

Learning Manual

Strengthening Community-Led Surveillance (CLS) and Advocacy for
Pandemic Preparedness and Health System Resilience in Nigeria

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Executive Summary

The Learning Manual on Community-Led Surveillance (CLS) and Primary Health Care (PHC) Advocacy in Nigeria is a practical guide designed for communities, civil society organizations (CSOs), and grassroots networks. It equips them with the tools to detect health threats early, document local service gaps, and advocate for stronger PHC systems.

Nigeria's health security challenges exposed during COVID-19 revealed that national systems cannot succeed without active community participation. Communities are often the first to notice unusual sickness, stock-outs, or service breakdowns, yet their voices rarely reach decision-makers. This manual bridges that gap by linking community intelligence to the Nigeria PPR–PHC Platform, ensuring grassroots evidence directly shapes national policies and budgets.

What CLS is

Critical for early detection of outbreaks and health service gaps

Step-by-step guidance

How communities can organize, collect, and report signals

Evidence into advocacy

Pushing for equitable PHC services and accountability

The manual covers advocacy approaches from dialogues and scorecards to policy briefs, media, and coalitions. Integration pathways that connect community reports into government TWGs and the national Platform. Practical tools reporting forms, checklists, meeting templates, advocacy briefs that make implementation simple and consistent.

By using this manual, communities move from being passive recipients of health services to becoming active protectors of health security and advocates for stronger PHC systems. It is both a training resource and an empowerment tool to institutionalize meaningful community engagement in pandemic preparedness and response.

1. Introduction

1.1 Background

Nigeria's health system has made important progress in strengthening pandemic preparedness and response (PPR). However, the COVID-19 pandemic exposed deep gaps between national systems and the communities they are meant to serve. While national agencies like the NCDC and NPHCDA coordinated response measures, communities often lacked structured ways to feed information into decision-making or to advocate for better access to services.

Primary Health Care (PHC) facilities, especially in rural and underserved areas, remain the first point of contact for most Nigerians. Yet, during health emergencies, these facilities and the communities around them are often overlooked in surveillance and planning. This leads to delays in detecting outbreaks, missed opportunities for prevention, and inadequate responses to local needs.

1.2 Why Community-Led Surveillance (CLS)

Community-Led Surveillance (CLS) is a system where communities take an active role in identifying, reporting, and responding to unusual health events. It is built on the principle that local people are often the first to notice when something is wrong whether it is unusual sickness, increased deaths, or stock-outs of essential medicines.

Unlike traditional surveillance, which is led from the top by government agencies, CLS works from the ground up. It empowers communities to contribute real-time intelligence, strengthens trust between citizens and authorities, and makes national response more timely and accurate.

1.3 Why PHC Advocacy

Advocacy is about turning community voices and evidence into action. For PHC, advocacy means making sure that services are available, accessible, and equitable. Communities and civil society organizations (CSOs) can use CLS findings to push for:

- Adequate staffing and supplies at PHC facilities.
- Removal of barriers such as high transport costs, discrimination, or stock-outs.
- More resources allocated to PHC and preparedness by government and partners.

When surveillance is linked with advocacy, communities move from being passive recipients of services to becoming active shapers of the health system.

1.4 Purpose of this Learning Manual

- Provide step-by-step guidance for communities and CSOs on how to implement CLS.
- Show how CLS evidence can be translated into advocacy messages that influence policy and practice.
- Strengthen the link between community action and the Nigeria PPR-PHC Platform, ensuring that grassroots voices are heard in national decision-making.
- Equip community representatives, Ward Development Committees (WDCs), and CSOs with practical tools and templates they can start using immediately.

1.5 How to Use This Manual

1

Community members and volunteers can use it to learn how to detect and report unusual health events.

2

CSOs and networks can use it to guide advocacy campaigns based on real evidence.

3

Government and partners can use it to understand how CLS feeds into official surveillance and PHC governance.

This manual is a dynamic resource, designed to evolve and strengthen with every community's experience, reflecting our collective commitment to continuous improvement in CLS and PHC advocacy across Nigeria.



