

COVID-19: Preparedness and response priorities for the ongoing humanitarian situation in Northeast Nigeria

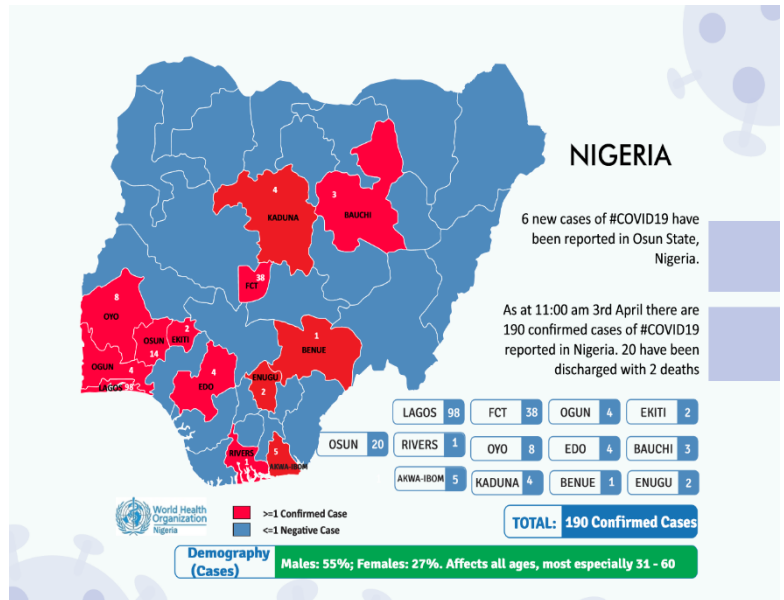
People affected by humanitarian crises, particularly those displaced and/or living in camps and camp-like settings, are often faced with specific challenges and vulnerabilities that must be taken into consideration when planning for readiness and response operations for the COVID-19 outbreak. They are frequently neglected, stigmatized, and may face difficulties in accessing health services that are otherwise available to the general population. It is of extreme importance from a protection, human-rights and public health perspectives, that people affected by humanitarian crises are included in all COVID-19 outbreak readiness and response strategies, plan and operations. There is a strong public health rationale to extend all measures to everyone, regardless of status and ensuring inclusiveness.

The impact of the humanitarian crisis in the conflict affected states of Borno, Adamawa and Yobe (BAY states) presents one of the greatest vulnerabilities to the spread of COVID-19. The situation is a complex protracted crisis with huge developmental needs, damaged infrastructure, lack of governance and rule of law outside Maiduguri and major garrison towns. The most vulnerable population groups are children, women, elderly and people with chronic medical conditions. The biggest fear is the effects on the decrease immunity associated with diseases and risks typical of humanitarian contexts such as malnutrition, measles, malaria, HIV etc.

Data from WHO Early Warning and Response System in June 2019 indicate that malaria compounded by malnutrition is the leading cause of morbidity and mortality for 34.4% of cases and 18.1% of reported deaths in the crisis affected areas. This is further compounded by the fact that 50% of health facilities that would have provided malaria prevention or treatment are completely or partially destroyed, worsened by inadequate malaria diagnostic kits and antimalarial drugs. Similarly, congested living environments in IDP camps and host communities along with poor sanitary infrastructures contributed to the massive cholera outbreak in Borno State in 2018 with 6,439 persons affected including 74 associated deaths mostly among IDPs. These are multi-sectoral issues which demand a multi-sectoral approach. Key sectors (CCCM, Protection, Health, WASH, Nutrition) are working together to ensure adequate monitoring, preparedness and response strategy.

The impact of the displacement for communities and persons displaced is huge and has remained key to increase in disease situation with consequences. Borno is currently experiencing an outbreak of measles with over 21,052 cases as at the end of December 2019. This is due to non-immunization amongst displaced children from locations that are security-compromised, which further puts at high risk children under 5 years already facing dangerously high levels of malnutrition, endemic malaria and other epidemic prone diseases. Cholera outbreak in Adamawa and Lassa fever in Borno has just stopped as no more cases reported during the last three weeks. The deterioration of the security situation in the past months has exacerbated the situation especially for displaced women, children and the elderly being the most vulnerable. Overall, in 2019, around 4.7 million people need humanitarian support including health services. Borno is the worst affected by the insurgency among the three North-east states and contribute 83% of the internally displaced persons as at 2019.

Maiduguri hub the international airport linked to Lagos and Abuja. Lagos is a hotspot State of COVID-19. Borno has a weak health system. The State has 9 international land borders connections with 3 countries, Cameroon being an affected country also cases reported from Chad.

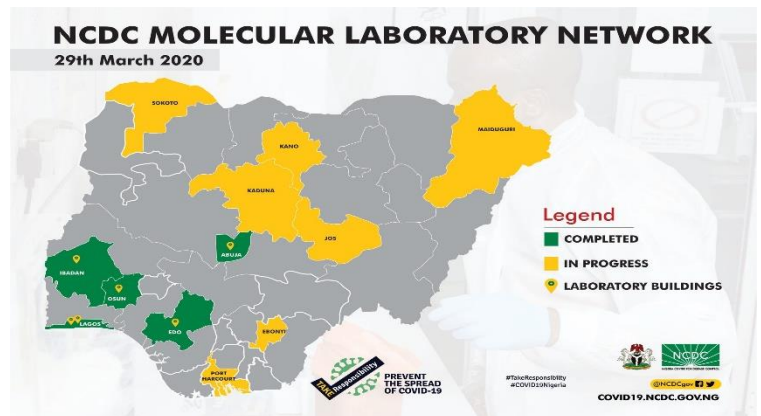


Need analysis:

The humanitarian situation is expected to worsen due to COVID 19, particularly due ongoing stressors experienced by the health system including disrupted health system in many inaccessible LGAs, non-functional health facilities, lack of health care staff, overwhelmed response capacity of international humanitarian agencies and lack of resources. A tightening of pre-existing movement restrictions, economic deterioration coupled with strained public services will further increase humanitarian needs and compound existing operational challenges.

