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CSOs Advocacy and the Legislative Process in Nigeria: A Case Study of the National Health Act, 2014

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Abstract

This paper examines the role of Civil Society Organisations (CSOs) in health care delivery through legislative advocacy. It highlights the various efforts of civil society organisations (CSOs) towards the passage of the National Health Bill (2014). The role of CSOs spanned the various stages of the legislative process. Evidence from their engagement and advocacy for the NHB shows that when CSOs are engaged in developing and reviewing national health plans, they can assist in identifying or sharpening national priorities and consequently help improve health outcomes. The paper concludes by highlighting key lessons learnt in the advocacy process and critical success factors which include knowledge of the legislative process, ability to leverage on existing relationships and networks, and partnership with international partners, among others.

Keywords: National Health Act, CSOs, Legislative Advocacy, National Assembly

1. Introduction

Civil Society Organisations (CSOs) are non-state, not-for-profit, voluntary organisations formed by people within the social sphere of civil society (Anheier, 2004). Often used interchangeably with non-governmental organisations (NGOs) who have more formal structures, CSOs cover a variety of "autonomous associations which develop a dense, diverse and pluralistic network…and consist of a range of local groups, specialized organizations and linkages between them to amplify the corrective voices of civil society as a partner in governance and the market" (Connor, 1999). Historically, civil society organisations have been associated with the rise of democracy in both Europe and North America. Recent years have witnessed a significant upsurge of organized private, non-profit activity in countries of Asia, Africa and Latin America (Salamon & Anheier, 1997). CSOs are widely recognized as an essential 'third' sector that have positive impact on good governance by promoting transparency, effectiveness, openness, responsiveness and accountability (Diamond, 1999; Gyimah-Boadi, 2004). They do so through numerous ways including policy analysis and advocacy; monitoring of state performance and the action and behaviour of public officials; building social capital; mobilizing particular constituencies; and engagement in development work (Salamon & Anheier, 1997).

Advocacy can take the form of counter-power actions and protests. This includes notably bringing issues to the agenda through awareness campaigns and "name and shame" strategies. But it can also be a cooperation between CSOs and authorities as the latter consult civil society and incorporate its propositions in its policy making process.

Legislative advocacy by CSOs refers efforts by them to shape policy by exerting influence on laws made by the legislature. Empirical research on CSOs reveals that they perform several advocacy functions that include identifying unaddressed problems and bringing them to public attention, giving voice to the wide range of economic and socio-political, concerns (Dodgson, Lee, & Drager, 2002; Keeble, 1999; Raghavan, 2001; Sheehan, 2000). At every stage of the legislative process CSOs can contribute either in informing or shaping the legislation and thus contributing in the policy formulation process. They do this by providing information that is vital for the development of a given legislation that has potential impact on society.

Covey (1994) identified five strategies deployed by CSOs in influencing public policy and legislation. These are: education, persuasion, collaboration, litigation and confrontation. At every stage of the legislative process, CSOs can deploy any of these strategies towards ensuring involvement in the legislative process. Effective advocacy strategy requires good knowledge of the legislative process which include how a bill gets passed in the Legislature, the processes, key decision makers and the power brokers. The effectiveness of legislative engagement, however, depends on knowledge of the legislative process and when to engage legislators at individual or committee stage.

2. Role of Government in Healthcare Delivery in Nigeria

It is impossible to define the role of Civil Society Organisations (CSOs) in Nigeria's health sector without first considering the role of government in healthcare delivery and the challenges that have continually bedevilled it since independence. Prior to the National Health Bill, healthcare delivery in Nigeria was not guided by any legal framework and interventions in the sector were mostly short-term. Scott-Emuakpor (2010) identifies seven (7) distinct phases in healthcare planning in Nigeria as follows: 1. The First Colonial Development plan from 1945-1955; 2. The Second Colonial Development plan from 1956-1962; 3. The First National Development Plan from 1962- 1968; 4. The Second National Development Plan from 1970-1975; 5. The Third National Development Plan from 1975-1980; 6. The Fourth National Development Plan from 1981-1985; 7. Nigeria's Five Year Strategic Plan from 2004-2008.