2. Understanding Community-Led Surveillance (CLS)

2.1 What is Community-Led Surveillance?

Community-Led Surveillance (CLS) is a system where ordinary community members actively detect, report, and respond to health threats in their environment. It is not limited to disease outbreaks; it also includes identifying service gaps, stock-outs, unusual events, and risks that affect community health.

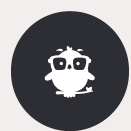
CLS works on the principle that people closest to the problem are often the first to see the signs of trouble. A mother may notice that many children in her village are coughing; a farmer may observe strange livestock deaths; a youth group may notice that drugs are missing in the local PHC. All these are signals that, if reported early, can prevent bigger problems.

2.2 Principles of CLS



Community Ownership

CLS belongs to communities, not external actors. Community members decide what is important to watch and how to respond.



Early Detection

The goal is to identify unusual health events before they escalate into outbreaks or crises.



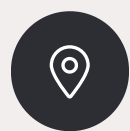
Two-Way Communication

Information flows from community → authorities, and feedback flows back from authorities → community.



Inclusivity

Vulnerable groups (women, youth, nomads, IDPs, PLHIV, persons with disabilities) are fully included.



Action-Oriented

CLS is not just about reporting problems but also about mobilizing quick community-level solutions where possible.

2.3 Why CLS is Critical in Nigeria

CLS is critical in Nigeria because it:

- Bridges the gap between national surveillance systems and communities, especially rural and hard-to-reach areas.
- Reduces delays in outbreak detection communities don't wait for "official experts" to arrive.
- Strengthens trust between government and citizens through regular feedback.
- Empowers communities to be active participants, not passive recipients of services.
- Supports PHC resilience by flagging local challenges early (shortages, absenteeism, poor service).

2.4 Difference Between CLS and Traditional Surveillance

Traditional Surveillance

- Led by government agencies.
- Relies on health facility data and official reporting.
- Often slow, top-down, and bureaucratic.
- Limited community involvement.
- Feedback rarely reaches communities.

Community-Led Surveillance (CLS)

- Led by communities and CSOs, linked to government.
- Relies on community observations and local intelligence.
- Fast, bottom-up, and flexible.
- Full community participation and ownership.
- Two-way communication: government ↔ community.

2.5 Global Lessons and Nigerian Adaptation

Countries like Cambodia have shown that CLS strengthens early detection and reduces outbreak risks. In Nigeria, CLS must be adapted to the local realities:

Use Ward Development Committees (WDCs) as natural entry points.

Integrate with existing PHC and community structures (village health workers, community volunteers, faith leaders).

Leverage mobile phones and social media (WhatsApp, SMS) for quick reporting.

Ensure gender-sensitive and inclusive participation.



3. Steps for Implementing Community-Led Surveillance (CLS)

Step 1: Mobilize and Orient Community Members

Identify trusted local actors (community leaders, youth groups, women's associations, religious leaders, PHC volunteers). Conduct a short orientation session on what CLS is and why it matters. Agree on roles: who observes, who records, who reports, and who follows up.

Checklist:

- Community volunteers identified
- Orientation session held
- Roles clearly assigned

Step 3: Collect Information

Decide on data collection methods:

- Paper forms (for rural areas without phones).
- Mobile apps (Kobo Collect, DHIS2, ODK).
- WhatsApp/SMS reporting groups.

Keep it simple and fast only collect what is essential (what happened, where, when, how many, reporter's name). Ensure confidentiality where needed (e.g., sensitive cases like HIV or gender-based violence).

Step 5: Provide Feedback to Communities

Authorities must not only receive reports but also send feedback. Feedback should answer: What was done? What is the next step? What role should the community play?

Feedback can be shared in community meetings, SMS, WhatsApp updates, or local radio announcements.

Step 7: Document and Learn

Keep a community surveillance logbook. Review signals monthly to identify patterns. Share lessons with other communities, CSOs, and the Platform.

