Crisis communication:** Procedures for crisis communication should also be established, with stakeholders and team members identified in crisis communication plans (based on the type of emergency) and trained on their respective roles in peacetime.
- III. **Response structures:** For every public health event in which the incident management system is activated, a risk communication pillar is established, incorporating members of NRCTWG (or its equivalent at the subnational level) who have technical roles to play. The pillar should have a multi-hazard composition based on the nature of the public health emergencies. As the public health event becomes bigger, more partners or MDAs with relevant functions should be included in the pillar.
- IV. **Sector approach to stakeholders' engagement:** In a huge outbreak or pandemic that affects several sectors in which a massive number of stakeholders are involved, a four-pronged sector approach to stakeholders' engagement should be adopted (sector-wide guideline development, technical support for guideline implementation, provision of regular update/key messages to the sector, and feedback mechanism for information from the sector)
- V. **Special task force role:** In a situation in which a special task force or its equivalent is established at the subnational level, activating the risk communication pillar may be advisable for amplifying messages from the incident management system

2.1.2 Stakeholders Coordination and Communication

- I. **Stakeholders' coordination:** Stakeholders' engagement, alignment, and coordination across sectors and levels are key to the success and sustainability of risk communication efforts.
- II. **Strategies for stakeholders' engagement:** An organisation's plan must be communicated to prospective stakeholders in a transparent way that will make it easy for them to comprehend the intention, their roles, and how it would affect them. The stakeholders' most suitable channels of communication should be considered when engaging with them. The team's ability to keep an open and curious attitude without judging stakeholders' values will help them understand the history and concerns of the stakeholders and will assist both sides in reaching creative solutions to overcome roadblocks and in aligning values and interests in the process.

- III. **Stakeholder mapping and analysis:** To perform the preceding functions successfully, stakeholder mapping and analysis should be done to identify the categories of available stakeholders according to their interests, strength, and influence. This enables clear role definition and seamless coordination for optimising available resources, consistent messaging, and trust-building. (See stakeholders' analysis and roles in the appendix.)
- IV. **Stakeholders' communication:** Meetings should be held regularly to discuss progress with the response, address challenges, and review activities and strategies as necessary. Communication among the stakeholders should be timely and consistent through means and platforms that are accessible and acceptable to all relevant stakeholders.
- V. **Accountability:** The stakeholders are meant to be accountable for the roles they play and resources used for the communication response, track commitments made to them, and ensure project team members coordinate consultation events, share information, and assign tasks and follow-up actions.
- VI. **Roles and responsibilities of stakeholders:** The leading agency in any response is the agency that is primarily responsible for the prevention and control of the hazard based on its nature as guided by the Act establishing the Agency. The NCDC will be the leading agency for public health emergencies caused by infectious diseases, NEMA for disasters, ONSA for conflicts, and so forth.

2.1.3 Public Communication

Public communication entails the timely dissemination of relevant, precise, accurate, and actionable messages to various audiences in acceptable formats through different preferred channels that are accessible to the audience.

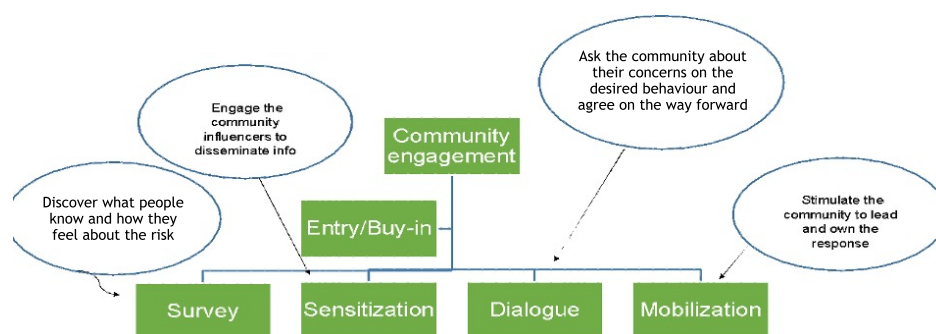
- I. **Preparedness:** Public communication preparedness begins with a thorough understanding of the country's risk profile, and from the profile, the communicator develops and maintains the following: audience targeting, messaging, checklists, contact lists, and public information materials. Prior to a public health event, the activities to be carried out include public education and campaigns, training, exercises, media relations, engagement with special needs population, and development of communication resources including websites and blogs.
- II. **Public education:** Public education is the process of making the public aware of risks and preparing for all hazards in advance. It continues during and after a response.
- III. **Message development:** Messages should have a scientific basis. The process for developing messages should be guided by data generated through opinion polls, perception surveys, key informant interviews, or focus group discussions as the need arises. It is also essential that the context in which public health emergencies occur should be considered while designing the messages. The designed messages should be prepared and pre-tested in peacetime but updated or adapted as an emergency evolves.

- IV. Process flow with timelines:** A clear message process flow with activities involving relevant stakeholders should be established to develop accurate, clear, and relevant messages.
- V. Spokespersons' preparedness:** Spokespersons should be identified and trained in peace time. The process and procedure for approval for reaching out to the media should be established. Procedures for crisis communications should also be activated when in crisis mode during emergencies.
- VI. Audience segmentation:** Segmenting the audience is important for inclusiveness and effective communication. The following criteria may be used to segment the audiences: risk level (exposure likelihood), vulnerability (women, children, elderly persons with co-morbidities), and special needs, including persons with disabilities and hard-to-reach populations.
- VII. Channels of communication:** The existing communication channels should be mapped out, and the most preferred channels accessible to the audience should be identified through audience analytics.
- VIII. Media engagement:** Both social and traditional media play a significant role during public health emergencies. It is therefore important to proactively engage the media community in the dissemination of information to the public. Media can also serve as a means for public participation through phone-in programmes and social media interactions. For accurate reporting by the media, media professionals must be trained on accurate reporting and translation of technical information into language understandable to the public. To optimise the media for sustainable advantage, media strategies and plans for public health emergencies should be developed and updated when necessary. It is helpful to keep a media database and maintain regular contact with media personnel for updates.

2.1.4 Communication Engagement With Affected Communities

Communities directly affected by hazards take priority in public health emergencies. Certain cultural practices might contribute to negative consequences of the hazard or make control efforts difficult. Therefore, it is important to engage the affected communities using a bottom-top approach to empower the local leaders and community members in identifying, planning for and responding to an emergency. They should be considered in decision-making; feedback should be obtained, and responses provided.

- I. **Community entry:** Getting the buy-in of the community gatekeepers is crucial to the success of community engagement. As custodians, the community gatekeepers hold sway in community members' affairs and should be identified and consulted for their understanding, guidance, and support for any actions or interventions in the community.
- II. **Community survey/Behavioural research:** It is helpful to consider innovative approaches including human centred design for conducting surveys at the beginning of the intervention and repeat as necessary to gain insights into community perspectives of the problem and to recommend or adapt solutions to the problems. Such surveys also provide an opportunity to understand the knowledge gap, circulating misconceptions, and misinformation/ disinformation in the community. Finally, surveys enable an understanding of different categories and behaviours of the target audiences and their preferred channels of communication.
- III. **Awareness education and behaviour change campaign:** Communicators can guide community members in making their own informed decisions by providing information about the situation, risk, resources available, and actions to protect themselves. It is necessary to jointly explore options and allow the communities to decide for themselves what is in their own best interest.
- IV. **Community dialogue:** Communicators should provide a two-way communication channel by engaging the community in active listening to understand their fears, concerns, and barriers and encourage them to take informed decisions and actions.
- V. **Social mobilization:** Communicators should empower the community to embrace ownership, leadership, and resilience-building interventions for sustainability. With guidance from public health authorities, community members can organise to identify and solve problems



Community Engagement Model for Outbreak Response in Nigeria

2.1.5 Infodemic Management

Public health emergencies are characterised by rapidly evolving information, uncertainties, fear, panic, and high information needs, making the unsuspecting public vulnerable to misleading information. If not promptly addressed, misinformation/disinformation or conspiracy theories can result in far-reaching consequences to individuals, populations, responders, and public health authorities. Delayed response to misinformation/disinformation can allow confusion to increase, weaken the messages' effectiveness, limit compliance with response protocols, or lead to more risky behaviour. It can also foster hostility towards responders, stigmatisation, and complications from risky behaviour that could distract from the response.

Infodemic management is the management of an overabundance of information, including false or misleading information, from physical and digital environments during a disease outbreak. It needs to be strategic, integrated, timely, and deliberate to avoid the negative consequences of infodemics. A whole-of-society approach to infodemic management requires the participation of all relevant stakeholders, including platform operators, fact-checkers, media, public health communicators, policymakers, civil society organisations, community members, and so forth.

An established process flow should be available, with a timeline for managing misinformation/disinformation or information overload. The process includes listening/scanning, classification, documentation, verification/fact-checking, response, dissemination/amplification, and feedback. However, response amplification needs to be done cautiously to avoid the further spread of the initial rumour/misinformation. The roles of various stakeholders involved in infodemic management should be clearly defined.

Integrated infodemic management entails the combination of online and community-based infodemic management systems. The online infodemic management system involves the use of social media platforms for the whole process, while the community-based approach consists of working with community-based networks for the process, especially listening, response, and dissemination. However, online documentation is later encouraged to integrate the records. The strategies recommended for infodemic management can be broadly classified into reactive measures (identify, simplify, amplify, and quantify) and proactive measures, including timely delivery of high-quality information, resistance campaign, building resilience (inoculation), and prebunking.

- I. Timely delivery of information can be reactive and proactive depending on when it is performed relative to when the information emerges; thus, events occur or reduce the chances of misinformation/disinformation.
- II. Debunking or response is a reactive measure to address misinformation/disinformation that is already circulating. Timely debunking is very necessary to avoid the consequences of misinformation/disinformation. *See Appendix for a framework for reactive infodemic management criteria for assessing threat/prioritising misinformation for a response.*
- III. Algorithms for the response/protocol should be developed, validated, and used at all levels. For

example, frequently asked questions (FAQs) should be used by the response team, matters relating to operational issues should be escalated to the incident manager or pillar lead, and political or sensitive issues should be escalated to political authorities.

- IV. Resistance campaign to misinformation is a proactive approach to preventing misinformation/disinformation and should be embraced by stakeholders. This strategy is important to reduce tolerance to misinformation/disinformation and discourage perpetrators of misinformation from doing so.
- V. Building individual and societal resilience is another option for proactively addressing misinformation/disinformation. This strategy also referred to as inoculation or pre-bunking, can be achieved by revealing the schemes of creators of misinformation/disinformation to the population.

2.2 Strategies & approaches

Every emergency with accompanying emotional response (including outrage) evolves in phases (see Section 6 Appendix for additional discussion of phases). Communicators are required to align communication priorities and strategies with the emerging phases. Three communication objectives—community engagement, strengthened decision-making, and evaluation—must be maintained throughout the phases.

Risk communication seeks to address both the threat (hazard) and the emotional response, which is largely influenced by risk perception by the public. The public's perception of the threat (hazard) usually differs from that of the experts' understanding of the risk based on the level of awareness/knowledge versus belief/faith, sociocultural factors, and self-efficacy.

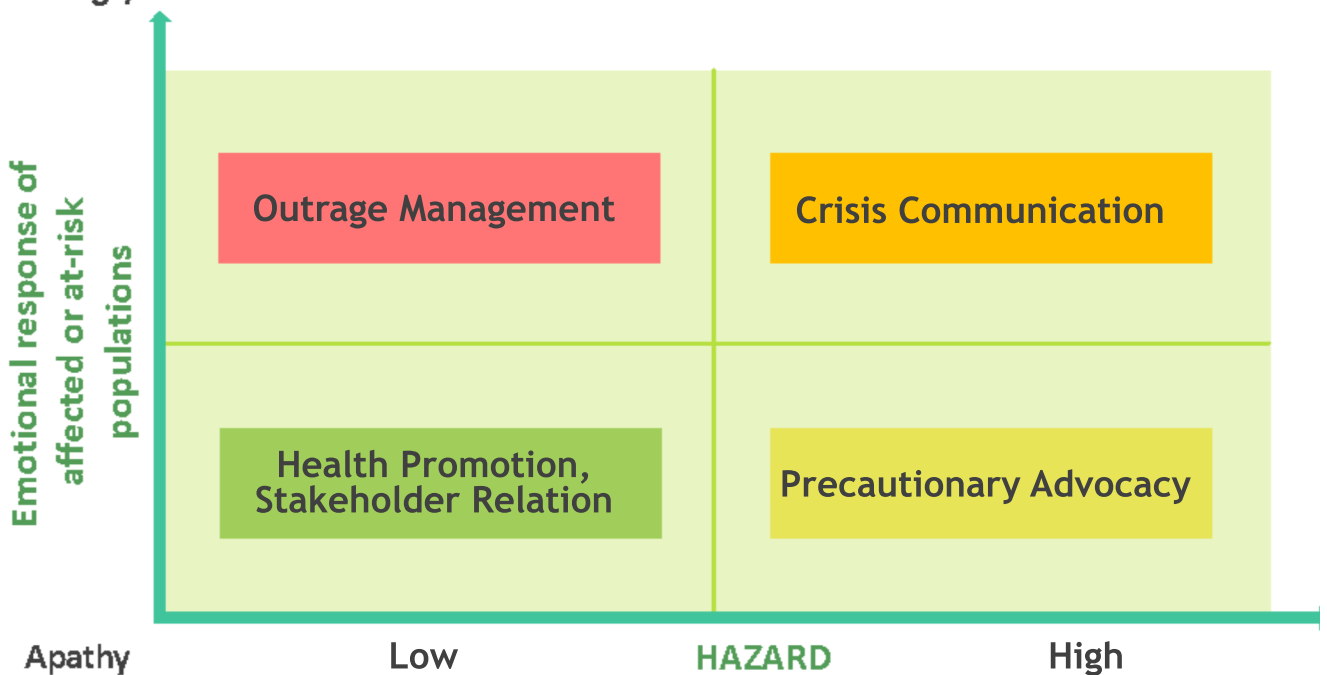
Therefore, the aim of risk communication is to

- I. Bridge the gap between experts' understanding and public perception of the same risk.
- II. Provide evidence-based knowledge about risks to inform decision-making and behaviour change
- III. Keep response in proportion to the hazard so people have an appropriate level of concern to motivate them to act according to the actual danger they face.

According to the WHO, four types of risk communication strategies have been described based on the combination of two factors, namely, the level of threat (hazard) as assessed by the experts and the level of perception of the threat by the public or affected community.



Outrage/Fear



Source: Peter Sandman

2.2.1 Crisis Communication

Crisis communication is the strategy adopted when the real threat level is high and when the perceived threat or the public’s accompanying outrage is high.

2.2.2 Outrage Management

Outrage management is the strategy adopted when the real risk is low, but the perceived risk or the public’s accompanying outrage is high.

2.2.3 Precautionary Advocacy

Precautionary advocacy is the strategy adopted when the real risk is high, but the perceived risk or the public’s accompanying outrage is low.

2.2.4 Health Promotion

Health promotion is the process of enabling people to improve and to increase control over their health. This strategy is adopted when the real risk is a low threat (hazard), and the perceived threat (hazard) or the public’s accompanying outrage is low. It is important to note that health promotion is not limited to the category of the situation described here but is used in combination with other strategies applied for different situations.

