

Regulating Public Health Emergencies in Nigeria: Prospects and Constraints

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ABSTRACT

Ensuring health security is considered as an important role of every sovereign nation. Every threat to health, especially the spread of communicable diseases, constitutes potential threat to human existence. As migration has become an integral part of economic and social development, various nation states face threats from infectious diseases and public health emergencies arising from unrestricted mobility of persons across national borders. The quest by states to protect the health of persons who live within their borders has galvanized an increasing level of regulatory frameworks geared at addressing issues of public health emergencies. Nigeria as an important component of the global village has put in place a number of such regulatory frameworks, the efficacy in implementation of which are constrained by both legal and ethical factors as are revealed in this work.

Keywords: Public health, emergency, disease, quarantine, law, Nigeria.

INTRODUCTION

The high mobility of persons and goods across national borders which is galvanised by the easy and continuously improving means of transportation, the quest for economic survival, and social and political instabilities prevalent in some countries, have gradually and progressively transformed the world into a global village. As human mobility increases, so are the challenges associated with it. The most crucial of such challenges that is considered a potential threat to human existence is the propensity of the spread of communicable diseases from one country to the other. The prevalence of such contagious diseases in modern times has become an issue of great concern to the global community. The recent Ebola virus disease pandemic in Africa, which has continued to constitute a significant threat to human existence in the Democratic Republic of the Congo,¹ has demonstrated that communicable diseases remain a global

challenge to public health. Studies on public health related constraints indicate that changes in disease patterns may be due to lifestyle,² detrimental health effects of environmental degradation, climate changes and internal conflicts.³

Traditionally, public health concerns were restricted to protection against the spread of infectious diseases, a responsibility which is statutorily vested in the national governments, and in contemporary times increasingly being assumed by international agencies. This obligation is based on international human rights conventions such as the International Convention on Economic Social and Cultural Rights of 1966 (ICESCR) which vests a duty on the States to take measures to ensure the prevention, treatment and control of epidemic, endemic, occupational

¹See World Health Organisation, "Ebola in the Republic of the Congo" available at <https://www.who.int/emergencies/diseases/ebola/drc-2019> (accessed 28/09/2019) which suggests that the Democratic Republic of the Congo is grappling with the world's second largest Ebola epidemic on record, with more than 2000 lives lost and 3000 confirmed infections since the outbreak was declared on 1 August 2018.

²World Health Organisation, Commission on the Social Determinants of Health Final Report, "Closing the Gap in a Generation, Health Equity through Action on the Social Determinants of Health" available at https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=4E60C1E625CA5A2918D4A501A36453FE?sequence=1 (accessed 04/04/2019).

³See, World Bank, "The Climate Change, Environment and Natural Resources Management" available at <http://web.worldbank.org> (accessed 04/04/2019)

and other diseases' affecting humans. The realisation that health is the state of complete physical, social and mental well-being of persons, not merely the absence of disease or infirmity forms the cornerstone of this obligation.⁴ Since good health is pivotal to life, it is imperative that every sovereign nation should ensure the protection of the health of individuals, both nationally and internationally, as recognised by the international norms. The World Health Organisation (WHO)'s constitution encourages this by declaring that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.⁵ The same realisation has compelled the enactment of laws and instituting of government policies in different countries including Nigeria which seek to guarantee the protection of individuals in the event of the occurrence of public health emergencies.

WHAT CONSTITUTES PUBLIC HEALTH EMERGENCY

Issues of public health encompass the provision of healthcare services, surveillance and control of communicable diseases, as well as safe and healthy working conditions, healthy living environments, access to safe drinking water and sanitation, health-related information and education.⁶ Factors leading to the breakdown of any of these safety measures could be classified as public health emergency depending on the impact and circumstances of such development. The World Health Organisation considers public health emergency as being of international concern where it is an extraordinary event which constitutes a public health risk to other States through the international spread of disease and potentially requires a coordinated international

response.⁷ Such 'extraordinary event' would ordinarily entail a situation that is serious, unusual or unexpected, that bears adverse implications for public health beyond the affected State's national borders, and requires urgent intervention of the international community. Some instances of diseases constituting public health emergencies which the society had grappled with include Small pox, Typhus, Yellow fever, Cholera, Avian influenza, and more recently the Ebola virus disease which has continued to record a sizeable number of fatalities among the rural dwellers in the DRC.⁸

