OBR-C-69-1-21

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Nigeria Centre for Disease Control:

On the Cusp of Change

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Dr Yetunde Anibaba, commissioned by Tony Blair Institute for Global Change prepared this case as the basis for class discussion rather than to illustrate either effective or ineffective handling of an administrative situation.

This work was supported, in whole or in part, by the Bill & Melinda Gates Foundation INV-009083. Under the grant conditions of the Foundation, a Creative Commons Attribution 4.0 Generic License has already been assigned to the Author Accepted Manuscript version that might arise from this submission.

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421-0096-1
OBR-C-69-1-21

Nigeria Centre for Disease Control: On the Cusp of Change

It was day 34 of the outbreak of the novel coronavirus in Nigeria, 131 confirmed cases, and God knows how many more to come. The Federal Government had just a couple of days before announced a lockdown of Lagos, FCT and Ogun State to contain the spread of the virus. Lagos and Abuja airports had already been closed to international flights. Schools had been directed to close and send students home, religious organisations could not have events with more than 20 people physically in attendance in the first instance, and now none at all. The mood in the nation was generally uncertain and somewhat apprehensive. In an article he authored in 2010, Chikwe Ihekweazu, the Director General of the Nigeria Centre for Disease Control, seemed to know that a time like this would come. Still, he probably could not have envisaged the extent and dimensions it would take in a country as large and complex as Nigeria, with its grossly underdeveloped health system. Already, they had worked round the clock to trace, test and isolate cases, test kits were in short supply, and the number of cases had continued to rise daily. It was times like these that made him wonder if the Nigeria Centre for Disease Control (NCDC) now had what it took to fulfil its obligations to the Nigerian people, and indeed Africa and the world. Since taking up office nearly four years ago, he and his team had been on a mission to build a public health institute that was resilient enough to guarantee the health security of Nigerians. There have been considerable changes since he took over, and they had hoped that 2020 would be the year when they begin to consolidate on those changes. Now they had to break from all that to face the imminent threat to the health of the nation. They were 'born' and had been preparing for a time as this, but were they ready? Were the structures they had put in place resilient enough to manage Nigeria's public health challenges within the limits of the Centre's mandate?

Public Health in Nigeria

Public health is *'the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society.'* [1] Hence, public health interventions aim to improve the mental and physical well-being of society through government policy and the activities of governmental health departments and non-governmental organisations. Infectious diseases, such as the COVID-19, yellow fever, cholera and HIV/AIDS, are some of the subjects of public health interventions. Public health interventions as prescribed by the WHO, include risk communication and community engagement, emergency vaccine development, clinical management training and learning. Other interventions include mass screening/testing programmes, drug supply and promotion of health and good hygienic practices.

In Nigeria, while malaria is the largest single cause of mortality, communicable[2] and infectious diseases remain the primary cause of death overall. The first formally recognised epidemic in

[1] http://www.euro.who.int/en/health-topics/Health-systems/public-health-services

[2] Contagious

Nigeria was the yellow fever epidemic that occurred in the Jos area in 1969. The Virus Research Laboratory of the University of Ibadan, Nigeria confirmed the diagnosis and established that there was widespread outbreak on the Jos Plateau and environs at the time.[3] From September 1969, when the case was first reported, to the end of December 1969, about 252 patients had been hospitalised. It was estimated that there were probably up to 100, 000 cases during the epidemic, with many of them unreported. Nigeria continued to experience regular yellow fever outbreaks until 1996.[4]

Following a significant outbreak of yellow fever in 1986/87, that affected 10 of the then 19 states of the federation, the Federal Government at the time introduced the disease surveillance and notification system, setting the tone for similar future policies on public health interventions in Nigeria. The introduction of the system allowed for the harnessing of human and other resources for the early detection and combating of disease outbreaks in Nigeria. Over the years, other diseases and health issues have formed part of the surveillance and notification activities of the relevant department under the Federal Ministry of Health (FMoH) public health departments including: cholera, meningitis, measles, malaria, Ebola fever and lassa fever.[5] Other non-communicable diseases that formed the subject of public health interventions in Nigeria in terms of policy and surveillance have been tuberculosis, leprosy, eye health, sickle cell anaemia and malnutrition.

However, the bureaucracy and inefficiencies that characterise most public service systems have hampered the effectiveness of the relevant departments in the FMoH, to prepare and respond adequately to outbreaks. Following the Ebola fever outbreak of 2014, the Federal Government, through the Federal Ministry of Health, realised that the country needed a more concerted and coordinated approach towards prevention and management of diseases of public health importance.

