

Localising the Global: The WHO International Health Regulations and Domestic Health Governance Mechanisms of Infectious Diseases in Nigeria

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ABSTRACT

The importance of international health law, particularly the International Health Regulations (IHR 2005) adopted under the auspices of the World Health Organisation, has been widely acknowledged by scholars and policy makers. Given its importance in global governance of infectious diseases and global health security, aspects of the IHR feature prominently in the literature on global health governance, law and diplomacy. Apparently, case studies dealing with its impact on specific countries remain under researched. Against this background, this article examines the impact of IHR 2005 on domestic health governance mechanisms of infectious diseases in Nigeria. This article argues that Nigeria has made remarkable progress in terms of governance of infectious diseases manifested in legal responses, institutional arrangements and policy initiatives. It concludes that what is needed at this point is for Nigeria to improve on, and sustain these health governance mechanisms, which were instrumental in the successful containment of the Ebola Virus Disease outbreak in 2014.

Keywords: *International Health Regulations, World Health Organisation, Governance, Infectious Disease, Health, Nigeria*

INTRODUCTION

The relationship between domestic actions and implementation of international health law has been widely analysed by scholars. Yet, case studies documenting the role of domestic health governance mechanisms of infectious diseases in the application of the World Health Organisation (WHO) International Health Regulations (IHR 2005) remain limited. The use of international law in tackling contagious diseases is not novel. It dates back to 1851 when the first International Sanitary Conference was convened. Although only four conventions were eventually ratified after a series of eleven international conferences held between 1851 and 1903, the diplomatic efforts demonstrated

the need to confront the trans-border spread of disease multilaterally through international conventions (Aginam, 2000).

The International Sanitary Regulations was adopted by WHO in 1951. It was a creation of the nineteenth century International Sanitary Conferences. The adoption was a glaring manifestation of the legacy bequeathed to WHO, which came into existence in 1948, by the International Sanitary Conferences. It was renamed International Health Regulations (IHR) in 1969 and amended in 1973 and 1981. The IHR was revised in 2005 to respond to the shortcomings of the International Sanitary Regulations in relation the constricted confines of the notifiable diseases (cholera, plague and yellow fever) in view of the emergence of new disease threats. Another major flaw was the reliance of previous regulations on voluntary official notification by countries, and the absence of formal internationally coordinated mechanisms to forestall the spread of diseases across borders. Moreover, there was nothing in the existing regulations stipulating how the WHO and the affected countries were to collaborate in the containment of disease. The revised IHR finally entered into force in June 2007 as a legally binding set of Regulations for all WHO member states. The aim and scope of the IHR 2005 are: “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public risks and which avoid unnecessary interference with international trade and traffic” (WHO, 2008).

The WHO has a particular duty to ensure the right to health is realised through measures within the health field. This responsibility derives naturally from the WHO’s Constitution, which views health as a positive goal not only the absence of disease (WHO, 1948). Thus, the attainment of health requires that people’s right to health is realised. Article 12 of the International Covenant of Economic Social and Cultural Rights (ICESCR) confirms the right to health as “the highest attainable standard of social and mental health” (UN, 1966). The second part of the Article urged state parties to the Covenant to take appropriate actions for the realisation of right to health. It requested state parties; “to adopt and implement a national public health strategy and plan of action on the basis of epidemiological evidence addressing the health concerns of the whole population” (UN, 1966). In this way, the IHR 2005 is in line with the ICESCR as it also requires countries to have their facilities to cope with the problems arising from the outbreak of infectious diseases and to make the facilities and measures available to their people and those of other countries. The IHR 2005 reaffirms the responsibilities of the state to protect the peoples’ right to health. The failure to fulfil the IHR obligations, theoretically, could be considered a breach of obligations to protect the human right to health.

