

# Influence of Government Policies on Disaster Preparedness and Response: Issues and Challenges in Dalori IDP Clinic, Borno State, Nigeria

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## ABSTRACT

Disasters are events bedevilling Development in society as a result of many deaths and injuries, but the frequency of their occurrence has forced the world to continue to plan on effective mitigation, preparedness, prevention and strategy to reduce the associated risk through improved knowledge, attitude and practice. The study is about the influence of government policy on disaster preparedness and response in Clinics/hospitals: issues and challenges in Dalori IDP Clinic Borno state Nigeria. A descriptive survey will be used for this study. The target population of this study will be 310 Staff at Dalori IDP Clinics composed of different cadres, among them being doctors, laboratory technologists, nurses, clinical officers, CHEWS, JCHEWS and supportive staff amongst others out of which 170 personnel was selected as the sample size of the study. A multistage sampling technique was used to select respondents for the study. A structured questionnaire was used to elicit information from the respondents. The returned questionnaire was thoroughly edited and fed into computer software and subsequently, the data were analysed with the aid of SPSS version 23. The result was presented in tabular format using a frequency distribution table. Linear regression was used to test the hypothesis. The study found that government policy in the Dalori camp did not significantly influence the implementation and practice of disaster preparedness and response. The study recommends among others that government should deploy more resources towards maintaining the acquired knowledge, attitude and practice of Health workers in disaster preparedness and prevention.

**Keywords:** Government policy, Disaster preparedness, Responses, Dalori IDP Camp, Borno state

## I. INTRODUCTION

Disasters are events bedevilling Development in society as a result of many deaths and injuries, but the frequency of their occurrence has forced the world to continue to plan on effective mitigation, preparedness, prevention and strategy to reduce the associated risk through improved knowledge, attitude and practice. The continued occurrence and magnitude of diseases have prompted World Health Organization (WHO) and other organizations to come up with best practice models for hospital and Disaster Management (Traub, et al 2007, Adams, 2009; De Lorenzo, 2007).

Over the years there have been efforts by WHO and other technical bodies in promoting hospital preparedness, examples being the 2008-2009 world disaster reduction campaign of hospitals safe from disaster and more recently the 2010 – 2011“ one Million safe schools and hospitals” initiative. This is because of the need to continue strengthening the healthcare system's preparedness and response to mass casualties to save as many lives as possible where disasters should occur.

Several policies are in place to govern emergencies around the world. The biggest organization that is concerned with emergencies is the world health organization (WHO). The mission of WHO's work in Emergencies and Crises is to help reduce the suffering of affected people through the implementation of programmes that prepare the health sector to deal with emergencies and support efforts for improving health during disasters and Develop Policies, Assess vulnerability Plans for Emergencies, train, educate, Monitor & Evaluate after crises, applying professionalism and

humanitarian principles (WHO/HAC, 008). The WHO Constitution (Article 2d) call on the Organization to furnish appropriate technical assistance in emergencies and provide necessary aid upon the request of Governments.

WHO is the lead agency for addressing the health aspects of emergency preparedness and response and its policy is determined by its governing bodies, particularly the World Health Assembly (WHA, WHO, 2007a). One of the cardinal objectives of the WHO is to promote emergency preparedness and response to member States (WHO/WPR, 2003). The resolutions have marked a major shift in the way emergencies are managed. In 1981, the WI-IA passed a resolution that stressed the importance of emergency preparedness. Despite the undoubted importance of relief in emergencies, preventive measures and preparedness are of fundamental importance” (WHO, 2007; WHO, 2000). During the International Decade on Natural Disaster Reduction (1990-1999), WHO further strengthened its efforts in emergency preparedness by passing resolutions (WI-IA 1989 and WHA 1993). In 1995 the WHA differentiated the role of WHO in emergency preparedness and disaster reduction from its responsibilities in emergency response and humanitarian action by passing resolution WHA48.2 which also recognized that disaster reduction is an integral part of sustainable, development and each country bears the primary responsibility for strengthening its capacity (WHO, 2007a; WHO, 2007b).