The Agency: Nigeria Centre For Disease Control (NCDC)

The Nigeria Centre for Disease Control (NCDC) is Nigeria's first public health agency with the mandate to protect the health of Nigerians, from the threat and occurrence of infectious diseases. Its history dates back to 2007 when the 51st National Council on Health in Lagos endorsed its establishment. The first formal step to establish the NCDC took place in 2011 when some departments in the Federal Ministry of Health, including the Epidemiology Division, the Avian Influenza Project and its laboratories, and the Nigeria Field Epidemiology and Laboratory Training Programme (NFELTP) were moved to form the nucleus of the Agency. The NCDC has the responsibility to lead the preparedness for, detection of and response to infectious disease outbreaks and public health emergencies. It also hosts the ECOWAS Regional Centre for Disease Control (RCDC), as well as the West African regional hub for the Africa Centre for Disease Control (ACDC).

The Centre experienced a new era of leadership in 2016 and has since been on a journey of transformation into a robust public health institute that could support a nation the size and complexity of Nigeria. Dr Chikwe Ihekweazu came with the personal vision '…*to build the confidence of Nigerians in the NCDC as the body established to protect the health of citizens through information, inclusion and timely response to health concerns.*' Since assumption of office as Director General of the Centre, Dr Chikwe Ihekweazu has championed this vision vigorously using every resource available to him. Within his first year in office, the NCDC had a ***working*** document in its 2017 - 2021 strategic plan, which sought 'to create a strong vision for the NCDC underpinned by clearly defined principles and supported by …well-articulated implementation and delivery plans.' The NCDC finally had a compass with which it could

[3] Carey, D.E., Kemp, G.E., Troup, J.M., White, H.A., Smith, E.A., Addy, R.F., Fom, A.L.M.D., Pifer, J., Jones, E.M., Brès, P. and Shope, R.E., 1972. Epidemiological aspects of the 1969 yellow fever epidemic in Nigeria. *Bulletin of the World Health Organisation*, *46*(5), p.645.

[4] https://ncdc.gov.ng/diseases/info/Y [14 September 2020]

[5] https://ncdc.gov.ng/diseases/a-z [30 March 2020]

navigate its activities, as well as monitor its progress and achievements and identify when it fell short.

The NCDC is organised into five interdependent directorates: Surveillance and Epidemiology, Public Health Laboratory Services, Health Emergency Preparedness and Response, Prevention Programmes and Knowledge Management, Finance and Administration (**Exhibit 1**). Within a couple of years of Dr Chikwe taking over the reins of leadership, each of these directorates had been infused with a new lease of life, leveraging heavily his network of relationships locally and internationally. Many consider that its most significant achievement is probably its fully operational National Reference Laboratory located in Gaduwa, Abuja. It also coordinates a network of regional laboratories around the country, including the Central Public Health Laboratory in Lagos. This means that it is equipped to diagnose diseases of public health importance including VHFs, meningitis, cholera, measles, yellow fever, rubella and now COVID-19, and more. It has also been able to establish advanced capacity such as genetic sequencing of pathogens. The National Reference Laboratory has trained several laboratory scientists and epidemiologists. It continues to develop these skills within the Agency and across different states as part of its mandate to build capacity across the country.

The Surveillance and Epidemiology team monitors the trends and incidence of diseases and outbreaks to be able to respond to disease situations proactively. The Agency's surveillance capabilities have also been significantly beefed up such that it now operates a functional Incident Coordination Centre (ICC), which immediately transforms into an Emergency Operations Centre (EOC) during outbreaks. While technology enthusiasts would not describe the ICC as the subject of a Sci-Fi movie[6], the Agency can gather and display case information about the incidence of different diseases real-time from field officers. It is also able to monitor and respond in good time, through its Surveillance Outbreak Response Management and Analysis System (SORMAS)[7] . Since the establishment of the Agency, it has led the implementation of the International Health Regulations (IHR) functions in Nigeria; its updated surveillance and reporting systems have equipped the Agency to fulfil its responsibilities in that regard, contributing effectively to global health security.

At the time Dr Chikwe came to the NCDC, it did not have legal status. Therefore, one of his primary goals in the early days was to see the Centre established as a legal entity. This was achieved on the 12th of November 2018, when the President of the Federal Republic of Nigeria provided final assent to the Bill for an Act to Establish the Nigeria Centre for Disease Control (NCDC). While Dr Chikwe and his team exhausted every avenue to be effective before the Act and made considerable progress, the signing of the Act was a significant milestone for the Agency. It provided the legal basis for its activities, improved access to much-needed resources including the recruitment of critically-needed personnel with specialised skills, as well as a purse of its own that it could manage as it saw fit and with minimal bureaucracy. Among other things, the NCDC Act also provided better specificity to its responsibilities in surveillance, outbreak response, developing a network of public health laboratories and coordinating the training of field epidemiologists.