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Importantly, the IHR 2005 gave a time frame for the implementation of the Regulations. Article 5:1 of the IHR provides:

Each party shall develop, strengthen and maintain, as soon as possible but not later than five years from the entry into force of these Regulations for that State Party, the capacity to detect, assess, notify and report events in accordance with these Regulations (WHO, 2008)

Article 13 further obliges state parties to:

Develop, strengthen and maintain the capacity to respond promptly and effectively to public health risks and emergencies of international concern as soon as possible but no later than five years from the entry into force of the Regulations (WHO, 2008)

Unfortunately, most African countries could not achieve the targets within the specified time frame. According to the 2014 WHO Capacities Implementation Status, juxtaposed with other regions of the world, Africa has made little progress, in view of the recent progress in the implementation of IHR 2005 (WHO, 2014). Against this background, this paper illustrates the impact of international law on contagious diseases control in developing countries, and contributes to our understanding of the dynamics of domestic health governance mechanisms of infectious disease in Nigeria.

THE EVOLUTION OF THE INTERNATIONAL HEALTH REGULATIONS: AN OVERVIEW

The adoption of IHR 2005 represent a major change in the global disease outbreak surveillance and control regime since the beginning of international health diplomacy in 1851. It also introduced several significant changes to the behaviour expected of states. Article 21 of the Constitution of the World Health Organisation empowered the World Health Assembly to adopt Regulations in several fields, such as: “a) sanitary and quarantine requirements and other procedures designed to prevent the international spread of disease; b) nomenclature with respect to diseases causes of death and public health policies; c) standards with respect to diagnostic procedures for international

use; d) standards with respect to the safety of parity and potency of biological pharmaceutical and similar products moving in international commerce; e) advertising and labelling of biological pharmaceutical and similar products moving in international commerce” (WHO, 1948). Article 22 further stipulates that: “Regulations adopted pursuant of shall come into force for all members after due notice has been given of their adoption by the Health Assembly except for such members as may notify the Director General of rejection or reservations within the period stated in the notice” (WHO, 1948).

To be sure, only two regulations had been adopted by the Assembly under Article 21 (a) and (b) since the establishment of the WHO. The First World Health Assembly adopted WHO Regulation No.1 regarding the unification of the statistical classification of morbidity and mortality primarily for comparability in 1948 (WHA, 1948). The Regulations were revised several times. The historical importance is twofold. First, they provided a guide to member states in compiling mortality and morbidity statistics by cause, age and sex and for various areas of the national territory. Second, the IHR 2005 introduced a novel scenario in international law, where a state can be bound by a regulation without signature ratification of a formal treaty.

The second WHO Regulation was adopted by the Fourth World Health Assembly in 1951 (WHA, 1951). They were replaced in 1969 by the International Health Regulations (WHA, 1969), which was ratified in 1971. The International Health Regulations represented a revised version of the previous International Sanitary Conventions including the 1903, 1912 and 1926 International Sanitary Conventions. The significance of the International Health Regulations lies in the fact that it guarantees maximum security against the international spread of diseases with a minimal obstruction to international travel and trade. They contain rules on notification and epidemiological information, national health organisations, imports, airports, health measures on transport, cargo, goods, baggage and mail as well as specific rules on issuance health documents and imposition of charges on health measures. In 1973, the World Health Assembly amended the Regulations, particularly to cut down the number diseases contained in the previous regulations from six to three namely, yellow fever, plague and cholera (WHA, 1973). Moreover, the need to remove smallpox from the list, in view of its global eradication, informed a further amendment of the Regulations in 1981 by the 34th World Health Assembly. (WHA, 1981)

The quest for a revision of IHR can be traced to changes brought about by globalisation in the early 1990s. Globalisation had resulted in increasing frequency and rapidity of international trade and travel as well as other processes such as increased migration and urbanisation. The consequence