The table below shows strategies for addressing different situations, associated emotions, and specific tasks required.

s/n	Situation	Audience emotion	Strategy	Issue	Task	Considerations
1	Low threat (hazard), Low perception	Interested and attentive, but not too upset to listen: The ideal audience but a fairly unusual one.	Health promotion	None, except perhaps the inefficiency of one-on-one dialogue. You have to be prepared to explain the technical details; this is the only audience that really wants to hear them.	To discuss the issues openly and rationally, explain your views and respond to audience questions and concerns.	Consider dialogue in person, supplemented by specialised media (website, newsletter, etc.). This is the easiest communication environment. It should be combined with other risk communication strategies during outbreaks.

2	Low threat (hazard), High perception	Outraged, largely at authority. A small group of "fanatics" is usually accompanied by a larger, less outraged constituency watching to see how the controversy evolves.	Outrage management	The audience's outrage is at you; there is a tendency for you to focus on that outrage rather than the issues, leading to more outrage.	To reduce audience outrage by addressing identified barriers, listening to concerns, acknowledging, apologising, sharing control and credit, etc. The controversy ends when the "fanatics" declare victory or their constituency thinks they have won enough.	Consider in-person dialogue in which the "audience" does most of the talking. Note that journalists may also be watching. Atleast you have the audience's attention, although it is hostile (or at least highly sceptical) attention.
3	High threat (hazard), Low perception	Apathetic and inattentive but undefended and uninterested in talking about the threat. Most people, most of the time, are in this category.	Precautionary advocacy	Audience inattention; audience size; media resistance; need to package everything into short sound bites; policy implications of provoking outrage.	To produce brief messages that reinforce whatever appeals are most likely to predispose the audience toward your goals. For serious hazards, this usually means provoking more outrage.	There is little need to listen to or to address audience concerns, reservations, or objections; this audience has few, if any.
4	High threat (hazard) high perception	Huge and very upset. In a crisis, the outrage is mostly fear and misery rather than anger; if either is unbearable, it may flip into denial, escalate into panic, or depression.	Crisis communication	The stress of the crisis itself; missing the difference between crisis communication and routine public relations.	To help the audience bear its fear and misery. Key strategies include avoiding over-reassurance, sharing dilemmas, being human and empathic, providing things to do, and acknowledging uncertainty.	Although outrage is very high, it is not directed at you.



Section 3: Guidelines, Plans, Tools, and Protocols for Implementation

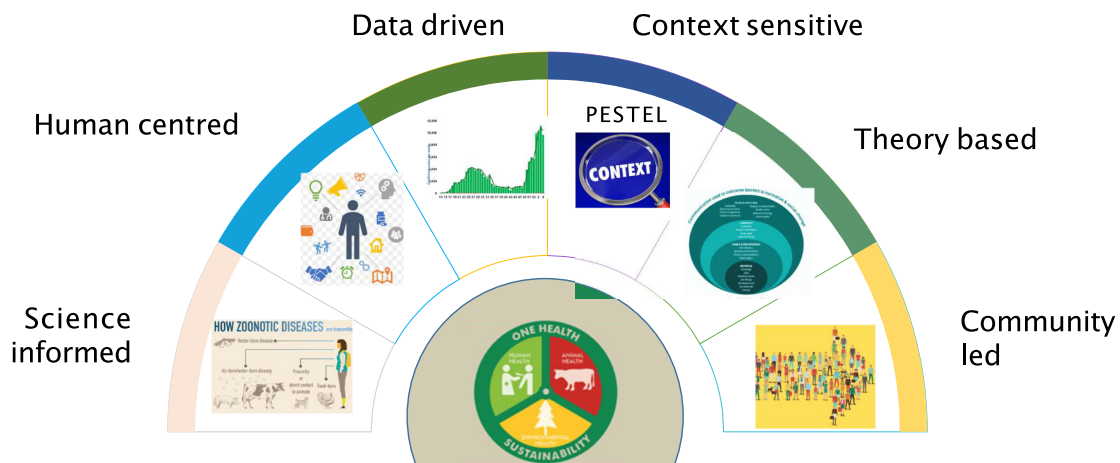
3.1 Plan Development

The multi-hazard guideline provides general direction and guidance for risk communication development and management during non-emergency and emergency phases of public health emergencies. In contrast, a multi-hazard plan specifies activities and timelines for implementing RCCE strategies before, during, and after public health emergencies. Depending on the nature of the emergency, a multi-disciplinary and multi-sectoral approach should be adopted. Furthermore, planning should include all relevant experts, informed by data, and performed using a bottom-up approach. Metrics for the monitoring and evaluation component of the plan should be jointly developed.

A multi-hazard risk communication plan builds upon the multi-hazard risk communication guidelines and other relevant tools. The plan links to existing plans, such as the Medical Emergency Plan, National Contingency Plan, Airport Emergency Response Plan, National Food Preparedness and Response Plan, Radio Nuclear Emergency Plan, Chemical Disaster Plan, and plans of other relevant MDAs. The stakeholders of these plans are relevant to developing the Risk Communication Plan and responding to public health events. Risk communication plans at the national and sub-national levels should be linked to ensure consistency in messaging to build trust. Focal people should be identified in all the plans. Social science theories, methods, and experts should be involved in conducting risk assessments to plan development and implementation. The social science intervention support for risk communication can be harnessed in the following ways:

- Social science approaches are used to understand communities, populations, and the social underpinnings of their knowledge, perceptions, and behaviours.
- Social science methods and experts can be engaged to rapidly assess knowledge, attitude, and practices (KAP) that influence risky behaviours.
- Social science methods and experts should be involved in developing acceptable, community/population-owned interventions using human centred design processes.

One health-based, community-driven RCCE strategy



According to WHO, risk communication uses a mix of approaches in planning and implementation based on context or local peculiarities. These include the following:

- I. Public communication
- II. Media communication
- III. Social media
- IV. Mass awareness initiatives
- V. Social and behaviour change
- VI. Health promotion
- VII. Social mobilisation
- VIII. Community engagement
- IX. Interpersonal communication
- X. Internal communication and partner coordination
- XI. Social and behaviour change communications (SBCC)
- XII. Communication for Behavioural Impact (COMBI), Communication for Development (C4D), Communication for Education (C4E), and so forth
- XIII. Reputation management and institutional communications
- XIV. Stakeholder communication
- XV. Partner engagement
- XVI. Strategic communication

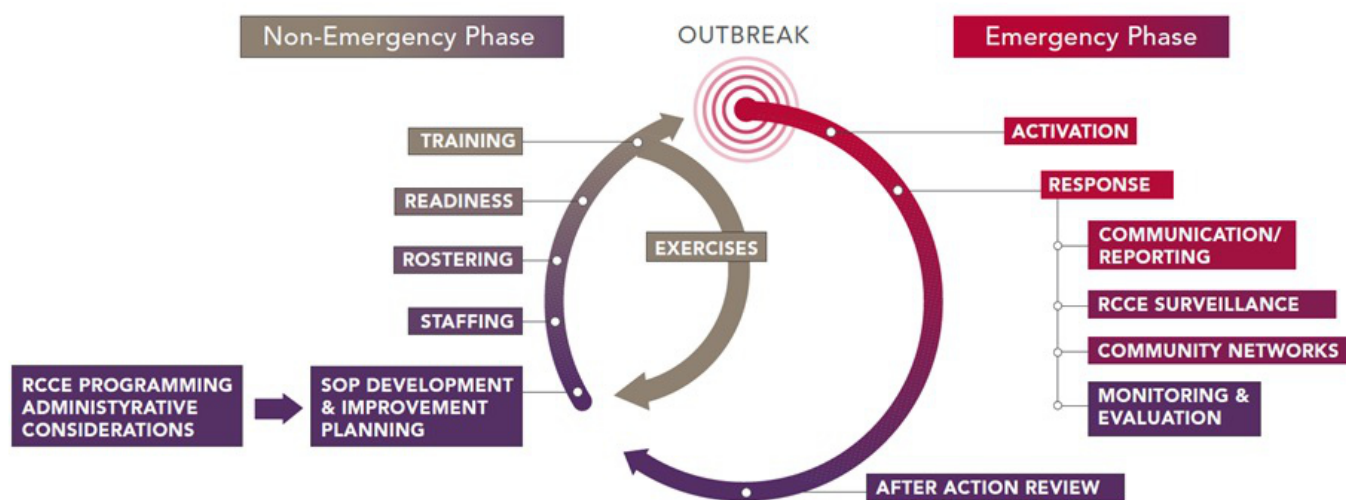
During the non-emergency or planning phase, a template must be prepared to take stock of all the messages, relevant stakeholders, communication linkages, and activities required for activation in the event of risk communication being needed during public health emergencies.

Necessary tools and protocols should be developed or adapted for the implementation of the plan. Staffing and roster of emergency risk communication staff should be developed. The capacity of the relevant officials should be built on the use of tools and protocols needed for implementing the plan. Simulation exercises should be conducted to test the validity of the tools and the suitability of the plans.

For effective communication response, risk communication officers must familiarise themselves with different categories of hazards, the critical response activities, protocols required for managing the response activities, the response’s communication needs, and both primary and secondary stakeholders involved in the response. *(See Hazard-specific response requirements in the appendix for more information).*

The plan should indicate when and how the response protocol should be activated during public health emergencies. Furthermore, the plan’s implementation should also be scalable and adaptable based on the nature and evolution of the public health emergencies. The plan should also indicate when protocol should be deactivated and when after action review be conducted to evaluate interventions and document lessons learnt.

RCCE Ops in the Response Cycle



Source: WAHO/CDC RCCE Operations In-depth Workshop, May 18-20, 2022

3.2 Guiding Documents for Risk Communication in Nigeria and other Countries

The following are some reference documents that guide risk communication and community engagement for public health emergencies communication response:

1. Communication Strategy: Local Empowerment and Environmental Management Project (LEEMP), Federal Ministry of Environment (2008)
2. National Health Promotion Policy, Federal Ministry of Health (Revised 2019)
3. Advocacy, Communication and Social Mobilization Strategic Framework and Implementation Plan. June 2010.
4. Viral Haemorrhagic Fevers Preparedness and Response Plan
5. NOA Contingency Plan
6. EDUCATION SECTOR COVID-19 CONTINGENCY PLAN
7. Risk Communication and Community Engagement. COVID-19 Prevention and Control in Nigeria
8. National Integrated Reproductive Maternal Newborn Child. Adolescent Health plus Nutrition Social and Behaviour Change (NIRMNCAH+N SBC)
9. Knowledge, Attitudes, and Sexual Behaviour Among the Nigerian Military Concerning HIV/AIDS and STDs. Armed Forces Programmes on AIDS Control (AFPAC), MOD 2021
10. Policy for the Gender Armed Forces of Nigeria, MOD 2021
11. National Pharmacovigilance Policy Guidelines, 2016 NAFDAC
12. COVID-19 Strategy Preparedness and Response Plan, WHO
13. National Strategic Plan for Elimination of Dog Mediated Human Rabies (2022 - 2026)
14. National PPR Strategy, FMARD
15. National American College of Sports Medicine Guidelines for Risk Communication
16. One Health Risk Communication and Community Engagement Training Package
17. Nigeria: National Disaster Response Plan
18. National One Health Strategic Plan (2019 - 2023), NCDC

19. NOA Social Mobilisation Guidelines, NOA
20. Accelerated reduction of maternal and Newborn mortality in Nigeria
21. Knowledge Management Guideline, FMoH
22. The Emergency Prepared Trackers, WHO
23. WHO Nigeria 2021 Annual Work Plan, WHO
24. Guidelines for the Registration of Drugs and Food Products, NAFDAC
25. Guidelines for Post Marketing Surveillance in Nigeria, NAFDAC
26. National Disaster Response Plead, NEMA
27. Presidential Crisis Communication Command Centre PC4, NSA
28. National Policy on Girl Child Education, FMWA
29. FOI Act
30. Preparedness to Collect Vaccine, NPHCDA
31. Administrative Vaccine, NPHCDA
32. Post vaccine administration, NPHCDA
33. National One Health Strategy Plan 2018, NCDC
34. Highly Pathogenic Avian Influenza Emergency Preparedness Plan (HPAI EPP), NCDC
35. National Policy for Safety, Security, Violence Free School (draft) by FME
36. National Health Act
37. National Public Health Emergency Contingency Plan, PHS
38. Port Health Services Implementation Guideline, PHSIG
39. National Port Health Services Policy
40. National Disaster Management Framework-NEMA
41. Search and Rescue Epidemic Evacuation Plan (SAREEP) -NEMA
42. Guideline for the use of Military Asset during Emergency-NEMA



Section 4: Institutional Governance and Coordination

4.1 Multi-Hazard Public Health Emergency Management in Nigeria

Through the NCDC, the Federal Ministry of Health is responsible for addressing public health emergencies as they occur. In tackling these public health emergencies, clearly defined structures operating within Emergency Operations Centre (EOC), such as national, state, and LGA risk communication TWG, must be established at national, state and local government if they are not already in existence. In addition to the broad guidelines for communication during public health emergencies, hazard-specific communication strategies and plans accounting for the peculiarities of the hazard and local vulnerability and leveraging existing structures and strength of the lead agency will enhance a more effective and efficient communication response within the context of a multi-hazard communication plan.

The NCDC hosts the National Risk Communication Technical Working Group (NRCTWG), and it is responsible for coordinating risk communication activities related to public health events in the country. The group's composition cuts across different ministries, departments, and agencies; partners; and relevant stakeholders. The FMOH coordinates the NRCTWG through the NCDC, collaborating with the organisations that compose the group. The NRCTWG is also affiliated with the Presidential Communication Command and Control Centre coordinated by ONSA to coordinate communication during security emergencies.