Prior to independence and in the immediate post-independence period, the focus was on providing universal healthcare and hence greater emphasis was laid on expanding rural services through the provisions of rural hospitals, dispensaries and clinics under a cost sharing arrangement with local governments. However, between 1956 and 1975 the overall progress made in achieving the goals of universal healthcare was negligible. Subsequently, the focus shifted to preventive health services under the Fourth National Development Plan (1981-1985) when the Basic Health Services Scheme (BHSS) came into place. It was a three-tier policy compromising Comprehensive Health Centres (CHC), Primary Health Centres (PHC) and Health Clinics funded by state and local governments with assistance from the federal government. As with the previous plan, the outlined goals of the policy were not achieved and services deteriorated abysmally as seen in the rising levels of industrial actions by doctors in the 1980s. Scott-Emuakpor (2010) further argues that subsequent healthcare plans and policies from 1980 did not meaningfully improve healthcare delivery in Nigeria either.

The National Health Policy and Strategy to Achieve Health for All Nigerians of 1988 was, for all intent and purposes, replications of earlier policies and failed to deliver any significant results. Thus, a Revised National Health Policy was endorsed formally by the government in 2004. The emphasis once more was on a comprehensive reform of the health sector in line with the Millennium Development Goals. Hence, there was a particular focus on core programmes of government that included HIV/AIDS, malaria, immunization, population, reproductive health, health management information system and traditional medicine (Lambo, 2004). In attempt to ensure universal health coverage (UHC), the Nigeria's National Health Insurance Scheme (NHIS) was introduced in June, 2005 to provide a sustainable alternative source of funding health care services. However, enrolment has been low and restricted to federal formal sector employees. In-take by stage governments has also remained critically low with only two (2) states reported to have adopted the programme as at 2015 (Uzochukwu et al., 2015).

Funding for the health sector has remained poor over the years and an analysis of the health budget in recent times shows that it has never met the 15% of the total budget minimum requirement agreement which was signed during the Abuja Declaration in 2001, by the African Union. Health budget as a share of the total national budget was 5.6% in 2014. It increased to 5.7% in 2015 and declined to 4.2% in 2016. The consequence of the poor health budget and utilization manifest in Nigeria's health statistics underperformance in relation to her African peers and other developing countries. For instance, BCG immunization coverage in 2014 for Ghana was 99%, Kenya (81%), India (91%) and Nigeria (74%) (World Health Organization). Similarly, the percentage of children below five years, suffering from malnutrition is relatively higher in Nigeria. It is also worth noting that despite the launching of the National Health Insurance Scheme in 1999, many Nigerians still pay out-of-pocket for health services and this is among the highest in the world. Out of pocket health expenditure as a percentage of total health expenditure in Nigeria was 71.7% in 2014, 26.1% in Kenya and 26.8% in Ghana. This further buttresses the argument that health care is out of the reach of the poor.

Owing to ineffectual policies, poor implementation and low funding, healthcare services provided by government has at best been marginal. This has led to the steady development and proliferation of the private sector as an alternative to the public health system. Regrettably, there has been very little by way of a framework, law or policy to regulate the activities of provide sector health providers, such as clinics, retail pharmacies, hospitals, etc. (Ogunbekun, Ogunbekun, & Orobaton, 1999). The consequence of this is high out-of-pocket share for health expenditures among Nigerians and low-quality products and services.

It is within this historical context that The National Health Act (2014) is best understood. Signed into law on December 9, 2014, it establishes a framework for the Regulation, Development and Management of a National Health System and sets standards for rendering health services in the Federation and other matters concerned therewith. The law aims to improve the country's healthcare system, including access to primary care for

vulnerable segments of the population, such as women, children and the elderly. Detailed provisions of the Act are discussed in subsequent sections.

It is against this background that this paper examines the role of Civil Society Organisations (CSOs) in health care delivery through legislative advocacy? It highlights the various efforts of civil society organisations (CSOs) towards the passage of the National Health Bill (2014).

3. Methodology

This study employs a mixed approach. The first consists mainly of a desk review to appraise existing literature on CSOs advocacy with regards the National Health Bill. By so doing, theoretical and methodological contributions in this area are identified. Secondary sources of data used include journal articles, newspaper publications, online data, government and organisational records. The benefit of this approach is that it helps to provide the background to the study based on materials and work already carried out. The data collected generally have a pre-established degree of validity and reliability and helped in the research design for the subsequent primary research undertaken. Qualitative informal interviews were conducted to gain deeper understanding of the following: (i) the major actors in the initiation and passage of the Act; (ii). role CSOs and NGOs play in the legislative process and passage of the NHB; (iii) the relative influence of indigenous NGOs/CSOs as against the international organisations on the process of the enactment of the National Health Act 2014; (iv) factors account for their influence in the advocacy for Act; and (v) useful lessons can be drawn from that experience in relation to the capacity of NGOs/CSOs to effectively bring an advocacy agenda to a successful conclusion (enactment, amendment, etc.) in the National Assembly. The study group include actors and stakeholders from Civil Society Organisations, Federal Ministry of Health, Members of the National Assembly, professional bodies, unions and associations. Twenty-two (22) individuals from fourteen (14) CSOs/NGOs were involved in the study.