Nigeria has experienced the outbreak of various communicable diseases in the past, among which are Lassa fever outbreak in the 70's, Yellow fever in the 80's, the Avian influenza outbreak in 2000s, and recently the Ebola Virus Disease (EVD) outbreak in 2014.⁹ Cerebro spinal meningitis and Polio myelites which were thought in the past to have been contained, are once more raising issues of public healthcare concerns in the country.¹⁰ The ability to identify, promptly respond to the outbreaks and curtail the spread of diseases bordering on public healthcare concerns depend on the availability and implementation of appropriate laws, policies and procedures at all tiers of government.¹¹

LEGAL FRAMEWORK FOR THE PROTECTION OF PUBLIC HEALTH

The Constitution of the Federal Republic of Nigeria (CFRN) 1999 while in principle recognizes and

⁴Preamble to the Constitution of the World Health Organization, 22 July 1946.

⁵The Constitution of the WHO was adopted by the International Health Conference, New York, 19-22 June 1945 (opened for signature on 22 July 1946 by the representatives of 61 States, 14 UNTS 185. See also article 55 of the United Nations Charter, which provides that the United Nations (UN) shall promote, among others, solutions of international economic, social, health, and related problems.

⁶School of Public Health, University of Maryland, "What is public health" available at <https://sph.umd.edu/content/definition-of-public-health>. (accessed 05/09/2019)

⁷World Health Organization, *International Health Regulations (2005)*: 2nd ed available at <http://www.who.int/ihr/publications/9789241596664/en/> (accessed 07/09/2019).

⁸See World Health Organisation, "Ebola outbreak in the Democratic Republic of the Congo declared a Public Health Emergency of International Concern" available at <https://www.who.int/news-room/detail/17-07-2019-ebola-outbreak-in-the-democratic-republic-of-the-congo-declared-a-public-health-emergency-of-international-concern> (accessed 28/09/2019).

⁹Lafond KE, Dalhatu I, Shinde V *et al.* "Notifiable disease reporting among public sector physicians in Nigeria: a cross-sectional survey to evaluate possible barriers and identify best sources of information" (2014) 14 *BMC Health Services Research* 568.

¹⁰Zoakah AI, Adebisi AO, Ashikeni M *et al.*, "Wild poliovirus in Nigeria" (2016)16(11) *Lancet Infectious Diseases* 1224

¹¹Onyemelukwe C. "Can legislation mandating vaccination solve the challenges of routine childhood immunisation in Nigeria" (2016) 16 *Commonwealth Law Journal* 100-124.

guarantees the protection of the basic human rights such as the right to life and dignity of human person, the right to privacy, freedom of movement, peaceful assembly and association, permits limitations on the enjoyment of such rights if such limitations are considered reasonably justifiable and being for the protection of public health.¹² One of such legislation that directly authorizes restriction on the enjoyment of the constitutionally guaranteed freedom of movement in Nigeria is the Quarantine Act of 1926.¹³ The Act, which has been described as archaic,¹⁴ states its objective in the preamble as being to provide for and regulate the imposition of quarantine and to make other provisions for preventing the introduction into and spread in Nigeria, and the transmission from Nigeria, of dangerous infectious diseases. ‘Dangerous infectious diseases’ as recognized under section 2 of the Act includes cholera, plague, yellow fever, smallpox and typhus, and any disease of an infectious or contagious nature which the President may, by notice, declare to be a dangerous infectious disease within the meaning of this Act. Thus, the power to declare disease as constituting public health emergency in Nigeria is vested in the President who also could make regulations for the control and prevention of the spread of such disease.¹⁵ State Governors are vested with residual powers to make declarations and regulations within the boundaries of the component states where the President fails to act.¹⁶

The real concern in the enforcement of the legislation on quarantine lies, not so much on the intrinsic abridgement of the enjoyment of the constitutionally guaranteed freedom which it portends, as that is always justifiable as being for the overriding public health, but on the observance by the relevant authority of the necessary protocol attendant such restriction. International human rights law, as observed by Human Rights Watch, has set down a bench

¹²See s 45(1)(a) of the Constitution.