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of this development was a pervasive feeling that pathogens could no longer be contained within state borders and that a new approach for responding to disease outbreak was required. Besides, the period also witnessed the emergence and re-emergence of diseases such as HIV/AIDS tuberculosis, Ebola among others, that pose trans-border health threats. Against the backdrop of increasing international disease threat and need to ensure global health security, the Forty- eight World Health Assembly requested the Director General in 1995 to revise the International Health Regulation. Consequently, an informal consultation was held in December 1995, which brought together relevant staff from the WHO with experts and governments officials drawn from a range of member states. The group recommended that the existing principle of maximum security against the international spread of diseases involving minimum interference with travel and trade should underpin the revised IHR. The group also identified a major gap basically the absence of any principle that would regulate procedures necessary for the management of new and re-emerging diseases, especially those that constitutes an international threat. The International Health Regulations cannot refer specifically to diseases that were not known at the time they were last revised. This was the case with the Acquired Immunodeficiency Syndrome (AIDS). The group also recommended that the regulations be revised and expanded. The 52nd World Health Assembly in 1999 considered a report by the WHO Secretariat on the progress of the revision and updating process of the International Health Regulations (WHO, 1999).

The International Health Regulations (IHR) was finally revised in 2005. It automatically replaces the provisions of the following international sanitary agreements and regulations: “a) International Sanitary Convention signed in Paris, 21 June 1926; b) International Sanitary Convention of Aerial Navigation Signed at The Hague 12 April 1933; c) International Agreement for dispensing with Bill of Health Signed in Paris 22 December 1934; d) International Agreement for dispensing with consular visas on Bills of Health signed in Paris 22 December 1934; e) Convention modifying the International Sanitary Convention of 21 June 1926, signed in Paris 31 October 1938; f) International Sanitary Convention 1944 modifying the International Sanitary Convention of 21 June 1926, opened or signature in Washington, 15 December 1944; g) International Sanitary Convention of 12 April, 1933, opened for signature in Washington 15 December 1944; h) Protocol of 23 April 1946 to prolong the International Sanitary Convention, 1944 signed in Washington; i) Protocol of 23 April to prolong the International Sanitary Convention for Aerial Navigation 1944 signed in Washington; j) International sanitary regulations, 1951, and the Additional Regulations of 1955, 1956, 1960, 1963 and 1965; and k)The International Health Regulations of 1969 and the amendments of 1973 and 1981” (WHO, 2005).

Furthermore, IHR 2005 consist of several innovations, which include: “a) a scope not limited to any disease or manner of transmission ...; b) state parties obligations to develop certain minimum core public health capacities; c) obligations on state parties to notify WHO of events that may constitute a public health emergency of international concern according to defined criteria; d) provisions authorising WHO to take into consideration unofficial reports of public health events and ask states to obtain verification from state parties concerning such events; e) procedures for the determination by the Director General of a public health emergency of international concern and issuance of corresponding temporary recommendations after taking into accounts the views of Emergency Committee; f) protection of the human rights of persons and travellers; and g) the establishment of National IHR Focal Points and WHO IHR Contact Points for urgent communications between state parties and WHO” (WHO, 2008).

By and large, the IHR 2005 created a governance system that brings together state and non-state actors in the fight against infectious disease. More importantly, the revised Regulations represent a shift from a list of specified diseases to ‘syndromic reporting’ in which states are required to report outbreak of various syndromes of urgent public health importance (WHO, 2005). David Fidler captured this very clearly when he wrote that: “this innovative approach – which provides for an ‘open category’ encompassing any disease that may seriously and generally put public health at risk – represents the real revolutionary element characterising the IHR 2005, since they allow a more flexible application with a better management of new health hazards” (Fidler, 2004).

WHO INTERNATIONAL HEALTH REGULATIONS AND DOMESTIC HEALTH GOVERNANCE MECHANISMS OF INFECTIOUS DISEASES IN NIGERIA

As earlier stated, the IHR 2005 comprises a number of new or expanded normative commitments including core capacity infrastructure, transparent and timely reporting of a wider range of diseases, and putting in place proportionate responses to outbreaks. Specifically, Nigeria had been a party to all the previous Regulations even before its full membership of the World Health Organisation in 1960. These are manifested in several public health laws, policies and institutional arrangements.