As per the HNO, 7.9 million people are expected to be in need of humanitarian assistance in 2020 of whom the humanitarian partners will target 5.9 million of the most vulnerable people. The unforeseen shock, such as the COVID-19 pandemic, is likely to impact current projections. The capacity of the health system to address the possible impact of the pandemic, remains limited.

COVID-19 is of public health importance because of the ability to spread rapidly through human to human contact. The rapid escalation of the outbreak of 2019-nCoV and its global spread has significant implication to public health security in Nigeria. The virus, transmitted mainly through droplet infections, has a very high potential of rapid spread. The fact that the States have major gaps in its preparedness underlines the need for rapid action and support.



The COVID-19 pandemic is placing significant strain on healthcare facilities that are already overwhelmed by lack of capacity as well as ongoing disease outbreaks such as cholera, lassa fever, measles and malaria, particularly in the northeast. As a result, precious health resources are being diverted from the critical needs to bolster access to basic healthcare nationwide. The Government will draw on resources from the national purse otherwise destined to combat other health emergencies and disease outbreaks. As cases increase, preventative health care will be severely impacted.

Among the critical factors that might contribute for this rapid spread are; the weak health system, high population concentration in certain urban centres like the city of Maiduguri, inadequate awareness on preventive measures, and a favourable traditional and cultural practice sport to the state efforts to contain the outbreak. The experience on managing outbreaks with droplet transmission in Nigeria is not strong.

The likelihood of having COVID-19 in Northeast is very high, since it is bordering three countries (Cameroon, Chad and Niger) and there is a constant movement of travellers from these neighbouring countries for trade as well as conflict around the lake Chad Basin. The impact caused by imported COVID-19 cases in Borno State is estimated to be high due to lack of previous experience in managing the disease and the large numbers of travellers using Maiduguri airport also truck and cargo with neighbouring countries. Although the country has the capacity to confirm COVID-19, event-based surveillance and community surveillance are not fully established in BAY State and Laboratory confirmation must be undertaking in Abuja.

Other factors include;

- *Weak community-based surveillance.*
- *Population living in overcrowded IDPs and urban centres*
- *High endemic region for cholera, measles, malaria*
- *Need for more IEC / BCC materials for COVID-19 Public Awareness in the 3 State.*
- *Need for simulation exercise for any pillar of the response.*
- *Weak capacity on COVID-19 Case Management.*
- *Weak screening mechanisms at PoE especially no screening system in place at international borders.*
- *Lack of fully equipped Isolation/treatment Centre for COVID-19-need for ventilators, oxygen etc.*



Intensive Care Unit (ICU) in State Specialist Hospital, Maiduguri



Key actions and priorities:

1. Coordination, planning and monitoring:

The existing Health Sector coordination mechanism will be used for coordination of response at state and LGA level. The Health Sector will continue its collaboration with WASH, CCCM, Shelter and all other sectors for a coordinated response that result in the timely containment of outbreak and facilitate joint interventions. The Sector will implement joint programmes with the Nutrition Sector on treatment of children with acute malnutrition with medical complications. The sector will work with WASH and CCCM sectors for more coordinated interventions in the areas of infection prevention and control, improvement of water and sanitation facilities, community mobilization etc. Similarly, Health Sector continues to promote joint planning and monitoring mechanisms across the sectors. The coordination of COVID-19 outbreak readiness and response operations in camps and host communities will be aligned with existing humanitarian coordination mechanisms across the sectors , OHCT and ISWG level which are already in place at state, LGA and also at camp level.

An incident management team is already working at the level of public health emergency operation centre (PHEOC), on key priority actions including rapid deployment of designated staff from state and partner organizations in high risk for priority preparedness and response actions, monitoring the POE operations, development and dissemination of IEC materials etc.

2. Surveillance, rapid response teams, case investigation and Points of Entry (POE):

The existing community-based surveillance (CBS) will be strengthened and expanded in all accessible areas. The presence or rapid deployment of an outbreak rapid response team needs to be ensured in all camps and hosting communities for investigation of alerts and referrals of suspected cases for diagnostics, potential isolation and case management.

Community mobilization teams and health volunteers are important allies for the early detection of COVID-19 cases in camps and host communities. CBS is an important intervention for contact monitoring, even in the absence of quarantine and isolation. Community health volunteers and other community elements of the camps and host communities will be trained on a simplified case definition and alert notification procedures. Case investigation needs to be ensured following alert notification.

Surveillance actions will focus on rapid detection of imported cases, comprehensive and rapid contact tracing, and case identification. In a scenario in which sustained community transmission has been detected, the surveillance coverage will be expanded to include monitoring the geographical spread of the virus, transmission intensity, disease trends, characterization of virologic features, and the assessment of impacts on healthcare services. Robust COVID-19 surveillance data are essential to calibrate appropriate and proportionate public health measures. The existing EWARS/IDSR mechanisms with more than 200 reporting sites will be strengthened for timely collection of alerts and disease data from the health facilities.

