

## **Full Length Research**

# **An analysis of communication strategies for mass mobilization against the spread of Covid-19 in Kogi State**

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The paper analyses communication strategies for mass mobilization against the spread of COVID-19 in Kogi state. This attempt at an *expose* seeks to find out the communication strategies that have been effective, for whom and in what context and the evidences that show the possibilities of strategies adopted. In order to better understand the issues, the health belief model was the anchor theoretical framework, which x-rayed the belief system that have and could be adopted by citizens over the years. This perspective affords policy formulators to know how behaviours are formed and what strategy will best fit a particular environment; risk communication and community engagement (RCCE) or behavioural change communication (BCC). Conclusively, this paper significantly points out the flaws in the strategy adopted on the national front because it affected the economic life of the people. The key to effective risk communication during pandemic is the adoption of behavioural change communication, which will engender reduced incidences when they arise.

**Keywords:** COVID-19, communication, mass mobilisation, strategies.

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## **INTRODUCTION**

Like every other pandemic that has ravaged the world in times past, the world was hit with COVID-19 in December 2019. The novel Coronavirus disease (COVID-19), first identified in Wuhan China, rapidly spread to almost every region of the world. The disease, is caused by a new and severe type of Coronavirus known as Severe Acute Respiratory Syndrome Coronavirus (SARS CoV-2). According to Worldometers (2020) the infection didn't have immediate treatment and vaccine, and has according to World Health Organization become a worldwide pandemic causing significant morbidity and mortality. However, the vaccine dilemma

has changed in recent months. There were 1,603,428 confirmed cases, 356,440 recoveries from the illness and 95,714 deaths worldwide as of April 9, 2020), and some parts of the world have witnessed the second and third waves of the pandemic.

The Nigerian situation stemmed from an Italian citizen who became the index case for COVID-19 on February 27, 2020, and as at April 9, 2020, there were 288 laboratory confirmed cases of COVID-19 in Nigeria with 51 discharges and 7 deaths. However, recent figures by the Nigerian Centre for Disease Control (NCDC) as of 8<sup>th</sup> March, 2021 stands at; total confirmed cases – 158, 535, discharged – 138, 041 and deaths – 1, 969. To prevent further spread of the virus, civil societies and government

agencies embark (ed) on enlightenment campaigns for good hygiene and social distancing. Temperature screening, conducted at airports and those returning from countries with numerous confirmed cases of COVID-19 are/were implored to self-isolate. The National Centre for Disease Control (NCDC) in association with State governments also began the tracing and tracking of possible victims and their contacts. On March 18, 2020, the Lagos State government suspended all gatherings above fifty people for four weeks and ordered all lower and middle level public officers to stay-at-home Ewodage (2020).

Similarly, the Federal government, on March 30, 2020 introduced various containment strategies such as closing of the national borders and airspace, schools, worship centers and other public places, canceling of mass gathering events and placing the Federal Capital Territory (FCT), Lagos and Ogun states on lock down for an initial period of fourteen days (Radio Nigeria, 2020). Covid-19 testing laboratories were set up in Lagos, Abuja and Irrua in Edo State while State governments opened isolation centers and imposed dawn to dusk curfews in their territories.

It can never be overemphasized that knowledge of infection pathways and relevant precautions to take is needed to control the pandemic. While communication strategies are adopted on a daily, it is expected that adequate knowledge will motivate individuals to make decisions which may prevent and curb the pandemic. Knowledge of regular hand washing, using hand sanitizers, wearing face masks, respiratory etiquettes, social distancing and self-isolation when sick are vital to reducing widespread infection (Leppin & Aro, 2009). Studies (Brug, Aro, Oenema, de Zwart, Richardus and Bishop; 2004, Choi & Yang; 2010, Hussain, Hussain, & Hussain; 2012) revealed that individuals' level of knowledge about an infectious disease can make them behave in ways that may prevent infection. Consequently, individuals may need to be informed about the potential risks of infections in order to adopt the right precautionary measures (Brug, Aro, Richardus, 2009). Knowledge of infection pathways and relevant precautions to take is needed to control the pandemic.

