The Law, National Health Insurance Scheme, Ebola, Lassa Fever Outbreak and National Security

Olanike S Adelakun, *American University of Nigeria*
Prof Sylvester S Shikyil, *American University of Nigeria*
Prof. Oladejo J Olowu, *American University of Nigeria*
ABSTRACT

Health emergency precipitated by the outbreaks of Ebola and Lassa viruses in Nigeria is a salutary reminder of the weak preparedness for pathogenic outbreaks with grave implications for lives, livelihood and national security. These crises have not been isolated and appear recurrent across Nigerian communities and beyond. The cross-cutting implications of these incidents in the Nigeria signal an increasing recognition of the threat these epidemics pose to national security, beyond its impact on human health. Epidemics impact on human security through the catastrophic loss of life, the fear it creates in communities and the potential disruption of political and public order. It also impacts on economic activity through the loss of labour and productivity as well as restrictions on travels and movement of goods and persons. Low income countries, where the burden of infectious diseases are generally high and the health systems are ill-equipped to respond to the basic health needs of the population, face greater vulnerabilities to the consequences of epidemics, setting back hard-earned health and socio-economic gains. While no comprehensive action plan exists to deal with national health emergencies in Nigeria, the frameworks under the Nigerian Constitution as well as the subsisting National Health Policy and the National Health Insurance Scheme are weighed against the tools developed by the World Health Organization and other international organizations in dealing with global health emergencies. Beyond the critical concerns raised about the weaknesses and shortfalls in the existing national frameworks, the paper recommends for development of a comprehensive, high-resolution and spatially defined database of past outbreaks and epidemics to understand the disease-specific epidemiological risks, the sub-national distribution of outbreaks and to support epidemic risk vulnerability analyses necessary for prioritizing support across the country.

Keywords: Health Emergencies; National Health Insurance Scheme; National Security; Ebola Virus; Lassa Fever; Law; Nigeria.
1.0 Introduction

Ever since the discovery of the pneumonia bacteria – *Legionella* – in 1976 and the HIV virus in 1983,¹ public health professionals have intensified efforts on the threats to public health posed by emerging diseases. Several other highly infectious diseases have emerged across the world such as Lassa fever, West Nile River, Monkeypox, MERS, Ebola virus, Influenza A virus, Zika virus disease and the likes which have posed a great threat to the global public health. Emerging diseases have been defined by the World Health Organization (WHO) as ‘one that has appeared in a population for the first time, or that may have existed previously but is rapidly increasing in incidence or geographic range’.² Emerging infectious diseases on the other hand have been defined to include new infections, known infections spreading to new geographic areas, unrecognized infections appearing in areas undergoing ecological transformation and re-emerging old infections due to resistance to antibiotics in known agents or as a result of inefficiency of public health measures.³

On the other hand, national security revolves round a lot of issues and should not be construed in the light of territorial defence alone,⁴ rather national security should be approached with a focus on physical, social and psychological effects on the lives of members of a society. In essence, national security concerns all spheres of human existence.⁵ With the tremendous movement of people, goods and services across the world coupled with the increased importation and exportation of substandard drugs, chemical substances, contaminated and expired food items, toxic wastes, and so on, concerns have been raised on the hazards these could cause on human health and security.⁶

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¹ Weber, D.J., et al, ‘Emerging infectious diseases: Focus on infection control issues for novel coronaviruses (Severe Acute Respiratory Syndrome-CoV and Middle East Respiratory Syndrome-CoV), hemorrhagic fever viruses (Lassa and Ebola), and highly pathogenic avian influenza viruses, A(H5N1) and A(H7N9)’ [2016] (44) *American Journal of Infection Control*; e91 <http://dx.doi.org/10.1016/j.ajic.2015.11.018> accessed 24 February 2017.


⁵ Ebeh, J.I., 4.

Health security had been linked to the global strategy to prevent movement of infectious diseases across borders.\(^7\) The outbreaks usually start from an isolated area where cultural practices and beliefs prevent victims from seeking appropriate medical treatment as a result of which the disease is easily transmitted to other nations due to a globalized environment.\(^8\) The rate at which highly infectious diseases emerge and spread calls for global response and preparedness for health related security threats across the globe, especially since they are spread from person to person, and some by mere physical contact with a carrier. Members of the public are at risk of contracting these diseases during patient care and could lead to an outbreak in health care facilities.\(^9\)

In the light of the above, global health initiatives and organizations have been called upon not to operate in isolation but to further acknowledge and identify the relationship between their works and global security issues.\(^10\) It had been postulated that global health, directly or indirectly, may ‘generate both benefits and threats to international security and counterterrorism.’\(^11\) As such, a direct correlation exists between national public health and national security.