As one of the critical achievements of the first iteration of NCDC's strategic plan, a Joint External Evaluation (JEE) of its activities around coordinating and facilitating the nation's health security was conducted in 2017. A progress review carried out in the third quarter of 2019 indicated that the Agency had moved up seven percentage points, with 10 out of the 19 technical areas measured recording verifiable increases.[8] While the NCDC team had hoped for an even better outcome, everyone acknowledged that the progress made had been 'exceptionally hard'. Specifically, in addition to the ICC and laboratory capacity mentioned above, the JEE report identified the following as some of the areas where the NCDC team had made good progress[9]:

[6] https://techcabal.com/2020/03/12/coronavirus-nigeria-centre-disease-control-technology/

[7] SORMAS is an open source e-health system.

[8] Mid-term review of 2017 Joint External Evaluation (JEE): Feedback to the honourable minister and country teams.

[9] Ibid.

- Enabling environment for IHR implementation: Passage of NCDC bill and assent by Mr President; establishment of functional IHR National Focal Point; desk review of relevant IHR laws across MDAs.
- Designation of points of entry (PoE) and capacity building: Three (3) international airports with one seaport designated with requisite capacities of staff across the various points of entry.
- One Health coordination: Establishment of a multi-sectoral mechanism at national level.

However, these achievements have occurred on the platform of internal changes that may have been thought nearly impossible or at least very difficult in a public service organisation.

The Road to Change

> *I think there was a fair bit of consensus in the ministry that its structures and bureaucracies, accounting systems and just the way they were organised were not best suited to respond to acute public health emergency… there were models from other countries in Europe, the US CDC … Ebola had heightened Nigeria's appreciation of the risk that we faced. There was generally a consensus that this was needed.*
>
> - Dr Chikwe Ihekweazu.

While Nigeria had always had diseases of public health significance requiring the intervention of the health ministry to contain, such as polio, cholera and lassa fever, it was the Ebola outbreak of 2014 that tested the mettle of the FMoH to respond at a higher level to such an outbreak. The ministry had to rely on the donor-supported emergency operations centre built for polio outbreaks, to launch its response to the Ebola outbreak, thus heightening the awareness of the scale of operations required to contain such outbreaks successfully. It would not be long before that preparedness was tested once again as the world was thrown into the throes of the COVID-19 pandemic, roughly six years after.

Becoming NCDC

In 2011, through a circular signed by the Permanent Secretary in the Federal Ministry of Health, personnel that made up various departments were deployed to constitute what is now known as the Nigeria Centre for Disease Control. The NCDC was to be established to have better management of disease outbreaks and was to be led by Prof. Abdulsalami Nasidi, a former director in Nigeria's Federal Ministry of Health. Many of the deployed personnel were, however, sceptical about moving from the ministry, because of the uncertainties around the move. There was no clear structure and no clarity about the direction of this new Agency. Also, some important functional areas that some considered strategic, including the International Health Regulation (IHR) function, were going to be moved to become part of this new Agency and some legacy staff of the FMoH were resistant to this move. Also, having a retired director in the FMoH lead the team was another cause of discontent. One of the founding members in the director cadre expressed the mood thus:

> *…that he did not evolve this concept at the particular time, and now when he is going, when he was gone, he is coming back to become DG again or something, so that he can lord it over them and excise some of the departments that were under Public Health into NCDC …and rendering the people that were coming behind him redundant…Even from the extant law of the civil service, if you were going to be employed as a consultant, you cannot lord it over them, rather, you will give them advice, and you will be subjected to the director that is there.*

So the resistance was on three fronts – those that were required to move did not want to move because of the uncertainties surrounding the transition; those that did not want the new NCDC to stand on its own because of the perception that they will lose relevance in certain spheres; and those that were dissatisfied with the fact that a retired director of the ministry

was assigned to head the team. This resistance to the move continued for another five years or thereabout until the outbreak of lassa fever in January 2016. The following quote captures the thought process of members of the senior team at the time:

> *We were told to move from the ministry to this supposed Agency, but we were not given full authority to do our work. We were still in the ministry but called NCDC, so we were occupying office space in the ministry…It was when there was an outbreak of lassa fever, that I said "look, there is no use just staying away. If you stay away, the whole problem will still boil down to us…. That was when we moved.*
>
> - A founding member of staff.

Hence, the imperative of the work they had to do was a significant driver of the move despite the initial resistance. Some other staff with the requisite experience were also posted from other agencies to beef up the workforce of the Centre, although this was still grossly inadequate in the light of the NCDC mandate. In all, probably about 30 people constituted the first set of technical personnel that made up the initial team.