Efforts and resources at points of entry (POEs) including Maiduguri international airport, Yola airport and all entry points on international border should focus on supporting surveillance and risk communication activities. The key actions are development of action plan, training of port health authority staff, establishment of isolation facility at the airport and transportation of suspected passengers to treatment centers, dissemination of IEC materials to passengers and monitoring of the POE screening process for effectiveness and necessary adjustments.

3. Infection prevention and control (IPC):

Infection prevention and control (IPC) practices in communities and health facilities should be reviewed and enhanced to prepare for treatment of patients with COVID-19, and prevent transmission to staff, all patients/visitors and in the community. Minimum requirements include functional triage system and isolation rooms, trained staff (for early detection and standard principles for IPC); and sufficient IPC materials, including personal protective equipment (PPE) and WASH services/hand hygiene stations. Community guidance should include specific recommendations on IPC measures and referral systems for public places such as schools, markets and public transport as well as community, household, and family practices. Assess IPC capacity in public places and community spaces where risk of community transmission is considered high. Develop and implement a risk mitigation plan for monitoring of healthcare personnel exposed to confirmed cases of COVID-19 for respiratory illness. WASH services in health facilities are critical and require enhanced minimum standards in handwashing, enhanced water supply, sanitation as well as adapted management of medical waste.

4. Case management:

Health facilities capable of providing clinical care for suspect and confirmed cases of COVID-19 need to be identified, and the necessary coordination shall be established for referral, treatment and discharge. Healthcare facilities should prepare for large increases in the number of suspected cases of COVID-19. Staff should be familiar with the suspected COVID-19 case definition, and able to deliver the appropriate care pathway. Patients with, or at risk of, severe illness should be given priority over mild cases. A high volume of cases will put staff, facilities and supplies under pressure. Special considerations and programmes should be implemented for vulnerable populations (elderly, patients with chronic diseases, pregnant and lactating women, and children). Measures need to be put in place to ensure routine health services remain available to all camp population and host communities inside the health facility's catchment area. It is important to separate people accessing routine services from suspect and confirmed COVID-19 cases. Access to emergency obstetric care and skilled birth attendance for all deliveries needs to be ensured for all women and girls in need, including post-partum monitoring.

Measures need to be put in place to limit potential exposure of patients with chronic conditions to COVID-19 infection by reducing visits to health facilities, e.g., by providing three months of treatment for stable NCD patients and those with Mental Health conditions, HIV and TB and follow up at home by community health workers if feasible. At the same time, the continuous clinical management of individuals with chronic diseases needs to be ensured, especially for conditions that are associated with the more severe forms of COVID-19 and higher risks of death. The existing services will need attention as there epidemic risks especially cholera is the major risk factor every year for which all hotspot locations will need treatment centers and enhanced response capacity in all hotspot areas.

5. Laboratories:

There are two major public health labs in Maiduguri located in University of Maiduguri Teaching Hospital and Umara Shehu Hospital. These laboratories have limited capacities for key diseases but not for COVID-19. In the event of widespread community transmission, surge plans should be activated to manage the increased volume of samples from suspected cases. WHO can provide support to access relevant reference laboratories, protocols, reagents, and supplies. Key actions are: to establish access to a designated international COVID-19 reference laboratory, adopt and disseminate standard operating procedures (as part of disease outbreak investigation protocols) for specimen collection, management, and transportation for COVID-19 diagnostic testing, ensure specimen collection, management, and referral network and procedures are functional, develop and implement plans to link laboratory data with key epidemiological data for timely data analysis, develop and implement surge plans to manage increased demand for testing; consider conservation of lab resources in anticipation of potential widespread COVID-19 transmission.

Laboratory pillar team has to monitor and evaluate diagnostics, data quality and staff performance, and incorporate findings into strategic review of national laboratory plan. Develop a quality assurance mechanism for point-of-care testing, including quality indicators

6. Risk communication and community engagement:

The existing structures of community mobilization teams and social mobilization staff and staff working with different sectors like CCCM, DTM, WASH, Food security will be engaged for mass awareness and community mobilization through close community interactions and dissemination of IEC materials.

Health and other sector partners will identify and work with local influencers in the site community (such as community leaders, religious leaders, youth and women leaders, health workers, community volunteers) and local networks (women's groups, youth groups, traditional healers, etc.). Where and when possible, community staff will work with camp management teams, camp/site committees and/or community leaders to carry out consultations on risk assessment, identification of high-risk population group, existing trusted communication channels (formal and informal), and setting up of surveillance focal points per blocks and sections, as well as community task teams, etc. Teams will provide clear and unequivocal messages focusing on what people can do to reduce risk or which actions to take if they think they may have COVID-19. Perceptions, rumors and feedback from camp residents and host communities should be monitored and responded to through trusted communication channels, especially to address negative behaviors and social stigma associated with the outbreak. Partners across the sectors will use the existing large-scale community engagement for social and behavior change approaches to ensure preventive community and individual health and hygiene practices, in line with the national public health containment recommendations.