The paper therefore examines how the law guarantees health security in Nigeria in the light of highly infectious diseases. The paper also critically analysed the legal framework for health emergencies in Nigeria. It also evaluates the role, impact and effectiveness of the National Health Insurance Scheme (NHIS) in light of Ebola and Lassa fever outbreaks in Nigeria. A correlation between law, public health and national security is established. The paper further examines the preparedness of Nigeria to handle similar outbreaks in the future without jeopardizing the health security of Nigerians.

Accordingly, the paper is divided into seven parts with Part I introducing the topic and giving an overview of the content. Part II focuses on an overview of health emergencies in Nigeria. Part III of the paper is dedicated to the assessment of the legal and institutional

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\(^9\) Weber, e93.


\(^11\) Kevany, 85.
frameworks for public health. In part IV, the correlation between law and national security was established. Part V examined the relationship between public health and national security. In Part VI, an analysis of the responses at various level of governance – national and international – was conducted. Part VII is the concluding part of this paper.

2.0 Overview of Health Emergencies in Nigeria

Health emergencies in Nigeria are as old as the country itself with pre-colonial people responding to the emergencies by applying their knowledge of indigenous medical and healthcare systems. However, limitation in the knowledge of traditional medicine and healthcare system as to the nature and cause of diseases, endemic and epidemic diseases were widely spread without any form of formal control till they subdued on their own.

During the period of colonization, disease control measures such as mobile medical field units for clearing and spraying vegetation, quarantine, migration control and migrant group monitoring were employed. Hospitals and medical facilities were also established and by the end of colonization in 1960, a curative healthcare system was established. However, attention was not paid to preventive measures in healthcare system during this period. Thus, it had been posited that health security infrastructure was not properly established from the moment healthcare system was established in Nigeria.

Health emergencies are defined in the light of causes and health consequences. As such, health emergencies have been described as situations ‘whose scale, timing, or unpredictability threatens to overwhelm routine capabilities.’ Morgans and Burgess defined health emergencies as a ‘sudden or unexpected threat to physical health or wellbeing which requires an urgent assessment and alleviation of symptoms.’ The World Health Organization defined public health emergency as ‘an occurrence or imminent threat of an illness or heath condition, caused by bio terrorism, epidemic or pandemic disease, or (a)

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13 Abubakar, 138.
14 Abubakar, 139.
16 Abubakar, 141.
novel and highly fatal infectious agent or biological toxin, that poses a substantial risk of a significant number of human facilities or incidents or permanent or long term disability.\textsuperscript{19} With the constant threat of emerging and re-emerging infectious diseases, the public health safety of Nigerians is a matter of great concern.

2.1 Ebola Virus

The first recognized outbreak of Ebola was in 1976 in Zaire of Central Africa and Sudan of Northern Africa.\textsuperscript{20} In December, 2013, there was a re-emergence of Ebola virus in Guinea which rapidly spread to Liberia and Sierra Leone\textsuperscript{21} and by August, 2014, Ebola was declared an international health emergency. For the first time, Ebola was recorded to have crossed international boundaries.\textsuperscript{22}

Ebola disease is caused by a non-segmented, negative ribonucleic acid virus which belongs to the family of Filoviridae.\textsuperscript{23} While the natural host of Ebola virus remains unknown. Research has also revealed that Ebola virus fragments in fruits and insectivore bats makes them reservoir of the virus.\textsuperscript{24} Infection of the disease can be transmitted only from a person with symptoms\textsuperscript{25} through direct contact with blood, body fluid or objects used to treat a person with the virus.\textsuperscript{26} Symptoms of Ebola have been reported to include fever, fatigue, loss of appetite, vomiting, diarrhoea, headache, abdominal pains and specific haemorrhagic symptoms.\textsuperscript{27}

At the time of the outbreak of Ebola virus disease, there were limited numbers of qualified health workers coupled with the weak systems of infrastructures, health information, surveillance, drug supply and governance that could effectively curb the spread