Checklist for Monthly Review:

- Number of signals detected
- Number of signals reported
- Response received from authorities
- Feedback given to community
- Lessons learned

Step 2: Define Priority Signals to Watch For

Communities should agree on the types of events that must be reported immediately. Examples include:

- Unusual sickness or deaths in people or animals.
- Sudden increase in cases of fever, cough, diarrhea, or bleeding.
- Shortage or stock-out of essential drugs or vaccines.
- Discrimination or denial of services at PHC facilities.
- Displacement, insecurity, or environmental changes affecting health.

Tip: Use simple language so all volunteers understand (e.g., "too many children coughing" instead of "respiratory outbreak").

Step 4: Report and Escalate

Community volunteers → report to CSO focal person/WDC.
CSO/WDC → submit to Platform Secretariat or local PHC officer.
Platform → link with NCDC/NPHCDA/state TWGs.

Golden Rule: Reports must move within 24–48 hours of detection.

Step 6: Act at Community Level (When Possible)

Not all issues need to wait for national response. Communities can take immediate actions such as:

- Mobilizing handwashing stations during diarrheal outbreaks.
- Supporting PHC staff to organize vaccination days.
- Conducting community education to stop harmful rumors.
- Setting up watch groups for unusual livestock deaths.



4. Understanding PHC Advocacy

4.1 What is Advocacy?

Advocacy is the deliberate act of influencing decision-makers to change policies, practices, or resource allocation in favor of community needs. For PHC, advocacy means ensuring health facilities are functional, accessible, and responsive to the people they serve.

It is not about protests or complaints alone it is about presenting evidence, solutions, and demands in a structured way that authorities cannot ignore.

4.2 Why Advocacy Matters for PHC



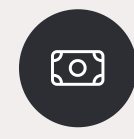
Brings community voices to the table

Ensures decision-makers hear real experiences from the grassroots.



Pushes for accountability

Demands that government deliver on promises and policies.



Secures resources

Makes sure budgets prioritize PHC and pandemic preparedness.



Reduces barriers

Addresses issues like stock-outs, discrimination, and transport costs.



Builds trust

When advocacy is consistent and constructive, communities and authorities work together better.

4.3 Core Skills for Effective Advocacy

1

Evidence Gathering

using CLS data, case stories, or community scorecards.

2

Message Framing

presenting issues simply and powerfully (e.g., "women walk 10km for vaccines" instead of "access challenges").

3

Target Mapping

identifying who has the power to act (Ward Councillor, PHC Director, State Assembly Member, Minister).

4

Coalition Building

working with other CSOs, media, and networks to amplify voice.

5

Engagement

using meetings, letters, public hearings, or media to present demands.

6

Follow-up

tracking commitments and pushing until action is taken.

4.4 Common Barriers to PHC that Need Advocacy

These barriers can be documented through CLS and turned into advocacy priorities.

Shortage of health workers in rural PHCs.

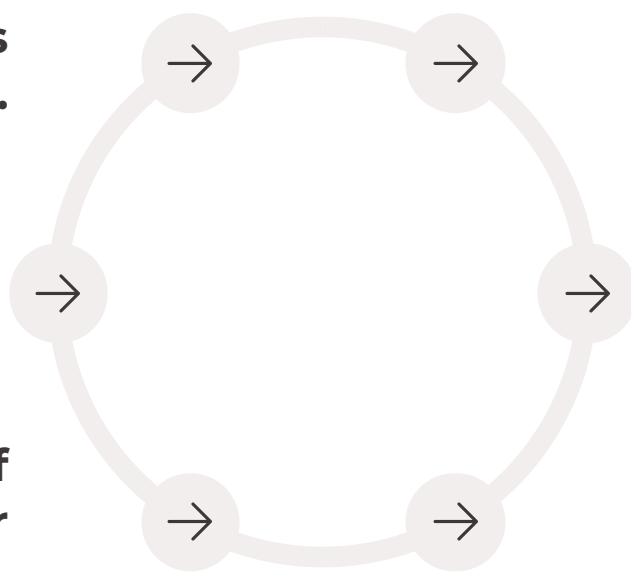
Stock-outs of drugs, vaccines, and essential supplies.

Weak referral systems that leave patients stranded.

High transport costs for patients in hard-to-reach areas.