4.2 Governance Structure - NEMA, NCDC, ONSA

Different clusters of critical stakeholders manage the three hazard categories, but each category has a lead agency responsible for managing the hazard. Different stakeholders involved in the management of different types of hazards are listed in the table below:

Aviation	<ul style="list-style-type: none"> • Nigerian Meteorological Agency • Nigeria Airspace Management Agency • Nigerian Civil Aviation Authority
Education	<ul style="list-style-type: none"> • Federal Ministry of Education • Riplington Education Initiative
Environment	<ul style="list-style-type: none"> • Federal Ministry of Environment • National Biosafety Management Agency • National Environmental Standard and Regulation Enforcement Agency • National Oil Spill Detection and Response Agency
Health	<ul style="list-style-type: none"> • Federal Ministry of Health • Nigeria Centre for Disease Control and Prevention • National Primary Health Care Development Agency • National Food & Drug Administration and Control • National Agency for the Control of AIDS • African Field Epidemiology Network • Breakthrough ACTION-Nigeria • Centre for Communication and Social Impact • Corona Management Systems • Institute of Strategic Communications, Development and Innovation Ltd/GTE • Lafiya Project • National Assembly Health Services Directorate • National Association of Nigeria Nurses & Midwives • Core Group Partners Project • Nigerian Red Cross Society • Rock of Ages Empowerment Foundation • Society for Public Health Professionals of Nigeria • The Society of Occupational and Environmental Health Physicians of Nigeria • United Nations International Children's Emergency Fund • United States Centers for Disease Control and Prevention • World Health Organization

Information	<ul style="list-style-type: none"> • Federal Ministry of Information and Culture • National Orientation Agency • Nigeria Health Watch
Security & Safety	<ul style="list-style-type: none"> • National Emergency Management Agency • Federal Road Safety Corps • Nigeria Security and Civil Defense Corps • Armed Forces of Nigeria • Nigeria Police Force • Office of the National Security Adviser • Federal Fire Service • Nigeria Immigration Service
Veterinary and Pest Control Services	<ul style="list-style-type: none"> • Federal Ministry of Agriculture and Rural Development • National Agricultural and Quarantine Services • Food and Agricultural Organization
Women affairs/Social Welfare	<ul style="list-style-type: none"> • Federal Ministry of Women Affairs • National Youth Service Corps

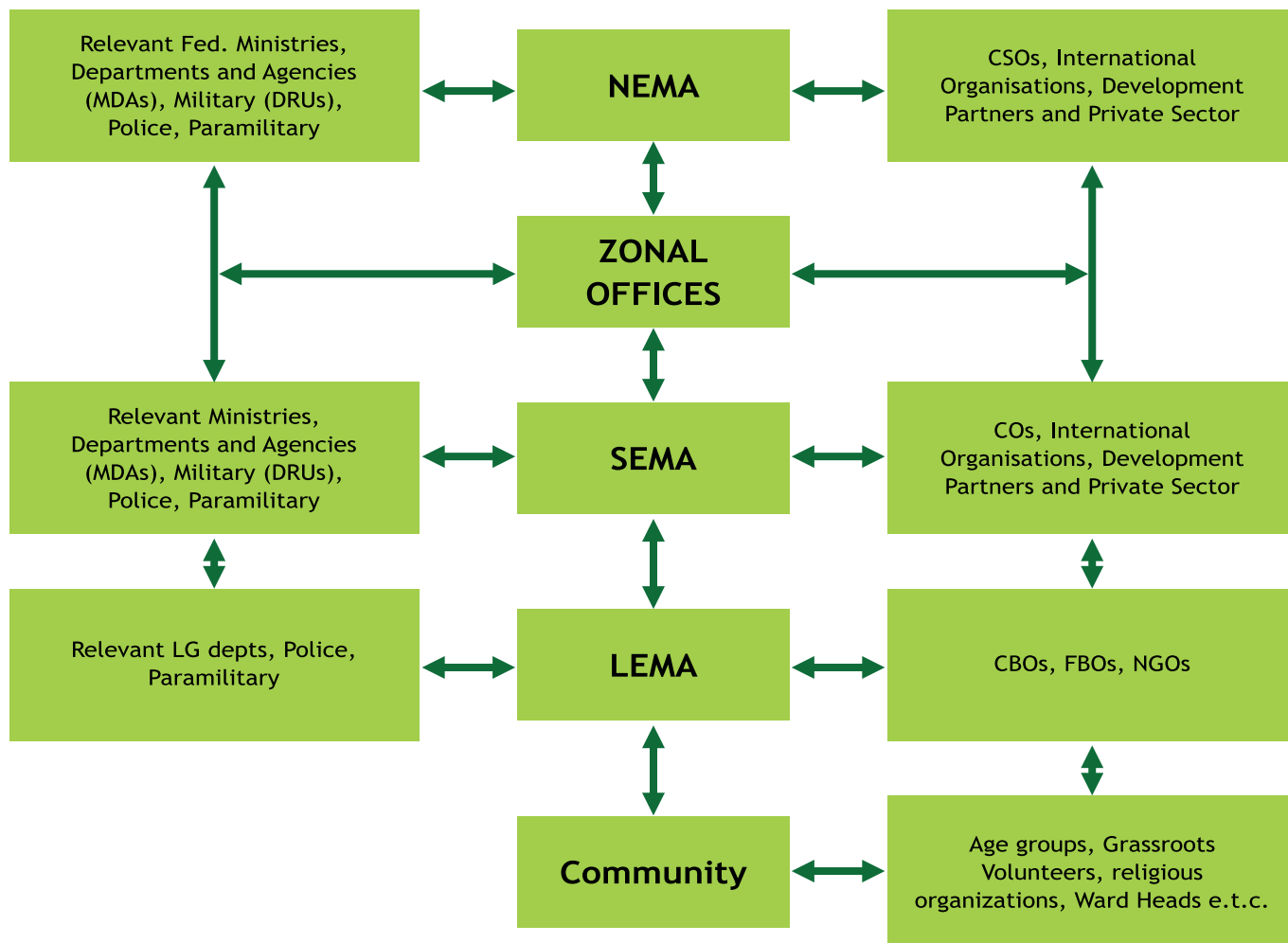
4.2.1 Governance Structure for NEMA

Nigeria has existing institutions and legislation for the effective mitigation and management of hazards and disasters with clear roles and responsibilities. However, over the years, response operations have not involved all stakeholders relevant to disaster management. The National Emergency Management Agency (NEMA) was established via Act 12 as amended by Act 50 of the 1999 constitution to manage disasters in Nigeria. NEMA has developed several plans and guidelines to provide a transparent and inclusive framework encompassing the broad spectrum of disaster management in fulfilling its mandate. These include institutional capacity, coordination, risk assessment, risk reduction, preparedness, prevention, mitigation, response, relief, recovery, information management, education, and communication.

Therefore, the framework is expected to serve as the guideline for all relevant stakeholders in executing their disaster management responsibilities and activities (there should be consistency in using “all relevant” for stakeholders). These documents have been modified over time to correct implementation gaps and increase the country’s efficiency and effectiveness of disaster management.

In fulfilling its mandate, the agency operates a mission control centre (MCC), which alerts the nearest rescue coordinating centre (RCC) or disaster response unit (DRU) of the Army, Navy, and Air Force for appropriate and immediate action during emergencies. Other strategies adopted by the agency

include operating mobile clinics and helicopters for search and rescue, contingency stockpiling, training and capacity building, advocacy/stakeholder meeting, and awareness creation.



Disaster Coordination Flow Chart

4.2.2 Governance Structure for NCDC

The NCDC was established in 2011 as a parastatal organisation of the FMoH with the mandate to coordinate the public health response to communicable diseases, environmental hazards, health emergencies, and other diseases of public health significance. The centre has a department of Health Emergency Preparedness and Response responsible for managing and mitigating the impact of public health disasters and emergencies. The centre has effectively collaborated with relevant stakeholders and partners, including the private sector, to achieve this mandate, notably preventing and controlling outbreaks such as Lassa fever, cerebro-spinal meningitis, Ebola virus disease, cholera, and COVID-19, among others. The strategies adopted include multi-sectoral and multi-partner coordination through the activation/operation of EOCs of various diseases), capacity building, and simulation exercises at the national and sub-national levels.

COMMUNITY - (Local chief, Religious leaders, Town announcers, Animal health/surveillance agents, Community volunteers, Surveillance key informants, Surveillance focal persons, Village development committee, Ward Development Committee)



LGA - Director Primary Health Care, LGA DSNO, LGA Health Promotion Officer or Social Mobilization Officer, Divisional Livestock Officer, Area Veterinary Officer, environmental health Officer, Disease Control Coordinator, Community Orientation and Mobilization Officer (COMO), Ward Focal Person, Civil Society Organization (CSO)



STATE - Commissioner of Health, Executive secretary PHCDA, Director PHC, State Epidemiologist, Director Veterinary Services, Director Environmental Health, State Immunization Officer, State Health Promotion Officer, EOC members, WHO State Coordinator, UNICEF State Lead, Implementing Partners (NGO)

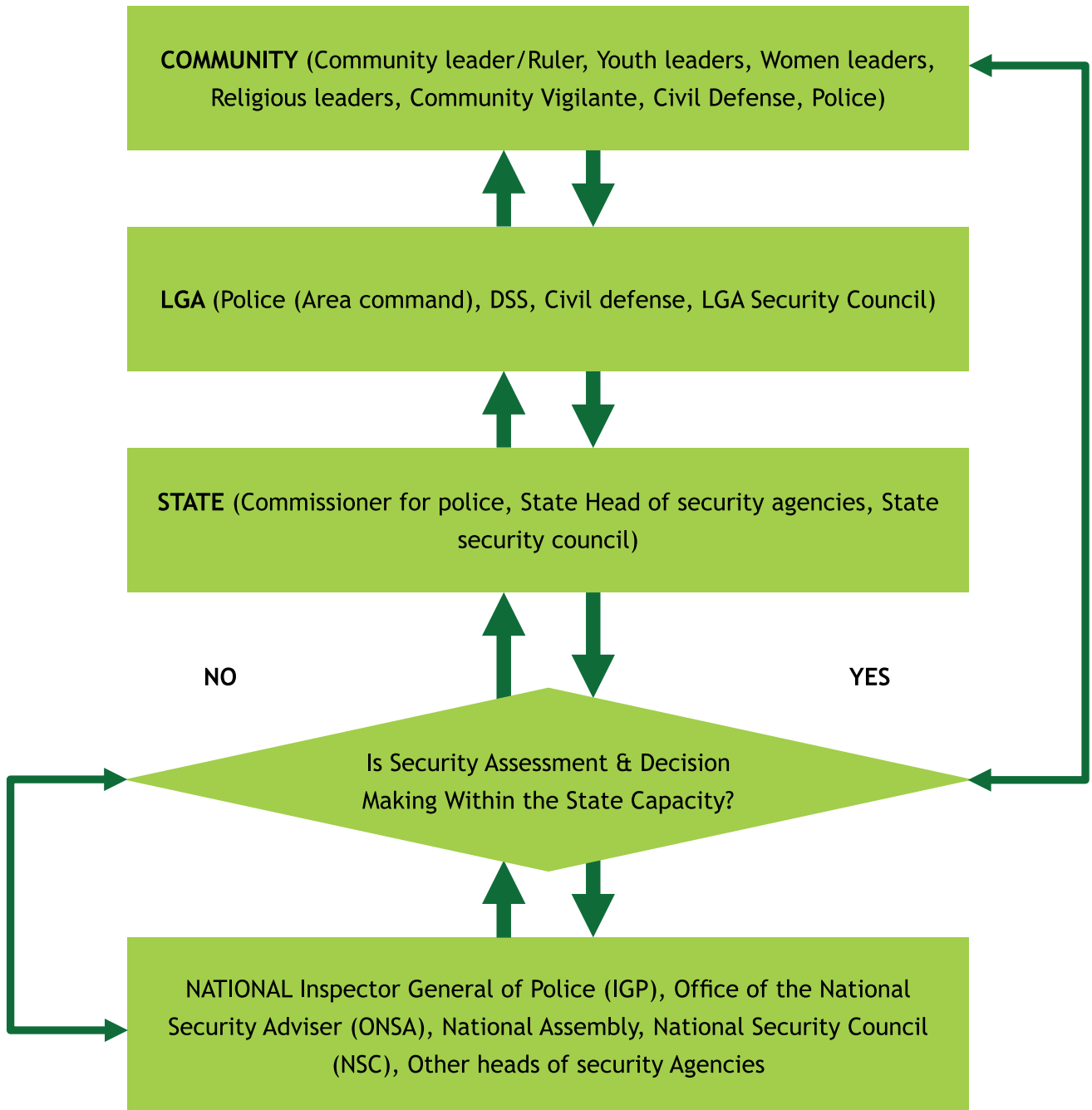


NATIONAL - (FMOH/NCDC) National Primary Health Development Agency (NPHCDA), National Agency for Food and Drug Administration and Control (NAFDAC), Nigerian Meteorological Agency (NIMET), Federal ministry of Agriculture and rural development (FMARD), UNICEF, World Health Organization (WHO), International Partners (NGO), Federal Ministry of Agriculture and Food Security (FMAFS)

Epidemic Coordination Flowchart

4.2.3 Governance Structure for ONSA

ONSA is responsible for the coordination of the security arm of the government for conflict prevention and control. The membership at all levels includes police and other security agencies, legislative arms, and a security council established by the executive arms of government. Membership includes police, civil defence, community leaders, religious leaders, community vigilante groups, and community-based organisations at the community level. The critical role of the community consists of intelligence gathering and reporting to the security agencies.



Security Coordination flow chart



4.3 The Roles and Responsibilities of Stakeholders

The National Risk Communication Technical Working Group (NRCTWG) was established in 2018 pre-COVID-19 pandemic. The technical working group was designed to be a multi-sectoral and multi-partner technical working group saddled with responsibility for the development and providing direction and management of risk communication and community engagement (RCCE) in Nigeria. The structure facilitates the enhancement of effective communication by adopting the one-health approach that considers human, animal, and environmental health variables that are consistent and evidence-based. The NRCTWG is currently coordinated by the Nigeria Centre for Disease Control and Prevention in collaboration with MDAs and supporting partners.

Objectives

- Develop and implement a risk communication and community engagement strategy (before, during, and after public health events) that is tailored to Nigeria's unique needs.
- Facilitate effective communication between different sectors, including health (human, animal, and environmental), security, and humanitarian, across all levels of government.
- Identify and prioritise communication needs and gaps in Nigeria's response to human, environmental, and animal health-related risks.
- Develop communication materials and tools that are appropriate for different audiences, including the general public, responders to public health emergencies, and policymakers.
- Conduct research and evaluation to assess the effectiveness of risk communication activities.
- Establish a mechanism for sharing and documenting best practices and lessons learned among members and partners.
- Plan for the cascade of the structure to states to ensure effective risk communication and community engagement at the subnational level.

The NRCTWG leverages on the mandate and strengths of its stakeholders to fulfil its multi-sectoral roles. The roles are assigned in line with the mandate and strengths of the stakeholders in a complementary manner. The roles of relevant stakeholders in the NRCTWG need to be clearly defined to avoid duplication of efforts, conflicting messages, and wastage of resources. The stakeholders include the leading agency, MDAs, partners, and subnational level structures, including the state's RCTWG/Social Mobilization Committees, MDAs, partners, NGOs, and communities. The roles include but are not limited to the following: coordination, capacity building, intelligence gathering, information sharing and dissemination, needs assessment, guidelines and tools development, surveys, monitoring, and evaluation, among others.

4.3.1 Roles and Responsibilities of the Lead Agency

The lead agency in any response is the agency that is primarily responsible for the prevention and control of hazards based on the nature of the hazard as established by the relevant acts. According to NCDC Act 2018, the NCDC will be the leading agency for public health emergencies caused by infectious diseases. In line with the National Emergency Management Agency (NEMA) that was established via Act 12 as amended by Act 50 of the 1999 constitution, to manage disasters in Nigeria, NEMA is, therefore, the leading agency for disaster coordination. ONSA is responsible for conflict response. Notably, the leading agencies collaborate with other relevant agencies for intelligence gathering, preparedness, planning, monitoring, and evaluation of response.

The responsibilities of the leading agency include:

- I. Monitor the hazard trend and pattern, the risk assessment report, and perception of the public
- II. Share the disaster information with NRCTWG
- III. Engage NRCTWG to conduct risk communication need assessment
- IV. Work with NRCTWG to develop and share RCCE guidelines and SOP for the response
- V. Work with NRCTWG to adopt an appropriate risk communication strategy
- VI. Transform scientific information into consistent health communication

4.3.2 The Responsibilities of NRCTWG to MDAs

The NRCTWG leverages on the strengths and mandates of relevant MDAs through multisectoral collaboration in fulfilling its communication roles for hazard preparedness and response in the country and performs the following:

- I. Build capacity of MDAs and stakeholders on RCCE
- II. Coordinate and align RCCE activities of all stakeholders for optimization of initiatives, efforts, available technical, financial, and material resources from all sectors
- III. Build strong linkages among relevant MDAs and the RCCE pillar at EOC for information sharing, feedback into operations, and dynamic and consistent messaging.