In January 2005 the World Conference on Disaster Reduction adopted the Hyogo Framework for Action. (2005-2015), which called for a strengthening of disaster preparedness for effective response at all levels and the integration of risk reduction planning into the health sector (UNISDR, 2005). As a result of this conference and against the ‘background of the devastating December 2004 Tsunami, the importance of preparedness was re-endorsed in May 2005 when WHO Member States adopted resolution WHA58.1 which called on WHO to intensify and improve its efficiency on emergency work and emphasized the need to strengthen the ingenuity and resilience of communities, the capacities of local authorities and the preparedness of health systems (WHO, 2007g; WHO, 2007b; WHO/HAC, 2008; WHO, 2005; Mock, 2007). The resolutions have been adopted to urge Member States to take action on particular health problems and to urge the WHO itself to carry out activities in support of Member States (Mock, 2007). The WHO is also expected to support Member States in each of the disaster

priority areas through the provision of technical assistance and also developing standards and training resources on health sector risk reduction and emergency preparedness. This strategy is a clear indication of the efforts by WHO in risk reduction and emergency preparedness. The responsibility of coming up with emergency preparedness plans and risk reduction activities is for the Governments, with WHO focusing on technical support.

In east African countries (EAC), some individual partner states of the EAC Sub-Region have developed policies, legal frameworks, institutional frameworks and National Platforms of Disaster Risk Reduction (DRR) (EAC 2012). Although all the EAC Partner States have policies on DRR, the policies in some countries have not yet been ratified by their cabinets (EAC 2012). The legal frameworks of Disaster Risk Reduction and Management (DRRM) in the Partner States are under formulation except in Tanzania where there is an act of parliament it is ‘Relief Coordination Act no. 9 of 1990’. In Burundi, there is the National Policy for Risk Prevention and Disaster Management, the National Disaster Management Policy of Kenya (NDMP) (GoK 2011), and Rwanda. National Disaster Management Policy (GOR 2012), Tanzania National Disaster Management Policy for Tanzania mainland (Existing Policy is being reviewed) (GoT 2004-2009). Also, there is a Disaster Management Policy in Zanzibar, and lastly Uganda National Policy for Disaster Preparedness and Management (GOU 2010). At present, all the Partner States have an institutional framework for disaster management. Based on these disaster management frameworks, the disaster risk management frameworks are proposed in Burundi, Kenya, Rwanda and Tanzania and newly approved in Uganda. These proposed or approved institutional frameworks of the Partner States are as follows (EAC 2012). In Kenya and Rwanda, the ministries for disaster prevention exist (the Ministry of State for Special Programmes in the office of the president in Kenya and the Ministry ‘of’ Disaster Management and. Refugee Affairs (MIDIMAR) in Rwanda) (EAC 2012).

In Uganda, the Directorate for Relief, Disaster Preparedness and Refugees in the Prime Minister’s Office is the organization for, disaster prevention while in Tanzania, the Disaster Management Department in the Prime, Minister’s Office: is for mainland and the Disaster Management Department in the Second Vice President’s Office for Zanzibar are the responsible organization: for disaster prevention. In Burundi, The directorate of civil protection in the Ministry of

Public Security is responsible for disaster management. In all Partner States, there are disaster management committees at local levels. In Kenya, there are disaster management committees at the national level, county level, district level and community level (GoK 2011).

In Tanzania, disaster management committees exist at national regional, district, ward and village levels (FEWS 2003; Government of Tanzania, 2009) for Tanzania Mainland while for Zanzibar there are disaster management committees at the National, District, and Shehia level. Non-Governmental Organizations (NGOs) also participate in the committees for continuous observation of disaster risks. In the case of Uganda, there are national disaster management committees, district: disaster management committees, and sub-county/ward/village committees.

In Nigeria, there are many stakeholders in the management of emergencies and disasters. These include the Nigeria air forces, The Nigeria police, Federal Road Maintenance Agency, Federal Road Safety Corp, and Nigerian Fire Service. Others are the National Security and Civil Defense Corp, the Red Cross and United Nations High Commission for refugees and some individuals among others. However, the extent to which the various activities of this stakeholder are harmonized, coordinated and synchronized in situations of national emergencies and disasters leaves much to be desired.