The media have consequently had a field day in reporting issues surrounding COVID-19 and by extension continued to sensitize the public on the safety protocols to abide by. In the wake of the COVID-19 pandemic, the Governor of Kogi State, Alhaji Yahaya Bello made a declaration of, '*we gat no Covid*' in the state but alongside setup a committee headed by his Deputy, Chief Edward Onoja to ensure the safe health of citizens in the state. Most importantly, the communication strategy adopted by the media in the state was perhaps the initiative of preventive health by rolling out jingles, while the state remained open for business. This is in contrast with the strategies adopted by the World Health

Organisation (WHO), independent countries and comity of nations. A Critical Discourse Analysis (CDA), backed by documentary evidences of the communication strategies adopted on different fronts are constructively dealt with in this paper, most especially as it concerns Kogi state. It is expected that strategies that fit the peculiarities of communities, and nations of the world need to be critically looked into and that's the idea behind this analysis.

Both local level engagement and social mobilization efforts that specifically support the delivery of COVID-19 specific control and mitigation measures and those that build broader social solidarity under constrained circumstances will only become more important as the pandemic evolves. Despite the official recognition of the value of community engagement, and the observation of protocols, there is still limited evidence-based guidance or standards for what effective community engagement or social mobilization efforts should entail in a state like Kogi or how this may differ by setting, or adapted to include specific groups within a community. But the problem seem to be the one-size fits all solution. It is against this backdrop, this paper aims to analyse the communication strategies for mass mobilization against COVID-19 in Kogi state. Consequently, this paper surrounds its discourse around these two major areas; to find out the communication strategies that have been adopted, for whom and what context during the COVID-19 pandemic; to ascertain the evidence that show the possibility of approaches that engage the people in mass mobilization against COVID-19.

## Literature Review/Theoretical Framework

A myriad of different studies have been conducted on various specific aspects of health communication. Overall, these studies indicate that communicating to people requires integration into a community that includes presenting material in a manner that persons are familiar with and allowing for discussion and input from members. For instance, cultural familiarity often affects the way that medical information is effectively communicated in some areas. This may occur when comparing the usage of traditional medicine versus Western biomedical medicine, people in rural settings typically tend to use traditional medicine because it is more fully integrated in African lifestyles and is more familiar than biomedical medicine (Aries, Joosten, Wedgda & van der Geest, 2007). This preliminary understanding of the weight given to known information sources is the first aspect of African culture that needs to be understood when communicating biomedical health information to the population. As a result, this norm of sticking to the familiar seen with traditional medicine usage is expanded to being applicable to behavioural

change and that is where strategic mobilization come to play. According to Wolf & Bond, (2002);

Among adults and adolescents, peer education increases the chances that individuals will change their behaviour by 1.74 times the normal amount simply due to the similarities that can exist between the educator and the target. Essentially, the higher the demographic similarities between the educator and the target group, the larger the increase in behavioural change towards the desired result.

These demographic similarities, along with trends toward the familiar, can be observed in effective health communication that is strategic. In the late 1940s, when health communication in a country like Ghana by the government was beginning, attempts at showing film clips and using other modern technology failed. It was only through the use of specially designed puppet shows and performances tailored to the specific ethnic groups that the desired behaviour and awareness level change occurred (Du Sautoy, 1958).

It has been determined that the best communication strategy for developing countries is based on the idea of integration with the community. The principles of "inclusion, participation and self-determination" help defeat the major problems seen with solely increasing comprehension of why a certain health behaviour is wrong (Ford, Abimbola, Renshaw & Nkum, 2005); such problems with just increasing comprehension include the fact that just understanding an issue does not lead to a change in behaviour and that awareness alone does not hold people responsible for their own health. Allowing people to have input on how health information is going to help them change by both discussing different communication channels to be used and setting goals for desired change together provide such responsibility (Ford, Abimbola, Renshaw & Nkum, 2005). Through these studies, it is clear that the closer a message is to the culture, expectations, and lifestyle of individuals and the more integrated a campaign is, the more effectively health communication information can be communicated to the people.

Nigeria's secular and developing state contributes for developmental activities. Therefore, the need for communication with the people through different media has assumed great importance. Communication with the people is necessary in any society and any form of government, especially democratic society depends much more. People must be told about government plans, programmes, policies, activities, successes and achievements. Reactions from the people to the policies and programmes must reach the policy-makers and administrators to modify, change, and continue the programme and to involve people and to get their willing

participation. Mass media is a potentially powerful tool in the effort to address the many public services and other social challenges facing this country. Media production is developing a strategic plan to address the entire scope of health communication, including research, creative strategy, production, distribution and evaluation.