4.3.3 The Responsibilities of NRCTWG to Sub-national Level

- I. Share RCCE guidelines and SOPs for the response with the states
- II. Support adoption of the national MHRC guideline by the states and LGAs for implementation
- III. Provide technical support to the states to implement risk communication strategies at the grassroots through LGAs
- IV. Ensure a multi-sectoral and multi-stakeholder approach through the engagement of all relevant stakeholders at the state and community levels
- V. Share communication materials with the states for adaptation to local needs
- VI. Ensure alignment with the national strategy
- VII. Obtain feedback on RCCE activities at the state level

4.3.4 The Responsibilities of MDAs to Stakeholders in Their Respective Sectors

- I. Sensitise the relevant stakeholders in their sectors to understand the hazard and what measures are adopted to control it
- II. Promote the adoption of safety measures by the stakeholders as prescribed by the lead agency based on the type of hazard
- III. Urge the stakeholders to disseminate key messages to their staff, family, and the community
- IV. Liaise with NRCTWG to build the capacity of stakeholders where necessary
- V. Mobilise support for stakeholders to facilitate the adoption of the desired behaviour
- VI. Facilitate participation of their state counterparts in state activities
- VII. Provide feedback to NRCTWG on their activities



Section 5: Monitoring and Evaluation

The monitoring and evaluation (M&E) of multi-hazard risk communication is critical to the success, sustainability, and scale of interventions or programmes. The role that M&E plays in multi-hazard risk communication plan implementation cannot be overemphasised. The M&E framework should also include feedback mechanisms from states and sectors to NRCTWG.

This document provides a general framework, but each intervention or programme should adapt the framework to build its own monitoring and evaluation. The M&E should be implemented at all phases of disaster cycles (preparedness, mitigation, response, and recovery). The focus for M&E includes strategies, messages, and planned activities, including but not limited to community engagement. The M&E plan should be based on the theory of change that explains how resources and activities translate into outputs that lead to desired outcomes.

The evaluation techniques should be selected based on relevance, and these may include examination of records and protocols, tracking of activities and indicators, monitoring of compliance and progress, KAP survey, opinion polls, perception surveys, key informant interview, focus group discussions, and other social science research techniques. In addition, the M&E should be aligned with indicators selected based on the components of the integrated model for risk communication as shown in the table below.

Note: Responsible person is the M&E focal person for the Risk Communication unit. Other responsible person can be assigned based on need and subject to availability of human resources.

5.1 Monitoring and Evaluation Framework

The M&E framework uses parameters based on the integrated model for risk communication with indicators that are not exhaustive. MDAs and pillar areas may consider additional indicators as may be relevant. It also indicates primary data sources, methodology for measurement and frequency of reporting.

The M&E framework uses parameters based on the integrated model for risk communication with indicators that are not exhaustive. MDAs and pillar areas may consider additional indicators as may be relevant. It also indicates primary data sources, methodology for measurement and frequency of reporting.

Focus area (Parameter)	Indicator(s)	Indicator guideline (Indicator type)	Data Source(s) for Measuring Indicator (means of verification)	How its Measured	Frequency of Data Collection
A functional and effective multisectoral risk communication system					
Outcome					
1. Risk Communication Systems					
Human resource (designated personnel for Risk Communication) & capacity building	Number of relevant MDAs designated personnel for Risk Communication at national and subnational level disaggregated by gender	Output	Primary source: National Risk Communication Technical Working Group (NRCTWG) Terms of Reference (ToR) and Information sharing repository/states equivalent		Annually
	Number of (designated personnel for Risk Communication trained on risk communication disaggregated by gender*	Output	Additional sources: MDA websites/microsites Training reports		
Resources (budget)	Number of relevant MDAs with budget line for Risk communication activities at national & subnational levels	Output	MDAs approved annual budget	Numerator: Observed (where applicable) - Amount spent disaggregated by funding source	Annual
	Proportion of MDAs budgetary allocation for risk communication activities	Output	MDA's annual financial report/external audit report	Denominator: Expected (where applicable) - Amount budgeted for in the NAPHS/MDAs annual budget	
	Proportion of budgetary releases for risk communication activities by MDAs	Output			
	Proportion of (NAHPS) annual budget funded through partner support	Output			
Simulation exercises	Number of simulation exercises conducted	Output	Primary source: NRCTWG information sharing repository/states equivalent Additional sources: MDA websites/microsites Annual reports/activity reports	Numerator: Number of simulation exercises conducted* Denominator: Number of simulation exercises planned	Annual
2. Stakeholder communication and coordination (internal & partner)					
Stakeholder mapping	Number of stakeholder mapping done/updated by relevant MDAs at national and subnational levels	Output	Primary source: National risk communication stakeholders database Additional sources: MDA websites/microsites NRCTWG information sharing repository	Available: Yes or No (where applicable) Numerator: Observed (where applicable) - Number of MDAs with updated stakeholders database Denominator: Expected (where applicable) - Number of MDAs in the NRCTWG	Quarterly/Annually

Stakeholders coordination	Number of existing overarching functional coordination platforms for risk communication activities at national and subnational level	Output	Meeting reports Primary source: NRCTWG information sharing repository	Existence of overarching coordination platforms : Yes/No	Annually
	Number of event based coordination platforms activated at national and subnational level	Output	Additional sources: MDA websites/microsites	Numerator: Number of functional event based coordination platforms Denominator: Number of expected event based coordination platforms•	
Stakeholders communication and accountability	Number of periodic activity/financial reports developed and shared with stakeholders	Output	Meeting reports Primary source: NRCTWG information sharing repository	Number of quarterly activity report submitted by MDAs and partners at national and subnational level	Quarterly/Annually
	Number of review meetings (quarterly review meetings, after action reviews) held	Output	Additional sources: MDA websites/microsites	Number of quarterly review meetings held Number after action reviews meetings held•	
3. Public Communications					
Government spokespersons and media stakeholders	Number of government spokespersons and media stakeholders trained on public health emergency preparedness and response disaggregated by MDAs and Gender	Output	National Risk Communication TWG Information sharing repository/states equivalent Additional sources: MDA websites/microsites Training reports		Quarterly/annually
Communication channels	Information needs assessment done at national and subnational	Output	Survey reports/Opinion polls National Risk Communication TWG Information sharing repository/states equivalent Additional sources: MDA websites/microsites	Information needs assessment done (Yes or No)	Periodically/as need arises
Content development	Number of SBC materials developed, revised, adapted, and disseminated	Output	National Risk Communication TWG Information sharing repository/states equivalent Additional sources: MDA websites/microsites		Quarterly/Annually

4. Community engagement with affected community

Community capacity assessment and strengthening	Number of sub national community capacity needs assessment conducted	Output	Survey reports		
	Number of community members trained on risk communication disaggregated by gender and community networks	Output	National Risk Communication TWG Information sharing repository/states equivalent		
	Number of updated databases for community networks at Sub national levels (State/LGA)	Output	Additional sources: MDA websites/microsites		
	Number of functional community networks at sub-national levels (per State/LGA)•	Output			
Community survey	Number of surveys/ Polls conducted• (eg Knowledge, Attitude, Practice, and Perception, Focused Group Discussions, Key Informant Interviews, In Depth interviews)	Output	Survey reports National Risk Communication TWG Information sharing repository/states equivalent Additional sources: MDA websites/microsites		Periodic
Awareness education and behaviour change campaign	Number of community level activities conducted	Output	National Risk Communication TWG Information sharing repository/states equivalent		Regularly
	Media Strategy developed (Yes/No)	Output			
	Media Strategy deployed (Yes/No)	Output			
	Number of community level activities conducted	Output			
	Number of individuals reached with content/key messages disaggregated by gender	Output	Additional sources: MDA websites/microsites		
	Proportion of individuals who intend to adopt the recommended behaviours disaggregated by gender	Outcome	Survey reports		
Proportion of individuals who reported adoption of the recommended behaviours disaggregated by gender	Outcome				

5. Infodemic management					
Rumour detection, collation & analysis	Number of infodemic management reports shared with stakeholders at national and subnational level	Output	Infodemic management reports Infodemic management dashboard		Weekly/monthly/annually
Training	Number of individuals/stakeholders trained on infodemic management at national level disaggregated by relevant MDAs and gender	Output	National Risk Communication TWG Information sharing repository/states equivalent		Weekly/monthly/annually
	Number of individuals/stakeholders trained on infodemic management at sub national level disaggregated by state and gender	Output	Additional sources: MDA websites/microsites Training reports		
Timeliness	Number of high impact rumours identified	Output	Infodemic management reports		Weekly/monthly/annually
	Proportion of high impact rumours responded to within 48 hrs	Output	Infodemic management dashboard		



Section 6: Appendix

- a. Strategy description template for hazard type
- b. National Risk Communication Stakeholders Matrix
- c. Disaster cycle phases and response protocol
- d. Hazard specific response requirements matrix
- e. Risk communication development and implementation guidance to states for preparedness and response to hazard in Nigeria
- f. Guide for deployed Rapid Response Team for Risk Communication Activities
- g. Framework for reactive infodemic management criteria for assessing threat/ prioritising misinformation for response
- h. Key informant interview questionnaire for KAP survey in the control of hazard (State/LGA)
- i. RCCE community activity form
- j. FGD Question Guide for Hazard Perception in the Community
- k. National Risk Communication Technical Working Group (NRCTWG) Terms of Reference (TOR)
- l. Infodemic Management Guideline (*attached as a separate document*)

A. Strategy description template for hazard type

S/N	Hazard Type	Key Components									
		Risk communication system for unusual and unsuspected events and emergencies		Internal and partner coordination for emergency risk communication		Public communication for emergencies		Community engagement with affected communities		Infodemic management	
		Objectives	Strategies	Objectives	Strategies	Objectives	Strategies	Objectives	Strategies	Objectives	Strategies

B. National Risk Communication Stakeholders Matrix

Organization	Division/Unit	Areas of strength/collaboration in risk communication	Structure/Mechanism	Risk Communication Component (s)
NAFDAC	Pharmacovigilance/post marketing surveillance	<ul style="list-style-type: none"> Advocacy Public Health Collaboration Investigation Regulatory intelligence Consumer complaints 	<ul style="list-style-type: none"> Issuance of safety Alert Newsletters Publications FAQs Healthcare provider Website (www.nafdac.gov.ng) Social media Use of cutting-edge technologies (PRASCOR, MAS) 	<ul style="list-style-type: none"> Risk communication systems Internal and partner communication and coordination Communication engagement with affected communities Dynamic rumour management
FMOH	Health promotion division	<ul style="list-style-type: none"> Coordination, Advocacy and policy development 	<ul style="list-style-type: none"> National Health promotion forum State Health promotion officer State Social mobilisation committee 	<ul style="list-style-type: none"> Risk communication/Health promotion
		<ul style="list-style-type: none"> Coordination & public communication 	<ul style="list-style-type: none"> 36 states plus FCT Health Promotion Officers 774 LGAs 	<ul style="list-style-type: none"> Public communication
		<ul style="list-style-type: none"> Social behaviour change & community engagement 	<ul style="list-style-type: none"> State HPO SBC materials Jingles/mass media Social Media channels @HPDGOV (twitter) @Health promotion Nigeria (facebook) Health Promotion Nigeria (Youtube) 	<ul style="list-style-type: none"> SBC Strategy adapted to suit local contexts Communication and engagement with affected communities/public communication
		<ul style="list-style-type: none"> Training 	<ul style="list-style-type: none"> National health promotion officer National health promotion forum (NHPF) 	

SPHPN		<ul style="list-style-type: none"> Public enlightenment 	<ul style="list-style-type: none"> Individual member Component public Health associations 	<ul style="list-style-type: none"> Community engagement with affected communities
		<ul style="list-style-type: none"> Community mobilisation 	<ul style="list-style-type: none"> Medical Officers of Health (MoHs) in 774 LGAs Individual members in 36 States + FCT 	
		<ul style="list-style-type: none"> Outbreaks/epidemic response, community assessment, intervention, and dissemination of feedbacks 	<ul style="list-style-type: none"> MoHs in 774 LGAs Individual members 	
		<ul style="list-style-type: none"> Training and capacity building 	<ul style="list-style-type: none"> MoHs in 774 LGAs Component public Health associations in 36 States + FCT 	<ul style="list-style-type: none"> Risk communication system
		<ul style="list-style-type: none"> Operational research, development of tools, guideline, development of protocols 	<ul style="list-style-type: none"> Individual members National and State leaders MoHs in LGAs 	<ul style="list-style-type: none"> Dynamic listening and rumour management
		<ul style="list-style-type: none"> Health policy 	<ul style="list-style-type: none"> National and State leaders National and State assembly, FMOH and agencies 	<ul style="list-style-type: none"> Internal and partner communication, coordination
WHO	RCCE	<ul style="list-style-type: none"> Advocacy, public enlightenment Technical support Training and capacity building Stakeholders engagement Communication and public enlightenment Media and social media surveillance 	<ul style="list-style-type: none"> National and subnational levels 	<ul style="list-style-type: none"> Risk communication system Internal and partner communication and coordination Communication and engagement with affected communities Public communication Dynamic listening and rumour management
NPHCDA	Advocacy, communication and social mobilisation	<ul style="list-style-type: none"> Community engagement and media engagement 	<ul style="list-style-type: none"> NACSM-WG CHIPS Agency 	
		<ul style="list-style-type: none"> Develop work plan and strategies 	<ul style="list-style-type: none"> NACSM-WG Risk communication pillar 	
		<ul style="list-style-type: none"> Build capacity and conduct review meetings 	<ul style="list-style-type: none"> NACSM-WG 	<ul style="list-style-type: none"> Internal and partner communication
		<ul style="list-style-type: none"> Sensitisation through rally and jingles, including media appearances 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Public communication

NCDC	Response	<ul style="list-style-type: none"> • Risk assessment • Risk communication, press release, messages • Data generation and dissemination 	<ul style="list-style-type: none"> • PHEOC framework • Social media • Website • Print media • Media engagement • Simulation exercise 	<ul style="list-style-type: none"> • Dynamic listening and rumor management • Internal and external communication • Public communication • Engagement with SE and Health education
NCDC	Corporate communication	<ul style="list-style-type: none"> • Interviews 	<ul style="list-style-type: none"> • Radio, zoom, television 	Public communication
		<ul style="list-style-type: none"> • Press release 	<ul style="list-style-type: none"> • Print media 	
		<ul style="list-style-type: none"> • PTF collaboration 	<ul style="list-style-type: none"> • Audio/Visual 	
		<ul style="list-style-type: none"> • Daily update on priority disease through various social media channels 	<ul style="list-style-type: none"> • Facebook, WhatsApp, twitter, Telegram, Instagram 	
CCSI	SBCC	<ul style="list-style-type: none"> • Communication strategy articulation • Research • Materials testing and production • Support for coordination • Community engagement • Digital and mass media • Capacity building 	<ul style="list-style-type: none"> • Content expert • Community mobilization in over 15 states 	Public communication engagement
MOD	MOD Health Implementation Programme	<ul style="list-style-type: none"> • Coordination and Advocacy 	<ul style="list-style-type: none"> • Prevention team 	Internal and partner communication and coordination
		<ul style="list-style-type: none"> • Training 	<ul style="list-style-type: none"> • Training dept USAMRD- A/N 	Dynamic reasoning and rumor management
		<ul style="list-style-type: none"> • Capacity building 	<ul style="list-style-type: none"> • 	Risk communication system
		<ul style="list-style-type: none"> • Survey within the barracks 	<ul style="list-style-type: none"> • Research and clinical • dept/USAMRD- A/N 	Communication engagement with affected communities
		<ul style="list-style-type: none"> • Awareness campaign and community radio 	<ul style="list-style-type: none"> • Barrack health committee • Prevention team • Armed force radio 	Public communication