The foregoing challenges necessitated the establishment of the National Emergency Relief Agency (NERA) in 1976 before decree no 12 of 1999 amended by act 5 of 1999 with a broader scope transformed it into the National Emergency Management Agency (NEMA), NEMA was among other teams designated to effectively coordinate the management of emergency and disaster efforts of all the stakeholders. However, despite the NEMA's establishment, the response to the disaster in Nigeria has fallen short of expectations. This has largely been attributed to inadequate capacity building and integration of effort; moreover, NEMA's intervention has continued to be focused largely on relief efforts as against pro-active approaches. The NEMA Act is divided into six parts and one schedule. These parts generally address the establishment, performance and capabilities, employment, finance, the appointment of Directors of the agency and other miscellaneous issues. On the other hand, the schedule is concerned with additional provisions concerning the Agency's Council, the first part of the Act which comprises Sections 1-5 is concerned with

the establishment, membership, tenure of office, membership termination as well as grant.

The National Disaster response plan (NDRP) establishes a process and structure for the systematic, coordinated and effective delivery of federal assistance to address the consequences of any major disaster or emergency declared by the president Federal Republic of Nigeria. The NDRP set four fundamental policies, planning assumption, a concept of operation, responses and recovery action and Federal Agency and Private sector responsibilities; organizes the forms of Federal Responds Assistance that a state is most likely to require under 13 support service areas; each of which has designated primary agencies, provide a focus for inter-agency and inter-governmental preparedness, planning, training, exercising, coordination and information exchange.

Regrettably, in Borno state, the hospitals are dominated by bomb blast victims as a result of terror/suicide attacks and epidemic diseases that often occur in the IDP Camps which are coupled with other disease conditions that are of public health importance. On weekly basis cases of gunshot and bomb blasts are rushed to the Hospitals/Clinics for treatment. 25 bomb blast victims were rushed to the Umaru Shehu Ultra-Modern Hospital on the 5<sup>th</sup> of April 2015 from Maiduguri-Dambo Road (SEMA). Eighteen (18) persons were taken to the UMTH as a result of a Bomb Blast along Muna Garage on the 8<sup>th</sup> of November 2017 (SEMA). Similarly, an attack was carried out on 8<sup>th</sup> JUNE 2017 at the Polo- Jiddari killing scores as reported (TVC) news. Cases of Cholera have been reported in October 2017 in Six different locations including IDPs and the host communities (Public Health EOC) Maiduguri Eye Hospital. The attack on Dalori Community on the 30<sup>TH</sup> January 2016 is one incident that saw great damage to lives and properties that brought shock to stockholders in the fight against insurgency in the Northeast, (Wikipedia). Dominated by these factors, Dalori IDP clinics recorded a series of such cases and manages them. However, some of these cases/victims lose their lives at the facilities/Clinics while others are referred to UMTH for emergency treatment. Therefore one wonders how well Dalori IDP clinics are prepared in handling emergency cases and what factors are affecting disaster preparedness and management at the clinics considering the influence on knowledge attitude and practice of the health workers concerning disaster preparedness and prevention. Hence this research is interested in examining the factors influencing knowledge, attitude and practice in

respect of disaster preparedness and management at Dalori IDP in Borno State, Nigeria.

This study provides a strong tool for factors influencing the government on the practice of disaster management, preparedness and response in the face of increasing incidences of different forms of health hazards leading to disasters in Borno State and Nigeria at large. This study helps medical facilities experiencing similar challenges with recommendations that will provide a probable approach to minimizing the impacts of natural and human-induced disasters.

## II. METHOD

### Study Area

Borno State is pluralistic in ethnic composition. About thirty languages are considered autonomous languages. Twenty-six of the languages spoken in Borno are classified by linguists as Chadic languages. The Kanuri with rich cultural heritage is however an exception and a member of the Saharan group of languages and is found predominantly in the central and northern parts of the state which forms the present Borno and Dikwa Emirates. The Fulfulde is an Arab language of considerable antiquity while Arabic is mainly spoken by the Shuwa Arabs. The Babur/Bura, rich in oral tradition and the second largest ethnic group mostly inhabit Biu Emirate in the southern part of the state.