Even after the team moved, it was not clear what the future held for the NCDC. There was still no real plan or structure in place, and no equipment or facilities to work with. According to one of the directors at the time, *'I had to bring in my personal printer'*. The location that was earmarked for the much-needed laboratory in Gaduwa had previously been assigned to the National Primary Healthcare Development Agency, but with some push from Prof. Nasidi, it was reassigned to the NCDC since it had lain idle. However, there was no electricity, equipment or other resources required to run a laboratory of any sort.

Many of the personnel felt they were hanging in limbo. Colleagues in the FMoH thought they had dug their own career grave, after all, this 'supposed Agency' did not even have legal backing, nor did they have clarity as to the scope of its mandate and authority. Morale was low as a result, and several of them began to think it might be better to return to the ministry.

Chikwe Ihekweazu – the Entrepreneurial Director General

In August 2016, news filtered in that a substantive Director General had been appointed by President Muhammadu Buhari to head the Agency. Dr Chikwe Ihekweazu came to the NCDC with a graduate degree and extensive experience in public health, with specialisation in Infectious Diseases Epidemiology, across Germany, the United Kingdom and South Africa, having worked for the national public health institutes in those countries at different levels. According to Dr Chikwe, as he is popularly called at NCDC, the invitation to serve as the DG was unexpected as he was not even based in the country at the time, nor did he apply for the position.

Before this time, however, he had realised that professionals like him in the diaspora could not merely complain about how bad things were back home; they needed to do something about it. One of his first attempts at this was starting a blog where he commented on health issues in Nigeria. In one of such blogs, he lamented the lack of preparedness of Nigeria's public health system for the prevention and control of infectious diseases. Shortly after, he got a call from the Minister of Health at the time, to meet for coffee in London; their discussions revolved around fighting the flu.[10] This was sometime in 2010.

In 2011, he moved from the UK to South Africa with his family where he became a co-director of the national tuberculosis centre in that country. It was during his stay in South Africa that he got a call from an official of the Nigerian government in July 2016, informing him that President Muhammadu Buhari would announce his appointment as the head of the fledgeling NCDC the next morning. While he was somewhat shocked by the suddenness of the appointment, he could hardly turn it down given his earlier stance that Nigerians in the diaspora needed to play their part in the country's development. He was also quite confident that this was something he was sufficiently equipped to handle from the perspective of his

[10] https://www.nature.com/articles/d41586-019-00615-x

area of expertise. He, however, did not anticipate the level of preparedness or lack of it, of the Agency or sector at the time.

Dr Chikwe came to the NCDC assuming the availability of a few essential components of a standard public health institute, including a laboratory, emergency operations centres, as well as colleagues with the required skills such as epidemiologists, virologists, microbiologists and so on, even if it was not a fully equipped system.

> *... when I arrived, I saw maybe 60 - 70 colleagues altogether, about half of those were technical staff, really not ready despite their best intentions to carry out the role that a national public health institute should be carrying out for a country the size and complexity of Nigeria.*

He was appointed along with four other chief executives of parastatals in the health sector, all of whom either came in directly from the diaspora or had just arrived not too long ago. While there was significant change going on in the sector, the workers in the sector did not seem to be aware of it; the incumbent chief executive of the NCDC was not expecting to leave, and no one was expecting Dr Chikwe there. Hence, one of the first things he quickly realised was that he was going to have to deal with the 'liability of outsidership' if he was going to make any headway with his mission. His ability to galvanise the team from the get-go would be critical to his success and the success of the Agency.

Kick-starting Change

Dr Chikwe came into NCDC leadership at a point when many of the Agency's employees had little faith in the organisation and their future role within it. A few of them had been lobbying for transfers out of the Agency, while others were either buying time before retirement or contemplating resignation. Many doubted that NCDC would be sustained and some never believed it would ever become a parastatal. A lot of Dr Chikwe's time at the beginning was therefore spent selling a new vision of a Nigerian public health institute that everyone could be proud of.

In his first few days in office, Dr Chikwe also realised that there was a clear need for direction. While there were general ideas of what people were and should be doing flowing from their responsibilities in the ministry, the Agency lacked a set of objectives that unified the people and departments. There was no strategic plan, roles were not clearly defined, and activities were not centrally coordinated along a set of objectives. However, he realised that to make this happen, he needed to understand what was available, who the people were, how they thought and felt about the Agency and the business of public health. One of the first things he did to bridge this gap was to meet with staff individually and in groups to identify challenges and to get their thoughts on how to move the Agency forward. These forums were also a platform for communicating his vision for the Agency and his optimism about its future. Many staff were pleased to have been 'consulted' by the DG and excited about the prospects of working in a dynamic federal institution with high societal relevance.