4. Results and Discussions

4.1 Overview of the National Health Act, 2014

The Bill For An Act To Provide A Framework For the Regulation, Development And Management of A National Health System And Set Standards For Rendering Health Services In The Federation, And Other Matters Connected Therewith, 2014, known popularly by its short title, *The National Health Bill*, has had a tortuous journey from the 4th Assembly (1999-2003) through to the 7th Assembly (2011-2015) when it was eventually passed.

As mentioned in the introduction, the Bill is said to establish minimum guarantees of basic healthcare services for select groups - such as children below the age of five, pregnant women, adults above the age of 65 and people with disabilities - and help extend primary healthcare to 60% of Nigerians living in hard-to-reach rural communities.

> The Bill also removes barriers to access emergency healthcare as it instructs medics to treat any emergency first before asking for money or police report… [it also] formally recognises the establishment of Village Health Committees which gives room for community participation and ownership of the health centres…*Tonte Ibraye, National Coordinator, White Ribbon Alliance for Safe Motherhood*

The Bill further seeks to reform the recruitment, training, and professional development of health sector workers. The provisions of the bill include, among others:

- Free medical care for children under five years old, pregnant mothers, the elderly (above 65 years) and disabled people.
- A guaranteed basic minimum health package for all Nigerians
- Unconditional acceptance and treatment of patients with emergency health conditions Confidentiality of medical records
- Ensured quality of healthcare services through the issuance of Certificates of Standard (Public and Private).

As contended by Jimoh (2014), the Bill is critically important for the core reason that:

> it represents the best attempt…at providing a legislative framework that seeks to comprehensively address the many challenges afflicting Nigeria's health sector, thus contributing towards the realization of the right to health and by extension the right to life of Nigerians guaranteed under Section 17(3)(c), 17(3)(d) and 33 of the 1999 Nigerian Constitution as amended.

Also noteworthy is a provision setting up the scheme for financing the programs envisaged under the legislation. The basic health care provision fund shall be financed from Federal Government Annual Grant of not less than 1% of its Consolidated Revenue Fund and grants by international donor partners. The funds shall be managed by three national entities which are: The National Health Care Development Agency, The National Health Insurance Scheme, and The Federal Ministry of Health. 50% shall be used for the provision of basic minimum package of health services to citizens, in eligible primary/or secondary health care facilities through the National Health Insurance Scheme (NHIS); 20% shall be used to provide essential drugs, vaccines and consumables for eligible primary health care facilities; 15% shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities; and 10% shall be used for the development of Human Resources for Primary Health Care; 5% of the fund shall be used for Emergency Medical Treatment to be administered by a Committee appointed by the National Council on Health (Jimoh, 2014). So far, more than two thirds of States and the FCT and their Local Government Areas have established State Primary health care Development Agencies in readiness for the implementation of this Act.

4.2 Major Actors in the Initiation and Passage of the Act

There are over fifty (50) CSOs in Nigeria that are concerned with health and their size, roles, capacity and operations differ greatly. In a bid to be more effective in achieving their set objectives, many CSOs concerned with health issues have formed membership "coalitions" or "networks" on different thematic areas. In general, however, only a few CSO networks possess expertise and experience in health policy and planning. Due to this limitation in capacity, the degree of CSOs engagement in national health policy in Nigeria has generally been very low.

Notwithstanding, the National Health Bill bucks the trend as seen in a robust involvement of CSOs in its emergence and its journey through the whole gamut of the legislative process. Some of the key players in the initiation and advocacy for the enactment of the National Health Bill include:

1. Nigeria Medical Association and Coalition
2. Health Reform Foundation of Nigeria (HERFON)[1]
3. Partnerships for Transforming Health Systems Phase 2 (PATHSII)
4. Health Sector Reform Coalition (HSRC) (The coordination body for the NHB)
5. Nigerian Urban Reproductive Health Initiative (NURHI)
6. International Vaccine Access Center (IVAC)
7. Civil Society for HIV/AIDS in Nigeria
8. Association for Reproductive & Family Health (ARFH)
9. National Reproductive Health Technical Working Group (with Prof. Oladapo Ladipo as its Chair and main driver)
10. African Youth Initiative on Population, Health & Development (ANDENOID)
11. Adolescent Care Support Empowerment Initiative
12. Civil Society Scaling-up Nutrition in Nigeria
13. Center for Social Justice
14. Market Women Association

Suffice it to say that several other NGOs and CSOs were similarly involved with the Bill at one stage or another. The engagement of some of these groups was thematic pertaining to specific areas of the Bill that they were either in support of or opposed to.