Askira and Uba Emirates came into existence as independent Emirates as a result of a boundary adjustment. In 1921 when there was a boundary adjustment between the provinces of Borno and Adamawa, a piece of the grid was given to, Mai Mama under the seal of King George V in recognition of his service to the British Crown. He virtually became the founding father of the town and Emirate of "Askira" which means gratitude in the Kanuri district. Like the Gwoza Emirate, Uba Emirate is also cosmopolitan in nature as the Marghi language is further divided into dialectical intimations grouped mainly under the north and south Marghi. The Shani Emirate is widely acclaimed for their Menware Festival mostly inhabited by the Dera speakers. There are also Hausas and Fulanis spread across the State. Borno state has an estimated area of 69,436 km<sup>2</sup> it is located between latitude 11° N and 15° N and longitude 11 E° and 14° 4 E (Ngala, 2007) (www.bornonigeria.com). With a projected population of 5,860,200, Konduga has a projected population of 246,900. However, this research is narrowed to health workers of Dalori IDP Clinic.

### Study Design

A descriptive survey was used for this study. This design involves observing and describing a phenomenon without influencing it in any way. Survey research design is a very valuable tool for assessing opinions and trends. In this study, this design will be used to examine the influence of government policies and practices on disaster preparedness and response in the Dalori IDP Clinic.

### Study Population

The target population of this study will be 310 Staff at Dalori IDP Clinics composed of different cadres, among them being doctors, laboratory technologists, nurses, clinical officers, CHEWS, JCHEWS and supportive staff amongst others. To this population, the results of the study will be generalized. This group of respondents was selected because they work in the four clinics within the Camp and have knowledge of the subject under investigation.

### Sample Size Determination

An estimated sample size of 170 was used in this study, 170 for the confidence interval of 95% and imaging error of 5% using the formula;

$$S = \frac{X^2 NP(1-P)}{d^2 (N-1) + X^2 P(1-P)}$$

Where

S = required sample size.

X = Z value (1.96 for 95% confidence level).

N = Population size (310)

P = Population proportion (assumed to be 0.5)

d = degree of accuracy (expressed as proportion 0.05)

Therefore;

$$S = \frac{1.96^2 * 310 * 0.5(1-0.5)}{0.05^2 (310-1) + 1.96^2 * 0.5(1-0.5)} = 170$$

Therefore, 170 health personnel were selected for the study. According to Gay (1987), the minimum sample size for descriptive survey research is 10% of the accessible population. Krejcie and Morgan (1970) provide a formula for calculating sample sizes. The sample size was used to calculate by category of respondents as follows; 25% of 100 (technical staff) = 25 for both and (supportive staff) for the 4 Clinics in the IDP Camp.

### Sampling Technique

A multistage sampling technique was used to select respondents for the study. The list of respondents to be used as a sampling frame was obtained from the staff database. Multistage sampling is important in reducing the influence of



extraneous variables in a study. Systematic random sampling was additionally used to select participating 85 technical staff and 85 management staff with the help of the Clinic Staff Register.

#### Instrument of Data Collection

The structured questionnaire was used to elicit information from the respondent. This instrument was structured using both open and closed-ended questions. The closed-ended questions were used to ensure objectivity and clarity of the subject "Responses" for ease of statistical analysis while the opened ended items allow the respondents some room for an independent opinion.

#### Data Management

The Data collected from the respondents was coded, transformed and analyzed using statistical packages for social Scientists (SPSS) Software version 23. The analyzed data was presented in the form of frequencies and percentages.

#### Ethical Considerations

Permission for conducting this study was sought from the following bodies, National Emergency Management Agency (NEMA), State Emergency Management Agency (SEMA), State Primary Healthcare Development Agency (SPHDA) and Borno State Ministry of Health.

### III. RESULT

Table 1: Distribution of Socio-demographic characteristics of the respondent

Gender	Frequency	Percentage %
Male	83	48.83%
Female	87	51.17%
Marital status		
Married	79	46.47%
Single	59	34.71%
Divorced	23	13.53%
Widowed	9	05.29
Age		
Below 25b years	21	12.35%
25 - 30 years	19	11.18%
31 – 35 years	43	25.29%
36 - 40 years	49	28.82%
Above 40 years	38	22.35%
Level of Education		
SSCE/GCE	21	12.35
College	105	61.76
Undergraduate	31	18.24
PG certificate	13	07.64

Source: fieldwork, 2022

The tables on socio-demographic data of respondents which shows that, which show that 83 questionnaires were given to the main respondents representing 48.83%, while 87 female respondents representing 51.17% were given the questionnaire. The above table indicates that 79 married persons representing 46.47% were given the questionnaire, 57 single respondents representing 34.71% were also considered, 23 of the respondents representing