> *I think things started moving from right when he came. He came with a vision of what he wanted a public health institute to be like …the good thing was that he didn't throw away the experience he met here. He worked with us experienced people and brought in some younger ones. That blend of experienced and the new ones is how we started to work in NCDC.*

Skilling Up

> *It's an environment where I find that the young ones are able to grow. There is no discrimination. Where I was before, certain trips cannot be taken by people who are not at the director level, but here I find that people can go anywhere.*

A short while after becoming DG, three things relating to the workforce became increasingly clear to him. First was that the Agency was significantly understaffed in comparison with the volume of work it ought to be doing. The second was that the competency level of many of

the existing personnel was grossly inadequate for the challenges set before the Agency. Thirdly, most of the staff were insufficiently motivated to exert themselves, nor was the remuneration common to the Nigerian public service enough to encourage people to put in the sort of effort that would be required to transform the Agency. He would have to engage with his creative side if he were going to get anyone to drive this vision with him.

Within the first few weeks, Dr Chikwe committed a significant portion of his time headhunting competent laboratory scientists, virologists and epidemiologists, to reduce the manpower gaps he had identified. Besides the challenge of identifying great talent, Dr Chikwe was limited by the bureaucracies in the Federal Ministry of Health, civil service rules on staffing (for example, the federal character principle) and the resources available. So, while he could not commit to paying competitive salaries, he firmly believed that the Agency would be able to attract support for workforce development if it delivered substantial results in the short-term.

Dr Chikwe's effort and persistence paid off as some expert returnees considered him a role model of what he preached - service, discipline and sacrifice. He also liaised with colleagues in other agencies and departments in the health sector to identify skilled health workers who could join in driving the vision he had for the NCDC. Perhaps the biggest driver of talent attraction to the Agency was Dr Chikwe's ability to paint an image of a vibrant Agency with a purpose, such that the NCDC mantra became 'keep pushing'. This vibrancy, as some staff would recall, was also one of the primary reasons they stayed back at the Agency. That vibrancy also sifted out personnel who were unwilling to commit to the mission of the Agency as some left of their own accord when they discovered the new NCDC was not public service 'business as usual'.

> *The change is tough, but you find out that with time, you have to flow with the change. Otherwise, you won't make any headway. So those who couldn't make it started withdrawing. For those of us who valued what we were seeing and could see beyond what NCDC was doing now, we forged ahead in spite of all the stress.*
>
> - One of the Directors.

In December 2018, following the passing of the NCDC Act, the Agency was finally able to recruit about 200 new staff to shore up its manpower capacity. Many were rookies in the business of public health but were willing to learn and work with a team that was doing meaningful work. As his practice was, Dr Chikwe addressed all the new staff one on one, sharing the vision of the NCDC with them, letting them know it was not business as usual in this parastatal given the nature of the mandate they had, and charging them to be willing to learn and play their part. One of the newly recruited staff had worked as a volunteer at the NCDC earlier, but in the absence of formal opportunities to work for the Agency, took an offer to work with GIZ, the German development organisation, on their regional pandemic programme. On hearing that NCDC was now recruiting, he resigned from GIZ and applied to join the team again. According to him, he returned because of the passion that the leadership of NCDC demonstrated for the work.

Organising to Learn – NCDC's Technical Working Groups (TWGs)

The major vehicle by which NCDC achieved its objectives was the Technical Working Groups (TWGs). The TWGs were multi-departmental, multi-sectoral, disease-specialised teams organised along 'disease' lines. Their goal was to facilitate research and evidence-based decision-making and practice around specific diseases. The TWGs were driven by the need to quickly gain and document specialised knowledge around a specific disease in order to ensure better and quicker response to outbreaks over time. A typical TWG could include people with different skills sets and function areas including communications, field epidemiologists, virologists, logistics for example; and from different sectors including other agencies, the local government, partners and the academia, with a member of the NCDC team coordinating its activities.