Randy (2004) opines that, in a country of Nigeria's size and population, diversity of religions, languages, regional imbalances and several other factors, it is not easy to evolve a national communication policy or generally acceptable information strategy. Nevertheless, such a policy is essential to give some direction to mass media.

### **Message Content**

One important aspect of message content involves the themes used to motivate the desired behaviour change. Some common motivational themes in mass media campaigns to prevent unhealthy behaviours include: fear of legal consequences, promotion of positive social norms, fear of harm to self, others, or property and stigmatizing unhealthy behaviours as irresponsible and dangerous. The actions promoted by the campaigns also vary, ranging from messages related to abstinence or moderation to more specific behavioural recommendations. Decisions related to message content are generally made based on the opinions expressed by experts or focus groups rather than on evidence of effectiveness in changing behaviour.

Another aspect of message content relates to the optimal amount of anxiety produced (Witte & Allen, 2000; Tay, 2002). The effectiveness of "fear-based" campaigns is the subject of a long-standing controversy. Some level of anxiety arousal is generally seen as a desirable motivator. However, several authors have cautioned that generating intense anxiety by emphasizing the severity of a problem and the audience's susceptibility to it can cause some people to ignore or discount the campaign messages. This was the approach the governor of Kogi state tried to demystify. He played down the fears that ensued and emphasized that it was like any other form of fever known to man and that regular exercise, accompanied with proper diet was enough to resolve such health challenges.

Although this caution appears to be justified, increasing the strength of a fear appeal also increases the probability that the audience will change their attitudes, intentions, and behaviours. These changes are maximized, and defensive avoidance minimized, when the anxiety-arousing message is accompanied by specific information about actions that people can take to protect themselves. The degree of persuasion versus defensive avoidance produced may be influenced by interactions between the message content and characteristics of the recipient. For instance, strong fear appeals may be more

effective for motivating a response among segments of the audience that initially do not view the problem addressed as being important or relevant to them. They may also be more persuasive to people who are already engaging in the desired behaviour.

### **Message Delivery**

A mass media campaign cannot be effective unless the target audience is exposed to, attends to, and comprehends its message. Two important aspects of message delivery are control over message placement and production quality. Control over message placement helps to ensure that the intended audience is exposed to the messages with sufficient frequency to exceed some threshold for effectiveness. It also allows for the optimal timing and placement of those messages.

This control can only be assured with paid campaigns. Those that rely solely on donated public service time may attain adequate exposure, but message placement and frequency are ultimately left to media schedulers and station management; paid advertising time always gets preferential placement. Assuming that the target audience is adequately exposed, high production quality of the campaign messages may maximize the probability that the audience will pay attention to them. High production quality may also improve the chances of eliciting the intended emotional impact.

### **Message Pretesting**

Pretesting of community health programmes and messages is also thought to be important for a successful outcome (Hornik & Woolf, 1999). Pretesting can help to assess which themes or concepts are most relevant to the target audience. It can also help to ensure that the target audience will attend to and comprehend the specific messages presented. The importance of pretesting is highlighted by an evaluation of a mass media campaign designed to prevent alcohol-related problems by encouraging drinking in moderation. No pretesting of ads was done for this campaign, and a survey conducted at mid campaign found that over a third of respondents thought that the ads were promoting alcohol consumption. Many mistook them for beer ads.

### **Review of Empirical Studies**

In 2015, Rosanna, Elisa and Silvio, studied Health Promotion Campaigns and Mass Media: Looking for Evidence. Their research revealed that Public health programmes may benefit from use of mass media to promote positive health behaviours, but there is not clear evidence about their impact. This study consisted in a literature review that explores the relationship, in terms of methodology and effectiveness, of the interventions for

health promotion carried out by the use of mass media in the last fifteen years. Pub Med, CINAHL, COCHRANE CCTR, EPPI-CENTRE TRo PHI, TRIP Database, SCOPUS and WEB OF SCIENCE were searched for studies, published between 2000 and 2014, focusing on health promoting campaigns using not interpersonal channels of communication (mass media, such as television, radio, newspapers, billboards, posters, leaflets). Abstracts of them were examined with respect to media tools, health topics, target age groups, programmes duration, outcomes (Knowledge, Attitude, and Practice - KAP).