LEGAL MECHANISMS

Article 3, paragraph 4 of the revised IHR emphasises the sovereign right of State to legislate in pursuance of their health policies but the discretion

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must be exercised within the boundary of the IHR 2005. Two sources of legal mechanisms authorise the Federal government to adopt precautionary and subdual actions based on either speculation about or during emergencies. One source of authority is the Nigerian Constitution. The Constitution permits the President to announce a public health emergency as well as restrict certain individual rights, including the right to personal liberty and property. The President is also authorised by law to declare a state of emergency either unilaterally or at the behest of a state governor in the event of any of the following: “ ... c) there is critical breakdown of public order and public safety in the federation or any part thereof as to require extraordinary measures to restore peace and security; d)there is clear and present danger of an actual breakdown of public order and public safety in the federation or any part thereof requiring extraordinary measures to avert such danger; e) there is occurrence or imminent danger, or the occurrence of any disaster or natural calamity, affecting the community or a section of the community in the federation; f) there is any other public danger which clearly constitutes a threat to the existence of the federation (Nigeria, 1999).

In 2014, the then Nigerian President, Goodluck Jonathan exercised his authority, as enshrined in the Constitution. He announced a national emergency following the outbreak of the Ebola disease in the country (Ebola, 2014). He also directed all relevant government agencies both at the federal and state levels to work in tandem towards the containment of the disease. A Special Intervention Plan and a Special Intervention Fund of NGN1.9 billion were also released to combat the virus (Ebola, 2014).

Another legal mechanism is the statutory (legal) regime. The 1926 Quarantine Act (revised in 2004) remains the only extant law governing matters related to public health crisis in the country (Nigeria, 2014). The Act provides for and regulates the imposition of quarantine, as well as prevention of the spread of infectious disease in Nigeria, and the transmission of the country Nigeria in accordance with the international Health Regulations. The Act regulates:

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 (Nigeria, 2014).

The Quarantine Act requires the President to declare any contagious disease as a deadly infectious disease. This authority was used in the past to categorise sleeping sickness as a harmful infection. Likewise, the President is empowered

by the Act to declare any location within or outside the country an infected local area. The Nigerian Public Health Bill is currently being considered at the Nigerian legislative chambers. The Bill is intended to replace the extant Quarantine Act (Senate, 2015).

INSTITUTIONAL COORDINATION MECHANISMS

A major requirement of the IHR 2005 is the building of core capacities at the various points of entry – airports, ports and land borders. This is imperative to facilitate timely response to events of public health emergency of international concern. It further stipulates the role of competent authorities at the various designated points of entry. To manage this effort, the Port Health Services, was established as a unit in the Public Health Department of the Federal Ministry of Health. It is noteworthy that the Port Health Services was established in 1925 in response to the plague epidemic (Ademuson, 2015). The Port Health Services is saddled with the responsibility of implementing the IHR at the designated points of entry. There are five designated international airports, where such services existed, namely Murtala Mohammed International Airport, Lagos, Port Harcourt International Airport, Margaret Ekpo International Airport, Calabar, Aminu Kano International Airport, Kano and Nnamdi Azikwe International Airport, Abuja. The five designated seaports are Apapa, Tinian Island, Warri, Port Harcourt, and Calabar Ports. There are land borders in 22 of the 36 states of the country.

The Port Health Services helps to ensure adequate disease surveillance the various Points of Entry. Other functions of the PHS include immunisation and issuance of international health certificate, boarding and inspection of ships, provision of curative and preventive health care services such as, referral and laboratory services in accordance with the provisions of the IHR 2005. In addition, they handle the health screening of pilgrims for hajj, refugees and deportees. However, the implementation of IHR by the Port Health Services has been bedevilled by several factors including the lack of health services at the screening posts and baggage checking at the airports, insufficient quarantine facilities and lack of cooperation between the Port Health Services and other agencies involved in the implementation of the IHR. Nevertheless, the Ebola crisis has been described as a blessing in disguise for ports health services. The Port Health Services came out of the Ebola crisis stronger in terms of increased staff strength, equipment, funding and political support.