Poor infrastructure (lack of water, electricity, or equipment in PHCs).

Stigma or discrimination against women, youth, PLHIV, nomads, or IDPs.



4.5 Linking CLS to Advocacy

Signal detected: Stock-out of malaria drugs in a PHC.

Evidence gathered: CLS reports show stock-outs in 3 consecutive months.

Advocacy message: "Communities in X LGA face malaria deaths because health centers lack drugs we call on NPHCDA to ensure consistent supply."

Target: State PHC Board and NPHCDA supply chain unit.

Action: Present evidence at the PPR-PHC Platform meeting and escalate to policymakers.



5. Advocacy Approaches for Communities and CSOs

5.1 Preamble

Advocacy is most effective when communities and CSOs use the right approach for the right audience. A village head may respond best to community dialogue, while a state commissioner may expect a policy brief. Similarly, the media and social platforms can amplify issues that communities alone cannot.

This section provides practical advocacy methods that can be adapted to different contexts. The aim is to ensure that the evidence gathered through CLS does not stop at reporting but is transformed into collective action that influences change.

5.2 Community Dialogues

Small group meetings where community members discuss challenges and agree on advocacy priorities. Useful for building unity of voice before engaging external stakeholders. Can be organized through Ward Development Committees (WDCs), village meetings, or faith-based gatherings.

Tip: Always document key issues and assign community champions for follow-up.

5.3 Community Scorecards

A participatory tool where community members rate health services (e.g., staff availability, waiting times, availability of medicines, cleanliness). Provides evidence in a simple visual form that is easy to present to policymakers. Encourages dialogue between service providers and communities to jointly address gaps.

5.4 Engaging Ward Development Committees (WDCs)

WDCs are recognized formal structures for PHC governance in Nigeria. CLS findings should first be presented at WDC meetings to strengthen legitimacy. WDCs can then escalate these issues to local government and state PHC authorities.

5.5 Policy Briefs and Position Papers

Concise documents (2–4 pages) that summarize problems, evidence, and recommendations. Best suited for engaging technical stakeholders, government officials, and donors.

Typical structure:

1. Problem statement
2. Evidence (CLS data, community testimonies)
3. Impact on people and health systems
4. Recommendations (specific, actionable, time-bound)

5.6 Media Engagement

Working with journalists and broadcasters raises visibility of community issues. Radio talk shows, press briefings, and human-interest stories are powerful tools. Must be used carefully: present facts, solutions, and community voices, not just complaints.

5.7 Social Media Advocacy

Social platforms expand reach, especially among youth and urban audiences. Create posts with short, clear messages, hashtags, images, and short videos. Build networks of digital champions to push messages consistently.

5.8 Building Coalitions and Alliances

Joining forces with other CSOs and networks increases bargaining power. Broad alliances (e.g., PHC networks, HIV/TB coalitions, disability groups) show decision-makers that the issues affect multiple constituencies. Coalitions also share costs and amplify reach.