Among 10, 571 publications 50 studies related to use of mass media in health preventing campaigns were included in the review. A single media was used in the majority of the programmes (58%) and television resulted the most used (26%), while 26% utilized mix of media and 16% all media together. Health topics of the programmes were: tobacco control (28%), substances misuse (18%), physical activity (18%), and sexual health (12%). Sixty eight percent of campaigns were directed to a single age class and adults were the most frequently involved (42%). Thirty two percent of programs addressed two or more age groups. Programs reporting at least one statistically significant improvement in outcome indicators categories were 68%. The study suggests that a standardised approach is needed to contribute to the progress of the scientific knowledge in the field of the implementation of public health intervention using mass media.

In another study, Naveena (2015) studied the importance of Mass Media in Communicating Health Messages: An Analysis. Naveena said, the demand for information about health has grown exponentially in the last few years. The media is an important ally in any public health situation. The local and international media play a vital role as the link between health workers and the larger public. Health authorities educate and entrust the media with essential health information, which is then relayed to the public in readily accessible formats through a variety of media channels.

The study revealed that mass media helps health workers expand their audience reach, which is crucial considering the fact that face-to-face channels of communication often require too many human resources and reach only a small number of people in large, underserved rural areas. The mass media provides an important link between the rural residents and vital health information. The mass media, in the form of the radio and television, are an effective way to persuade target audiences to adopt new behaviours, or to remind them of critical information. Besides informing the public about new diseases and where to seek help, they can also keep the public updated. The study which was based on secondary data collected relevant sources. The researcher noted that, the mass media holds out a

possibility of on-demand access to content anytime, anywhere, on any communication devices.

Furthermore, Megan (2010) carried out a research on "A Brief Look at Effective Health Communication Strategies in Ghana". Megan was of the opinion that, Health communication is widely considered to be a major aspect of any public health campaign. Strategies integrated into a community, based on personal contact and delivered through culturally appropriate media, are effective communication tools in Ghana. However, no comprehensive research has been conducted to analyse the success of public health campaigns that include extensive use of interpersonal communication. The goal of the research conducted was to discuss the impact of personal contact in the success of Ghanaian public health initiatives. An analysis of four different public health campaigns in Ghana was performed, examining the communication strategies used in each. It was determined that using interpersonal communication, in conjunction with other appropriate strategies, gives the highest success rate in Ghanaian health campaigns.

## Theoretical Framework

### Health Belief Model

The health belief model is one of the first theories of health behaviour; the health belief model was developed in the 1950's by social psychologists Irwin M. Rosenstock, Godfrey M. Hochbaum, S. Stephen Kegeles, and Howard Leventhal at the U.S. Public Health Service to better understand the widespread failure of screening programs for tuberculosis. The health belief model (HBM) is a psychological health behaviour change model developed to explain and predict health-related behaviours, particularly with regard to the uptake of health services.

The health belief model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action and efficacy explain engagement (or lack of engagement) in health-promoting behaviour. A stimulus, or cue to action, must also be present in order to trigger the health-promoting behaviour. The health belief model has been applied to predict a wide variety of health-related behaviours such as being screened for the early detection of asymptomatic diseases and receiving immunizations. More recently, the model has been applied to understand patients' responses to symptoms of disease, compliance with medical regimens, lifestyle behaviours (e.g., sexual risk behaviors), and behaviours related to chronic illnesses, which may require long-term behaviour maintenance in addition to initial behaviour change. Amendments to the model were made as late as 1988 to incorporate emerging evidence within the field of psychology about the role of self-efficacy in decision-making and behaviour.

### Tenets of the theory

1. The health belief model proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviours to prevent the health problem from occurring (or reduce its severity). Perceived seriousness encompasses beliefs about the disease itself (e.g., whether it is life-threatening or may cause disability or pain) as well as broader impacts of the disease on functioning in work and social roles.

2. The health belief model predicts that individuals who perceive that they are susceptible to a particular health problem will engage in behaviours to reduce their risk of developing the health problem. Individuals with low perceived susceptibility may deny that they are at risk for contracting a particular illness. Others may acknowledge the possibility that they could develop the illness, but believe it is unlikely. Individuals who believe they are at low risk of developing an illness are more likely to engage in unhealthy, or risky, behaviours. Individuals who perceive a high risk that they will be personally affected by a particular health problem are more likely to engage in behaviours to decrease their risk of developing the condition.

3. The health belief model predicts that higher perceived threat leads to higher likelihood of engagement in health-promoting behaviours. However, Perceived benefits talks about health-related behaviours that are also influenced by the perceived benefits of taking action.

4. Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease risk of disease. If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behaviour regardless of objective facts regarding the effectiveness of the action. For example, individuals who believe that wearing sunscreen prevents skin cancer are more likely to wear sunscreen than individuals who believe that wearing sunscreen will not prevent the occurrence of skin cancer.

Perceived barriers also have to do with health-related behaviours, which are also a function of perceived barriers to taking action. Perceived barriers refer to an individual's assessment of the obstacles to behaviour change. Even if an individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behaviour. In other words, the perceived benefits must outweigh the perceived barriers in order for behavior change to occur. Perceived barriers to taking action include the perceived inconvenience, expense, danger (e.g., side effects of a medical procedure) and discomfort (e.g., pain, emotional upset) involved in engaging in the behaviour.

For instance, lack of access to affordable health care and the perception that a flu vaccine shot will cause significant pain may act as barriers to receiving the flu vaccine. Modifying variables Individual characteristics, including demographic, psychosocial, and structural variables, can affect perceptions (i.e., perceived seriousness, susceptibility, benefits, and barriers) of health-related behaviors. Demographic variables include age, sex, race, ethnicity, and education, among others. Psychosocial variables include personality, social class, and peer and reference group pressure, among others. Structural variables include knowledge about a given disease and prior contact with the disease, among other factors.

The health belief model suggests that modifying variables affect health-related behaviours indirectly by affecting perceived seriousness, susceptibility, benefits, and barriers. There is also Cues to action; here the health belief model posits that a cue, or trigger, is necessary for prompting engagement in health-promoting behaviours. Cues to action can be internal or external. Physiological cues (e.g., pain, symptoms) are an example of internal cues to action. External cues include events or information from close others, the media, or health care providers promoting engagement in health-related behaviours. Examples of cues to action include a reminder postcard from a dentist, the illness of a friend or family member, and product health warning labels. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers. For example, individuals who believe they are at high risk for a serious illness and who have an established relationship with a primary care doctor may be easily persuaded to get screened for the illness after seeing a public service announcement, whereas individuals who believe they are at low risk for the same illness and also do not have reliable access to health care may require more intense external cues in order to get screened.

Self-efficacy was also added to the four components of the health belief model (i.e., perceived susceptibility, seriousness, benefits, and barriers) in 1988. Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behaviour. Self-efficacy was added to the health belief model in an attempt to better explain individual differences in health behaviors. The model was originally developed in order to explain engagement in one-time health-related behaviors such as being screened for cancer or receiving an immunization. Eventually, the health belief model was applied to more substantial, long-term behavior change such as diet modification, exercise, and smoking. Developers of the model recognized that confidence in one's ability to effect change in outcomes (i.e., self-efficacy) was a key component of health behaviour change.

## **Relevance of the Health Belief Model to the Study**

The health belief model has been used to develop effective interventions to change health-related behaviours by targeting various aspects of the model's key constructs. Interventions based on the health belief model may aim to increase perceived susceptibility to and perceived seriousness of a health condition by providing education about prevalence and incidence of disease, individualized estimates of risk, and information about the consequences of disease (e.g., medical, financial, and social consequences). Interventions may also aim to alter the cost-benefit analysis of engaging in a health-promoting behaviour (i.e., increasing perceived benefits and decreasing perceived barriers) by providing information about the efficacy of various behaviours to reduce risk of disease, identifying common perceived barriers, providing incentives to engage in health-promoting behaviours, and engaging social support or other resources to encourage health-promoting behaviours.

Furthermore, interventions based on the health belief model may provide cues to action to remind and encourage individuals to engage in health-promoting behaviours. Interventions may also aim to boost self-efficacy by providing training in specific health-promoting behaviours, particularly for complex lifestyle changes (e.g., changing diet or physical activity, adhering to a complicated medication regimen). Interventions can be aimed at the individual level (i.e., working one-on-one with individuals to increase engagement in health-related behaviours) or the societal level (e.g., through legislation, changes to the physical environment).

## **METHODOLOGY**

This paper adopted the qualitative method with a Critical Discourse Analysis (CDA) design, while discussing the subject matter of communication strategy in the context of the COVID-19 pandemic. The critical Discourse analysis helps in achieving the aim of this paper as it highlights the issues of structural inequalities in the adoption of viable communication strategy in domains like the media and politics or governance. According to Van Dijk, (2008) critical discourse analysis combines cognitive theories with linguistic and social theories. By integrating a cognitive approach, researchers are better able to understand how larger social phenomenon are reinforced through popular, everyday discourse.