The Nigerian Centre for Disease Control (NCDC) is another institution established in response to the requirement of the IHR. The NCDC was established primarily to identify, assess and communicate current and emerging threats to human health posed by infectious disease. NCDC

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partner with other national health agencies in Africa in the discharge of its responsibilities of developing and strengthening disease surveillance and early warning systems. The agency also involved in providing scientific information and training.

POLICY INITIATIVES

Another way in which WHO Regulations has influenced public policy in Nigeria is in the area of integrated disease surveillance and response. Article 5.1 of the IHR 2005 requires State Parties adopt or strengthen their infrastructure for public health surveillance and responses (WHO, 2008). Nigeria introduced the disease surveillance system in 1988. The establishment was informed by the outbreak of yellow fever in 1986/87, which affected 10 out of the then 19 existing states of the Federation. The extent of the outbreak was ascribed to weak or rather absence disease surveillance and notification mechanisms in most states (FMOH, 2005). Sequel to this, the Federal Ministry of Health set up a committee to review the disease surveillance and notification mechanisms in the country. A Disease Surveillance and Notification System (DSNS) was subsequently developed in 1988/89. The DSNS identified and designated 40 diseases of public health importance that require routine monthly notification. The DSNS also selected 10 epidemic prone diseases out of the 40 for immediate reporting. Apart from disease identification, the DSN introduced standard reporting forms namely DSN 001 for immediate reporting and DSN 002 for monthly reporting (FMOH, 2005). Another important milestone was the introduction of methodology that will guide information flow between the various levels. The National Council on Health gave its consent to the adoption of Disease surveillance and Notification (DSN) in the country in 1989.

Although significant strides were made in the implementation of the disease surveillance system in the late 1980s and early 1990s, it did not produce the expected outcome - the information required for immediate response. This is attributable to the vertical surveillance systems adopted by some disease control programmes. Besides, the involvement of laboratories was unsatisfactory. This disappointing situation was not peculiar to Nigeria, other countries in the WHO African Region faced similar challenge. As a corollary, the World Health Organisation Regional Committee for Africa in her 48th Session in September 1988 in Harare, Zimbabwe pushed for a total revision of the existing surveillance system by member states. The Committee further promoted the adoption of an integrated disease surveillance system by countries in the region. The IDSR that emerged from this development was endorsed by countries in the WHO African region including Nigeria.

As part of the initial step in the implementation process of the IDSR in Nigeria, an orientation workshop was organised in June 2000 primarily to

sensitize the major stakeholders. Furthermore, a steering Committee was set up in January 2001 to midwife the implementation process. The Committee undertook a thorough assessment of the existing surveillance system. It found that one of the shortcomings of the previous system was the use of vertical surveillance by certain disease programmes. Other flaws include proliferation of reporting forms and format which resulted in incomplete and untimely reporting; dearth of pre-positioned medicines and vaccines; lack of communication tools; absence of case management protocols, insufficient laboratory equipment; high rate of communicable diseases e.g. malaria, diarrhoea, pneumonia, measles, tuberculosis and HIV/AIDs; and poor funding (FMOH, 2005). The committee came up with three major recommendations. First, it suggested the establishment of a national standard case definitions and management protocols for priority diseases. Second, it proposed requisite training for IDSR and thirdly the provision of budget line for IDSR (FMOH, 2005). As a consequence, the National Policy on Integrated Disease Surveillance and Response was formulated in 2005. The Policy provided a comprehensive national guideline for IDSR with details of sectoral responsibilities. It also defined the roles for the tiers of the Nigeria's health system as well as the private sector.