13.53% were divorcees and 9 representing 05.00% were widows. In table 4, 21 respondents representing 12.35% were below 25 years, and 19 respondents representing 11.18% are between the age of 25 – 30 years. 43 of the respondents representing 25.29% are between the age of 31-35 years, and 49 out of the 170 respondents representing 28.82% are between the age of 36 and 40. 38 respondents representing 22.35% are above

40 years. The above table, which is on the education level of respondents, indicates that 21 respondents representing 12.35% had secondary education 105 respondents representing 61.76% are the product of colleges. This number is large because Nurses and other Paramedical staff

constitute the greater number of technical personnel in the IDP Camp. 31 of the respondents representing 18.24% are graduates from different universities. 13 of the respondents representing 07.64% are postgraduate.

**Table 2: distribution of the respondent's awareness of the existence of government policy**

Question	Yes=%(N)	no=%(N)
Do you know the existing government policy in this camp	<b>89.4(152)</b>	<b>10.6(18)</b>

Source: fieldwork, 2020

The table sought to find out the level of awareness of the respondents on the existence of government policy in the camp. The table revealed that the majority of the respondents 89.4% (152)

agreed that they were aware of the existence of government policies concerning conflict preparedness and response.

**Table 3: Assessment of government policy on disaster preparedness and response**

Policy/Strategies	SA=%(N)	A=%(N)	D=%(N)	SD=%(N)
Well equip disaster preparedness and management	16.5(28)	5.9(10)	42.3(72)	35.29(60)
Personnel prepare at all times to cope with and manage disaster	11.8(20)	12.4(21)	52.3(89)	23.5(40)
Promote research and technology in disaster risk reduction	5.9(10)	11.8 (20)	61.8(105)	20.6%(35)
Timely coordination and effective emergency response	13.0(22)	5.9(10)	60.6(103)	26.5(45)
Public awareness and education	12.4(21)	11.8(20)	58.8(100)	17.1(29)
Adequate expertise and technology	5.9(10)	1.8(3)	68.8(117)	23.5(40)
Develop a conflict early warning system	5.3(9)	7.6(13)	45.9(78)	41.2(70)
Ensure adequate staffing	4.1(7)	2.9(5)	44.7(76)	48.2(82)
Ensure adequate facilities and equipment	1.2 (2)	4.7(8)	39.4(67)	54.1(92)
Strengthen entomological services and conflict surveillance	13.5(23)	18.8(32)	45.9(78)	21.8(37)

Source: fieldwork, 2020

The table indicates that the majority of the respondents 42.3 %(72) disagreed that there were well equip disaster preparedness and management. The table adds that 52.3% (89) of the respondents disagreed that medical personnel prepare at all times to cope with and manage disaster, 61.8% (105) constitute the majority of the respondents disagreed that government policy here promotes research and technology in disaster risk reduction, 60.6% (103) disagreed that there were timely coordination and effective emergency response to emergencies among health personnel, 58.8% (100) disagreed that there a policy on public awareness and education. Also, the table indicates that 68.8 % (117) disagreed that there was adequate expertise

and technology policy. In addition, the table shows that 45.9% (78) disagreed that government develop a conflict early warning system in the Dalori camp. The table shows that the majority of the respondents 48.2 %(82) strongly agreed that government ensure adequate staffing in the camp, and 54.1% (92) strongly disagreed that government ensure adequate facilities and equipment in the camp. The table indicates that the majority of the respondents 45.9% (78) disagreed that the government has strengthened entomological services and conflict surveillance in the Dalori camp. It is clearly shown in the table that government policies were not effective in the area of conflict preparedness and response.

**Hypothesis**

**Table 4: Effect of government policy on disaster preparedness and response in Dalori**

Variables	R	R <sup>2</sup>	F	β	T	P
Constant	.101	.092	13.565		1.322	.000<.05
Equipment				.018	1.554	.000<.05
Timely preparation				-.080	0.260	.030<.05
Promote research and technology				.043	1.888	.000<.05
Public awareness and education				.043	2.666	.000<.05
Develop a conflict early warning system				.046	1.337	.000<.05
Adequate staffing				.004	1.398	.000<.05
Adequate facilities and equipment				.037	1.013	.000<.05
Strengthen entomological services and conflict surveillance				.047	2.011	.000<.05

**Dependent Variable: kinds of policies**

The results presented in Table showed that government policies have not significantly and jointly influence conflict preparedness and response in the Dalori camp (R = .101 = R<sup>2</sup> = .092, F = 13.565, t = 1.322, p< .05). This means that the government policy itemised in the table had not jointly contributed to the effective implementation of conflict preparedness and response by the hospital health personnel.