4.3 Role of CSOs and NGOs in the Legislative Process and Passage of the National Health Bill (NHB)

Presidential assent to the NHB in October 2014, a decade after it was proposed came on the heels of unprecedented and persistent pressure and advocacy from various stakeholders from both the public and private sectors, including NGOs, CSOs, medical associations and the general public. Civil society engagement with the Bill spanned its ten-year history (2004-2104) and touches on the various stages of the legislative process from drafting, 1st, 2nd and 3rd Readings, passage and presidential assent. The key milestones of the National Health Act are as outlined below:

[1] Health Sector Reform Foundation of Nigeria is made of the following core group members, HERFON, PATHS2, Save the Children International, and Evidence for Action. Others include the Federation of Women Lawyers (FIDA), Federation of Muslim Women Association of Nigeria (FOMWAN), Advocacy Nigeria, Nigerian Urban Reproductive Health Initiative (NURHI), Civil Society for HIV&AIDS in Nigeria (CISHAN), National Association of Women Journalists (NAWOJ), White Ribbon Alliance, Nigeria, Wellbeing Foundation, Medical Women Association of Nigeria (MWAN), National Council of Women Societies, Medical and Dental Council of Nigeria (MDCN), Nigerian Medical Association (NMA), Allied Health Professional Associations, Market Women Association, UNICEF etc.

Table: Key milestones of the National Health Act (2004-2014)

Milestone	Date	Legislative Progress/setbacks and delays
First draft of National Health Bill	2004	Drafted by Change Agents
Approval by FMOH/TMC	2005	Delay in sending the Bill to the National Assembly by the Executive arm before the end of 2005.
Edited 2004, 2005, 2006, 2008, 2009, 2010		-
Approval by National Economic Council	2006	This only happened after a public hearing by the House Committee on Health in 2006 and a subsequently review by the Senate Committee on Health in Port Harcourt in 2006
Passed by House of Representatives	2007	The Senate Health Committee class of 2004-2007 did not however pass the Bill
Passed by Senate and House of Representatives	2009	Process resurrected and reviewed by the National Assembly, the Senate Committee on Health, House of Representatives in 2008
Harmonised version passed	19 May, 2011	The National Assembly legal department referred it back to the National Assembly to rectify conflicts with existing regulations in 2009. This was reviewed by the Senate and House of Representatives to reflect the suggested amendments by legal department in 2010 before harmonised version was passed.
Presidential assent not given	2011	-
First and Second Reading at the Senate Plenary	2012	This was the result of the Senate's decision to repackage the Bill as a private member Bill, which marked a major turning point. It was followed by a public hearing by the Senate in 2013
Passage by the Senate in Plenary on 19 February 2014	2014	House of Representatives concurrence in September 2014
Harmonised copy passed by both National Assembly chambers	October 2014	-
Transmitted to the President for assent	28th October 2014	-
Assent by President	31st October 2014	

Source: HERFON, 2014

The NHB was first drafted in 2003/2004 by Change Agents within the context of the Health Sector Reform Agenda of 2004-2007. In 1999, the UK's Department for International Development (DFID) helped to establish a Change Agent Programme to foster broad health sector reform in Nigeria, with specific improvements in immunisation services and HIV/AIDS prevention. The programme brought together professionals from different backgrounds with a collective interest in changing the way the country's healthcare is delivered. These 'change agents' were saddled with tackling the issues of poor health policy, governance, planning and finance. DFID funded the birth of Health Reform Foundation (HERFON), which brought together these change agents in 2002. In 2003, the change agents stared the drive for the National Health Bill. The programme paved the way for increased civil society participation in the National Health Bill, achieving some critical milestones.

The drafters were interested in developing a legal framework to replace the National Health Policy. The review process benefited heavily from the goodwill of Prof. Eyitayo Lambo, who was appointed Minister of Health in July, 2003. Given his antecedents as Change Agent Program (CAP) Director, the Minister developed synergy

with Change Agents that led to the drafting of the Bill as well as its presentation to and eventual adoption by the National Council on Health. Subsequently, the Coalition of CSOs that advocated for the Bill was also able to build a strong relationship with both Senate and the House of Representatives in drafting of succeeding versions of the Bill and building rapport with civil servants. It has been observed that this successful collaboration between the Ministry and Change Agents is attributable to the convergence of interest of both parties in pushing forward the Bill.