It is axiomatic that the current IDSR strategy in Nigeria represents a clear departure from the previous cumbersome and ineffective vertical disease surveillance system. Its relevance lies in its excellent coordination mechanism. The primary focus in the IDSR system is the local government area in Nigeria (FMOH, 2009), The IDSR also consists of a list of prudently selected 40 communicable and non-communicable diseases and public health events, which were grouped into three classifications: epidemic prone diseases, diseases targeted for eradication and elimination and other diseases of public health importance. However, the Federal Ministry of Health, however, pointed out that the IDSR notifiable diseases, conditions and public health event are subject to modification..

Table 1

List of Nigeria Integrated Disease Surveillance and Response (IDSR) Notifiable Diseases, Conditions and Pubic Health Events

Categories of Notifiable Diseases	Notifiable Diseases
Epidemic Prone Diseases	Cholera, Diarrhoea with blood, Measles, Meningitis, Viral haemorrhagic fevers (Lassa, Ebola Virus Disease, Human Influenza caused by a new subtype, yellow fever, Severe Acute Respiratory Syndrome (SARS), Smallpox, Dengue fever, Anthrax, Severe Acute Respiratory Illness (SARI)

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Categories of Notifiable Diseases	Notifiable Diseases
Disease Targeted for eradication and elimination	Acute Flaccid Paralysis (AFP) / poliomyelitis, Dracunculiasis, Leprosy, Neonatal tetanus, Lymphatic filariasis, Tuberculosis
Other diseases of public health importance	Diarrhoea in children less than five years of age, Human immunodeficiency virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS), malaria, Onchocerciasis, Sexually transmitted infections (STIs), Trypanosomiasis, Buruliulcers, Asthma, Diabetes mellitus, epilepsy, High blood pressure, Sickle cell disease, Malnutrition, plague, Trachoma, typhoid, Hepatitis-B, Pertussis, Human Rabies, Schistosomiasis, Noma

Adapted from: National Policy on Integrated Disease Surveillance and Response, Federal Ministry of Health, Abuja, Nigeria, 2005

A discussion on the pattern information flow of in the IDSR system in Nigeria is particularly germane at this point. One dominant pattern of information flow is reporting and feedback. The flow starts from the health facility - public and private, where diseases with epidemic potential as well as those marked for eradication and elimination are reported to focal persons. The focal person, using the designated reporting forms, forwards its report to the Local Government Area Disease Surveillance and Notification Officer (DSNO) using the designated IDSR reporting forms. The LGA DSNO collates data received from the health facility data from the health facilities, which is sent to the next level - the State Ministry of Health (SMoH) (FMOH, 2009). The SMoH through its epidemiology unit collates data received from the LGAs and send it to the Epidemiology Division of the Federal Ministry of Health. The SMoH analyses and provides feedback to the health facilities and the public. Another duty undertaken at this point is the planning of appropriate operations and strategies for disease control (FMOH, 2009). At the FMOH, data is collated and forwarded to the statistics division - the National Management Information System (NHMIS). Three important actions are taken at the federal level namely analysis, feedback and planning for appropriate operations and strategies for disease control.

Figure 1

Flow of Integrated Disease Surveillance and Response (IDSR) Data in Nigeria

Health Facility Public or Private	Collect data on standard IDRS format
LGA Health Department	Receive form from HF. Collate and forward to SMoH Analyse and feedback to HF

State Ministry of Health Epidemiology Unit	Collate data and forward to FMOH. Analyse and feedback to LGA
Federal Ministry of Health (Epidemiology Division)	Collate data and forward to NHMIS. Analyse and feedback to SMOH
WHO	

Key: Reporting Feedback
Adapted from National Policy on Integrated Disease Surveillance and Response,
Federal Ministry of Health, Abuja, Nigeria, 2005