\textsuperscript{22} Weber, e96.
\textsuperscript{23} Madariage, M.G., ‘Ebola Virus Disease: a perspective for the United States’ [2015] (128) \textit{American Journal of Medicine} 682.
\textsuperscript{24} Weber, e95.
\textsuperscript{26} Weber, e95.
of the disease. Twenty (20) cases of Ebola were documented in Nigeria with 8 resulting to death of the patients. The first case of Ebola in Nigeria was reported on 20 July 2014 when a traveller who was acutely ill arrived at the international airport in Lagos, Nigeria was confirmed to have Ebola Virus Disease after being admitted to a private hospital.

On the advice of the Nigeria Centre for Disease Control, the Federal Ministry of Health declared an Ebola emergency in the country. By July 23, the Federal Ministry of Health in collaboration with Lagos State Government and international partners activated an Ebola Incident Management Centre in response to this health emergency. However, the confirmed Ebola Virus Disease index patient died on 25 July 2014. His protocol officer also died of Ebola. Some doctors and nurses were infected by the virus; four (4) later died. On 26 March 2016, the Public Health Emergency of International Concern regarding Ebola in West Africa was officially lifted with about 28,616 cases and 11,310 deaths resulting from the outbreak.

2.2 Lassa Fever

Lassa fever is a negative ribonucleic acid virus which belongs to the Arenaviridae family. Diagnostically Arenaviridae is divided into 2 complexes; namely old world complex and new world complex. Lassa fever belongs to the old world complex. Lassa fever is a form of acute viral haemorrhagic sickness caused by Lassa virus that is transmitted to humans when they have contact with food or household items contaminated by excreta of multimammate rat who is the host of the Lassa virus.

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31 Ibid.
35 Weber, e93.
36 Mastomys natalensis.
Lassa fever is endemic in rodent prone parts of West Africa including Liberia, Guinea, Nigeria and Sierra Leone with recorded infections of about 100,000 – 300,000 and 5,000 deaths annually.\(^{38}\) The common symptoms of Lassa fever include conjunctivitis, cough, abdominal pain, sore throat, nausea, cervical adenopathy, and ulceration of the buccal mucosa.\(^{39}\) The virus could be traced to Nigeria when, in 1969, 3 American nurses and 2 Yale students studying the disease became ill in Lassa, Nigeria with 2 of the nurses and 1 of the students losing their lives to the disease which was identified as Lassa fever.\(^{40}\)

Between August 2015 and May 2016, 273 cases of Lassa fever and 149 deaths across 23 States in Nigeria were reported.\(^{41}\) Between December 2016 and 17 February 2017, 215 suspected cases of Lassa fever were reported across 10 States with 37 deaths. In a press release on 3 March, 2017, Borno State was recorded to have its first outbreak of Lassa fever in almost five decades.\(^{42}\) As at 27 January 2017, Lassa fever outbreak was active in nine States in Nigeria while it increased to thirteen States as at 3 March 2017.\(^{43}\)

3.0 Law and Public Health

The 1999 Constitution\(^ {44}\) is the foundation of the legal framework for public health in Nigeria. Though the Constitution does not expressly indicate roles of different arms of government in health issues, section 17 (3) (d) enjoins the government to direct its policy towards ensuring that there are adequate facilities for all persons.

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\(^{38}\) Weber, e93.


3.1 Overview of Health Laws

The National Health Policy and Strategy to Achieve Health for All Nigerians of 1988 was the first comprehensive national health policy enacted in Nigeria. Due to the age of the 1988 Health Policy, recommendations to effect changes that would accelerate Nigeria’s health development were made at a national health summit in 1995 after which the Federal Ministry of Health organized a review of the policy between 1996 and 1997 but the revised policy was never endorsed formally.\(^{45}\) However the health sector change reform agents continued to clamour for a revision of the health policy and stakeholders made suggestions which were incorporated in and led to the revised National Health Policy (NHP) in 2004. The overall objective of the 2004 NHP is to:

‘…strengthen the national health system such that it will able to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians through the achievement of the health-related Millennium Development Goals (MDGs).’\(^{46}\)

Chapter six of the 2004 NHP recognizes the need for national interventions in addressing disease burdens and other health problems that could contribute to the poor health status of Nigerians. The chapter provides for specific strategies for tackling and controlling HIV/AIDS, malaria, immunization, onchocerciasis, tuberculosis, leprosy, national blood transfusion, female genital mutilation, reproductive health, adolescent health, food and nutrition, child health, drug control and food hygiene and safety. The Policy did not specifically make provision for emerging disease or response to health emergencies.\(^{47}\) The 2004 NHP was operationalized through the National Health Sector Reform Program (2004-2007), the National Strategic Health Development Plan (2010-2015) and annual operational plans.\(^{48}\)


\(^{46}\) Chapter 3, Revised NHP, 2004.