## **Critical Discourse Analysis of Communication Strategies and the Kogi Perspective**

The novel covid-19 pandemic that ravaged the world in

the last one year brought about policy frameworks, documented strategies targeted at charting the course of reducing or eliminating the impact of the virus. Before long, the virus had caused havoc due to the early pervasive negligence on the part of nations, organisations and even individuals. Consequently, countries and even academics began to churn researches and eventual policy strategies to stem the tide.

In a study description by Sarah Blake and Thoi Ngo on April 29, 2020, they constructively did a rapid *review of community engagement and social mobilization strategies for covid-19 responses*, which was aimed at understanding evidences on interventions intended to mobilize community level action to control infectious disease outbreaks and other emergencies and to identify approaches and practices that can inform efforts to address COVID-19 related risk in low resource settings. In addition to document lessons and potential good practices from past crisis by identifying critical gaps in current evidences, they further aver that while specific policies or behavioural measures may vary in effectiveness, they must account for the lack of essential physical infrastructure and social dynamics in settings such as urban slums and informal peri-urban settlements, refugee or internally displaced persons (IDP) camps, or in poor rural communities (Favas et al., 2020; OCHA, 2020; van Zandvoort et al., 2020; World Health Organization, 2020). At the same time, the crisis threatened to have a disproportionate effect on poor communities, and to exacerbate existing inequities in access to education, health care and social services (OCHA, 2020; Vegas, 2020). In communicating the devastating effect of the virus, this descriptive study anchored it on existing principles and commitments for engaging communities through leading humanitarian response agencies, global health officials and health researchers that have invoked community engagements. a critical source that will serve in communicating better was the Ebola outbreaks in west Africa and the democratic republic of Congo by linking community and health systems based approaches to ensure equitable access to services and resources. For instance the World Health Organisation (2020) published a stand-alone guidance document on risk communication and community engagement (RCCE), which stresses their value in countering misinformation, among other functions. These risk communication and community engagement strategy could be facilitated by humanitarian responses, community partners that are always on standby or specially assigned to attend to the health needs of communities. Here, communicating the risk of the pandemic appeals to the emotions of not caring for the lives of others like family members, friends, associates etc.

The World Bank Group report on *Protecting people & Economies: integrated policy responses to COVID 19*

(2020) emphasized the need to communicate effectively, either as a strategy or policy framework. The report stated that Leadership is essential, and governments can use factual, clear communication to align behaviour and build trust. This, perhaps, was an area the governor of Kogi State, Yahaya Bello won the hearts of citizens. They however, reiterate that success in containing the pandemic depends on government policy, but also on people's behaviour. Governments will need to take leadership in working with the private sector, communities, and the media to support responsible collective action and maintain social cohesion – vital for stability and successful recovery. Clear, consistent, and transparent communication from leaders creates trust and conveys a sense of stability during a time of uncertainty.

Effective leadership at the national and local levels is integral to shaping individual and community behaviour and should be underpinned by decisions grounded in sound evidence. Furthermore, to encourage collective action and social cohesion in the face of a pandemic that threatens societies, governments need to engage local leaders, businesses, civil society organizations and influencers to ensure appropriate information flows and concerted action. According to the report, progressively strengthening health systems is essential to durably control COVID-19 and prepare for future outbreaks. In the short run, building capacity to test, trace, and isolate cases and strengthening other aspects of disease surveillance can help contain potential new waves of infection. The “one-health” measures now urgently required to prevent and contain disease outbreaks will remain vital in the longer term. Health-system strengthening also implies using reliable data to target action and provide concrete, science-based communication to the public. This will build public trust and accelerate disease control today, while drawing evidence from the current crisis to strengthen future preparedness. There may also be opportunities to draw upon the tertiary education system to provide rapid training of nurses, lab technicians, and other health professionals.