After an outbreak, a TWG continued working, starting with exploring the response of the team to that outbreak, seeking answers to questions about what the team got right or wrong,

and what could be learnt about the disease that could aid better response in the future. This exploration allowed the TWG to put together a guiding document to facilitate better preparedness and response to the next outbreak. It also helped the team to monitor diseases with epidemic potential. Expressing the value and benefits of the TWGs, especially with respect to building their capacity to respond to lassa fever[11], one of the directors noted:

> *For lassa fever now, it has been with us (Nigeria) for over 50 years and yet we did not really understand what lassa fever was all about. We are getting to understand it now. We had our first international lassa fever conference in January 2019. We were able to bring in people from the international [scene] that have been working in silos on lassa fever.*

Partnerships

> *There has been a Nigeria CDC in existence for many years, but what we now have is an Agency with the capacity to respond to outbreaks. Thank you for all you do.*

NCDC has enjoyed the partnership of numerous international organisations which has aided the successes recorded so far. These include the World Health Organisation (WHO), Tony Blair Institute for Global Change, Public Health England (PHE), the United States Centre for Disease Control and Prevention, Bill & Melinda Gates Foundation, African Field Epidemiology Network and many more (see appendix for a complete list). The NCDC team has enjoyed a very robust relationship with these partners since 2016, such that many partners have temporary bases at the NCDC office, working seamlessly with the team in various areas.

By virtue of Dr Chikwe's experience and exposure on the one hand, and his demonstrated integrity on the other, the Agency was able to attract many international partners that were keen on working with a credible entity to fight diseases of both local and global public health importance. Apart from the WHO and other United Nations organisations that were, as it were, required to work with them, the US CDC is the NCDC's longest-standing partner. The partnership has been both direct in terms of funding and provision of other resources, as well as in terms of implementation. Leveraging their initial relationship with the US CDC, they were able to attract other partners operating in different areas. One of the US CDC's earliest contributions to the new NCDC was the provision of laboratory equipment worth one million dollars at the time.

Another key partner has been the Tony Blair Institute. TBI came on board serendipitously. Dr Chikwe had met members of the team in Liberia during the Ebola response. While the other partners were contributing to core technical areas, the TBI team was the group that managed the strategic and administrative aspect of activities, ensuring that the activities of the diverse organisations were coordinated. Recognising that this was a capability that the fledgeling NCDC required, he reached out to the TBI team requesting for assistance. Following a six-month pro bono engagement, a proposal for funding was developed to expand TBI's activities at the NCDC and it found support with the Bill & Melinda Gates Foundation. TBI partnered NCDC from 2017 until early 2020 with their primary focus on building effective managerial structures and leadership capabilities for the Agency, as well as helping to craft a strategic direction and develop a strategic orientation for the Agency. That initial six-month engagement produced NCDC's first strategic plan that formed the framework for NCDC operations from 2017 - 2021. Several other partners continue to work with the NCDC around capacity building, funding, technical and implementation expertise, and equipment provisioning.

A significant part of what the NCDC does is donor-funded. It is not surprising therefore that in the early days, partners drove the terms of the relationship to the extent that the NCDC team simply aligned with the direction the partners wanted them to, just to get things moving. However, as the Agency came into its own and established a measure of credibility and expertise, having built their strategic plan and identified their areas of priority, they were able

[11] Nigeria has the largest number of cases of lassa fever in the world.

to articulate the nature of assistance they needed the partners to provide. Many agree that this smooth relationship has resulted from partners' confidence in Dr Chikwe primarily, and now by extension, the team. A member of the team recalls,

> *I have had a partner confide in me privately that what is bringing them in here is because of Dr Chikwe. Because of his leadership style. He is transparent. He has integrity and accountability too. He helps push people to do their thing. I haven't seen tribalism or any [of the sort] with him. Once you show yourself as good and once partners see these kinds of things – a visionary, they want to be part of the success story.*

A Potpourri of Successes and Challenges

> *Often, the focus of success (or absence of it) is in the leadership of the organisation. However, at the NCDC, most of our success has come from the hard work, diligence, dedication and commitment of my colleagues - from the drivers to the directors who have led from the front.*
>
> - Dr Chikwe.

The NCDC has recorded many succcesses as highlighted much earlier and has evolved into a mission-driven, mission-focused organisation. The excitement and energy around the work they did were palpable when one hung around the team. There are, however, still many internal and external dynamics the team needed to grapple with, which are fundamental to NCDC's ability to continue to fulfil its mission for the long-term. At the NCDC midterm strategic review in 2019, everyone agreed that the team had come a long way in terms of the technical successes articulated earlier around the enhanced capacity of the Agency to respond to and contain disease outbreaks. However, this has been driven by many internal changes within the Agency itself.

One of the most outstanding achievements of Dr Chikwe and his leadership team concerning the internal functioning of the Agency was getting most people to be on the same page about how the organisation needed to function to achieve its objectives. Observing Dr Chikwe's work ethic, the rest of the team quickly realised that this DG was here to work and provide much-needed leadership, both directly and indirectly. He would come into the office early and daily except when he was away on official assignment, stay at work as long as the work required, and get involved in doing the work itself. In essence, he led by example.