\(^{47}\) Chapter 6, Revised NHP, 2004.

In 2014, the first health regulation legislation was enacted in Nigeria. The enactment of the NHA coupled with new health trends, unfinished Millennium Development Goals, the new Sustainable Development Goals and the Nigerian government’s recommitment to public health necessitated the need for a new NHP. In 2015, the Federal Ministry of Health constituted a technical working group to review the NHP of 2004.

Sequel to the enactment of the NHA in 2014, another NHP was developed and approved in 2016. The NHP seeks to promote the health of Nigerians in order to accelerate socio-economic development. Public health care was identified as the bedrock of the national health system. The 2016 NHP reiterated the commitment of the government to the health problems identified in 2004 NHP and also gives priority to public health. One major objective of the 2016 NHP is the dedication towards prevention and control of communicable and non-communicable diseases. Other health problems such as mental health, oral health, eye health and disabilities are also recognized for promotion. The policy recognized the need to have adequate healthcare infrastructure that meet all quality and safety standards.

The 2016 NHP is of significant value with the inclusion of public health emergency preparedness and response objective. Initiatives to achieve this include maintenance of capabilities stakeholders for regular risk analysis which includes vulnerability and risk assessment; development and implementation of health emergency and preparedness plans; strengthening of health emergency management capacity and coordination; strengthening surveillance and response capacity in line with International Health Regulation; upgrade of health infrastructures and security in public health institutions in charge of biological agents.

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50 Federal Ministry of Health, ibid, xi.
51 NHP 2016.
52 Paragraph 3.4.2 NHP 2016.
53 Chapter 4 NHP 2016.
54 Paragraph 4.2.6 NHP 2016.
55 Paragraph 4.1.4 NHP 2016.
The policy calls on stakeholders to advocate for the amendment of the Nigerian Constitution to make health rights enforceable in Nigeria and to clearly state the responsibilities of each level of government in health issues.\(^{56}\)

### 3.2 National Health Insurance Scheme Act

In a bid to ensure access to quality and affordable healthcare for all Nigerians, the government is committed to universal health coverage by the enactment of the National Health Insurance Scheme Act\(^{57}\) (NHIS Act) in 1999 which established the National Health Insurance Scheme (NHIS). The sole purpose of NHIS is to provide health insurance which entitles the insured persons and their dependents to good quality and cost effective health services.\(^{58}\)

After Nigerian independence in 1960, efforts were made to achieve a health service by means of parliamentary intervention through a pre-paid contributory element.\(^{59}\) This was the first recognition for the need of health insurance in Nigeria; however the bill was defeated in Parliament.\(^{60}\) The drop in oil process in the 1980s affected the economy and had a negative impact in the public health facilities in Nigeria as a result of which the government could no longer provide free health services and opted for contributory methods to support health care funding.\(^{61}\) The committees set up to look into the issue of healthcare funding came up with the idea of National Health Insurance.\(^{62}\)

Based on the recommendations of the committees, the Minister of Health, in 1985, convened a consultative meeting with stakeholders.\(^{63}\) In 1988, another committee came up with a new model to implement social health insurance in the country. The new model was described as detailed in terms of requirement and procedure which required a board managed

\(^{56}\) Paragraph 5.3 NHP 2016.

\(^{57}\) National Health Insurance Scheme Act, Cap N42, Laws of the Federation of Nigeria, 2010.

\(^{58}\) Section 1 NHIS Act.


\(^{62}\) Ibid, Dogo-Muhammad.

\(^{63}\) Onoka, Hanson and Hanefeld, 1108.
by States for health insurance. With stakeholders’ support of the model coupled with the recommendation for adoption by the National Council for Health and the support of the International Labour Organization, the Federal Executive Council approved the model in 1989. However, implementation of this model was not effective due to the economic situation of the country.