Awareness raising activities may also represent an opportunity to include joint messaging and an occasion for MHPSS actors to provide psychological first aid (PFA) to alleviate the stress and anxiety resulting from the situation. If the response to disease outbreaks such as COVID-19 is to be effective, it is important to ensure that gender norms, roles, and relations that influence women's and men's differential vulnerabilities and status in the societies are considered and addressed

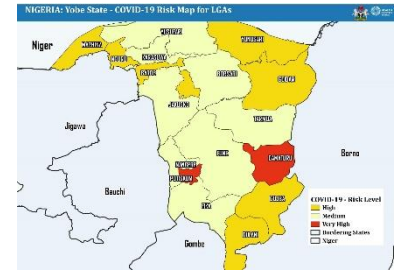
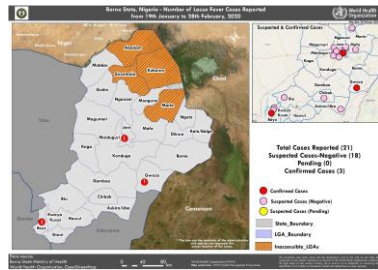
7. Operational and logistics support:

The existing operational support and Logistical arrangements to support incident management and operations will be reviewed to adjust with the needs of the response. Expedited procedures may be required in key areas (e.g. surge staff deployments, procurement of essential supplies, staff payments). Health sector coordination team will map available resources and supply systems in health and other sectors; conduct inventory review of supplies based on WHO guidelines The team working under the pillar of supply chain and logistics will review supply chain control and management system (stockpiling, storage, security, transportation and distribution arrangements) for medical and other essential supplies. Health partners will prepare for staff surge capacity and deployment mechanisms; health advisories (guidelines and SOPs); pre-and post-deployment package (briefings, recommended/mandatory vaccinations, enhanced medical travel kits, psychosocial and psychological support, including peer support groups) to ensure staff well-being.

Borno SMOH Declares an end to the Lassa Fever Outbreak:

On the 19th of March, 2020, the Honorable Commissioner for Health, Dr. Salisu Aliyu Kwaya-bura has declared an end of Lassa fever outbreak in Borno state, following concerted partners' response, led by the World Health Organization. The recent outbreak, which was the second in almost five decades, was isolated from a 30-year old man from Garba Buzu settlement in Maiduguri Metropolitan Council on 23 January 2020. With the technical guidance of WHO, a team comprising of the Commissioner of Health as Chairman, the chief Medical Director of the Hospitals Management Board, an infection prevention group at the University of Maiduguri Teaching Hospital, UNICEF and among others-initiated response activities including robust surveillance, contact tracing, risk communication and case management as soon as the index case was reported.

As of 25th February 2020, 21 cases were reported including 3 confirmed cases with 2 deaths from 9 local government areas. These are Jere, Maiduguri, Gwoza, Monguno, Bayo, Mafa, Biu, Chibok and Askira/Uba LGAs. Since then, no new cases of Lassa fever were isolated from any part of Borno state. Although, the outbreak of Lassa fever has been declared over in Borno state, surveillance and risk communication continue to ensure that no suspected cases are missed and that the public protects themselves. In another development, the Borno state Commissioner for Health has also briefed journalists on the Borno state preparedness for COVID-19. Acknowledging that Borno state has not confirmed a case of COVID-19, Kwaya-bura stated that it is imperative to scale up preparedness especially surveillance and risk communication.



COVID-19 Risk Map for Yobe State LGAs:

Health sector information management officer in collaboration with WHO in Yobe state has produced a risk map of all LGAs in Yobe state showcasing the risk level and bordering states in Nigeria as well as country bordered by the state.

Early Warning Alert and Response System (EWARS)

Number of reporting sites in week 12: A total of 197 out of 274 reporting sites (including 32 IDP camps) submitted their weekly reports. The timeliness and completeness of reporting this week were both 69% respectively (target 80%)

Total number of consultations in week 12: Total consultations were 32,192 marking a 10% decrease in comparison to the previous week (n=36,167)

Leading cause of morbidity and mortality in week 12: Malaria (suspected n= 7,292; confirmed n= 4,445) was the leading cause of morbidity reported through EWARS accounting for 32% of the reported cases, while neonatal deaths (5) was the leading cause of mortality reported through EWARS accounting for 41% of the reported deaths

Number of alerts in week 12: Forty-four (44) indicator-based alerts were generated with 98% of them verified

Figure 1 | Trend in consultations

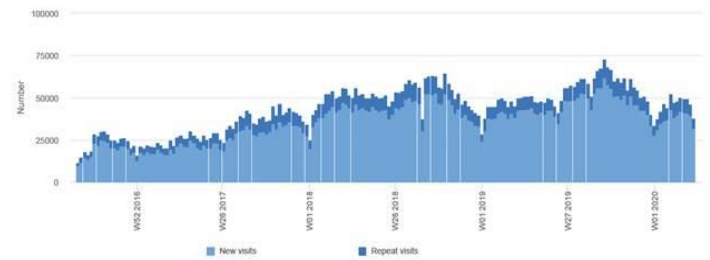


Figure 1a | Proportional morbidity (W12)



Malaria (confirmed)
Malaria (suspected)
Acute Respiratory Infection
Acute Watery Diarrhoea
Bloody diarrhoea

Figure 1b | Proportional mortality (W12)

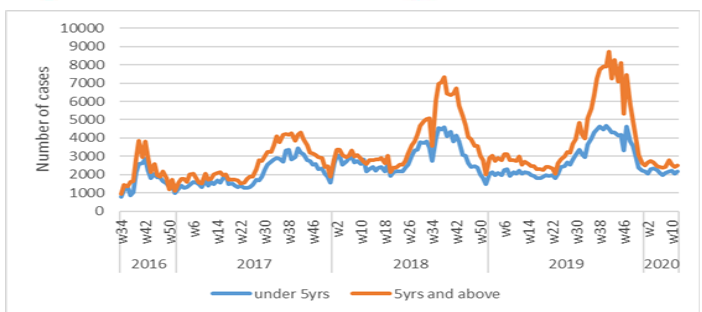


Malaria (confirmed)
Malaria (suspected)
Acute Respiratory Infection
Acute Watery Diarrhoea
Bloody diarrhoea
Severe Acute Malnutrition
Maternal death
Neonatal death
Other

Morbidity Patterns

Malaria: In Epi week 12, 4,445 cases of confirmed malaria were reported through EWARS. Of these, 400 were from General Hospital in Biu, 247 were from Pulka PHC in Gwoza, 204 were from Uba General Hospital in Askira-Uba, 157 were from Gwange PHC in MMC, 136 were from Biriyelel MCH in Bayo, 118 were from Algon clinic in Monguno, 108 were from Wandali PHC in Kwaya Kusar and 101 were from Askira General Hospital. One (1) associated death was reported from Whitambaya Dispensary in Hawul.