5.9 Continuous Engagement

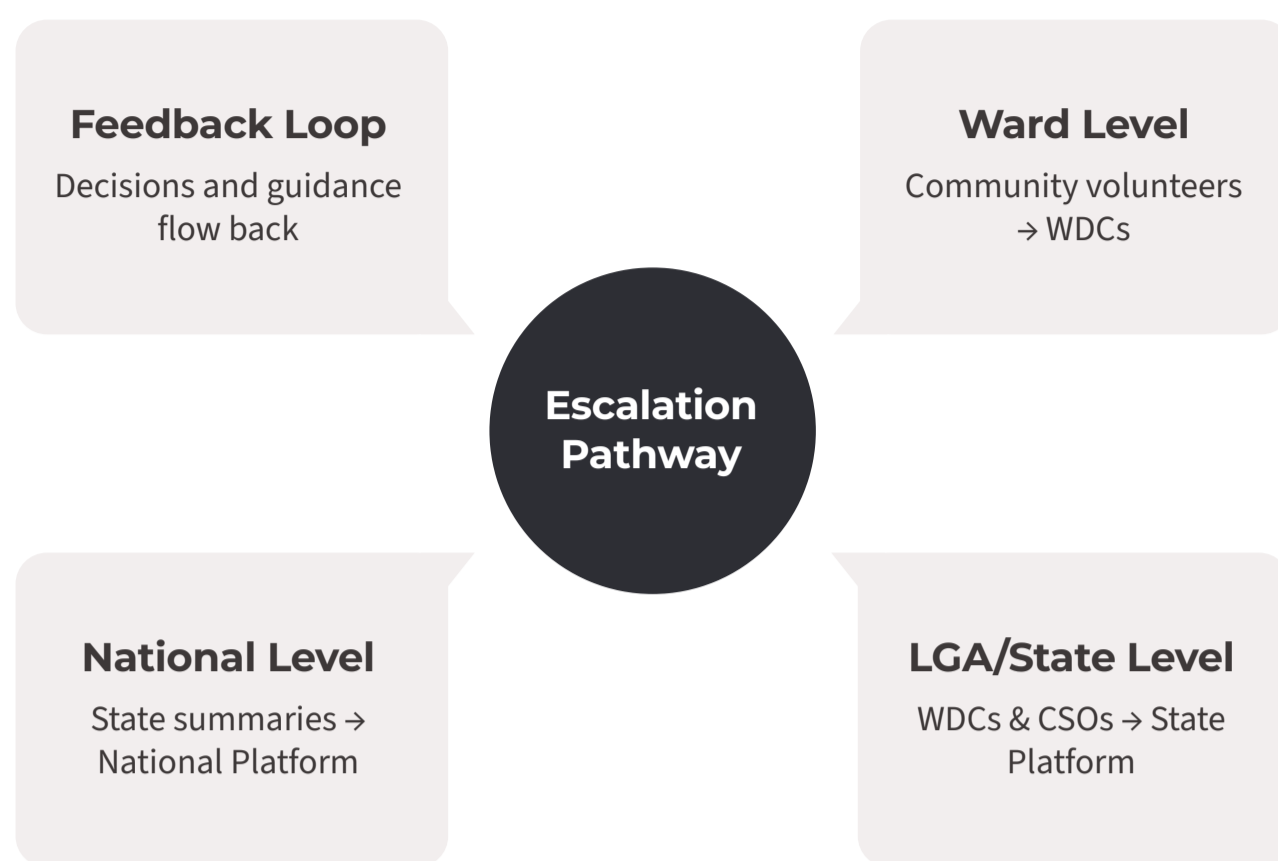
Advocacy is not a one-off event but a cycle of pressure, follow-up, and accountability. Track promises made by authorities and follow up with letters, calls, and reminders. Celebrate and publicize progress (small or big) to motivate communities and attract more support.

6. Integrating CLS and Advocacy into the PPR–PHC Platform

6.1 Preamble

Too often in Nigeria, communities gather evidence of problems stock-outs, outbreaks, poor services but that evidence stays at the village level or in the files of small NGOs. Policymakers make decisions without ever hearing these voices, and communities lose trust in the system.