¹³That legislation is presently undergoing the process of amendment in the National Assembly. See A Bill for An Act to Establish the *Nigeria Public Health (Quarantine, Isolation, and Emergency Health Matters Procedure) Act*.

¹⁴Makinde OA and Odimegwu CO, “A qualitative inquiry on the status and adequacy of legal instruments establishing infectious disease surveillance in Nigeria” (2018) 31 *The Pan African Medical Journal* 22.

¹⁵See sections 3 and 4 of the Quarantine Act.

¹⁶See section 8 of the Quarantine Act.

mark that states should observe in the process of quarantining of persons in times of public health emergency as follows:

restrictions on human rights in the name of public health or public emergency [should] meet requirements of legality, evidence-based necessity, and proportionality. Restrictions such as quarantine or isolation of symptomatic individuals must, at a minimum, be provided for and carried out in accordance with the law. They must be strictly necessary to achieve a legitimate objective, the least intrusive and restrictive available to reach the objective, based on scientific evidence, neither arbitrary nor discriminatory in application, of limited duration, respectful of human dignity, and subject to review. When quarantines are imposed, governments have absolute obligation to ensure access to food, water, and healthcare.¹⁷

Where the occasion of quarantine fails to satisfy these basic international protocols, it cannot be justified as being for the protection of the health of the society. Judicial interventions have been sought in some jurisdictions where the process of quarantine is considered as constituting unwarranted infringement on human rights. In *Jew Ho v Williamson*¹⁸ the US Circuit Court for the Northern District of California found that the quarantining of some Chinese residents was unreasonable, unjust, oppressive, and discriminatory, being contrary to the provisions of the fourteenth amendment of the US constitution, and was accordingly struck down. In *Mayhew v Hickox*¹⁹ an Ebola contact victim was placed under mandatory quarantine for twenty-one days upon her return to the United States. She contested the quarantine decision based on the fact that she was asymptomatic and Ebola can be transmitted only by symptomatic persons, as such the mandatory quarantine constitutes an unreasonable violation of her right. The court found that the public health authority did not satisfy the burden of proving that quarantine is necessary to protect other individuals from the dangers of infection. The decision to quarantine was accordingly set aside and substituted with an order for a direct active monitoring of the contact as outlined in the Centers for Disease Control and Prevention

¹⁷‘West Africa: Respect Rights in Ebola Response| Human Rights Watch’ available at <http://www.hrw.org/news/2014/09/15/west-africa-respect-rights-ebola-response> (accessed 29/09/2019).

¹⁸103 F. 10 (N.D. Cal. 1900).

¹⁹No. CV-2014-36 (D. Maine Oct. 31, 2014).

(CDC) guidelines. Similarly, in *Jacobson v Massachusetts*²⁰ the court held that it is a requirement under public health regulations that the exercise of power or decisions, including quarantine and isolation, should be reasonable and balance individual rights.

The reason for quarantine should not be simply the seclusion or exclusion of the victims from the public, but more importantly to administer the necessary curative measures that would ensure the restoration of the victims to their normal way of life in the society. The victims' interests should thus remain of paramount concern of the government even under quarantine. A quarantining condition that fails to attain the basic needs of the victim or purpose for that course could be classified as discrimination, a conduct which is prohibited by law.²¹ The experiences of some of the victims of the Ebola virus disease in the peak of the spread of that disease in West Africa including Nigeria provide a good illustration. It was reported that in Nigeria the healthcare providers abandoned Ebola patients and walked away from an Ebola treatment Center (the Infectious Disease Hospital) in Yaba, Lagos, the quarantining facility provided by government. The healthcare providers on the other hand allegedly abandoned the patients because of what they perceived as the lacklustre attitude of their country's health officials to the plight of the Ebola patients who were quarantined at the Center. The Ebola patients were reportedly housed in a dilapidated and abandoned building at the Center without quality care, functioning water supply and no air conditioning facilities. The families of the patients were compelled to provide the basic needs of the patients, paid for some drugs and oxygen.²² The abandoning of a patient in a

hospital by healthcare providers for whatever reason must be considered as an infringement by the healthcare providers on the right to healthcare of the patient, a situation aggravated by the failure of the government to provide for the basic needs of the victims.