Despite this initial momentum however, the Bill stagnated for a while owing to the inability of the Executive to transmit the Bill to the National Assembly for legislative consideration. Thus, a whole year (2005) elapsed before the Bill was eventually sent to the National Assembly. The first public hearing on the Bill was held by the Senate Committee on Health which was chaired by late Senator Ibiapuye Martyns-Yellowe. Based on submissions at the hearing, the Senate Committee met in Port Harcourt later to review the Bill. Subsequently in the same year, the National Economic Council and the National Council of State approved the draft Bill with the *proviso* that provisions of the Bill should be financed by 2% of the Consolidated Revenue of the Federal Account.

Legislative action on the Bill by the 5th Assembly continued with the passage of the Bill by the House of Representatives. However, Senate was unable to pass the Bill during the same period. Given that an identical Bill must be passed by both Chambers (concurrence) before it can be transmitted for presidential assent, the Health Bill died when the 5th Assembly adjourned *sine dine*.

In the 6th Assembly, the Bill was re-introduced in both Chambers as stipulated by the Standing Orders of both the House and the Senate which requires that a Bill, even if considered by the previous assembly but not passed by both chambers, can only be re-introduced as a fresh bill in the subsequent assembly. The Standing Orders, however, make provisions for expedited passage of such re-introduced Bills. Thus, the Bill began the second leg of its legislative journey at the National Assembly. Unlike with the previous Assembly, Senate took a more proactive stance towards the Bill under the chairmanship of Senator Iyabo Obasanjo. The Senate Health Committee developed a productive alliance with civil society organisations to ensure that the Bill gets expedited hearing. The key organisations that worked with the Committee were the Health Reform Foundation of Nigeria (HERFON) and the Partnership for Transforming Health Systems (PATHS). Both groups were funded by Department for International Development (DFID). With the support of both HERFON and PATHS, the Senate Committee held a workshop on the Bill in Accra, Ghana. In the same vein, the 6th House of Representatives undertook a review of the Bill and in 2009, the Bill was passed by both chambers for the first time. In fact, according to Dr. Mike Egboh, former National Programme Coordinator of the Partnerships for Transforming Health Systems Phase 2 (PATHSII), it was "Civil Society Organizations/NGOs, under the umbrella of Partnership for Advocacy in Child and Family Health (PACFAH) and the Nigeria Medical Association (NMA), [that] came together to develop the contents of the Bill with the help of consultants at HERFON."

Despite the legislative progress above, the Bill suffered a setback when it was returned by the National Assembly's Legal Department due to conflicts with existing legal regulations. Specific contentious issues included the section that authorised 5% of the Fund for Federal Ministry of Health (FMOH) for 'emergency preparedness' and 10% for human resource development. These contentious provisions observed in the House version of the Bill were expunged and the Bill was reviewed by both the Senate and the House of Representatives and sent back to the Legal Department of the National Assembly. Tension was steadily rising owing to the delays in the passage of the Bill and pressure on the National Assembly by civil society groups also increased considerably and culminated with a demonstration by the Market Women Association at the National Assembly on May 18th 2011. Six years after the Health Bill was first introduced in the National Assembly, a harmonized version of the Bill was passed by both Chambers on May 19th, 2011 and transmitted to President Goodluck Jonathan for assent.

The high expectations of advocates of the Bill was however dashed when the President declined to assent to the Bill. This was largely due to disagreements among stakeholders as opponents to the Bill mounted a vigorous campaign against it arguing that the Bill perpetuates the subjugation of other health professionals by doctors. Similarly, many faith-based organisations including the Catholic Church and Jama'atu Nasril Islam (JNI) opposed certain provisions of the Bill on religious grounds. They raised some issues on key aspects of the Bill that border on socio-cultural and religious sentiments that are deeply entrenched. These included sections on human embryos, harvest human eggs and sperms and their commercialisation. They rather called for strengthening of the health care delivery system, improvement of the medical facilities in the country's medical facilities, and curbing of wastage. According to Rev. Fr. Evaristus Bassey, a clergyman and development practitioner, "the Church is looking to get out of the 'tomb mentality' to extend a hand of fellowship and reach

out to people with the same purpose to achieve the common good for the wellbeing of society." Furthermore, "fiduciary aspects of the Bill also had implications for the yearly budgeting process which was of interest to the Federal Ministry of Finance" (Obi, 2014). Finally, the Bill was sent to the President in the period preparatory to the general elections and was therefore not of significant priority to the President.