Figure 2: Weekly Trend of Malaria Cases by Week in Borno State Wk34 2016 – 12 2020



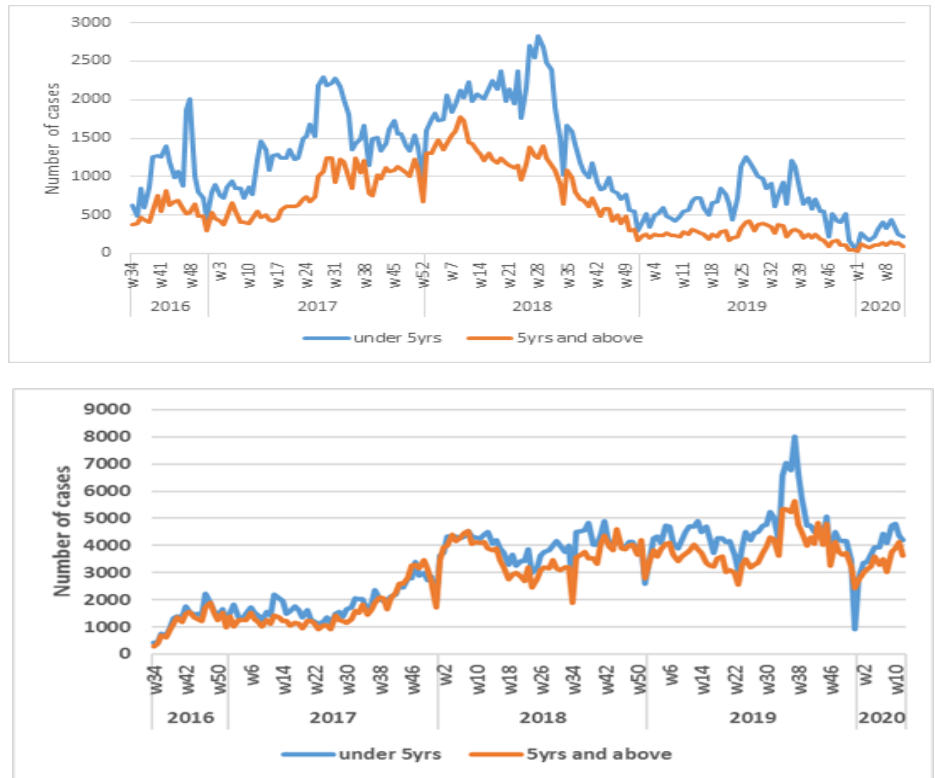
Acute watery diarrhoea: In Epi week 12, 315 cases of acute watery diarrhea were reported through EWARS. Of the reported cases, 57 were from PUI mobile clinics in MMC, 43 were from Sabon Gari Lowcost IDP camp clinic (MDM) in Damboa, 34 were from Herwa Peace PHC in MMC, 33 were

from FHI360 PHC Damasak in Mobbar, 17 were from Kautikari Federal Health Clinic in Chibok and 16 were from Hausari IDP camp clinic (MDM) in Damboa. No associated death was reported.

Figure 3: Trend of acute watery diarrhea cases by week, Borno State, week 34 2016- 12 2020

Acute respiratory infection: In Epi week 12, 7,393 cases of acute respiratory infection were reported through EWARS. Of the reported cases, 854 were from PUI mobile clinics in MMC, 444 were from Pulka PHC in Gwoza, 358 were from FHI360 clinic Banki in Bama, 311 were from Hausari IDP camp clinic (MDM) in Damboa, 307 were from General Hospital Ngala (FHI360), 239 were from ICRC FSP Clinic in Monguno, 237 were from Sabon Gari Lowcost IDP camp clinic (MDM) in Damboa and 229 were from ICRC GGSS IDP Camp Clinic in Monguno. No associated death was reported.

Figure 4: Weekly Trend of Acute Respiratory Infection in Borno State, Wk 34 2016- 12 2020



Suspected Measles: Eighty-six (86) suspected measles cases were reported through EWARS in week 12. Of the reported cases, 17 were from General Hospital Magumeri, 16 were from PUI Mobile clinics in MMC, 9 were from Vinadam Dispensary in Hawul, 6 cases each from Biriye MCH in Bayo and Garu MCH in Chibok, 3 cases each from Gomari PHC in Jere, ICRC FSP Clinic in Monguno and Wawa Dispensary in Kwaya Kusar. Twenty-one (21) additional cases were reported through IDSR* from Dikwa (1), Konduga (1), MMC (1) and Monguno (18) LGAs making a total of 107 suspected measles cases. No associated death was reported

Suspected Yellow Fever: Six (6) suspected yellow fever cases were reported through EWARS from Jaragol Clinic (1) in Bayo, Njimtilo Health Clinic (1) in Konduga, Giwi Dispensary (1) in Askira-Uba, EYN Wamdeo (1) in Askira-Uba, ICRC Clinic in Monguno and Limanti Dispensary (1) in Bayo. Three (3) additional cases were reported through IDSR* from Askira-Uba (1), Kala-Balge (1), MMC (1) LGAs making a total of 9 suspected yellow cases. No associated death was reported.