The Nigerian National Health Act of 2014 which provides a framework for the regulation, development and management of a national health system and sets standards for rendering health services in the federation, and other matters, bears enabling provisions that could address some of the challenges patterning to the issues of public health emergency if given a broad focus and allowed to operate at that level. The Act establishes the National Health System which comprises of all stakeholders in the provision of healthcare, right from the federal to the village level, including those operating in the private sector and even the traditional and alternative healthcare providers. The Act encourages cooperation and synergy among those operating within the National Health System to ensure that all persons living in Nigeria enjoy the best possible health services within the limits of available resources.²³ Such cooperation among the stakeholders is expected to guarantee early identification of issues of public health concern and the referring of such concern to the appropriate health establishment.

The Federal Ministry of Health is vested with powers by the Act to ensure, among others, the provision of Quarantine facilities and Port Health Services.²⁴ The exercise of this power would ordinarily be guided by the provisions contained in the Quarantine Act, the Constitution, and other international obligations of Nigeria as contained in the regional and international instruments such as the African Charter on Human and Peoples Rights of 1981 and the United Nations Declaration of Human Rights of 1948 both of which promote the respect for human rights in all circumstances, especially the right to health. The African Charter, for instance, sets out in article 16, the right of every individual to enjoy the "best attainable state of physical and mental health" and declares that states parties shall take "the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."

²⁰197 US 11 (1905).

²¹See Nwafor GC and Nwafor AO, "Experiences of the Ebola victims in the West African nations: a human rights imperative" (2017) 6(1) *International Journal of Public Law and Policy* 78 at 92.

²²Ebola Patients Abandoned, Health Team Down Tools- Health- Nairaland' available at <http://www.nairaland.com/1862229/ebola-patients-abandoned-health-team> (accessed 29/09/2019); See also 'Nigeria Hasn't Given Priority to Ebola Treatment, Abandons Nano Silver Treatment' available at <http://www.nursingworldnigeria.com/2014/08/nigeria-hasn-t-given-priority-to-e> (accessed 29/09/2019). See generally Nwafor GC and Nwafor AO, "The Healthcare Providers-Patients Relationship and State Obligations in Times of Public Health Emergency" (2016) 9 *African Journal of Legal Studies* 268 at 293.

²³Section 1(1) (2) of the National Health Act

²⁴Section 2(1) (j) of the National Health Act

The efficacy of the Federal Ministry of Health in discharging this function generally becomes an issue in the event of public health emergency. The recounted experiences of the victims of the Ebola pandemic in the country, especially those quarantined at the Ebola treatment Centre (Infectious Diseases Hospital) in Lagos without food or water, and other basic medical needs, casts a slur on the Federal Ministry of Health's fulfilment of the obligations vested on it by the National Health Act. The fact that the incident case, Patrick Sawyer, travelled by air from Liberia to Lagos without dictation, and whose subsequent admission in a Lagos hospital led to the spread of the disease and death of a number of healthcare professionals²⁵ demands some reinforcement of control exercised by the Federal Government's agency at the ports of entry into the country as required by the Act.

Section 20(1) of the Act provides, upon penalties, that a health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason whatsoever. Among the uncomplimentary conducts of the health care providers witnessed at the peak of the spread of the Ebola, was the rejection, or abandoning of patients by the health care providers in preference for self-preservation. Respite only came to the victims with the intervention of mostly international volunteer organisations some of whose personnel actually paid with their lives to save the Ebola victims.²⁶

Some of the reasons that have been adduced for healthcare providers preference for self to patients interest include: cost of setting up a clinic, a hospital or a medical institute; increased

awareness in the patient community about their legal rights, doctors are conscious of the legal implications of any negligence in treating the patients; some health care providers do not (or cannot) offer the best line of treatment to the patients due to inexperience, or lack of training on the use of standard treatment facilities in their own clinics or hospitals.²⁷ Even as compelling as some of these reasons may seem, the health care providers ethical obligation to the patient as reinforced by the Act demands preference for the patient's interest at all times. Where the patient's condition is beyond the health care provider's knowledge and experience, or in the event of the non-availability of the requisite medical facility, the patient should be referred to the appropriate health care establishment.