The National Health Bill was then revived in the early days of the 7th Assembly in 2011. Suffice it to note that even though civil society organisations have been involved with the NHB since throughout its emergent stages, advocacy for the Bill was often fragmented with each group canvassing for its own position. As demonstrated above, the very decision by President Jonathan to withhold assent was in part due to pressure from faith based CSOs. However, by 2011, a coalition of civil society organisations formed on 9th March. Known as the Health Sector Reform Coalition (HSRC), it brought together a diverse and multi-disciplinary range of stakeholders, including Nigerian health-delivery civil society organisations; legal and health-sector professional bodies; INGOs and the media. The HSRC became an umbrella body that brings all the Civil Society Organizations in Nigeria's Health sector together to improve transparency and accountability and better engagement with the Federal Government.

From the outset, the Coalition set out its *modus operandi,* which according to Prof. Oladapo Ladipo, included:

> …ensuring the Bill passed into law before the expiration of the sixth assembly in May 2011. They set out a clear action plan to achieve this. They also agreed on a contingency plan, should the Senate fail to pass the Bill. This included clear success indicators, such as mass public awareness and engagement, mobilised support of the Nigerian diaspora, and 2% of the national consolidated fund allocated to the delivery of healthcare, especially primary healthcare.

Part of the coalition's strategy was to push for the strongest National Health Act possible – one which would include: a focus on delivering primary healthcare to Nigeria's most disease-prone areas; the allocation of 2% of the consolidated fund towards primary healthcare and the National Health Insurance Scheme (NHIS); clearly defined the roles for the different tiers of government, so they would be best able to deliver a quality health service.

The Coalition identified the key stakeholders which included the government, health professional groups, and international partners, among others. The group held several high level consultations across the country to flesh out the core issues of the Bill that need addressing and secure the buy-in of stakeholders so as to avoid some of the hurdles previously faced. The Coalition wrote letters to the President, Senate, House of Representatives as well as major religious leaders/bodies across the country including the Sultan of Sokoto, Jama'atu Nasril Islam (JNI), Catholic Secretariat and professional associations such as the Medical Association of Nigeria. In May 2011, with the Bill about to go to the Senate, the Coalition also mobilised 5,000 people, led by the Market Women Association, who held a rally at the National Assembly advocating for the passage of the Bill and presidential assent. One member of the Association expressed the importance of the Bill like this: "we wanted the Bill passed and done quickly. We believed that it will reduce the rate of deaths among pregnant women in Nigeria because everyone will go to the hospital, and see a doctor for free."

Furthermore, the Coalition reached identified several influential individuals, both locally and internationally to support the Bill and push for its passage. They called them 'champions' and comprised of celebrities, entrepreneurs and businessmen and women including: Bill Gates, Aliko Dangote, President Bill Clinton, UN Secretary-General Ban Ki-moon and UK Prime Minister David Cameron. Prominent Nigerians who also became Coalition 'champions' included Helen Mark (wife to Senator David Mark), Chief Edwin Clark, Chief Tony Anenih, Chief Turner, Hon Saudatu Sani (Senior Special Assistant to the President on the National Assembly), Sultan of Sokoto, Chief Raymond Dokpesi, the Private Sector Health Alliance (including Jim Ovia), Frank Nweke Jr, Prof Osotimehin, Chief Olisa Agbakoba, former President Olusegun Obasanjo, Dame Patience Jonathan and many others.

Thus, CSO advocacy on the Health Bill in the 7th Assembly (2011-2015) was much more robust and coordinated. It is significant to note that there was a major shift in approach by the Senate. Whereas previous Bills were executive in nature, i.e. bills deal with public policy and originate from the Executive Branch of Government, the 7th Senate repackaged the National Health Bill and introduced it as a Members' Bill, i.e. bills originating from Members of the Legislature. A member can initiate legislation in pursuance of his electoral promises or upon request by private citizens and organizations. The effort in Senate was championed by late Senator Giant Dalyop Danton as Senator Iyabo Obasanjo not re-elected. Efforts by Senate to hurry the Bill through the legislative processes suffered a setback with the unexpected demise of Senator Dantong in July 2012. Subsequently, Senator Ifeanyi Okowa took over as Chairman of the Committee. Thus, in 2012, following

the re-introduction of the Bill, it received First and Second Reading at the Senate plenary. This was followed by public hearings in 2013 in which CSOs participated in varying degrees including the organisation of press conferences and preparing policy briefs for legislators, provision of technical support to the Committees on Health and convening strategic meetings with the National Assembly. They also initiated meetings between Senate and House Committees towards harmonising the Bill, organised stakeholders' participation at public hearings, carried out advocacy visits to leadership of the National Assembly and the Health Committees and organised media events to educate journalists and the general public on the Bill and seek their support and input.