CGPP	Health	<ul style="list-style-type: none"> House to house mobilisation 	<ul style="list-style-type: none"> Volunteer Community mobilizers (VCM) 	Community mobilisation
		<ul style="list-style-type: none"> Advocacy visit 		
		<ul style="list-style-type: none"> Compound meetings 		Stakeholders engagement
		<ul style="list-style-type: none"> Community dialogue 		
		<ul style="list-style-type: none"> Motorised campaign 	Ward supervisor	
		<ul style="list-style-type: none"> Use of IEC materials and BCC tools 	LGACs	Capacity building
		<ul style="list-style-type: none"> Coordination 	Community informant	
		<ul style="list-style-type: none"> Trainings Sensitisation meetings 	Core program staff	Interpersonal communication
FME	Education support services/multilateral branch	<ul style="list-style-type: none"> Training the trainer 	Capacity building of FME/state officers on risk communication	Risk communication system
		<ul style="list-style-type: none"> Collaboration with partners and other agencies 	Strategies, plans, SOPs, Simulation exercises to test the systems etc.	
		<ul style="list-style-type: none"> Coordination of state MOEs and UBEC 	Appoint and train risk communication officers in schools & coordinate their responses	
		<ul style="list-style-type: none"> Develop resource materials and policies 	Collaboration with Stakeholders	
		<ul style="list-style-type: none"> Monitoring and Evaluation 	Using Federal and State quality assurance officers	
NEMA	Planning, research and forecasting	<ul style="list-style-type: none"> Early warning 	GIS	Risk communication system
	Planning	<ul style="list-style-type: none"> Capacity building 	Zonal and operational officers	Internal and partner communication and coordination
		<ul style="list-style-type: none"> Sensitisation 	Volunteers	Community engagement with affected communities
	Communication unit	<ul style="list-style-type: none"> Information sharing 	Call centers	Risk communication systems

USAID BA-Nigeria	Risk communication and community engagement	<ul style="list-style-type: none"> • Technical assistance • Health Systems Strengthening • Capacity building • Stakeholder coordination • Social and Behaviour Change Material Development and Dissemination • Community Engagement • Mass Media • Social Media • Digital Health Interventions • Support to national hotlines • Offline and Online listening • Human Centred Design • Research, Monitoring and Evaluation • Knowledge management and documentation 	<ul style="list-style-type: none"> • RCCE/SBC experts • Media and Radio partners • Community volunteers and LGA Supervisors • SBC-ACG • Airtel 421 • 7722 • Social media handles • Community of practices 	<ul style="list-style-type: none"> • Risk communication system • Internal and partner coordination • Public communication • Community Engagement (routine and surge) • Infodemic Management • Capacity building
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C. Disaster cycle phases and response protocol

Preparedness

Preparedness is the initial step of the disaster response protocol. It involves actions to mitigate the effect of a disaster should it occur. These actions include assessment of risk communication needs, and development of risk communication plans, including media and crisis communication plans, development of protocols/SOPs, identification of team members, assigning roles and responsibilities, training of team members, development of message templates, stakeholders' engagement, resource identification and mobilisation, and identification and training of spokespersons. The direction of the risk communication approach should be informed by evidence/research (e.g., perception survey). Research findings in addition to a comprehensive audience and stakeholder analysis will ensure the design and implementation of an inclusive and impactful strategy.

Risk communication should be done at all levels, and the risk communication team should include members with technical expertise from the leading agency for public health emergencies, communication experts or organisation, media, and other relevant agencies that have defined functions in the response. This team should cut across local and international partners, including the private sector, that may provide technical, material, and financial resources for the response. All orientation requirements for the team to function effectively, such as the need to understand communication procedures and how to use protocols and other tools, should be addressed early. For example, the data and communication surveillance team should be established and trained with protocols developed for infodemic management. In addition, there is a need to work closely with the surveillance unit to obtain early warning information, monitor progress, and harvest feedback in a timely fashion to enable adequate and appropriate communication response.

The audience should be identified, segmented, analysed, and involved in planning for the response. Audience knowledge and perception surveys should be conducted to identify and plan for gaps in perception, confidence, and trust in the system and authorities. The relevant and most acceptable channels of communication to the audience need to be identified and used. A hotline to facilitate two-way communication between the agency and the general public should be established and published. Reliable sources should be identified, such as websites where people can get factual information about the events, updates on the response, and useful information to protect themselves. Ensure that the source is easily accessible and frequently updated. Messages should take into consideration the culture of the people and be translated to locally acceptable language and formats. It is necessary to establish relationship with the media and address their training needs. The SBCC materials should be developed with rich insights gleaned from the audience and relevant stakeholders and pre-tested to be made ready for adaptation when emergency occurs.

Special considerations and necessary support should be provided for vulnerable, handicapped, minority, and hard-to-reach populations. Another area for consideration is the development of messages for

persons with disabilities, obtaining their contact details and those of organizations supporting them.

Evaluation of past risk communication interventions is helpful to allow for meaningful adjustments to be made for current and future events through application of lessons learnt from previous outbreaks. An ongoing M&E approach of risk assessment for improving risk communication should be in place as risk issues constantly evolve and those related to an outbreak of disease often evolve rapidly. A comprehensive, systematic, and ongoing M&E approach is essential to make risk communication activities as effective as possible. For example, monitoring for unintended consequences of the communication, and emerging questions, concerns, and misconceptions, allows an organisation to address these in a timely and responsive manner. Necessary documentation and approval for resources and budgetary requirements for the response should be made and adequate arrangements should be in place for scaling up resources as the events escalate. The buy-in and understanding of all relevant stakeholders should be obtained to facilitate access to resources during response.

Mitigation

The mitigation phase involves actions taken from a communications perspective to reduce the chance of occurrence of a public health emergency or to reduce its negative impact should one occur. It includes the routine release of public health information in addition to other public health measures.

The communication objectives in this phase are to provide accurate information, updated and latest information on the risk situation as newer facts emerge, correct misinformation and misconceptions, and address the public's concerns through listening and learning. This phase promotes the behaviours that empower individuals and the public in managing the risk at their levels, and support informed decision-making at the level of communities towards risk mitigation.

The media command centre that had been activated earlier is to address all the media requirements indicated earlier, such as press releases, technical updates, media interviews, scientific papers, release of newsletters, advisories issued by NCDC departments, and any other material related to health event desired to be released by the Ministry of Health. Furthermore, information gaps and the rumours and misinformation circulating amongst the population must be addressed promptly.

Response

This is the phase that involves the actual implementation of the risk communication plan, with occurrence of public health events. Response phase describe the actions taken from a communications perspective during a crisis or emergency. This phase includes immediate activities within 24 hours and activities that will have to be continued during the remain of the event.

Required steps during response

For immediate response the important points to be addressed are:

(i) acknowledging the event, (ii) stating the risk due to the event with empathy (iii) identifying a credible spokesperson to be responsible for release of information on the present situation (iv) information on preventive actions and behaviour for prevention of spread of disease (v) prompt sharing information with relevant stakeholders and public.

Step 1 Verify situation and its source (credibility) and seek opinion of the subject matter expert

Step 2 Activate core team of experts from subject discipline (public health, clinicians, veterinarians etc). Administration and communication is to inform the objective and decision making. The frequency of meeting can be decided based on the event. This is to be communicated with senior management.

Step 3 Notifications of all the teams (technical team, RC team, media spokesperson) including the stakeholders, senior management, policy makers, national and state governments, including local bodies.

Step 4 Assess level of crisis of extent of impact of disease/event population groups vulnerable community agent (disease causing organism bio-terrorism activity, fatality, severity of disease) extent of media coverage inquiries determine the logistic requirement for managing the event.

Step 5 All the teams should be assigned their respective duties and informed of their roles (technical, administrative, , spokesperson etc.)

Step 6 Preparation of information and seeking approvals. Information should be prepared and the messages should convey accurate information, with empathy about what the public might want to know is inform and with appropriate information.

Step 7 Inform public and engage the affected communities: Release information to the public through media briefs, press releases, web pages, employees, health care workers policy makers, legislators, etc

Step 8 Monitor the event as it unfolds further media reports, revisiting the plans and making necessary procedural changes. After the initial phase of crisis has been addressed, media is likely to raise the issue as to how the event occurred the public concerns situations that might have gone worse

Step 9 Stakeholder communications: these are necessary for getting their support and commitment to manage the event/ crisis.

Step 10 Engagement of affected communities including population with special needs through community gatekeepers/leaders and outreach, health care delivery system, mailings, webpage, tollfree numbers (oster to manage to be prepared) and social media.

Recovery Phase

The recovery phase is a learning phase that documents what worked and what did not work in management and communication during an emergency. The goals are to improve public response to future emergencies, support public policy and resource allocation, and enhance the capabilities of the organisation for response. The public is highly sensitised in the post-emergency period and is in an active mode of learning and taking actions for risk avoidance and mitigation. The goals of the recovery phase could be achieved by interviewing stakeholders and seeking their input on how to improve the response in future emergencies, by holding discussion forums on the management of emergency and risk communication, and by providing enabling examples and good practices for reduction of risk at the level of communities for acceptance and adoption.

As risk communication is a required core capacity under IHR, communication with WHO is necessary in the event of occurrence of potential PHEIC in the country. E-communication channels include those from the NFPIHR to WHO, and similar channels are utilised by WHO focal point to National Focal Person of the country.

After Action Review

NRCTWG will conduct a review of the effectiveness and clarity of the risk communication plan and see that all the latest details of contacts were reported, procedures and practices were reported and followed, and key individuals were familiar with their roles and responsibilities.

Evaluations conducted or reviews published or any critiques from stakeholders could be utilised for making improvements in the RC plans. The NRCTWG will with rapid response team, technical experts and other stakeholders to come up with recommendations for improvements in the RC plan, an exercise that could be taken up as constant input for the RC planning process.

Future Directions

It is important and necessary to work with stakeholders and review the RC plan to integrate all the important elements for improving outcomes in future.

D. Hazard Specific Response Requirements matrix

Epidemics

S/N	Types of Hazard	Key Response Activities	Communication Response/Needs	Protocol	Stakeholders/ Key Actors	Secondary Stakeholders
1.	Infectious disease outbreaks (COVID-19, Cholera, Lassa fever)	<ul style="list-style-type: none"> Risk assessment Advocacy Channels of Communications Set up a rapid response team to address communication crisis Notifications/ through relevant communication channels 	<ul style="list-style-type: none"> Defining objectives and goals Defining target audience Designing the message 	<ul style="list-style-type: none"> Resource mobilisation Develop specific guidelines and materials Dissemination of the guidelines and materials Conduct training Engage affected communities Campaigns (Mass media, traditional and social media) Conduct social and community listening Feedback 	<ul style="list-style-type: none"> MDAs Legislators Partners NGOs CSOs Media practitioners 	<ul style="list-style-type: none"> Traditional rulers and religious leaders Vulnerable groups
2.	Non-Infectious Disease (poisoning)	<ul style="list-style-type: none"> Risk assessment Advocacy Channels of Communications Set up a rapid response team to address communication crisis Notifications/ through relevant communication channels 	<ul style="list-style-type: none"> Defining objectives and goals Defining target audience Designing the message 	<ul style="list-style-type: none"> Resource mobilisation Develop specific guidelines and materials Dissemination of the guidelines and materials Conduct training Engage affected communities Campaigns (Mass media, traditional and social media) Conduct social and community listening Feedback 	<ul style="list-style-type: none"> MDAs Legislators Partners NGOs CSOs Media practitioners NAFDAC 	<ul style="list-style-type: none"> Traditional rulers and religious leaders Vulnerable groups

Disasters

SN	Types of Hazard	Key Response Activities	Communication Response/Needs	Protocol	Stakeholders / key actors	Secondary Stakeholders
1	Road Crashes	<ul style="list-style-type: none"> Rescue services Enforcement First Aid 	<ul style="list-style-type: none"> Call centre Close user group (CUG) 	FRSC Contact code 122	<ul style="list-style-type: none"> NEMA Transport union Motoring public 	NGOs
2	Building collapse	<ul style="list-style-type: none"> Search and rescue First aid Hospital for treatment 	<ul style="list-style-type: none"> Media report Call NEMA Toll Free line (112) 	Activate various partners and mobiliser resources	<ul style="list-style-type: none"> NEMA HOSPITALS FRSC NSCDC NOA 	MDAs
3	Fire outbreak	Fire & Rescue service	<ul style="list-style-type: none"> Media report Call NEMA Toll Free line (112) 	Activate various partners and mobiliser resources	<ul style="list-style-type: none"> NEMA Fire service HOSPITALS 	
4	Air Crash	<ul style="list-style-type: none"> Fire & Rescue service Triaging and evacuation of victims 	<ul style="list-style-type: none"> Media centre Family resistance centre Security and cordoning of crash side Handling of relatives 	<ul style="list-style-type: none"> Crash alarm Communication centre Call out every major responder Activate the EOC Search and rescue 	<ul style="list-style-type: none"> NEMA Police Fire Service Medical Hospitals NIMET 	<ul style="list-style-type: none"> Training public & neighbouring communities Airport authority
5.	Land slide	Search and rescue First aid Hospital for treatment	<ul style="list-style-type: none"> Media report Call NEMA Toll Free line (112) 	<ul style="list-style-type: none"> Activate various partners and mobilizer resources 	Nigeria Geological Survey	
6	Flooding	Search and rescue First aid Hospital for treatment	<ul style="list-style-type: none"> Media report Call NEMA Toll Free line (112) 	<ul style="list-style-type: none"> Activate various partners and mobilizer resources 	<ul style="list-style-type: none"> NEMA Hospitals NOA Nimet FMHDM 	MDAs

7	Communal conflict	Search and rescue First aid Hospital for treatment	<ul style="list-style-type: none"> • Media report • Call NEMA Toll Free line (112) 	<ul style="list-style-type: none"> • Activate various partners and mobilizer resources 	NEMA Hospitals NOA Nimet FMHDM	MDAs
8	Biological (Weather related) <ul style="list-style-type: none"> • Meningitis • Cholera • Malaria 	<ul style="list-style-type: none"> • First Aid. • Separate healthy from the sick. • Activate medical service. 	<ul style="list-style-type: none"> • Call medical toll- free numbers • Involve epidemiologists for investigations 	<ul style="list-style-type: none"> • Report to primary health. • Take sick ones to hospitals • Report to health care workers • Inform parents (if its schools) 	Hospitals NEMA	<ul style="list-style-type: none"> • Parent & Guardians • Head of establishment
9	Chemical <ul style="list-style-type: none"> • Oil spillage 	Rescue activities First aid	<ul style="list-style-type: none"> • Call centres • Call first responders 	<ul style="list-style-type: none"> • Call Toll free line • Local media information 	<ul style="list-style-type: none"> • NOSDRA • NEMA • Ministry of environment • Security 	NGOs

Conflicts

SN	Types of Hazard	Key Response Activities	Communication Response/Needs	Protocol	Stakeholders/ Key Actors	Secondary Stakeholders
1	Communal and religious conflicts	<ul style="list-style-type: none"> Intelligence gathering Quelling the crisis (deployment of relevant security forces, condoning of the area) 	<ul style="list-style-type: none"> Create incident command posts Information dissemination by appropriate authority, through dialogue, community engagement and media engagement (State Govt. & State police command) Advocacy 	<ul style="list-style-type: none"> Intelligence gathering Information management Deployment of emergency medical response Strategic level (Government) Tactical level (heads of responding agencies e.g diff commanders in diff units) Operational (field officers and first responders) 	<ul style="list-style-type: none"> Local vigilante DSS Civil defence 	<ul style="list-style-type: none"> Road safety Ambulance services NEMA/SEMA/LEMA Religious, traditional and community leaders NOA Youth leaders Women leaders Peace and conflict resolution
2	Militancy and banditry	<ul style="list-style-type: none"> Intelligence gathering Quelling the crisis (deployment of relevant security forces, condoning of the area) 	<ul style="list-style-type: none"> Create incident command posts Information dissemination by appropriate authority, through dialogue, community engagement and media engagement (State Govt & State police command) Advocacy 	<ul style="list-style-type: none"> Intelligence gathering Information management Deployment of emergency medical response Strategic level (Government) Tactical level (heads of responding agencies e.g Diff units) Operational (field officers and first responders) 	<ul style="list-style-type: none"> Local vigilante DSS Civil defence 	<ul style="list-style-type: none"> Road safety Ambulance services NEMA/SEMA/LEMA Religious, traditional and community leaders NOA Youth leaders Women leaders Peace and conflict resolution