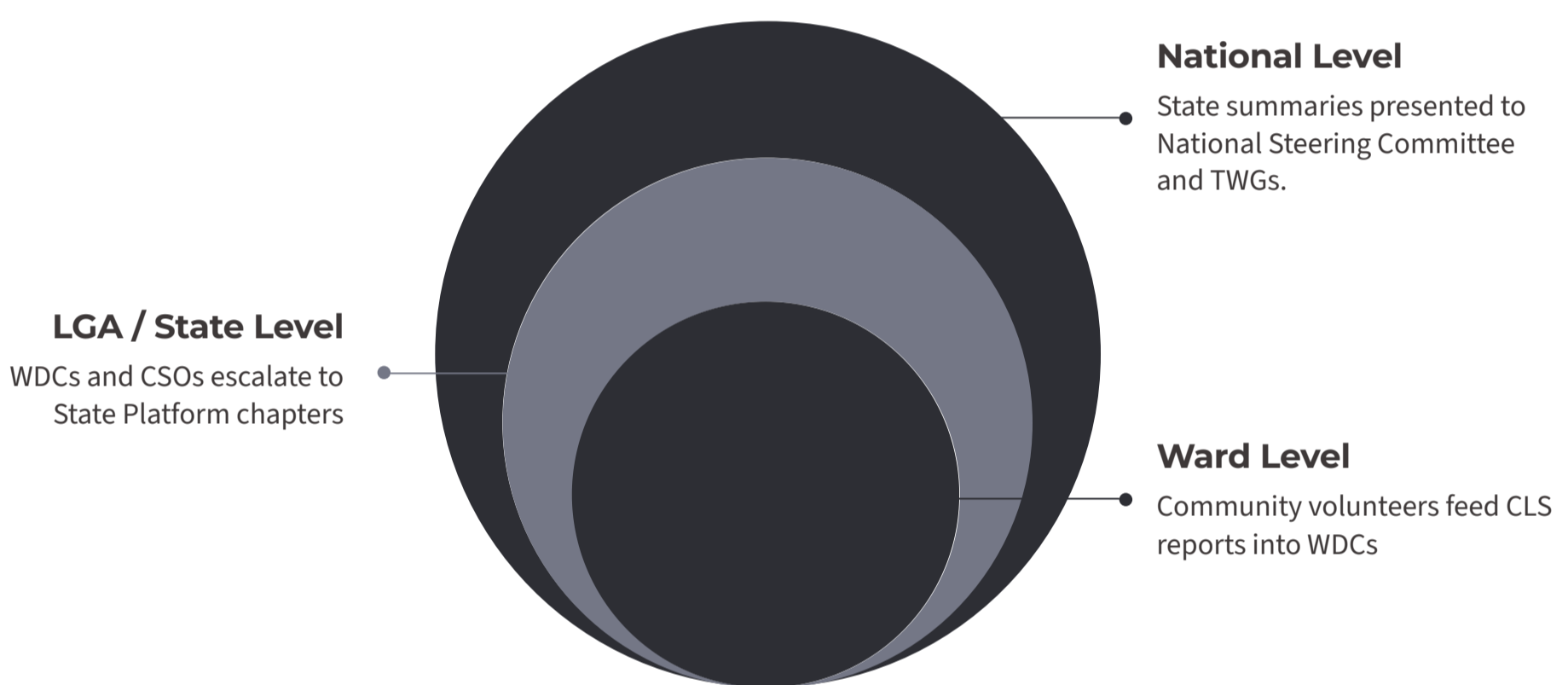
The PPR–PHC Platform changes this dynamic. It is designed as the bridge between grassroots intelligence and national decision-making. By integrating CLS and advocacy into its structures, the Platform ensures that what is seen and felt at the community level directly shapes national policies, budgets, and preparedness plans.



6.2 Direct Entry into Technical Working Groups (TWGs)

Each TWG under the Platform has reserved seats for CSO and community representatives. CLS reports and advocacy briefs are submitted through the Secretariat but carried into TWG meetings by these reps. This guarantees that community voices are not just "noted" but are part of formal agenda items and technical discussions.

6.3 Escalation Pathway



This creates a closed loop: evidence flows upward, and feedback flows downward to the same communities.

6.4 Advocacy as a Platform Function

CLS findings are translated into policy briefs, scorecards, or advocacy notes by the Advocacy & Resource Mobilization TWG. These are then used in structured engagements with:

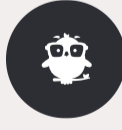

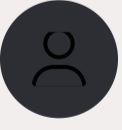


- Federal Ministry of Health (FMoH)
- NCDC, NPHCDA, and other agencies
- National Assembly Committees (for budget advocacy)
- Development partners and donors

This way, advocacy is not "stand-alone activism" but a recognized function of the Platform.

6.5 Safeguards for Equity

The Platform tracks not just the number of CLS reports, but whose voices are reaching the top (women, youth, nomadic groups, IDPs, PLHIV). Quotas and rotation rules in representation ensure that marginalized groups are not silenced. Feedback obligations require reps to return to their constituencies with updates, closing the accountability gap.