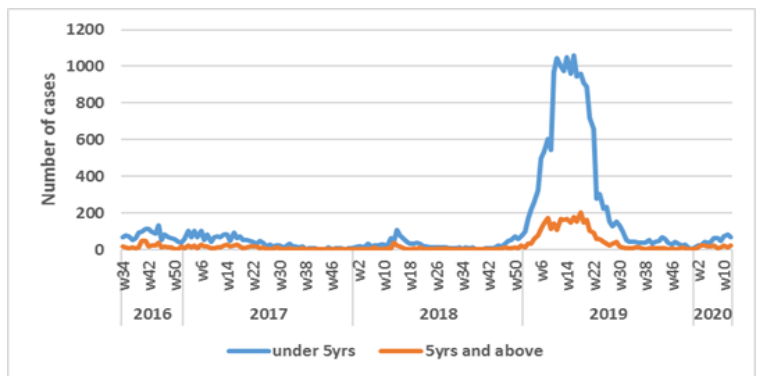


Figure 5: Weekly Trend of Suspected Measles Cases in Borno State, Wk 34 2016 - 12 2020

Suspected Meningitis: Two (2) suspected meningitis cases were reported through EWARS from University of Maiduguri Teaching Hospital (2) in Jere. No associated death was reported

Suspected VHF: No suspected VHF case was reported through EWARS in week 12

Suspected cholera: No suspected cholera case was reported in week 12

Malnutrition: 1,179 cases of severe acute malnutrition were reported through EWARS in week 12. Of the reported cases, 85 were from Gajiram FSP in Nganzai, 58 were from Kurbagayi MCH in Kwaya Kusar, 39 were from Umaru Shehu Hospital in Jere, 38 were from Muna Garage Camp Clinic A in Jere, 35 were from General Hospital Ngala (FHI360) and 30 were Muna Garage Camp Clinic B in Jere. No associated death was reported

Neonatal death: Five (5) neonatal deaths were reported through EWARS from University of Maiduguri Teaching Hospital (5) in Jere

Maternal death: No maternal death was reported through EWARS in week 12.

**IDSR- Integrated Disease Surveillance and Response*

Health Sector Actions

ALIMA in collaboration with SMOH, continued the provision of lifesaving medical and Nutrition services to the disaster affected communities as well as supporting the Borno State Government in Health Systems Strengthening through provision of service delivery, essential medicines, training and infrastructure improvement initiatives. 11,500 outpatient consultations were provided and managed 158 patients in the Inpatient Department. 558 deliveries were assisted by a skilled attendant and 1,102 PNCs and 4,127 ANC consultations were conducted. A total of 14 C-Sections were performed at Monguno General Hospital. 15 Measles cases were treated at health facilities in Monguno with most of the cases were from Fulatari, Abbari and Julari village. There is continuous sensitization and awareness to the community in order to strengthen the promotion of appropriate health seeking behaviour. Working alongside the local government authorities, immunization campaign has been launched in the above mentioned and surrounding villages where new IDPs influx is more. The community health volunteers are providing health education to the local community in raising awareness about personal hygiene and benefits of childhood immunization.

There is readiness to support the Borno state in case management and training as part of emergency preparedness plan for COVID-19 outbreak. Sensitization has commenced in Monguno as part of response to COVID-19 pandemic with good IPC in place at the hospital.

953 ANC and 143 PNC consultations were provided in which 349 ANC are first visit and PNC within 72 hours of delivery is 120 at Muna Clinic with 4 referrals. The Teachers Village clinic, 831 pregnant women in total came for ANC (ANC1, 371) while the total PNC consultations were around 201 (PNC within 72hours 147). In Askira/Uba and Hawul LGAs in south Borno, 9 PHCs and 1 General Hospital in Askira were supported. A total of 3,519 OPD consultations for children under 5 were conducted which is a bit low considered to last month consultation due to the reduction in malaria morbidity. 40 hospitalizations for under 5 years. Additionally, 237 deliveries were recorded and 1,048 ANC consultations were conducted. 152 children admitted suffering from SAM in ATFC and treated 6 complicated SAM cases at the ITFC in Askira General Hospital.

BEmOC activities were conducted at CBDA Clinic where 102 deliveries were recorded which is high compared to last month delivery, a total of 9 referrals was made to secondary/tertiary care and 142 deliveries were conducted at TVC Clinic, the total number of deliveries is higher compared to last month deliveries. Traditional Birth Attendants (10) in Muna and TVC (8) were engaged to refer patients from the community for delivery at CBDA and TVC Clinic. Concerning training, 10,286 caretakers completed ALIMA facilitated MUAC-mother training sessions; and 91% have shown mastery in the use of the MUAC tapes during the training post-test evaluations.

Major challenge is the closure of international Airport/boarders as a result of the covid-19 pandemic leading to delay in delivery of international procurement and local purchase.

UNICEF continues to support the SMOH with integrated PHC services. A total 181,379 of children, women and men were reached with integrated PHC in all the UNICEF supported health facilities in the IDP camps and host communities in Adamawa, Borno and Yobe States, out of which 93,949 (51.8%) were children below five years.