EBOLA VIRUS DISEASE OUTBREAK AND DOMESTIC HEALTH GOVERNANCE MECHANISMS OF INFECTIOUS DISEASE: A REFLECTION

The Ebola Virus Disease outbreak provides a clear picture of the benefits as well as the practical difficulties of containing an infectious disease. The Ebola disease outbreak occurred in Lagos following the arrival of a Liberian diplomat, Patrick Sawyer, at the Lagos International Airport on 20 July, 2014. The primary patient, who had contracted the virus in Liberia before his arrival in the country, was suspected to have potentially exposed seventy-two individuals. Shortly after, another outbreak occurred on 1 August 2014, after the close contact to the primary patient, who was under quarantine in Lagos travelled to seek medical attention from a private physician. The WHO officially declared Nigeria Ebola free on 20 October 2014, barely four months after its outbreak.

The swift containment of Ebola Virus Disease in Nigeria with only a few casualties (19 individuals were infected with only 7 deaths recorded) has been described as a great success story. The outbreak played into the strengths of the domestic health governance mechanisms in the country. The outbreak has strongly demonstrated the underlying benefits of a functional national disease surveillance and notification system. To be sure, early recognition and detection of infectious diseases contributes to timely intervention and reduces casualties. In dealing with the outbreak the Federal Ministry of Health in tandem with the Nigerian Centre for Disease Control mobilised other institutions and resources to fight the disease. As earlier stated Federal government approved a special intervention plan to contain and prevent the spread of Ebola outbreak and the sum of USD\$11.5 million was released to support the implementation. The Nigerian Centre for Disease Control in collaboration with state governments, the WHO, UNICEF, *Medicin Sans Frontieres* and the US Centre for Disease Control established the Incident Management Centre (Emergency Operations Centre (EOC)) at the Central Public Health Laboratory in Yaba, Lagos and Rivers States to respond to the outbreak (Ikhuoria, 2016). (See figure 2) The results were impressive. It led to the isolation of all individuals suspected of an

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infection and those with confirmed cases of an infection were sent to facilities in Lagos and Port Harcourt.

Nigeria executed a highly organised response to the Ebola outbreak, a feat accomplished through effective deployment of domestic governance mechanisms of infectious disease. For example, Ports Health Services through the IHR regulation mechanisms, embarked on early contact tracing (Shuaib, 2016). It also cooperated with the airlines and other agencies to ensure notification of the outbreak. The effective contact tracing process has been adjudged the major reason for the success story. The response also benefitted from existing use of public health institutions, such as the Nigerian Centre for Disease Control. The spread of public awareness through the media also contributed in part to the effectiveness of the fight against Ebola. The short messages directly addressed what people could do to protect themselves such as washing of hands frequently, not touching corpses, and reporting anyone to the health authorities if they showed symptoms.

The WHO, for its part, summarizes the factors responsible for Nigeria's performance in curbing the epidemic as follows: "rapid utilisation of public institutions and prompt establishment of EOC, availability of a first rate virology laboratory to make quick and reliable diagnosis, availability of qualified contact tracers who were able to detect infections early and isolate suspected cases, full attention of the country's leadership including that of the Head of State, general allocation of resources and quick disbursement and effective communication campaigns and experience accumulated fighting previous outbreaks, such as polio" (WHO, 2015). Besides, it has been argued that the response in Nigeria would not have been successful if not for the country's experience in combating polio. In the process of combating the polio virus Nigeria developed public health institutions and strategies to fight infectious disease. This incidence demonstrates the importance of developing an efficient domestic health governance of infectious disease.