3	Insurgency	<ul style="list-style-type: none"> • Intelligence gathering • Deployment of troops 	<ul style="list-style-type: none"> • Create incident command posts • Information dissemination from strategic, tactical and operational level 	<ul style="list-style-type: none"> • Intelligence gathering • Information management • Strategic level (Government) • Tactical level (heads of responding agencies e.g Diff commanders in diff units) • Operational (field officers and first responders) 	<ul style="list-style-type: none"> Local vigilante Defence HQ • Strategic level (presidency, Defence HQ, ONSA, NSC) • Tactical level (Defence HQ) • Operational (field officers and first responders) 	
4	Farmer, herdsman crisis	<ul style="list-style-type: none"> • Intelligence gathering • Quelling the crisis (deployment of relevant security forces, condoning of the area) 	<ul style="list-style-type: none"> • Create incident command posts • Information dissemination by appropriate authority, through dialogue, community engagement and media engagement (state Govt & state police command) • Advocacy 	<ul style="list-style-type: none"> • Intelligence gathering • Information management • Deployment of emergency medical response • Strategic level (Government) • Tactical level (heads of responding agencies) • Operational (field officers and first responders) 	<ul style="list-style-type: none"> • Local vigilante • DSS • Civil defence 	<ul style="list-style-type: none"> • Road safety • Nigeria Police Force • NSCDC • Ambulance services • NEMA/ SEMA/LEMA • Religious, traditional and community leaders • NOA • Youth leaders • Women leaders • Peace and conflict resolution officers

5	Political crisis	<ul style="list-style-type: none"> • Intelligence gathering • Quelling the crisis (deployment of relevant security forces, condoning of the area) 	<ul style="list-style-type: none"> • Create incident command posts • Information dissemination by appropriate authority, through dialogue, community engagement and media • Engagement (state Govt & state police command) • Advocacy 	<ul style="list-style-type: none"> • Intelligence gathering • Information management • Deployment of emergency medical response • Strategic level (Government) • Tactical level (heads of responding agencies e.g. Different commanders in different units) • Operational (field officers and first responders) 	<ul style="list-style-type: none"> • Local vigilante • DSS • Civil defence 	<ul style="list-style-type: none"> • Road safety • Nigeria Police Force • NSCDC • Ambulance services • NEMA/SEMA/LEMA • Religious, traditional and community leaders • NOA • Youth leaders • Women leaders • Peace and conflict resolution officers
7	Violent protest	<ul style="list-style-type: none"> • Intelligence gathering • Quelling the crisis (deployment of relevant security forces, condoning of the area) 	<ul style="list-style-type: none"> • Create incident command posts • Information dissemination by appropriate authority, through dialogue, community engagement and media • Engagement (state Govt & state police command) • Advocacy 	<ul style="list-style-type: none"> • Intelligence gathering • Information management • Deployment of emergency medical response • Strategic level (Government) • Tactical level (heads of responding agencies e.g. Different commanders in different units) • Operational (field officers) 	<ul style="list-style-type: none"> • Local vigilante • DSS • Civil defence 	<ul style="list-style-type: none"> • Road safety • Nigeria Police Force • NSCDC • Ambulance services • NEMA/SEMA/LEMA • Religious, traditional and community leaders • NOA • Youth leaders • Women leaders • Peace and conflict resolution officers

E. Risk communication development and implementation guidance to states for preparedness and response to hazard in Nigeria

Component	Steps	Expected outcome
How do you ensure an effective risk communication system for hazard containment?	<ol style="list-style-type: none"> 1. Establish a risk communication and community engagement team 2. Develop risk communication plan with budget for hazard prevention and control 3. Map and mobilize resources for the plan 4. Implement and monitor the plan 5. Document activities, challenges, and lessons 	Functional and responsive state risk communication pillar for containment of the hazard/outbreak in the state
How do you coordinate stakeholders for the containment of hazard /outbreak?	<ol style="list-style-type: none"> 1. Map and develop database of stakeholders 2. Analyze and update the list of stakeholders 3. Activate stakeholders coordination meetings 4. Establish communication platform with stakeholders 5. Develop information flow chart to LGAs and partners 6. Share timely information among stakeholders and across levels 7. Develop accountability framework for stakeholders 	Optimised use of resources and consistent messaging among stakeholders on the hazard/outbreak prevention and control
How can you communicate hazard prevention and control messages effectively to the public?	<ol style="list-style-type: none"> 1. Analyze and segment your audience 2. Identify target behaviour for change among the audience 3. Develop evidence-based, data-informed, and context-specific messages for the audience 4. Identify different channels of reaching the audience 5. Determine the strategy for reaching the audience 6. Develop/adapt and translate messages into local languages 7. Disseminate accurate and timely information to the public 8. Use mix of communication approaches, such as rally, media appearances, social media, airing of jingles, place posters in public places: park, churches, mosques, markets, etc. 9. Proactively engage the media through talk shows, interviews, etc. 	<p>Audience informed with consistent, clear, relevant, and acceptable messages on recognition, reporting, and prevention of the hazard.</p> <p>Audience assured of capability of government and its responding agencies to control and prevent the outbreak</p>

		<p>10. Identify spokesperson (subject matter knowledge, current information about the event, respected and trusted, empathic, good communication skills)</p> <p>11. Develop capacity of the media for outbreak reporting and infodemic management</p>	
	<p>How do you facilitate ownership of the prevention and control of the hazard by the affected community?</p>	<ol style="list-style-type: none"> 1. Identify community gatekeepers and secure their buy-in 2. Conduct engagement meeting with community stakeholders to understand their sociocultural practices and concerns about the hazard 3. Engage community influencers in the use of various approaches like town hall meetings, churches, mosques, rallies, association meetings to disseminate accurate information to the audience on prevention, symptoms and reporting of the hazard 4. Conduct dialogues to understand and resolve emerging issues like misconception, stigma, panic etc during the outbreak 5. Dissemination of communication materials in public places such as schools, markets, churches, etc. 	<ol style="list-style-type: none"> 1. Secured buy-in and ownership of the prevention and control response by the community 2. Incorporated feedback from the community for improving the response 3. Assured community without stigmatisation of the response
	<p>How do you establish an effective infodemic management system for public health emergencies?</p>	<ol style="list-style-type: none"> 1. Set up processes or meetings or arrangements to understand and report rumours and conflicting messages in the community 2. Identify an hotline whereby community can report or ask questions 3. Identify local media through which the community can obtain information 4. Conduct media scan to detect circulating misinformation or sentiment of the people 5. Train and leverage community networks for detecting and reporting circulating information/misinformation and concerns of the community 6. Document information obtained on rumour log 7. Identify a dedicated person for collating and analyzing documented information at the LGA level 8. Develop a report of analyzed rumours and rumour management activities 9. Are the community networks used for debunking misinformation in circulation? 10. What are the other mechanisms for detecting and addressing rumors in the community? 	<ol style="list-style-type: none"> 1. Reduced amount of circulating misinformation 2. Most Misinformation originating at the community level debunked in a timely way 3. Improved trust in health authorities, systems and experts

F. Guide to deploy Rapid Response Team (RRT) for Risk Communication activities

Objective: To guide the RRT in conducting risk communication activities in a systematic manner.

Steps include:

- A. Rapid risk communication need assessment
- B. Setting objectives
- C. Stakeholders engagement
- D. Audience segmentation and analysis
- E. Message development and dissemination plan
- F. Feedback management

A. Rapid Risk Communication Need Assessment		
Objectives	Actions	Questions
Conduct risk appraisal	Obtain information from surveillance team/unit (Event Based Surveillance)	<ol style="list-style-type: none"> 1. How many cases do you have? 2. Where are they located? 3. How did they get infected? 4. What household practices increase the risk? 5. Who are the most affected? What proportion? 6. Who are the vulnerable? What proportion? 7. Is there stigmatisation of the affected persons, place or related procedure? 8. Is there amplification or spread of the hazard?
Conduct risk perception	Obtain information from clinicians in health facilities, CBOs, community leaders, partners organizations.	Apply KAP questionnaire here
	Conduct community dialogue meeting/FGD to obtain conflicting messages and understand needs and concerns of the people	Apply focus group discussion guide or guide for meeting. Note if there are circulating misinformation and myths
Conduct capacity assessment	Assess risk communication structure/system	<ol style="list-style-type: none"> 1. Is there a core team for RCCE activities? 2. Is the RCCE team established or ad hoc? 3. Are there terms of reference for the established team? 4. Is there a guideline/SOP for communication before during and post public health emergencies 5. What strategy is being adopted? Is it clear? 6. Is there a plan with budget? 7. Is there clear plan for resource mobilisation 8. Is there a monitoring and evaluation process for the plan? 9. Are there trained manpower for the following? <ol style="list-style-type: none"> a. Coordination, planning, and M&E b. Development or application of communication approaches and tools

		<ul style="list-style-type: none"> c. Message development and dissemination d. Interpersonal communication e. Media relations f. Advocacy and community engagement g. Infodemic management
	Assess stakeholders coordination and communication	<ol style="list-style-type: none"> 1. Is there a list or database of stakeholders? 2. Is there a process for stakeholders engagement? 3. Is stakeholders analysis performed? 4. Are roles shared among the stakeholders? 5. Are there stakeholders who are missing on the list or inactive? 6. Are the stakeholders meeting? Any minutes of meeting? 7. Is there a platform for communication among stakeholders? 8. Is risk information shared with stakeholders? 9. Are stakeholders accountable for their activities?
	Assess public communication process	<ol style="list-style-type: none"> 1. Is the audience segmented in relation to the hazard/event and other relevant criteria? 2. Is there a mechanism for assessing the needs of the segmented audience (e.g., polls, survey, social listening)? 3. Are the needs of the audience clearly articulated? 4. Are messages developed or adapted for addressing audience needs? 5. How are messages developed or adapted? 6. What means are used in getting the messages to the audience? 7. Are there SBCC materials (print) available for dissemination? 8. Are there audio/visual SBC materials produced and airing? 9. Are the messages translated into local languages? 10. Is there a trained spokesperson? 11. Is there engagement with the media? <ul style="list-style-type: none"> a. Are there media appearances? b. Any press conference? c. Any press releases? d. Are the reporters/ editors trained on outbreak reporting? 12. Is there a hotline? 13. Any use of social media platforms? What are the social media handle (s)? 14. Are there trained and dedicated individuals on use of social media for health communications?

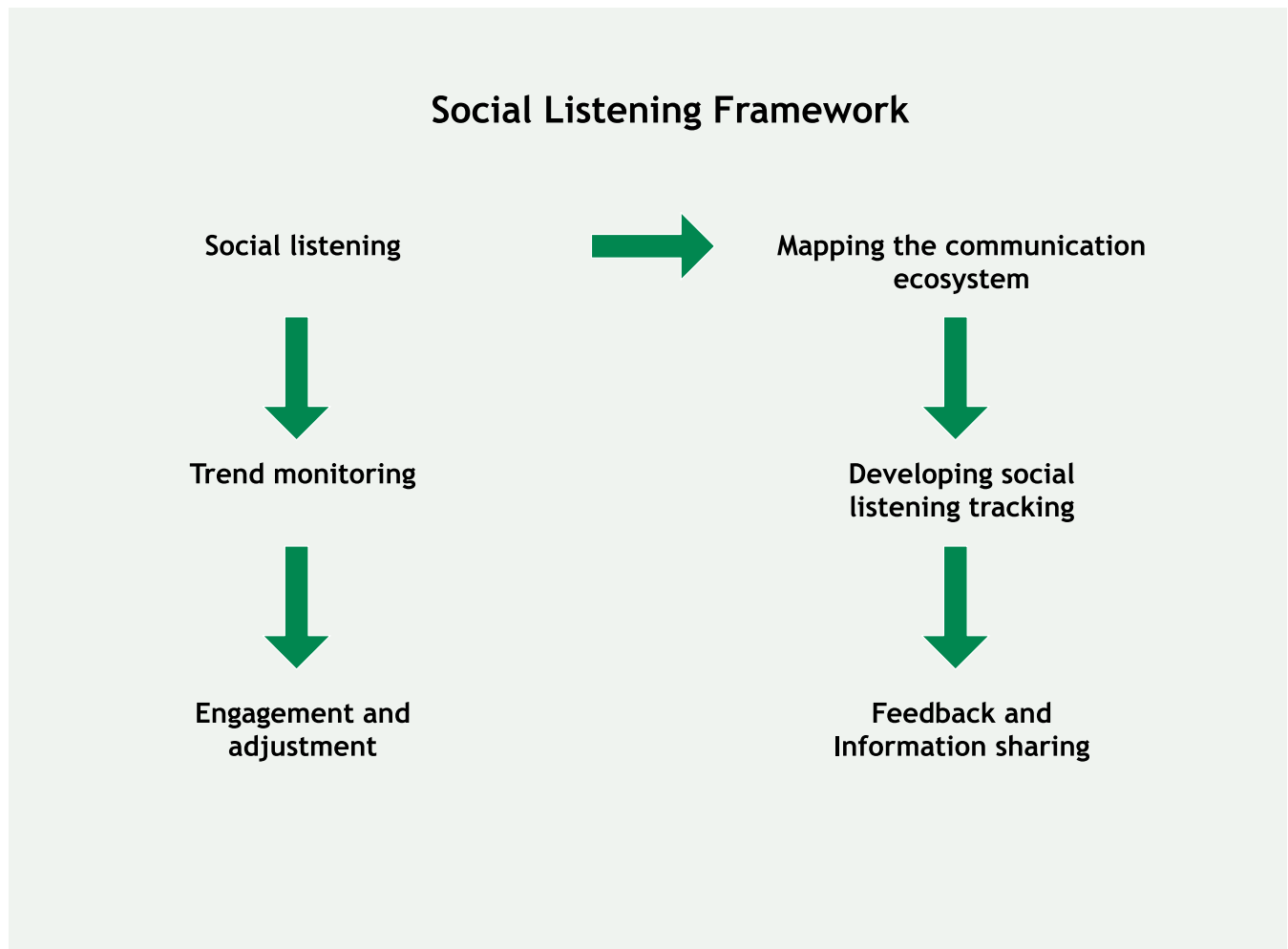
	Assess community engagement process	<ol style="list-style-type: none"> 1. Is there a meeting for the buy-in of community leaders? 2. Is there a meeting to understand the needs and concerns of the community? 3. Is there a list of community influencers? 4. Are community influencers involved in communicating the messages? 5. Is there a list of community networks (e.g., CBOs, FBOs)? 6. Are community networks involved in message dissemination and social listening? 7. Are there trained community volunteers or town criers for disseminating messages? 8. Any plan for community dialogue to address emerging issues like rumour, stigma, and panic? 9. Are SBC materials displayed in public places in the community? 10. Is there a mechanism for two-way community feedback and use of the feedback
	Assess infodemic management systems	<ol style="list-style-type: none"> 1. Are there processes or meetings or arrangements to understand and report rumours and conflicting messages in the community? 2. Is there a hotline where community members can report or ask questions? 3. Is there a local media outlet through which the community can obtain information? 4. Is media scanning conducted to detect circulating misinformation or sentiment of the people? 5. Are the community networks trained and leveraged for detecting and reporting circulating information/misinformation and concerns of the community? 6. Is information obtained documented? 7. Is there a dedicated person for collating and analyzing documented information at the LGA level? 8. Is there a report of analyzed rumours and rumour management activities? 9. Are the community networks used for debunking misinformation in circulation? 10. What are the other mechanisms for detecting and addressing rumors in the community?