During the reporting period, 77,849 Out-Patient Department curative consultations were recorded with Malaria – 21,176 being the major cause of consultation, followed by ARI – 18,050; AWD – 7,195; measles – 263, and other medical conditions – 31,165. A total of 97,349 prevention services were recorded including 4,759 children vaccinated against measles through RI services; 46,357 children and pregnant women reached with various other antigens; Vitamin A capsules – 11,408, Albendazole tablets for deworming – 12,2687, and ANC visits – 19,745, and 2,393 LLINs distributed through RI and ANC clinics in Adamawa, Borno and Yobe States. A total of 3,481 deliveries (skilled delivery – 3,019, unskilled – 417) and 2,700 postnatal/home visits were recorded.

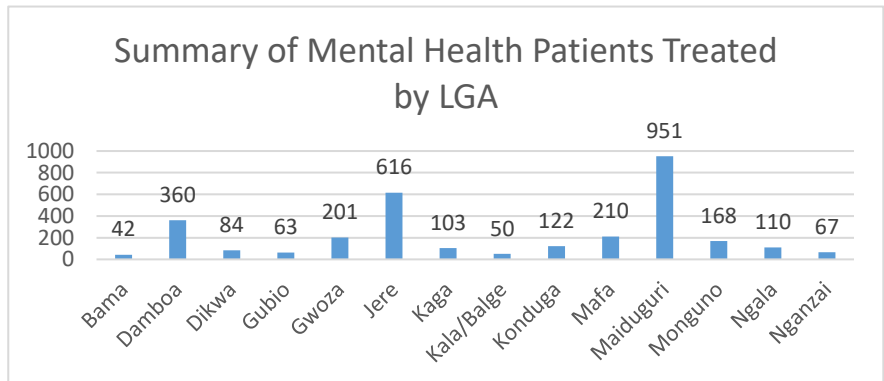
WHO supported Yobe SMOH to develop draft COVID-19 Preparedness and Response plan in the wake of the COVID-19 pandemic. WHO teams in Yobe provided technical support in drafting preparedness plan across 8 key thematic pillars-Coordination; Surveillance and Epidemiology, Point of Entry (POE); Laboratory; Case Management; Infection Prevention and Control (IPC); Risk Communication and Social Mobilization; and Logistics and Supplies. WHO is also supporting SMOH and partners, to commence implementation of key preparedness activities such enhanced surveillance, risk communication and social distancing measures, IPC and establishment of Isolation Centers. So far, although no

suspected case(s) is reported in Yobe, two well-equipped 20-bed capacity Isolation Centers have already been established in Yobe State University teaching Hospital (YSUTH) and State Specialist Hospital (SSH) Damaturu.

The Borno state Commissioner for Health briefed journalists on the Borno state preparedness for COVID-19. Acknowledging that Borno state has not confirmed a case of COVID-19, Kwaya-bura stated that it is imperative to scale up preparedness especially surveillance and risk communication. “We do not have any cases of COVID-19 in Borno state yet, the State Ministry of Health with the support of WHO and partners has activated Emergency Operations Centre that developed a comprehensive preparedness plan ahead of COVID-19 outbreak,” says Kwaya-bura.

The Health Commissioner highlighted the level of preparedness that Borno state has taken including initiating temperature screening at the airport for all travelers as well as detailed documentation and close monitoring of travelers arriving from countries where COVID-19 transmission is active. Other response trims include case management, infection prevention control, contact tracing, surveillance and risk communication.

WHO-Mental Health supported specialized mental health services with 103 mental health outreach care sessions across 14 LGAs (Bama, Damboa, Dikwa, Gubio, Gwoza, Jere, Kaga, Kala/Balge, Konduga, Mafa, Maiduguri, Monguno, Ngala, and Nganzai) in 41 health facilities. A total of 3,147 patients were treated, 24 referred to Federal Neuro Psychiatric Hospital (FNPH) Maiduguri for further management and 9 admitted for inpatient treatment.



In any epidemic, it is common for individuals to feel stressed and worried. Furthermore, frontline workers (including nurses, doctors, ambulance drivers, case identifiers, and others) may experience additional stressors during the COVID-19 outbreak. Some of these fears and reactions spring from realistic dangers, but many reactions and behaviours are also borne out of lack of knowledge, rumours and misinformation. Series of meetings by key MHPSS SWG had a round table discussion on MHPSS in relation to COVID-19 outbreak. Key areas considered for preparedness and response plan include:

- Helping older adults cope with stress during the COVID-19 outbreak
- Supporting the needs of people with disabilities during a COVID-19 outbreak
- Messages & activities for helping children deal with stress during the COVID-19 outbreak
- MHPSS activities for adults in isolation/quarantine
- Supporting people working in the COVID-19 response
- Community MHPSS messages during the COVID-19 outbreak e.g. facts against myths, and what to do when confused, distressed, sad, worried, angry or scared.

UNFPA in collaboration with Ministry of health continue to strengthen preparedness, prevention and response to covid19 outbreak. Continue access to comprehensive sexual reproductive healthcare services despite the covid19 pandemic remain our priority. The safety of pregnant, lactating women and delivery during this period take the front approach, we have also in compliance with covid19 guideline strategically put place an aqua kit, hand sanitizers being used by client and the service providers, social distancing is also being observed across supported integrated facilities. The SRH services is being deliver strategically through the MISP framework prioritizing coordinated approach, reducing transmission of HIV aids, ensure clinical management of rape is available for survivors of sexual violence, safe delivery, ANC, PNC, STIs, including Family Planning services. SRH/ASRH Information and sensitizations is key with covid19 response plan and we have reached 1,689 individuals with Sexual reproductive health/covid19 through sensitization and awareness rising. We also reached 40 lactating mothers and pregnant women with critical materials including Dignity kits across integrated facilities.