At this time, public and private sectors resorted to retainership of private health care providers on a fee for service basis. With time, the private health care method became more expensive and corrupt with employees colluding with private health care providers to receive unnecessary health care. In 1995, a National health summit was held where the need to introduce private option of Health Maintenance Organizations (HMOs) and providers into public health systems was agreed. With this new development, the first HMO started operation in 1996 with the second following in 1996. These HMOs were owned by large healthcare provider facilities, health management firms and persons with commercial insurance background.

The success of the early HMOs convinced the National Health Council to include HMOs in the developing NHIS and thereafter mandated the Federal Ministry of Health to modify the proposal for NHIS. While policy development was progressing at this point, there was no legal backing for NHIS but with a change in military government in 1998, bureaucrats presented the draft NHIS policy and it was signed into law in 1999.

The NHIS Act had been criticized as being signed into law without stakeholders’ consensus. Civil servants resisted deductions from their salaries for this purpose giving examples of earlier failed Federal Government contribution schemes while private

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64 Umez-Eronini, E.M., ‘National Health Insurance’ (Presented at Abia Health Summit on Funding of Health Care Delivery at the State Level, Umuahia, Nigeria, 2001).
65 Onoka, Hanson and Hanefeld, 1108.
68 Onoka, Hanson and Hanefeld, 1109.
69 Onoka, Hanson and Hanefeld, 1108.
70 Onoka, Hanson and Hanefeld, 1109.
employers showed less interest in the law since health insurance was optional and not mandatory.\(^{72}\)

In 2003, the NHIS Council was dissolved and a new Minister for Health was appointed who has a background in international health.\(^{73}\) The new Minister for Health declared his plan to implement the NHIS and in June 2005, the formal sector social health insurance program commenced with the President being the first to enrol.\(^{74}\) With the change in government in 2007, a new Minister for Health was appointed.

By 2008, the NHIS received funds from the Millennium Development Goals office of the President to subsidize maternal and child health programs using HMOs as intermediaries.\(^{75}\) The end of 2010 saw NHIS being less dependent on the Federal Ministry of Health and relied more on HMOs for technical advice.\(^{76}\) By 2011, the NHIS developed strict guidelines for the accreditation of HMOs and started engaging directly with Healthcare providers by accrediting and monitoring healthcare providers independently of federal and state Ministries of health.\(^{77}\) However, with the inability of the NHIS to extend to the employees of State governments,\(^{78}\) the NHIS rolled out new programs for different sectors of the society.\(^{79}\)

The beneficiaries under the NHIS are expected to contribute 15% of their monthly salary to the scheme with the Federal government paying 10% and the beneficiary paying 5% but with the poor acceptance and low subscription to the Scheme, the contribution of NHIS to health funding remains low in Nigeria.\(^{80}\)

\(^{72}\) Onoka, Hanson and Hanefeld, 1109.

\(^{73}\) Asoka, T., 129.


\(^{76}\) Onoka, Hanson and Hanefeld, 1111.

\(^{77}\) Onoka, Hanson and Hanefeld, 1112.


4.0 Law and National Security

In the history of human existence, authorities have strived to put institutions and mechanisms in place towards protecting and preventing territorial breach and guarding against vulnerability and threat from within and outside which could jeopardize their security. Traditionally, national security has been conceptualized from the defence point of view which focuses on acquisition of large weapon system and sophisticated military personnel.\footnote{Nwolise, O.B.C., ‘Fundamental Imperatives of Policy and National Security: Nigeria beyond 2020’ in Danfulani, S.A. (eds), National Security in a Democratic Polity: Opportunities, Challenges and Prospects for Nigeria (Ibadan: Safari Books Ltd., 2011) 95-118.} In this vein, national security has been defined as ‘the ability of a society to perpetuate its existence and sustain its values in the face of threats and challenges from internal and external sources.’\footnote{Peters, J., ‘National Security Management: The Concept and the Process in the Second Republic’ [1983] (1)(1) Spectrum: A Current Affairs Digest, 19.}