At the international level is the International Health Regulations (IHR) which was revised in 2005, a WHO instrument which regulates public health issues, stipulating guidelines to prevent, detect and effectively respond to public health threats and public health emergencies of international concern.²⁸ The purpose of IHR is to prevent, to protect against, control, and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to the public health risks, to avoid unnecessary interference with international traffic and trade.²⁹ Generally, the revised IHR emphasizes the containment of public health threat at the source of the event, reporting all public health risks, including chemical and radio nuclear threats; and specifies responses to improve flexibility in communication, as national capacities to identify and diagnose diseases differ and delay in reporting of such health emergencies affect global health security. The IHR 2005 demands that the implementation of the regulation shall be done with full respect for the dignity, human rights and fundamental freedoms of persons, such that reasonable measures are effected to ensure that rights are protected while tackling public health issues and

²⁵The most notable casualty is Dr Stella Ameyo Adadevoh of the First Consultant Hospital, Lagos who diagnosed the first victim of the virus Patrick Sawyer, a Liberian, and prevented the spread of the disease by the patient by keeping him in the hospital against the wish of the patient. She contracted the virus from the patient and died on the 19 August 2014. See Globe Intel "Stella Adadevoh Biography" available at <https://globintel.com/nigeria/stella-adadevoh-biography-wiki-death-and-cause-husband-son-family-legacy-ebola-virus-google-doodle/> (accessed 10/10/2019). See Robert Roos(ed) CIDRAP NEWS university of Minnesota, 2014 available at <http://www.cidrap.umn.edu/news-perspective/2014/09/quarantine-escapee-sparked-more-ebola-nigeria> (accessed 10/10/2019).

²⁶*Should doctors "have" to treat Ebola patients? - AMERICAblog* available at americablog.com/2014/09/doctors-treat-ebola-patients.html (accessed 30 September March 2019).

²⁷Nwafor GC and Nwafor AO, "The Healthcare Providers-Patients Relationship and State Obligations in Times of Public Health Emergency" (2016) 9 *African Journal of Legal Studies* 268 at 273

²⁸Gostin LO, *Global Health Law* (Cambridge: Harvard University Press, 2014) p...

²⁹Strengthening health security by implementing the International Health Regulations (2005) available at <https://www.who.int/ihr/procedures/pheic/en/> (accessed 29/09/2019).

emergencies.³⁰ State actors are required to develop public health capacities to detect and respond to diseases outbreak.

The need for early detection and prevention of the spread of infectious diseases informed the adoption by the African region of the Integrated Disease Surveillance and Response (IDSR) strategy established by the World Health Organization (WHO) Regional Committee for Africa in 1998.³¹ The IDSR policy was developed to guide and to provide the necessary environment for the planning, implementation, monitoring and evaluation of an IDSR by all tiers of government including parastatals, private health sector, non-governmental organizations and partners.³² The IDSR strategy aims to strengthen surveillance and response at each level of the health system from the primary healthcare centers to the teaching hospitals and to streamline IDSR priority diseases.³³

Nigeria adopted the IDSR policy in 2005 as a guide for addressing public health threats in the country. The reporting pattern under the policy flows from the healthcare facility at the Local Government Areas to the State Ministry of Health (SMOH) and then to the Federal Ministry of Health (FMOH). The FMOH collates data and forwards same to the statistics division for analysis and feedback is sent to the point of origin.³⁴ The IDSR strategy has not, however, shown to be protective in the detection of infectious diseases and their prevention as records suggest greater responses to the spread than prevention of the spread of diseases in Nigeria.³⁵ In other words, the responses by government are more reactive than proactive.

³⁰See Article 3(1) of the IHR 2005.