> *…I think that when institutions are generally weak … leadership matters more than ever … it's with the little things day-to-day. I would come to work at a specific time, leave quietly and gave a lot of energy into the work we were doing. There was a comment passed that really alluded to the fact that, like everyone else, he* (I) *will soon get tired and become like everybody else. So, there is a certain persistence that is required, once you start coming at a specific time, behaving in a specific way that you really don't have the luxury of dropping the ball… Once people [perceive] that this is not sustainable, they will go back to their old ways.*

His behaviour was generally at variance with traditional public service orientation. He was not only present at the office, but he was also accessible to the staff. He knew that the bureaucracy was a luxury the Agency could not afford and a hierarchical approach to things would limit the Agency's effectiveness. Dr Chikwe, therefore, reached beyond hierarchical lines to identify, motivate and recognise team members that were eager and able to get the job done. When new members joined the team, he went out of his way to meet them. He ensured he held enough of a conversation with them to identify where their interests and capabilities lay and even assigned responsibilities to them directly. He also ensured that he remembered their names after the first meeting, so they felt 'seen'. By this, he empowered even the younger team members and helped them to build their confidence and skills quickly.

However, this leadership style that was inclined to consult and engage with employees irrespective of their cadre in the organisation and without necessary recourse to their departmental heads would turn out to be a double-edged sword. It was alien to the public

service, and some of the senior personnel in the Agency felt Dr Chikwe attempted to 'divide-and-rule'. One of NCDC's founding members in the director cadre expressed it this way:

> *As a government parastatal, we are bound by public service rules ... when you work like that, it brings indiscipline into the system; the junior ones won't respect their bosses.*

Dr Chikwe further inadvertently heightened the discontent by democratising access to many partner-sponsored capability building programmes. The NCDC had become a place where it was perfectly normal to be at work late into the night and to be called up at odd hours to attend to a public health emergency. Recognising that he did not have the leeway to adjust the public service remuneration to match the commitment of his team members, partner-sponsored training programmes and development opportunities, such as local and internal conferences, were the only tools with which to incentivise the team. He ensured he attracted many such opportunities and opened it up to the staff, so much so that one of them commented: '*I have never had this much training in my life.*'

However, some of the senior personnel believed they should be in the position to determine which member of their team got those opportunities. As was common in the public service, those opportunities were allocated based on hierarchy, and in many cases, only the most senior personnel got them. Dr Chikwe felt differently, as he was keen to ensure that only team members that had demonstrated their mettle for the related area of work got those opportunities. One of the team members that was 'poached' from another agency described it thus:

> *…where I was before, certain trips cannot be made by people who are not at the directorate level, but here I find that [anyone] can go anywhere.*

While the set-up of the Technical Working Groups (TWGs) was perhaps the primary internal structural change that contributed the most to all the achievements of the NCDC, it was also the area that many agreed had become the most problematic for one main reason – its operations did not align with the bureaucratic departmental structure of the traditional public service system. Instead, it had to co-exist with it causing frictions between more senior career civil servants that have spent perhaps two to three decades of their lives within the traditional public service structure and the other members of the team. In addition to structure however, there were also concerns about the lack of a centralised database. The legacy departmental systems seemed to be relegated in favour of the TWGs such that the latter was at the forefront of surveillance and response activities, often possessing the more up-to-date data than the departments. Generally, there was no systematic effort or mechanism to harmonise the activities of the TWGs with that of the departments. According to one of the directors,

> *TWGs are not really on the structure of NCDC. They are an addendum. (But) TWGs are now more grounded than the real structure.*

Concerns around work-life balance coupled with a remuneration system that did not take into account the nature of the work NCDC personnel did, also stood out as a threat to the sustainability of the gains the Agency had recorded. According to one of the directors, '*sometimes, you are at work till late in the night; sometimes, you have to come in at 5 a.m., sometimes, at 3 a.m.*' While everyone recognised the imperative of that level of commitment to the work, there were indications that burnout was imminent. Many of the personnel were committed to the Agency's mission and claimed not to have looked out for another job since they were hired two years ago. There were, however, indications older, more experienced staff had begun to feel the pressure of the misalignment between the incentives and the nature of the work. One of them opined that:

> *A lot of government staff have been poached; NGOs, international bodies who have seen that they are capable of doing the work and are willing to pay more. You are building them to strengthen the institution, and they are leaving. If we don't improve that (remuneration), it's going to affect the Agency a lot.*