However, the issue of security had gone beyond territorial breach or threat. Research has gone far to reveal that the traditional concept of security is of less importance as the issue of security is more complex with the emergence of a globalized world.\footnote{Abubakar, J.A., 134.} Hence security is viewed from the perspective of human security as opposed to national security alone with the two concepts complementing each other but with human security encompassing all spheres of human life.\footnote{Abubakar, J.A., 134.} To this end, national security has been described as ‘an all-round protective umbrella for every citizen, every sector of the system; every core value; every rule of law as well as the image and glory of a state.’\footnote{Akpuru-Aja, A., ‘National Security and Imperatives for Good Governance and Democratic Stability’ in Danfulani, S.A. (eds), National Security in a Democratic Polity: Opportunities, Challenges and Prospects for Nigeria (Ibadan: Safari Books Ltd., 2011) 201-219.}

5.0 Public Health and National Security

With the spate of disease outbreaks capable of inflicting serious human suffering, deaths and economic losses, if public health systems are not well equipped to handle outbreaks, the population becomes vulnerable\footnote{World Health Organization, ‘Strengthening Health System Emergency Preparedness: toolkit for assessing health system capacity for crisis management’ (Copenhagen: World Health Organization, 2012) <http://www.euro.who.int/__data/assets/pdf_file/0008/157886/e96187.pdf> accessed 28 February 2017.} which may jeopardize national security. In
the event of a disease outbreak without a strong and rapid response system, the disease will rapidly multiply, causing deaths, especially in instances of highly infectious diseases.

The shift of the concept of national security from the state centred approach to a people centred approach, recognized as human security, reflects the inclusion of health security as an important component of national security. The discourse on human security was thus approached from two perspectives – the freedom from want perspective and the freedom from fear perspective – with the proponents of the freedom from want perspective being of the view that there is the need to broaden threat agenda to include hunger, disease and natural disaster on the ground that these catastrophes are capable of killing more people than the combination of war, genocide and terrorism.

The advocates of the freedom from fear perspective, on the other hand, approach human security by seeking for protection of individuals from violent conflicts in recognition of the fact they are strongly associated with poverty and inequalities and as such the main concern should be emergency humanitarian assistance, conflict resolution and prevention; and peace building.

In the light of this development, the United Nations identified health security as a possible type of human security threat. The eminent effect that a compromise of health security would leave on national security had led to the concept of public health security which the WHO has defined to mean ‘activities required both proactive and reactive to minimize vulnerability to acute health events that endanger collective of national populations.’ The increased concern for public health security was justified by international travel and commerce, change in climate and ecosystems, poverty, deliberate release of infections or chemical agents which have increased risks of disease outbreaks.

88 Abubakar, 136.
90 Abubakar, 136.
6.0 Responses to Health Emergencies

6.1 National Responses

With the first declared Ebola virus disease case in Lagos in July, 2014, the Port Health Services conducted early contact tracing and ensured notification of the outbreak through International Health Regulations mechanisms.\textsuperscript{94} Manifest was collected from for the flights and effort was made to contact passengers who were on board to determine their health status but no ill or deceased passenger was identified.\textsuperscript{95}

The response was rapid, making use of available public health services at the onset of the outbreak in Nigeria in addition to an Incident Management System which helped to contain the situation.\textsuperscript{96} The Nigeria Centre for Disease Control and Lagos State Ministry of Health established the Incident Emergency Centre which was the overall implementing arm of the national response. The Emergency Operations Centre immediately developed a staff response to facilitate information sharing, team accountability and resource mobilization.\textsuperscript{97} Organizational structure in terms of six response teams within the Emergency Operations Centre was developed which are: epidemiology/surveillance, case management/infection control, social mobilization, laboratory services, point of entry and management/coordination.\textsuperscript{98}

Ebola information campaigns and awareness was launched all over the countries with advice to contact a primary health facility on any related symptom.\textsuperscript{99} Messages in various local dialects were launched on radio stations to ease public fears.\textsuperscript{100} Thereafter, the Emergency Operations Centre took over management of each confirmed and suspected case, triaged potential patients and decontaminated areas where they inhabited.\textsuperscript{101} Persons with suspected infection were isolated at Ebola treatment facilities. Whenever a contact with a suspected patient becomes ill, the contact tracing team gathered data on the persons exposed