**IV. DISCUSSION**

Government policy is a driving force in disaster preparedness and response, table 28 indicated that the majority of the respondents said yes to the existence of government policy on conflict preparedness and response. However, it was found that such policies like well equip disaster preparedness and management, personnel preparation at all times to cope with and manage disasters, research and technology in disaster risk reduction, timely coordination and effective emergency response to emergencies among health personnel, public awareness and education, adequate expertise and technology policy, the early warning system in Dalori camp was not effectively implemented despite the involvement of many stakeholders in the management of emergencies and disasters. These include the Nigeria air forces, The Nigeria police, Federal Road Maintenance Agency, Federal Road Safety Corp, and Nigerian Fire Service. Others are the National Security and Civil Defense Corp, the Red Cross and United Nations High Commission for refugees and some individuals among others. However, the extent to which the various activities of this stakeholder are

harmonized, coordinated and synchronized in situations of national emergencies and disasters leaves much to be desired because of poor implementation.

Regrettably, the foregoing challenges necessitated the establishment of the National Emergency Relief Agency (NERA) in 1976 before decree no 12 of 1999 amended by act 5 of 1999 with a broader scope transformed it into the National Emergency Management Agency (NEMA), NEMA was among other teams designated to effectively coordinate the management of emergency and disaster efforts of all the stakeholders. However, despite the NEMA's establishment, the response to the disaster in Nigeria has fallen short of expectations. This has largely been attributed to inadequate capacity building and integration of effort; moreover, NEMA's intervention has continued to be focused largely on relief efforts as against pro-active approaches. The NEMA Act is divided into six parts and one schedule. These parts generally address the establishment, performance and capabilities, employment, finance, the appointment of Directors of the agency and other miscellaneous issues. On the other hand, the schedule is concerned with additional provisions concerning the Agency's Council, the first part of the Act which comprises Sections 1-5 is concerned with the establishment, membership, tenure of office, membership termination as well as grant.

To enhance the effective management of disaster, the National Disaster respond plan (NDRP) establishes a process and structure for the systematic, coordinated and effective delivery of

federal assistance to address the consequences of any major disaster or emergency declared by the president Federal Republic of Nigeria. The NDRP set four fundamental policies, planning assumption, a concept of operation, responses and recovery action and Federal Agency and Private sector responsibilities; organizes the forms of Federal Responds Assistance that a state is most likely to require under 13 support service areas; each of which has a designated primary agency, provide a focus for inter-agency and inter-governmental preparedness, planning, training, exercising, coordination and information exchange. However, despite the several efforts put in place, such efforts are inadequate and yielded little fruit in disaster preparedness and response in the Dalori camp.

## V. CONCLUSION

The issues of disaster date back years with difficulties in undertaking disaster management assessment leading to calls for continued development of standardized tools. The continued occurrence and magnitude of diseases have prompted World Health Organization (WHO) and other organizations to come up with best practice models for hospital and Disaster Management. Over the years there have been efforts by WHO and other technical bodies in promoting hospital preparedness, examples being the 2008-2009 world disaster reduction campaign of hospitals safe from disaster and more recently the 2010 – 2011“ one Million safe schools and hospitals” initiative. This is because of the need to continue strengthening the healthcare system's preparedness and response to mass casualties to save as many lives as possible where disasters should occur. Given this, it has been found that government policies in Dalori Camp did not have a significant influence on the effective preparation and response to disasters in the place. This has given birth to the following recommendations.

### Recommendations

It is here recommended that;

1. Government should deploy more resources towards maintaining the acquired knowledge, attitude and practice of Health workers in disaster preparedness and prevention.
2. Government should partner with other Disaster organizations towards improving the lots of internally displaced persons in the emergency response effort.
3. There exist little research work on “influence” on knowledge, attitude and practice, the recommendation is here made for further research work on influence in particular and

other related variables such as; preparedness, teamwork, knowledge and attitude among others to improve the body of knowledge on this ever-growing area of public health concern.

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