Also, the World Bank Group emphasized the need to provide widespread and effective communication because, inadequate risk awareness and information can significantly weaken the COVID-19 response and expand the timeline and severity of outbreaks. Since individual actions are critical for epidemic containment, an emphasis on behavioural pushes and on fostering trust should be central to the communication efforts, as well as highlighting specific risks affecting women and men, girls and boys. Experience from previous epidemics (SARS and EVD) have shown that the costs of misinformation and panic are high since they interrupt the emergency response and health service delivery (Bali, et al. 2016). Mitigating against misinformation, and engendering trust

and cooperation, will require a combination of regulation, multi-sectoral partnerships (e.g., with social media and telecom companies) and collaboration with relevant stakeholders (i.e., influencers, and traditional and community leaders) who may help in addressing local sanitary practices, gender differences in hygiene practices and behaviours affecting epidemiological risk (e.g., in the case of ebola, lassa fever, corona virus etc.).

The RCCE strategy demystifies social distance inertia or fatigue, contradictory messaging from authorities and organized opposition, which may jeopardize control measures. According to the IFRC, UNICEF and WHO in December 2020, the RCCE strategy should be nationally led, community-centered, participatory, nurturing trust, open and transparent, informed by data, integrated, coordinated, inclusive and accountable. These parameters have been questioned many times in Nigeria by her citizens on how the Nigerian centre for Disease Control (NCDC) have followed through these. They are likely to be many approaches, suited to different environments and aspects of the pandemic but not a one-size elastic fitting. This was the query of the Kogi state government at the inception of the pandemic.

The Risk Communication and Community Engagement (RCCE) pillar adopted by the Nigeria Centre for Disease Control (NCDC) provides coordinated multi-sectoral partnership with stakeholders related to prevention, treatment and care related to COVID-19. The strategy outlined in this document is flexible, adaptable and relevant to emerging priorities while ensuring effective communication between communities, stakeholders and implementing agencies. It is expected that this strategy would continue to be modified and improved based on evidence from periodic reviews, responsive feedback and audience polls/surveys, etc. However, the success of the efforts to control COVID-19 in Nigeria greatly depends on the ability to communicate clear, convincing, actionable messages with the populace in their cohorts, which was enabled with the engagement of digital media predominantly. But have the Nigerian people become better by all this statements?

The leader of the State in the person of the Governor, Yahaya Bello ruled out the possibility of COVID-19 wreaking havoc in the state and that if there was any virus, it was being politicised for selfish interests like economic gain. In communicating his position on the issue, the Governor did not fail to emphasize that he was doing it for Kogites, who voted him to power to protect their interest. Apart from the cry that the economy of the state was suffering as a result of the lockdown, he never saw the need to. While the media was awash with his statements on the crisis, he questioned the *copy and paste* approach to resolving the issues by locking down an economy that was bleeding and majorly dependent of the informal sector to survive at that point.

On the other hand, when the behavioural approach of a

leader tallies with that of the led, it becomes easy to sail. Since our environment; cultural, political, economic and religious beliefs influences the attitudes we form and how we behave, there is the need to as a matter of urgency, gather ourselves from the recent pandemic and evolve behavioural change communication (BCC) strategies. The Governor's approach or strategy (not documented) is/was evident of how lackadaisical governments have approached the health situation in the country. The facilities provided in the wake of the pandemic in the state could however be likened to that provided for at the primary health care level and even though a committee was set up and Chaired by the Deputy Governor, Chief Edward Onoja, it only re-echoed the position of the world health body by initially closing all place of worship, schools and all other gatherings in order to prevent the spread. This approach to the situation smacked of confusion without effort.

The peculiarity of our clime may necessarily not afford us the luxury of the kind of communication strategies adopted in other parts of the world. The media rolled out jingles and public service messages to warn the populace of the dangers but the issue remains that our health concerns are largely and strongly rooted in tradition, religion and every other superstitious belief one can think of, which may not answer for us because we have been tailored to the behavioural pattern of the colonial warlords.

## CONCLUSION/RECOMMENDATION

This paper significantly points out the flaws in the strategy adopted on the national front because it has affected the economic life of the people. It exposed the non-existence of a social system which is meant to cater people in times like this. However, times like this call for an inward look to adopt customized strategies that will not significantly affect the nation negatively most especially as it concerns the economy. The fact remains that, we may not be able to effectively communicate the risk associated with disease without changing the behaviour of recipients of medical care. In other words, adopting the Behavioural Change Communication (BCC) is key to reducing mortality during pandemics. This in effect, means a preemptive approach in order to beat the tide of pandemics whenever they arise. Developed nations of the world would continue to feed on our ignorance if we fail to see that it is an opportunity for them to offer ridiculous loans and grants in order to reap from our fragile economy and also have a say in our political life as a nation.

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