\textsuperscript{94} World Health Organization, International Health Regulations, 2\textsuperscript{nd} ed. (Geneva: WHO, 2005).
\textsuperscript{95} Shuaib, 868.
\textsuperscript{96} Shuaib, 868.
\textsuperscript{97} Ibid.
\textsuperscript{101} Shuaib, 867.
to that contact from the date of symptoms and conducted laboratory tests on all of them.\textsuperscript{102} The laboratory facilities at Lagos University Teaching Hospital enhanced rapid identification of confirmed cases and quick discharge of those that tested negative to the virus.\textsuperscript{103}

Jaye Gaskia of Sahara Reporters was of the view that Nigeria put together a coordinated and effective response to contain the Ebola virus disease outbreak in an unusual and unexpected way that shows the strength of the country.\textsuperscript{104} The national response was found to be among the best public health practices in the world.\textsuperscript{105} It had been posited that the swift response in containing the outbreak was made possible by the availability of skilled personnel in the polio eradication program as well as experience from the polio program structure.\textsuperscript{106}

After 20 reported cases of and 8 deaths from Ebola Virus Disease, Nigeria was declared Ebola free in October, 2014.\textsuperscript{107} All these cases were linked directly or indirectly with contact with the index patient that flew in from Liberia.\textsuperscript{108} After Nigeria was declared Ebola free, the government ensured adequate training for epidemiologist of all states in addition to Directors of public health and laboratory scientists in all 34 States not affected by the Ebola outbreak with a task on all States to develop Ebola response plan and set up treatment centres.\textsuperscript{109}

In September 2016, a new National Health Policy was adopted which makes provision for preparedness and response to emergency health crisis in Nigeria. Furthermore, in 2015, the National Biosafety Management Agency (NBMA) Act\textsuperscript{110} which established the National Biosafety Management Agency was enacted. The Agency has the responsibility to provide regulatory framework and institutional mechanism for safety measures for the application of

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{102}]{Shuaib, 868.}
\item[\textsuperscript{103}]{Ibid.}
\item[\textsuperscript{105}]{Onyeonoro, 18.}
\item[\textsuperscript{106}]{Vaz, S142.}
\item[\textsuperscript{109}]{Vaz, R.G., \textit{et al}, ‘The Role of the Polio Program Infrastructure in Response to Ebola Virus Disease Outbreak in Nigeria 2014’ [2016] (213) (S3) Journal of Infectious Diseases S140.}
\item[\textsuperscript{110}]{National Biosafety Management Agency Act 2015.}
\end{itemize}
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modern bio-technology in Nigeria in order to prevent negative effect of same on human health, plants, animals and environment.

To contain and manage Lassa fever, two national laboratories – Virology laboratory, Lagos University Teaching Hospital and Lassa Fever Research and Control Centre, Irrua specialist hospital – were operational to support laboratory confirmation of Lassa fever cases in 2016.111 As at March 2017, the laboratories with capacity for Lassa fever testing has increased to five including University College Hospital.112 The Nigeria Centre for Disease Control Lassa fever working group, in collaboration with World Health Organization and Centre for Disease Control leads coordination of weekly Lassa fever review meeting with reports shared with the national surveillance and outbreak response committee.113

Furthermore, the Nigeria Centre for Disease Control publishes a weekly situational report on its website and continuously creates awareness on Lassa fever through its Facebook channel, twitter channel and continuous jingles on radio stations across the country.114 Towards the end of 2016, a team from Nigeria Centre for Disease Control went round all the State capitals delivering medicine and prevention and response materials on Lassa fever such that all States of the Federation are fully equipped for an emergency outbreak.115

Tomori, a professor of virology, was reported to have said ‘Lassa lacks the zeal and trepidation that Ebola outbreak inspired and Nigeria still wakes up every year an outbreak is reported, running like a decapitated chicken in any which direction, and forgetting about the disease till another year another outbreak’116

113 NCDC, above note 111.
6.2 International Responses

With the outbreak of Ebola in Nigeria in July 2014, the Nigerian health officials repurposed technologies and infrastructures from World Health Organization and other partners to help find cases and track potential chains of transmission of Ebola virus disease.\(^{117}\) The World Health Organization as well as United States Centre for Disease Control and Prevention, Médecins Sans Frontières (MSF), UNICEF and other partners supported the Nigerian Government with expertise for outbreak investigation, risk assessment, contact tracing and clinical care.\(^ {118}\)