In concrete terms, through the public hearings, CSOs ensured that the interests of Nigerians are properly considered in the legislation. A key player at this stage was the Health Sector Reform Coalition (HSRC) which campaigned mainly in the area of availability and adequacy of medical services to accident victims and also in cases of emergency at both public and private hospitals. The HSRC advocated severe sanctions on therapeutic cloning and harvesting of human organs. The Coalition also supported and canvassed for basic minimum healthcare for all through funding provided by the Federal Government and counterpart funding from States and Local Governments. This comprehensive health coverage guarantees free healthcare for children below the age of give, pregnant women, the elderly and people with disabilities.

The other key area of interest to the HSRC concerns the recurrent issue of industrial action that has consistently bedevilled the health sector for generations. In general, CSOs were keen on ensuring that this challenge is addressed by the proposed health legislation. As a result of this advocacy, adequate provision was made in the legislation which empowered the Minister of Health to promptly resolve, within a forth night, any industrial action in the health sector.

Table: Coalition's critical achievements between 2004 and 2010

Drafted and processed the first National Health Bill in 2004
Revised national health policy and other sectoral policies, such as private public partnerships, health financing and health promotion
Influenced and contributed to the approval and revision of the draft Bill six times between 2005 and 2010.
Key Health reform champions in government

Other professional organisations also made significant contributions at the public hearings. The Nigerian Medical Association (NMA) advocated for an accelerated passage of the Bill. According to Former President, Nigeria Medical Association (NMA), Abuja Chapter, Dr. Sarah Essiet John:

> Primarily, the NMA canvassed for a robust legal framework that can lead to effective healthcare delivery in Nigeria in areas such as access, quality and affordability. Additionally, we emphasized the need for healthcare services at the rural level where poverty is endemic and preventable diseases prevalent. Other areas of concern include medical tourism through which, we argued, Nigeria loses $500 million annually, inequitable distribution of health human resources as well as brain drain of health human resources in Nigeria's health system.

Also, the Pharmaceutical Society of Nigeria (PSN) also played a key role in the passage of the National Health Bill. Specific areas of interest advocated for by the PSN include the 'equalization principle' as entrenched in the 1999 Constitution which guarantees equal rights and privileges for all citizens of Nigeria. Also, the PSN actively canvassed for the removal of restrictions in healthcare and its opening up to all major Health Professional Associations and Trade Unions. These were duly considered and incorporated in the National Health Act.

Another key player throughout the gestation period of the National Health Bill and its journey through the whole gamut of the legislative process is the Joint Health Sector Unions (JOHESU). Their role in legislative advocacy spanned a decade. When the Bill was introduced in 2011, the group led an effective advocacy against provisions of the legislation that it considered discriminatory, monopolistic and detrimental. Through its efforts and unrelenting pressure, the 2014 version of the Bill incorporated these inputs and both the House and the Senate harmonized.

On 19th February, 2014 the National Health Bill was passed by the Senate in plenary. Advocacy by the Coalition heightened at this stage as the focus shifted to the House of Representatives. The Coalition circulated the Bills among Members of the House of Representatives and produced research and Bill analysis reports making a strong case for the Bill. Furthermore, the Coalition sent out text messages to all Members encouraging them to pass the Bill. The coalition sent SMS messages twice a day for six days to 5,000 people, including all Members

of the House of Representatives urging them to pass the Bill. Over 500 messages were sampled and shared with the public through adverts in Nigeria's *Guardian* and *Daily Trust* Newspapers. This was extended to influential people in the business community and the private sector as well as international bodies such as the DFID and the World Bank. With unrelenting advocacy by the core group of the Health Sector Reform Coalition, the House of Representatives also passed the Bill on July 8th before the annual recess and transmitted it to the Senate for concurrence.