The effort to reduce excess maternal morbidity and mortality continue as 362 women attended ANC, 22 deliveries supported by skilled birth attendance, 377 women of reproductive age received family planning services across the service points and 22 PNC consultation were provided at UNFPA integrated Health facility.

Coordination: Monthly Sexual reproductive health partners’ coordination meeting held virtually. Covid19 preparedness, prevention and response was discussed giving vulnerability of pregnant, lactating mother and during delivery, partners are working closely with pillar lead of covid19 taskforce to ensure training of personnel and PPE,

aqua kit and hand sanitizers all positioned as well as social distancing observe in all the facilities most especially with the IDP camps. Borno state response plan and other WHO guidance prioritizing women and reproductive age shared with partners.

Supply lifesaving drugs and commodities: The supply chain and provision of medical supplies and commodities remain a priority of the agency, we handed over 190 Emergency Reproductive Healthcare Kits. It is a lifesaving sexual and reproductive healthcare reusable and disposable equipment and commodities, distributed to secondary health facilities to support emergency obstetric case and ensure all delivery are safe across BAY states.

The referral level facilities that benefited include:

1. University of Maiduguri Teaching Hospital. Kit 11 A 1 cartons, kit 12, I carton, Kits 11B, 20 cartons
2. State Specialist Hospital, kit 7, 1carton, kit 9, 1 carton, kit 11A, 1carton kit11b 20 cartons, kits12 I carton
3. Ultramodern Umaru Shehu Yar'adua hospital. Kit11A, 1 carton, Kit 11b, 15,000
4. General Mamman Shuwa Memorial Hospital (Nursing Home) Kit 11b, 15,000
5. Bama General Hospital, kit 11b 10,000
6. Monguno General Hospital: kit 11b 10 cartons
7. Biu General Hospital kit 11b 15 cartons
8. General Hospital Kwaya Kusar kit 11B 10 cartons
9. General Hospital Bayo kits 11 B 10 cartons
10. Mala Kachalla MCH kit 11B 10 cartons
11. Yerwa Maternal and Child Health kit 11b 13 cartons
12. Fatima Ali Sheriff Kit 11B 10 cartons
13. General Hospital Marama kit 11B 10 cartons
14. General Hospital Molai Kit 11B 15 cartons

Capacity Building: To ensure qualitative service provision we have trained and deployed 30 Doctors, midwives/Nurses in clinical management of rape to strengthen healthcare/medical care services to survivors of sexual violence and gender based violence across Borno, Adamawa and Yobe states. Receiving the 190 Emergency reproductive health kits are: Director Medical Emergency and Humanitarian Response Services.



Nutrition updates

ALIMA provided total of 1,599 OPD consultations for children under 5 in Muna Clinic with 22 referrals and 3,252 consultations for all ages in TVC Clinic with 35 referrals. Nutrition interventions were conducted in all ALIMA ATFC, at Muna Clinic a total of 149 new SAM cases were admitted and 84 cases were discharged from the program. 13 SAM cases with complications were transferred out to ALIMA ITFC at UMTH. In total, ALIMA supported ITFC at UMTH admitted 61 new SAM cases with complications and discharged 58.

A total of 1,496 OPD consultations for all ages at Water Board Reception Clinic in Monguno. Nutrition interventions were conducted in the ATFC at Water Board Reception Clinic where with 35 new SAM cases were admitted and 7 were discharged from the program. 4 SAM case with complications was transferred from ATFC at ITFC.

Public Health Risks and Gaps

- High risk of epidemic outbreaks especially cholera, meningitis, measles, yellow fever. The northeast region is highly endemic for malaria and cholera.
- Unpredictable security situation hampers movements of health workers, drugs and other medical supplies.
- Although health situation is improving under the NE Nigeria Health Sector 2019 Strategy, the health service delivery continues to be hampered by the breakdown of health facilities infrastructure.
- There is a serious shortage of skilled health care workers, particularly doctors, nurses and midwives, with many remaining reluctant to work inaccessible areas because of ongoing armed conflict.
- Continuous population displacements and influx of returnees and/or refugees disrupt and further challenges the health programs implementation.
- Access to secondary health care and referral services in remote areas is significantly limited.
- Unavailability of network coverage in the newly liberated areas negatively affects timely submission of health data for prompt decision-making.

Health Sector Partners and Presence

Federal Ministry of Health and Adamawa, Borno and Yobe State Ministries of Health, UN Agencies: IOM, OCHA, UNFPA, UNICEF, UNDP, WHO, National and International NGOs: ALIMA, Action Against Hunger, Action Health Incorporated, AGUL, CARE International, COOPI, GOAL PRIME, Janna Foundation, MSF (France, Belgium, Spain and Switzerland), ICRC, INTERSOS, Malteser International, Medicines du Monde, Premiere Urgence Internationale, International Rescue Committee, eHealth Africa, FHI-360, International Medical Corps, Catholic Caritas Foundation of Nigeria, Nigerian Red Cross Society, Victims of Violence, Terre des hommes, SIPD, Swift Relief Foundation, Nigeria Centre for Disease Control, RUWASA, BOSEPA, PCNI, BOSACAM; other sectors (WASH, Nutrition, Protection, CCCM, Food Security, Shelter and RRM), Nigerian Armed Forces and Nigerian Air Force.

-Health sector bulletins, updates and reports are now available at <http://health-sector.org>

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