The International Medical Organization (Médecins Sans Frontières), which is an international humanitarian agency, deployed emergency teams to Ebola infected areas to help in containing the spread of the disease.\(^ {119}\) Oxfam International, which is an international non-governmental organization, also responded to the Ebola outbreak by providing health centres with water infrastructures, medical equipment and community hand washing stations in affected countries.\(^ {120}\)

The Centres for Disease Control and Preventions, an international agency, had recorded their response to the Ebola outbreak in parts of West Africa as the largest emergency response in the history of the agency.\(^ {121}\) The Centre deployed specialists in several fields to the African countries affected by the epidemic.\(^ {122}\)

At the onset of the outbreak of Ebola in Guinea and Liberia, the World Health Organization graded the outbreak a Level 2 on Emergency Response Framework but with the import of the disease into Nigeria, the disease was regraded to Level 3 which requires that additional and substantial resources must be mobilized. As at August 2014, the regional


\(^{118}\) Ibid.


UNICEF had mobilized $5.6 million, 12 support missions on ground and 22 in the pipeline, donated disinfection and hygiene supplies. Specifically in Nigeria, the UNICEF trained and deployed 20 teams to different radiuses of Ebola contacts using GPS tracking and smart phones for data.\textsuperscript{123} This is in addition to thousands of SMS sent through U-Report Nigeria.

The dynamic training of Ebola virus made the World Health Organization to determine the need for skills oriented training to prepare responders, both national and international, to effectively carry out their task in Ebola affected communities.\textsuperscript{124} More than 8,000 health professionals in Ebola affected countries as well as international organizations were part of the training and a review of the impact of the Ebola response training was conducted in order to formulate recommendations for future health emergencies.\textsuperscript{125}

With the recent Lassa fever outbreak in Borno State, the World Health Organization swiftly moved in to contain the outbreak by training health personnel on clinical case management, contact tracing, healthcare workers’ mobilization and public awareness creation.\textsuperscript{126} The World Health Organization, Ministries of Health of Guinea, Liberia and Sierra Leone, the Office of United States Foreign Disaster Assistance, the United Nations and other partners have worked together to establish the Mano River Union Lassa Fever Network.\textsuperscript{127}

7.0 Conclusions

The concept of national security now goes beyond territorial security or securing the lives and properties of citizens with heavy reliance on arms and uniformed men. The correlation between public health, public security, health emergencies, national security and the law has been well established such as if one component is affected, the national security could be jeopardized.

\textsuperscript{125} Ibid., 182.
\textsuperscript{127} Ibid.
With the evidence of emerging and re-emerging of diseases outbreaks across the world and specifically in Africa, the need to be prepared for health emergencies at any point and any time and with special attention to rural and sub-urban areas cannot be overemphasized.

While the Nigerian government was swift in responding to the Ebola Virus Disease outbreak and showed political will to end the outbreak in Nigeria, which contributed to the successful eradication of Ebola in Nigeria, the same commitment is not evident in the Lassa fever outbreak which had cost the lives of hundreds of Nigerians.

Health Laws and Policies that are enacted and adopted in Nigeria have rich provisions to secure the health of Nigerians, however, more efforts needs to be put in place to implement the laws in order to be effective. To ensure national security, the public health of Nigerians must be given high priority because if public health is compromised, the security of the nation itself is at stake. There is the need for constant reassurances through action and dedication to make Nigerians feel secured as regards their health status and availability of rapid response where required.

8.0 Recommendations

To ensure health security of Nigerians, there is the need to have a uniform health insurance scheme that will be affordable and compulsory for all Nigerians and residents of the country irrespective of age, gender or social status. The NHIS is a welcome development but the limitation in its scope and application still leave a larger percentage of the populace at health security risk. There is the need to publicize widely new developments in law and maintain the zeal with which Ebola was handled all over the country. Every Nigerian is entitled to access to health facilities, and this should be made a fundamental right if much progress is to be recorded in the health sector.

While the government has fulfilled its role in providing primary health facilities across all local government areas in Nigeria, there is the need to adequately train the health personnel on response techniques. Furthermore, hidden charges that discourage people from patronizing the primary health centres should be addressed.
To secure health security, adequate funding is required. The Nigerian government should not wait until there is a disease outbreak before allocating funding to address the outbreak. The health budget needs to be adequate in order to promote health related researches and to ensure that modern and high technology facilities are readily available to handle any form of health emergency, whether foreseen or not.
Bibliography


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