6.6 Why Integration Matters

 <p>Prevents missed warnings Community signals reach national responders early</p>	 <p>Strengthens policy relevance Decisions are grounded in real evidence, not assumptions</p>	 <p>Drives resources Advocacy backed by hard data has more weight with funders</p>
 <p>Builds trust Communities see their inputs reflected in actual government action</p>	 <p>Institutionalizes participation No more one-off invitations – community engagement becomes part of the system</p>	

6.7 Call to Action

For CLS and advocacy to succeed, integration into the PPR–PHC Platform must not be symbolic. It requires active champions at every level community volunteers, CSOs, state coordinators, and national TWG reps to ensure that grassroots intelligence drives Nigeria's pandemic preparedness and PHC governance.

7. Practical Tools for CLS and PHC Advocacy

7.1 Preamble

Guidelines and theory are important, but what makes CLS and advocacy real at community level are the tools that people can actually use. These tools simplify implementation, help communities stay organized, and ensure their evidence and advocacy are credible. They can be adapted to fit local realities — whether in a rural village, an IDP camp, or an urban settlement.

Tool 1: Sample CLS Reporting Form

Community-Led Surveillance Report

Date/Time of Event: _____

Location (Village/LGA/State): _____

Type of Event (tick):
 Unusual sickness Deaths Animal deaths
 Stock-out Discrimination Other _____

Number of People/Animals Affected:

Brief Description: _____

Immediate Action Taken by Community:

Name of Reporter: _____

Contact (Phone/WhatsApp): _____

Tool 2: Checklist for Community Volunteers

- I know the signals my community agreed to monitor.
- I reported any unusual events within 24-48 hours.
- I informed the Ward Development Committee (WDC) or CSO focal person.
- I received feedback on actions taken (if not, I followed up).
- I attended the monthly review with my peers.

Tool 4: Template for a Simple Advocacy Brief

Title: Clear, short issue (e.g., "Stock-outs of Malaria Drugs Threaten Children in X LGA")

1. **Problem Statement:** What is happening?
2. **Evidence:** What data or CLS reports support this?
3. **Impact:** Who is suffering, and what are the consequences?
4. **Recommendation:** What should be done, by whom, and when?
5. **Community Voice (quote/testimony):** "My child missed treatment because the drugs were not available" Mother in Y ward.

Tool 5: Contact Points

National Level:

- FMOH – Department of Public Health
- NCDC – Surveillance & Epidemiology Unit
- NPHCDA – Primary Health Care Services Department
- Secretariat – Nigeria PPR–PHC Platform

State Level:

- State Ministry of Health
- State Primary Health Care Board
- State Emergency Preparedness Committee

Local Level:

- Ward Development Committees (WDCs)
- Local CSO networks
- Community Leaders and Focal Persons

Tool 3: Template for Community Feedback Meetings

Agenda for Feedback Session

1. Welcome and prayer.
2. Review of signals reported last month.
3. Feedback from authorities (what was done, what remains).
4. Community reflections — what worked, what didn't.
5. New issues emerging.
6. Agreement on next steps and champions.

Minutes Format:

Date & Venue: _____

Issues Reported: _____

Actions Taken: _____

Unresolved Issues: _____

Next Steps: _____

Community Sign-off: _____

Conclusion

This manual is more than a training guide; it is a blueprint for community empowerment in health security. It recognizes that pandemics cannot be prevented or contained by government alone. Communities, when organized and supported, are the frontline detectors, responders, and advocates who can make Nigeria's health system more resilient.

The integration of CLS with PHC advocacy ensures that evidence from the ground becomes influence at the top. It institutionalizes a two-way flow of information: communities provide intelligence to the Platform, and authorities provide feedback and action to communities.

Every signal counts

Community observations become part of national surveillance systems

Every voice matters

Grassroots perspectives shape policy decisions and resource allocation

Every action strengthens preparedness

Community engagement builds resilient health systems from the ground up

If consistently applied, this manual will help build a culture where every signal counts, every voice matters, and every action strengthens preparedness. In doing so, Nigeria's PPR-PHC Platform becomes not just another coordination body but a living system of accountability and resilience, anchored in the power of its people.