External Challenges

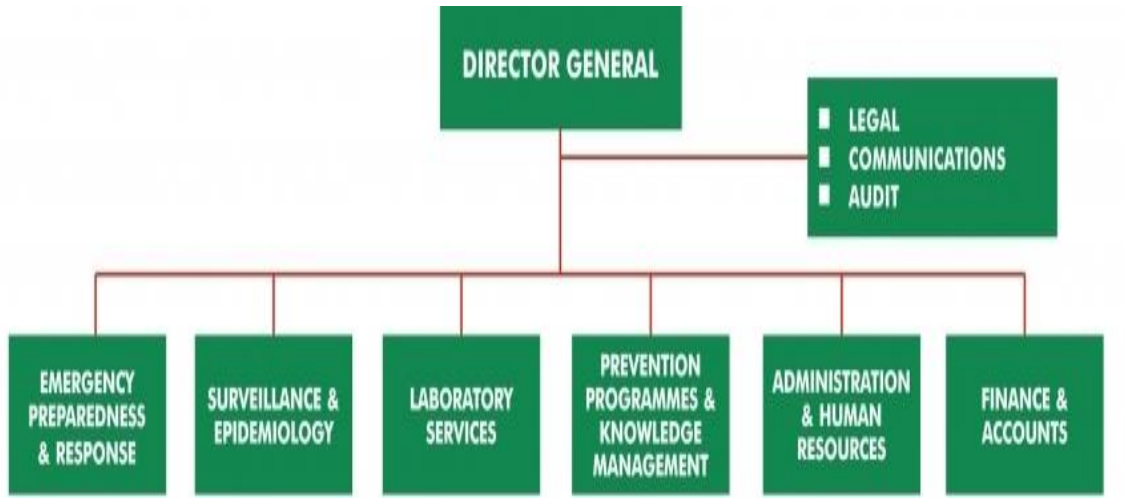
During the midterm strategic review, several challenges external to the organisation, that could hamper the fulfilment of its mission, were also identified (Exhibit 1). These include getting the states on board with the level of preparedness required to ensure they could respond to outbreaks effectively. As part of its mandate, the NCDC is expected to work with the states' health systems to facilitate their preparedness in the event of an outbreak, as well as just ensuring they were equipped for preventative activities, guided by WHO's Integrated Disease Surveillance and Response Strategy. The NCDC weighed the capability of the states to perform their part and then deployed capability building opportunities for states' employees, to equip them to effectively work with the NCDC and other relevant federal agencies and partners in the business of disease prevention and control. While some states have been responsive and made considerable progress in preparedness, others have not demonstrated enough political will. In the latter case, the NCDC has had to deploy its already stretched resources to address outbreaks in those states. NCDC has however continued to devise mechanisms to drive the agenda via various means. For example, it extends local and international capability development opportunities to the states' personnel.

Another fundamental challenge faced by the Agency is funding. In 2018, government allocation to the NCDC was about $4 million, roughly 0.03% of the US CDC's $11 billion in the same year. Nigeria's health system as a whole is grossly underfunded with less than 5% of the annual budget allocated to health in the same period. So, one of Dr Chikwe's core responsibilities in the early days was looking for resources. He leveraged his network of contacts in international organisations to locate the resources required, in addition to the Federal Government's subvention, to fund the Agency's activities. While there have been considerable improvements since the early days, heavy dependency on donor funding remains a significant challenge as donors would generally prefer to fund their own areas of interest, thus forcing the hand of the NCDC in disease areas the latter may not consider a high priority for the country per time.

What the Future Holds

In summary, the changes and achievements in NCDC appear to have been driven first by Dr Chikwe's visionary drive and integrity, a leadership team that bought into the vision and were committed to getting the work done and building a responsive public health institute. Having young, vibrant and visionary foot soldiers, as well as the support of the Federal Ministry of Health and very committed partners, has also been indispensable. The level of cultural change required to sustain the gains in the NCDC may be challenging to quantify, but there is no doubt that the Agency has evolved into a focused and respectable organisation. It remains to be seen what a post-Chikwe Ihekweazu era would look like. What leverage does he have to institute lasting structural change in the Agency? Would there be a pre- and post- Chikwe era distinguished by a relapse into the old ways? Or is the NCDC simply going to grow from one level of effectiveness to the other? How could he and his leadership team ensure that the investments of time, resources and trust in the existing team continue to yield more and more improvements after they were gone? The recent COVID-19 outbreak had tested everything that they had built over the last few years, especially coming on the heels of a lassa fever season they were still battling. But they had done quite well, even earning commendation from the President. Would they be able to sustain this? Had he and his team built an institution that was resilient enough to withstand another outbreak of this nature, or worse, after they were gone? These were the questions that dominated Dr Chikwe's thoughts, as they prepared to announce a considerable increase in the number of confirmed cases of the COVID-19 pandemic yet again.

Exhibit 1: NCDC organisational structure.



Source: https://ncdc.gov.ng/ncdc.