³¹World Health Organization, "An integrated approach to communicable disease surveillance" (2000) 75(51-52) *Weekly Epidemiological Report* 417

³²Makinde OA and Odimegwu CO, "A qualitative inquiry on the status and adequacy of legal instruments establishing infectious disease surveillance in Nigeria" (2018) 31 *The Pan African Medical Journal* 22

³³Quinn SC and Kumar S, "Health inequalities and infectious disease epidemics: a challenge for global health security" (2014) 12(5) *Biosecure Bioterror* 263-73.

³⁴Epidemiology Division, Federal Ministry of Health, "National Technical Guidelines for Integrated Disease Surveillance and Response March 2013" available at https://ncdc.gov.ng/themes/common/docs/protocols/4_1476085948.pdf (accessed 29/09/2019).

³⁵Onyido AE, Ezike VI, Ozumba NA, Nwankwo AC, Nwankwo EA., "Yellow fever vectors' surveillance

The incidence of Ebola outbreak in the country in 2014 demonstrates the consequences of insufficient regional and national public health regulations and management system, especially at the national borders like the land, air and sea ports. The outbreak of that disease in the West African region was first reported in Guinea in March 2014 following the death of a two year old child who was infected with the disease.³⁶ The virus rapidly spread to the neighboring countries such as Liberia and Sierra Leone. The WHO report in April 2014, showed 157 suspected and confirmed cases in Guinea, 22 suspected cases in Liberia, and 8 suspected cases in Sierra Leone.³⁷ By the month of July 2014 the disease was exported into Nigeria through a Liberian-American, Patrick Sawyer, who travelled by air from Liberia to Lagos in Western Nigeria.³⁸ The oil city of Port Harcourt in the southern part of Nigeria also had a share of the devastating impact of the disease.³⁹ The Nigerian IDSR policy in place could not detect

in three satellite communities of Enugu Municipality, Nigeria" (2009) 30(1) *Nigerian Journal of Parasitology* available at <https://www.ajol.info/index.php/njpar/article/view/43981> (accessed 29/09/2019).

³⁶'Guidelines for Evaluation of US Patients Suspected of Having Ebola Virus Disease' CDC 2014 available at <http://emergency.cdc.gov/han/han00364.asp> (accessed 5 September 2014). See also 'Ebola pandemic' available at http://en.wikipedia.org/wiki/Ebola_virus-epidemic-in-West_Africa where it was also reported that the first human case of the Ebola virus disease leading to the 2014 outbreak was a 2 year old boy who died on 6 December 2013 in the village of Meliandou, Gueckedou prefecture, Guinea. His mother, 3 year old sister and grandmother then became ill with symptoms consistent with Ebola infection and died. People infected by those victims spread the disease to other villages (accessed 11 September 2014).

³⁷'Outbreak of Ebola in Guinea and Liberia' Centers for Disease Control and Prevention available at <http://www.cdc.gov/vhf/ebola/outbreaks/guinea/> (accessed 5 September 2014). See 'Ebola virus disease, West Africa Situation as of 7 April 2014-Guinea' World Health Organization 2014 available at <http://reliefweb.int/report/guinea/ebola-virus-disease-west-africa-situation-7-april-2014> (accessed 6 September 2014).

³⁸'2014 Ebola Pandemic' available at http://en.wikipedia.org/wiki/Ebola_virus_epidemic_in_West-Africa (accessed 9 September 2014).

³⁹For a recount of the experiences of the victims, see Nwafor GC and Nwafor AO, "Experiences of the Ebola victims in the West African nations: a human rights imperative" (2017) 6(1) *International Journal of Public Law and Policy* 78 at 92.

or prevent the spread of the disease until a number of casualties were recorded in the country.

Public health emergency situations often expose the lapses in the national public health infrastructure such as the non-existence, or porously conditioned or makeshift health care facility for the victims of an infectious disease. Insufficient trained human capacity to execute the essential public health functions in the community, inadequate supply or lack of access to essential medicines and other medical products are always among the constraints to an effective management of sporadic conditions that constitute threats to public health. Again, the experiences recounted by the victims of Ebola belly's these facts, a crisis that claimed the lives of both the health care providers and patients prior to the emergency advanced external interventions.