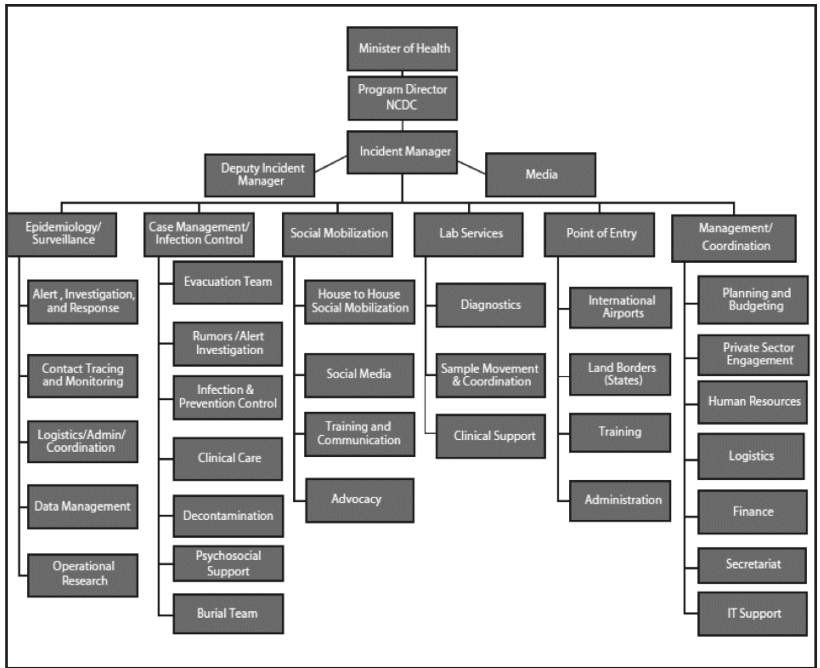
To acknowledge the success of Ebola virus disease containment in Nigeria is not to suggest that there are no longer challenges. Nigeria is still faced with serious constraints in implementing the IHR. Potential obstacles to functional disease surveillance and control system include insufficient funding, inadequate staffing and inappropriate or insufficient training of existing staff, corruption in the health sector. There is also the problem of dysfunctional health systems and weak communication infrastructure in the remote areas. Inadequate political will and commitment to public health has also posed serious threats. Clear manifestation is the neglect of health issues by the various tiers governments in the country.

Another challenge is the donor partner priorities that may be at variance with national priorities is also a serious constraint. The rigid

restrictive policies of donor agencies hinder the full utilisation of human and financial resources for integrating disease surveillance systems. To illustrate, financial resources allocated for activities under a particular donor-funded disease project like tuberculosis project, may not be applied for activities under an HIV/AIDS project even if the outcome of such an activity will have mutual benefit for both project. Similarly, the activities of individuals hired under a donor-funded project are strictly limited to the confines of the donor project. For example, a virologist employed under a donor-funded project dealing with measles may not be allowed to place his expertise at the service of his government during an epidemic of yellow fever. These obstacles notwithstanding, the domestic health governance mechanisms succeeded in reducing the number of casualties dramatically.

Figure 2

The Organisational Chart of the Nigeria Ebola Response Incident Management Centre, July-September 2014



Adapted from: Faisal Shuaib *et al*, 'Ebola Virus Outbreak- Nigeria, July- September 2014,' *Morbidity and Mortality Weekly Report*, Centre for Disease Control and Prevention, Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6339a5.1>

CONCLUSION

So far, this paper has demonstrated the role of domestic health governance mechanisms in the implementation of international law, IHR 2005, under the auspices of the World Health Organisation. It has shown that Nigeria has made remarkable progress in terms of governance of infectious disease manifested in legal responses, institutional arrangements and policy initiatives. The efficacy of these governance mechanisms was put to test during the Ebola Virus Disease outbreak in 2014. Interestingly, the containment was a huge success in terms of the number of people that lost their lives. However, in order to ensure sustainability of these health governance mechanisms for infectious diseases, the government should focus more on disease prevention through capacity building. The point being made is that adequate resources should be made available for developing not only capacity to report, detect, and investigate suspected infectious disease outbreaks and prevent sporadic cases, especially of known disease, from escalating to epidemics, but also for requisite manpower training. In the final analysis, corruption in Nigeria's health sector must be tackled to sustain the domestic health governance mechanisms of infectious diseases. This is imperative to ensure transparency and accountability in the disbursement of funds allocated for the prevention and control of infectious diseases in the country.

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