B. Setting Objectives		
	Aim	Objectives
Set behaviour objectives	<ol style="list-style-type: none"> 1. To avoid getting infected 2. To reduce the risk of spread to others 3. To avoid or reduce complication of the hazard/disease 	<ol style="list-style-type: none"> 1. Specific actions the audience should take to protect themselves and others at individual, family, community, and society levels 2. The roles stakeholders would play for limiting exposure breaking transmission or minimizing the impact of the hazard
Set communication objectives	<ol style="list-style-type: none"> 1. To inform, educate, and empower people on what they need to know, feel, and do to remain protected and to protect others and the community. 2. To inspire individual and collective responsibilities for prevention, detection, and control measures 3. To build trust and confidence among the public and affected communities in the authorities, health systems, health professionals, responders, and recommended interventions for prevention and control of the hazard and its consequences 4. To advocate to the authorities to address the concerns and needs of the public in responding to the outbreak 	<ol style="list-style-type: none"> 1. Ensure consistent messaging to the public through the media, distribution of SBC materials, sensitization, airing of audio and radio jingles 2. Conduct sensitization meetings 3. Engage community influencers to support the message dissemination 4. Conduct community dialogues to address the concerns of the people 5. Debunk rumors 6. Support people in attaining behavioural objectives
C. Stakeholders' Engagement		
Stakeholders' engagement	Map and analyse stakeholders	<ol style="list-style-type: none"> 1. Identify stakeholders in the state 2. Define their interests 3. Assess their potential effect on the event
	Meet with stakeholders and agree on roles	<ol style="list-style-type: none"> 1. Invite the stakeholders to a meeting 2. Discuss the findings of the risk communication need assessment 3. Communicate the objectives above 4. Agree on roles with the stakeholders 5. Define coordination mechanism 6. Establish communication platforms

D. Audience Segmentation and Analysis		
Audience segmentation and analysis	Segment the audience based on association with risk/event	<ol style="list-style-type: none"> 1. Those that are affected 2. Those that are vulnerable 3. Those at high risk 4. Those at low risk 5. Those at no risk
	Analyse the audience for the concerns, needs, and expectations	<ol style="list-style-type: none"> 1. Level of understanding 2. Demography: age, sex 3. Needs 4. Concerns 5. Expectations
	Identify how to reach the audience	<ol style="list-style-type: none"> 1. Identify the best channels of reaching each group of audience 2. Use more than one channel for reaching each audience 3. Consider the most effective formats of reaching the audience: graphics, audio, or video
E. Message Development and Dissemination		
Message development/adoption and dissemination/translation	Key messages and considerations in developing them: what, why, and how	<ol style="list-style-type: none"> 1. Who is the audience for your messages? 2. What is the target behaviour in the audience? 3. Are you developing, adapting, or adopting existing messaging? 4. Are your messages informed by data? 5. What do you want the audience to do? 6. Why do you want the audience to know or perform the action? 7. What is the best format for the message? 8. Translate into local language and dialects
	Pre-test the message	<ol style="list-style-type: none"> 1. Review the materials 2. Pre-test the materials 3. Incorporate findings of review and pretest
	Dissemination plan	<ol style="list-style-type: none"> 1. Determine the most appropriate strategy for dissemination: use of multiple channels, campaign, programmes 2. Through what channels do you want to share the message with the audience? 3. Who should share the message? 4. When should it be shared?

F. Feedback management		
Feedback	Collect feedback	<ol style="list-style-type: none"> 1. Observe change in knowledge, behaviour, and norms 2. Conduct meetings to obtain feedback from the community 3. Engage the leaders, CBOs, FBO for feedback
	Collate and analyse feedback	Analyse feedback
	Share findings with response team	Share findings with Emergency Operations Centre, other relevant pillars, health care professionals, community and policy makers.
	Adjust messaging and approach accordingly	Ensure findings are incorporated into response planning and operation

G. Framework for reactive infodemic management & criteria for assessing threat/prioritising misinformation for response:



Rumour Prioritisation Matrix

Indicator	Low risk	Medium risk	High risk
Risk for vaccine hesitancy and risk to demand	Low risk to vaccine demand	Potential to trigger vaccine hesitancy	Potential to lead to vaccine refusals
Risk to demand for testing services	Low risk to demand for testing	Potential to trigger hesitancy to get tested	Potential to lead to rejection of testing
Risk to adoption of preventive measures/practices	Low risk to adoption of preventive measures	Potential to trigger non-adherence to preventive measures	Potential to lead to adoption of harmful behaviours and rejection of healthy/preventive practices
Risk to uptake of health services	Low risk to demand for health services	Potential to trigger poor uptake of health services	Potential to lead to failure to access health services
Reach and scope of rumor	Limited potential reach or scope	Moderate potential reach or scope	Wide or cross country reach or scope
Likelihood of issue spread or escalation	Unlikely to spread in community or online	Spreading in community and/or online	Spreading rapidly in community and online
Response capacity	Strong messaging and capacity in place	Limited existing messages and resources to manage crisis	Limited existing messages and capacity exceeded

H. KEY INFORMANT INTERVIEW (KII) QUESTIONNAIRE FOR KAP SURVEY IN THE CONTROL OF HAZARD IN STATE/LGA, NIGERIA

Serial No: Community: Ward:
LGA: State: Date: Interviewer:

Section A: Socio Demographic Characteristics of the Respondent

1. Age (as at last birthday) in years 2. Sex A) Male B) Female
3. Occupation 4. Religion
5. Educational level A) No formal education B) Primary C) Secondary D) Tertiary
6. Placement; A) Host community B) IDP Camp

Section B: Knowledge aboutdisease

1. Are you aware of disease? A) Yes B) No
2. What do you know about disease?
.....
1. What do you believe is the cause of disease?
.....
2. Can you describe how one can get disease?
.....
3. How do you know that somebody has disease?
.....
4. How can disease be prevented?
.....
5. Do you think some people can die fromdisease? A) Yes B) No
6. Can you describe those that are most likely going to die fromdisease?
.....
7. Have you heard of asymptomatic case? A) Yes B) No
8. What does it mean to be asymptomatic?.....
9. Can asymptomatic patient transmit the disease to their loved ones? A) Yes B) No
10. Where do you get information on disease from?:.....

Section C: Attitude todisease

1. disease exists in our communities A) Agree B) Don't know C) Disagree
2. Contacts of confirmed disease case should undergo isolation?
A) Agree B) Don't know C) Disagree
3. People who show symptoms of the disease should perform test to confirm if they have the disease A) Agree B) Don't know C) Disagree
4. Are you willing to test for disease if you show symptoms?
A) Yes B) No C) Don't know
5. If you say no to question 4, why?
6. Are you willing to go to hospital to receive care if you have disease?
A) Yes B) No C) Don't know
7. If you say no to question 6, why?
8. Do you believe good personal hygiene can prevent disease?
A) Yes B) No C) Don't know
9. Do you believe good environmental hygiene prevent disease?
10. Regular hand washing can prevent disease A) Agree B) Don't know C) Disagree
11. Most disease patients recover from the disease A) Agree B) Don't know C) Disagree
12. disease patients that receive proper treatment early recover faster A) Agree B) Don't know C) Disagree
13. It is safe to deny attention or run away from anybody who is from a place with or has contact with a confirmed disease cases A) Agree B) Don't know C) Disagree
14. There is discrimination against family members or contacts of disease patients in this community. A) Agree B) Don't know C) Disagree
15. Information from government on disease situation in the country can be trusted. A) Agree B) Don't know C) Disagree
16. Advice from health authorities (PTF/NCDC/SMOH) on protection against is very helpful and should be followed. A) Agree B) Don't know C) Disagree
17. Advice from health authorities (PTF/NCDC/SMOH) on protection against that is coming from religious and traditional leaders should be followed.
A) Agree B) Don't know C) Disagree
18. Advice from traditional healers or spiritual healers other than health authorities (PTF/NCDC/SMOH) on protection against is very helpful and should be followed.
A) Agree B) Don't know C) Disagree

19. Government measures on containment of disease is adequate
A) Agree B) Don't know C) Disagree D) Angry at Government
20. In complementing government efforts, individuals should be responsible for protecting themselves from disease Agree B) Don't know C) Disagree
21. In supporting what government is doing, It is the business of the community to lead initiatives for preventing or stopping disease transmission in the community
A) Agree B) Don't know C) Disagree D) Angry at Government
22. Do you support Government decision to lockdown your community during outbreak of disease?

Section D: Practice prevention of disease among respondent

1. Do you wash your hands regularly? Yes No
2. If yes, How often? A) Every time B) Only when I touch people or surfaces C) Only before I eat food
3. If No, what stops you from doing so?
4. When you cough, do you cover your mouth with tissue paper or cough into your bent elbow? A) Yes B) No C) Don't know
5. If No, what stops you from doing so?
6. Did you travel recently to a place or country with widespread transmission of disease A) Yes B) No C) Don't know
7. If yes, did you self-isolate for 14 days when you returned? Yes No
8. Did you have fever or cough within those days? A) Yes B) No C) Don't know
9. When you have fever, where do you go for treatment?
10. If you have contact with a confirmed case, would you self-isolate for days?
A) Yes B) No C) Don't know
11. If you have contact with a confirmed case and you develop fever or cough what will you do?
.....
12. Do you know the phone no to call if you think you have been in contact with a confirmed case and you are showing symptoms?
13. What do you think individuals, groups & communities can do to stop the spread of disease

Section E: Gender and violence

1. Are you aware of violence against women or children in your community in the last one year?
A) Yes B) No
2. Are you aware of violence against women or children in your community in the last one week?
A) Yes B) No
3. If yes, how many cases of such did you hear about in the community? A) < 5 B) 6 -10 C) >10
4. How many of such cases that you know were reported to the police? A) All B) some C) None
5. What forms of violence against women do you know?
6. Violence against women occurs as a result of fault of the women.
A) Agree B) Don't know C) Disagree D) Sometimes
7. Your community openly kick against violence against women. A) Agree B) Don't know C) Disagree

I. RCCE community activity form

A. General Information			
	Event Date: _____ DD / MM / YYYY	<ul style="list-style-type: none"> Community Sensitization Community Health Dialogue Compound Meeting Community drama Motorized campaign Market Storms 	<ul style="list-style-type: none"> Neighborhood Walk Targeted Mobilization (Religious centers, Affinity groups, school units) Others (specify) _____
A1.	Community Event Type (Select one) ✓		
A2.	State:	A3. LGA:	A4. Ward:
A5.	Event Venue and Community:		
B. Health area(s) addressed during the event			
B1.	DISEASE AREA ADDRESSED DURING COMMUNITY EVENT (underline health area addressed)	a.) Diphtheria b.) Lassa Fever c.) mpox (Monkeypox) d.) Cholera e.) Rabies f.) COVID-19 g.) Other specify _____	
C. Use of visual, audio, or audio-visual materials			
C1. a	Was audio material used during this activity? (Loudspeakers, jingles and Pre-recorded messages)	a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO	
C1. b	Was visual material used during this activity? (Job aids, flip charts, posters, banners)	a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO	
C1. c	Was audio-visual material used during this activity? (Video)	a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO	
C2.	How many print materials were distributed during this activity? (Posters and Flyers)	
C3.	How many people received print materials?	Male _____ Female _____	
D. Referrals made from community events			
D1	During this event, did you refer for vaccination? a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO		
	Which vaccine did you refer for? (e.g., COVID, Diphtheria, HPV, RI): _____		
D1.a	Total number of persons referred	Male <input type="checkbox"/> Female <input type="checkbox"/>	
D2	During this event, did you identify any suspected case for other infectious diseases? (e.g. Diphtheria, COVID, Lassa Fever, mpox etc.) a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO		
D2.a	Total number of persons identified and reported	Male <input type="checkbox"/> Female <input type="checkbox"/>	
E. Number of persons reached during the community activities			
E1	Number of persons (10 years and above) reached with messages (use the tally sheet)		
	Male _____ Female _____ Total.....		
F. Rumor Tracking and Management			
F1	Are there new rumors/misinformation heard from this activity? If yes, what rumor?	a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO _____ _____ _____	

Name of reporting personnel/Designation: _____

Signature/Date: _____

J. FGD Question Guide for Hazard Perception in the Community

1. Have you heard of Disease? And what is the local name for the disease?
2. What do you know about Disease?
3. What do people believe is the cause of disease?
4. Can you explain if and how the disease is affecting people of this community
5. What do you think that people do that make them at risk of getting the disease? *(Explore further to gain insight on attitude towards established household practices that increase the risk of transmission. Understand the beliefs that shape the household practices and the cultural norms that uphold the household practices)*
6. Can you share any information or story circulating in the community about disease? Can you list the source of the information?
7. Do people believe the circulating information or story? And why do they believe it?
8. Where do people affected receive treatment for the disease?
9. How do people protect themselves from getting the disease?
10. Do you know of any advice given by Government or health authorities for protecting people from getting the disease? Can you discuss them?
11. Do you know of any advice or arrangement by Government or health authorities for treating those affected by disease? Can you discuss how people affected use them?
12. What challenges do people face in carrying out the recommendations of the health authorities either for treating or protecting themselves?
13. How do people in the community relate with those affected by the disease or their family members?

K. TERMS OF REFERENCE GUIDING THE NATIONAL RISK COMMUNICATION TECHNICAL WORKING GROUP

Background

The National Risk Communication Technical Working Group (NRCTWG) was established in 2018 pre COVID-19 pandemic. The technical working group was designed to be a multi-sectoral and multi-partner technical working group saddled with responsibility for the development and providing direction and management of risk communication and community engagement (RCCE) in Nigeria. The structure facilitates the enhancement of effective communication by adopting the one-health approach that considers human, animal, and environmental health variables that are consistent and evidence-based. The NRCTWG is currently coordinated by the Nigeria Centre for Disease Control and Prevention in collaboration with MDAs and supporting partners.

Shared Vision

"To foster a culture of effective risk communication in Nigeria that engages and empowers individuals, communities, and institutions to prevent, detect, and respond to health, environmental, and animal-related risks."

This shared vision emphasizes the importance of risk communication as a tool for engaging and empowering individuals, communities, and institutions to take proactive steps to prevent and respond to the risk of public health emergencies by fostering a culture of effective risk communication and community engagement. The Technical Working Group can help build resilience and preparedness that enable the country to respond more effectively to public health emergencies, environmental threats, and animal-related risks.

This shared vision also recognizes the importance of collaboration and partnership, both within and outside the Technical Working Group. By working together with stakeholders across sectors and levels of government, the Technical Working Group can ensure that risk communication is consistent, coordinated, and evidence-based, in which communication gaps and needs are identified and addressed promptly and proactively.

Overall, this shared vision sets a clear direction for the Technical Working Group and underscores the importance of risk communication in building safer and more resilient communities.