STATUTORY INADEQUACIES

Among the noticeable challenges in addressing matters of public health in Nigeria is the non-existence in the country of any comprehensive legislation on public health. The Quarantine Act of 1926 which stands as one of its kind, is old and the provisions are inadequate to provide the essential guides for addressing issues of public health emergencies. As a pre-independence statute, with only six substantive provisions,⁴⁰ the applications of some of the provisions in the modern Nigerian federal structure has become untenable. It does not seem realistic that only the President can declare a place in Nigeria as an infected local area,⁴¹ which is defined in the Act as a well-defined area, such as a local government area, a department, a canton, an island, a commune, a town, a quarter of a town, a village, a port, an agglomeration, whatever may be the extent and population of such areas.⁴² The Act envisages the exercise of such power even in the most remote parts of the country. The federal structure of state governance in Nigeria devolves power from the federal, to state and local governments which are vested with both executive and legislative powers.⁴³ This constitutional arrangement statutorily guarantees the impact of governance in all parts of the country. The vesting, in the

⁴⁰ Excluding the short title and interpretations contained in sections 1 and 2 respectively.

⁴¹ See section 3 of the Quarantine Act.

⁴² See section 2 of the Quarantine Act.

⁴³ See sections 2, 4 and 7 of the Constitution of the Federal Republic of Nigeria 1999.

President who operates at the federal level, the power to declare 'local area' as an infected area, would not only encroach on the powers of the local government administration, but militates against the required urgency in dealing with issues of public health emergency. Although the Act confers a residuary power of declaration of emergency on the state governor,⁴⁴ the implications of a state governor having to wait for the outcome of the President's decision on the impact of the spread of infectious disease in the state could be catastrophic. The experiences on the impact of the Ebola virus disease in the African nations indicate that diseases that raise emergency situations usually originate from among the rural dwellers and within the jurisdiction of local government administration. The government at that level are thus better placed and should be empowered to respond very quickly to such issues of health emergency. The regulations enacted as subsidiary legislation to the Act are specifically targeted at ports of entry and exit from Nigeria. There is no real concern as to diseases that often spread sporadically among the rural dwellers.

The essence of quarantine does not stop with the seclusion of the infected persons, it extends to caring for the secluded persons by providing the essential medical needs and ensuring that such persons are ultimately reintegrated in their communities. The account of persons who were quarantined in Nigeria at the peak of the spread of the Ebola virus disease in the country suggested the contrary. The noticeable governmental lapses in addressing the needs of such persons cannot be divorced from the unavailability of specific legislation on the care for the infected persons during healthcare emergency.

CONCLUSION

Quarantining of suspected contacts and isolation of patients without further care are not sufficient to curb or forestall the grave impacts of public health challenges. The existing Quarantine Act in Nigeria is outdated and needs a significant

⁴⁴ See section 8 of the Quarantine Act If and to the extent that any declaration under section 2 or 3 or this Act has not been made, and to the extent that regulations under section 4 of this Act have not been made by the President, power to make any such declaration and to make such regulations may be exercised in respect of a State, by the Governor thereof as fully as such power may be exercised by the President, and subject to the same conditions and limitations.

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remodeling to address the needs of the quarantined persons in line with the international best practices. The IHR 2005 has provided guidelines for addressing issues of public health emergencies, but there is a need to incorporate this into the national statutory instruments to mandate compliance by all those involved in the healthcare services. The infrastructural and medical inadequacies in the public health centres constitute threats to the lives of both the health care providers and the patients during public health emergencies. It would seem that in the absence of the needed resources, the health

care providers would continue to prefer the preservation of selves to the patient. Public health emergencies need proper surveillance and reporting system to monitor and curtail the spread of infectious diseases and this cannot be achieved without adequate regulatory framework. A legislation specifically addressing issues of public health capacity of the state, for improved prevention, easy detection, prompt response to infectious diseases threats and improve outcomes is imperative for a strategic positioning of the country to combat the incidences of pandemic diseases.

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