Objectives

- Develop and implement a risk communication and community engagement strategy (before, during and after public health events) that is tailored to Nigeria's unique needs.
- Facilitate effective communication between different sectors, including health (human, animal, and environmental), security, and humanitarian, across all levels of government.
- Identify and prioritise communication needs and gaps in Nigeria's response to human, environmental, and animal health-related risks.
- Develop communication materials and tools that are appropriate for different audiences,

including the general public, responders to public health emergencies, and policymakers.

- Conduct research and evaluation to assess the effectiveness of risk communication activities.
- Establish a mechanism for sharing and documenting best practices and lessons learned among members and partners.
- Plan for the cascade of the structure to states to ensure effective risk communication and community engagement at the subnational level.

Membership

The multihazard Technical Working Group will be composed of representatives from relevant MDAs with pre-requisite background in the animal, human, environment, security, communication and humanitarian sectors, as well as representatives from vulnerable groups and relevant partner organisations. Members should have experience in risk communication, public health, environmental health, animal health, security, disaster management, community engagement, communication, behaviour science, social and behaviour change or related fields. These nominated desk officers will be a node for information sharing and updates. The Technical Working Group will be chaired by NCDC with first co-chair from one of the MDAs and second co-chair from a partner agency. The first and second co-chairs will be rotated annually among MDAs and partner agencies. A secretariat will be established to provide administrative support.

Roles and Responsibilities

- The Technical Working Group will be responsible for discussing risk communication needs, developing communication guidelines, strategies and materials, and assessing the effectiveness of risk communication activities. Meetings will be held quarterly, however, ad hoc meetings can be organised as need arises.
- Members will share information and expertise to ensure that risk communication is consistent across sectors and levels of government.
- The Technical Working Group will work with relevant stakeholders to identify and address communication gaps and needs.
- The Technical Working Group will develop a plan for cascading the structure to states, including identifying key partners and stakeholders, and developing training materials for state-level communicators.
- TWG to facilitate training and capacity-building activities to enhance risk communication skills at all levels.
- Work with relevant stakeholders to provide guidance on risk communication research.
- Develop a multi-sectoral and all-hazards risk communication strategy.
- Advocate for risk communication and community engagement causes
- Develop disease/hazard-specific emergency risk communication strategy.
- Improve monitoring and evaluation process to provide feedback into the programme.

- Develop protocols and SOPs for conducting risk communication activities (Pretesting, Community engagement, Media engagement, etc.)
- Review and develop multihazard Social and Behaviour Change Communication materials.
- Update risk communication and community engagement guidelines based on Joint External Evaluation (JEE) recommendations.
- Mobilise resources for the implementation of RCCE preparedness and response plans.
- Develop and implement a robust data information system for knowledge capturing, archiving retrieval and sharing
- Produce and publish a risk communication quarterly bulletin.
- Engage and support RCCE pillars in disease-specific technical working groups/emergency operations centres
- Provide direction and ensure alignment of infodemic management interventions at all levels for effective RCCE before, during, and after any public health events and emergencies.

PARKING LOT

Knowledge Management

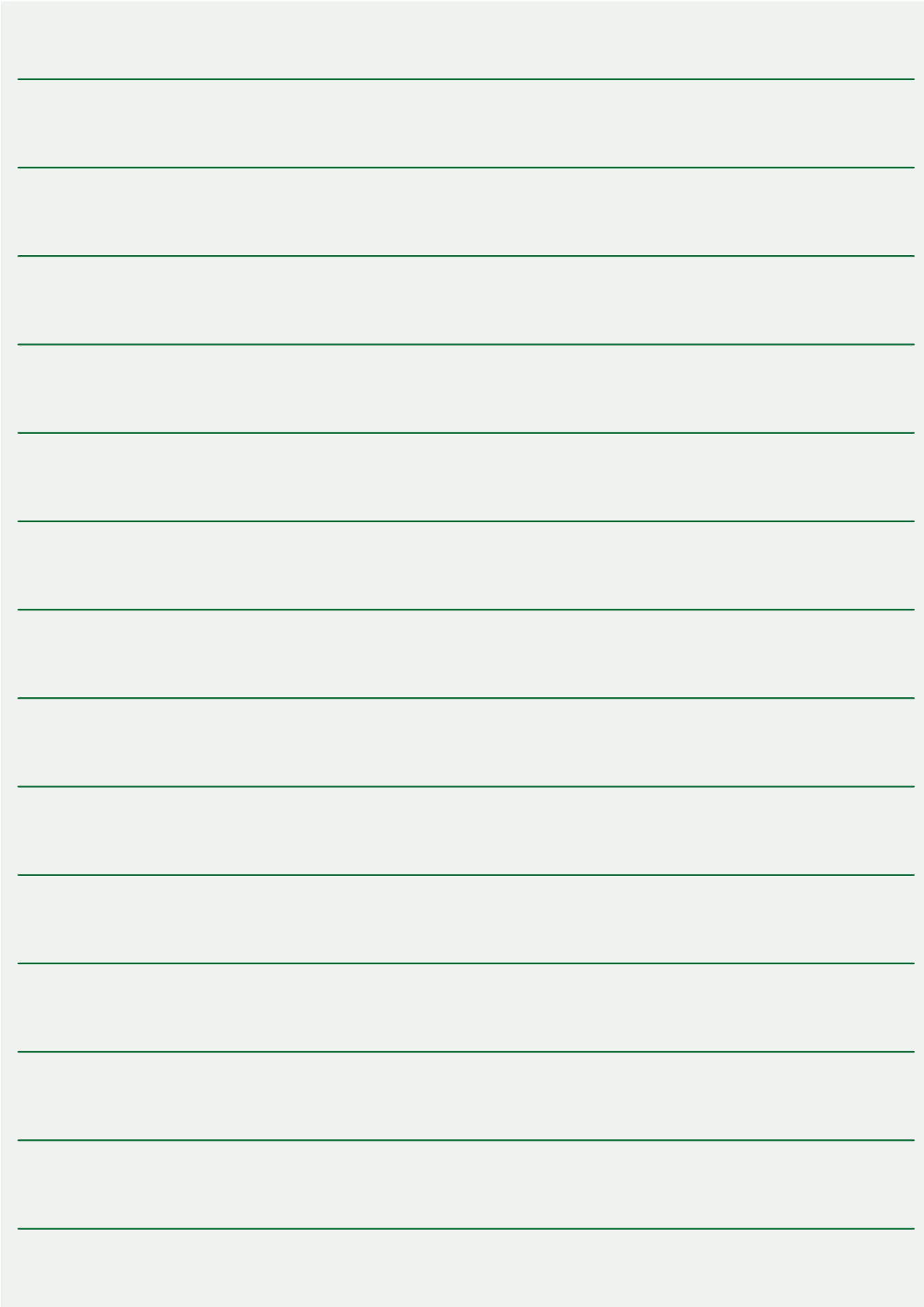
The technical working group should document knowledge and experiences. Encourage members of the technical working group to document the activities and strategic campaigns implemented by their organizations. This documentation could include reports, case studies, lessons learned, best practices and action images. The TWG should adopt a knowledge-sharing culture and encourage the team to share their expertise and experience with others. Encourage open communication and collaboration among team members.

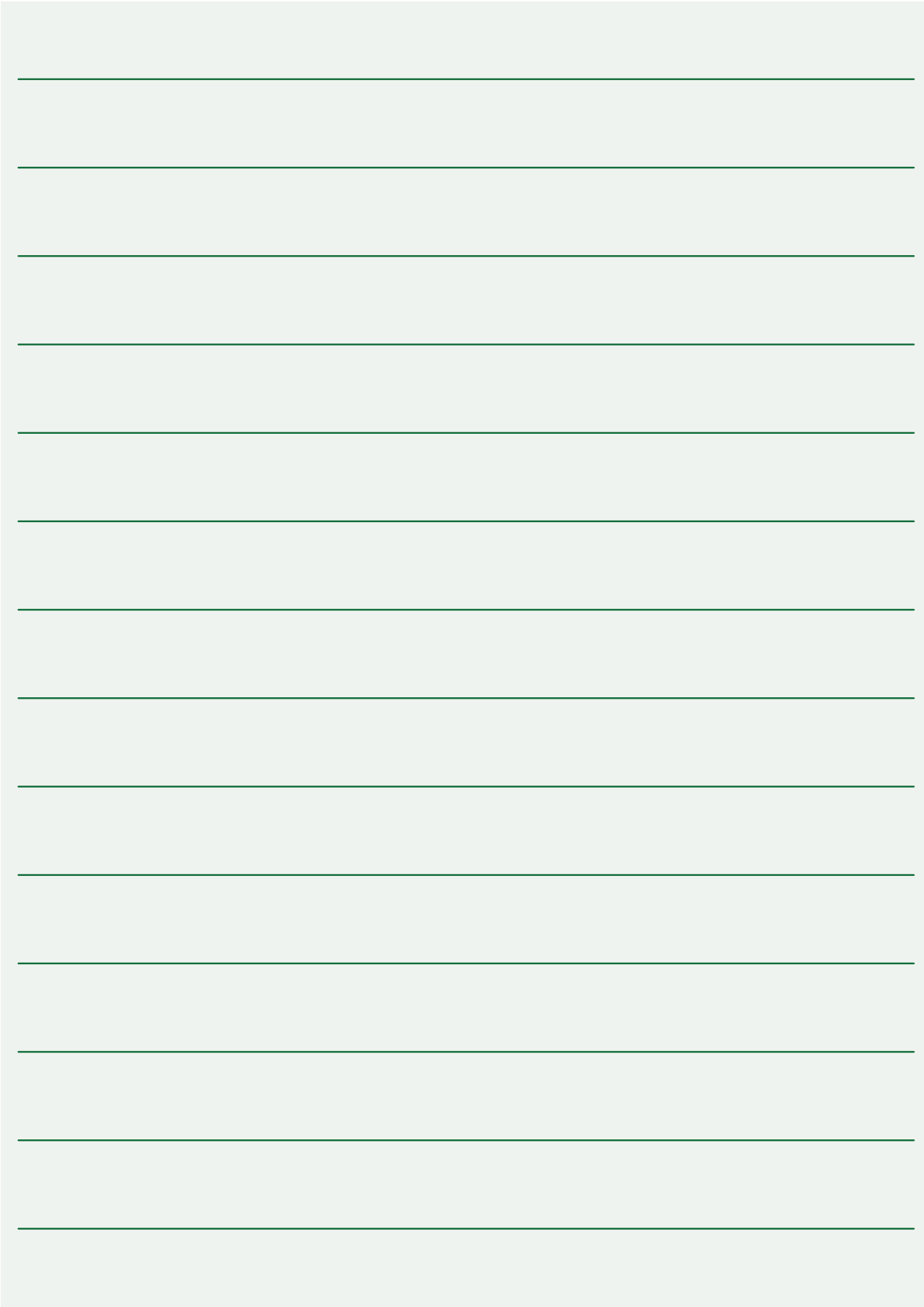
A centralised repository should be established to store all knowledge assets, such as reports, guidelines, and case studies. Use digital tools and platforms, including online forums, virtual meetings, and social media, to enhance knowledge management. Organize regular training sessions for members on risk communication, knowledge management, and information dissemination. This will enhance the team's skills and knowledge base, improving risk communication efforts.

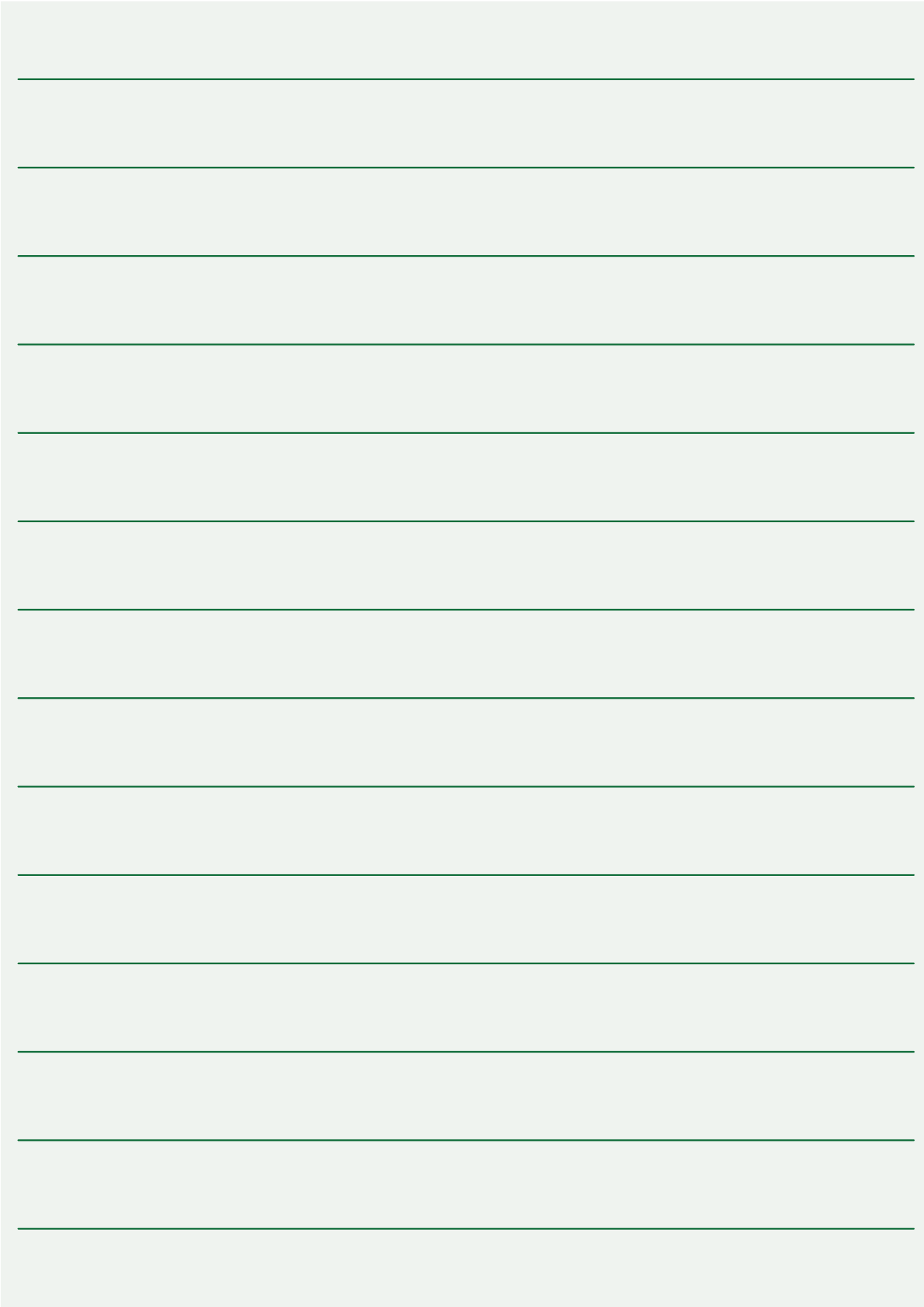
Finally, develop a framework for monitoring and evaluating the knowledge management system quarterly (preceding the NRCTWG quarterly meetings) to determine its effectiveness. Collect feedback from team members and stakeholders to identify areas for improvement.

Reporting and Monitoring

The Technical Working Group will report to the Nigeria Centre for Disease Control and Prevention (NCDC). The report will be shared with relevant MDAs and partners as needed. The Technical Working Group will also monitor and evaluate the effectiveness of risk communication activities and report on progress and challenges to relevant stakeholders.







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