However, it is important to note that advocacy on the Bill was not always ideologically homogenous. In fact, the passage of the Bill, led to an outcry by individuals and organizations (including the Catholic Church) who vehemently objected to some provisions of the Bill. Whereas professional bodies like the Nigeria Medical Association (NMA) campaigned for the Bill's speedy passage arguing that it provides a framework and strategies for the effective planning, financing, governance, delivery, monitoring and evaluation of healthcare services in Nigeria, others, including Pharmaceutical Society of Nigeria (PSN) and Coalition of Civil Society Organisations were fundamentally opposed to certain provisions of the law on such matters as abortion. In fact, these opposing CSOs formed a strong coalition modelled on religious convictions and cultural beliefs to ensure that the so called obnoxious provisions of the Bill were completely expunged. The coalition consisted of the following: Foundation for African Cultural Heritage (FACH), Catholic Medical Practitioners of Nigeria, Islamic Education Trust, Association of Muslim Scientists, Global Prof-life Alliance (GPA), Life Choice International Initiative, Project for Human Development (PHD), Nigerian Life League, Happy Home Foundation, Islamic Medical Association of Nigeria, Good Parenting and Youth Empowerment Initiative, Doctors Initiatives and Sympathy Worldwide Organisation, among others.

Advocates of the Bill were interested in both expediency but also the perceived benefits to Nigeria's healthcare system owing to the legislation. Thus, the advocated that the National Assembly amends sections of the Bill to expand the base for the participation of all relevant stakeholders. In particular, therefore, they lobbied to have the following sections of the Bill amended: Section 1(1), Section 6(2)(f), (g) and (h), Section 9(2) (a) and Section 13. In addition, the CSOs in this broad group wanted the Federal Ministry of Health have supervisory and oversight powers over government agencies including the National Primary Healthcare Development Agency and the National Health Insurance Scheme to ensure that the core objectives of the Bill are actualised. In this regard, they campaigned that Sections 48 – 59 of the Bill be deleted.

On the other hand, those CSOs with fundamental objections to the Bill argued that the 2011 version of the Bill essentially replicates the 2008 version which was denied presidential assent following public outcry against its core provisions. Thus, they insisted that the following sections of the Bill be deleted in their entirety: 17(1), 31(5), 32, 43(c) (d) (e) (f), 46(3), 50, 51(1) (2) (3) (4), 52, 53, 54, 55, 56, 57 and 58. At the centre of their contention is the conviction that the National Health Bill does not sufficiently address the real primary health challenges confronting Nigerians. Instead, it has been pre-occupied with issues that may be important in the long term and certainly for developed countries but not immediately relevant to Nigeria. Thus, they urged the National Assembly to widen public debate on the Bill so as to get input of Nigerians across every strata of the society. In effect, through the activities of these CSOs, the attention of Nigerians was drawn to the limitations of the Bill while the National Assembly was challenged to resist the urge to transplant legislations from other countries without adapting it to local realities.

In light of the outcry from faith based organisations as discussed above, the Health Sector Reform Coalition (HSRC) organised a series of workshops for all stakeholders and the media to discuss the provisions of the Bill and clear up some of the apprehensions of opponents. In particular, HSRC showed how the new version of the Bill differed from that of 2011 on which many of the arguments of opponents were premised. Additionally, as with earlier stages of the Bill, the Coalition reached out to what it termed 'champions' comprising of legislators, traditional authorities, heads of religious bodies, representatives of the business community and private sector, among others, to ensure that a harmonised and 'clean' version of the Bill was produced expeditiously for presidential assent.

The Coalition also sponsored and facilitated dialogue sessions between stakeholders and legislators from both Chambers to discuss areas of disagreement. In order to avoid ensure legislative compliance, the Coalition held an advocacy meeting with the legal department of the National Assembly. This helped to avoid delays similar to what happened in 2009 when the Bill was returned by the department because some of its provisions were in conflict with existing regulations. Similarly, furtherance of this objective, the Senate Committee on Health held interactive sessions with CSOs opposed to be Bill, including representatives of the Catholic Church, in order to reach agreement on controversial and unresolved aspects of the Bill.

The broad and high level consultations between the National Assembly, HSRC and other stakeholders went a long way in resolving many of the issues raised by those that were opposed to the Bill. Subsequently, the Conference Committee (consisting of Senate and House Health Committees) harmonised the Bill earlier passed by both chambers leading to the adoption of the harmonised copy of the Bill by both the Senate and the House of Representatives. The harmonised Bill was officially transmitted to the President for assent on October 28th 2014.

The role played by CSOs was not only restricted to legislative stages that rest with parliament. Following concurrence and due passage of the National Health Bill by both Chambers of the National Assembly and eventual transmission of the Bill to the president for assent, the Coalition carried out forensic scrutiny of the version of the Bill transmitted to the President by the National Assembly to ensure that it is the original passed by both chambers of the National Assembly. Whereas this may appear trivial, there have been cases where versions of legislations finally assented to are different from those passed by parliament. Given the tremendous effort CSOs put into ensuring that the National Health Bill reflected the challenges, peculiarities and interests of the Nigeria people, and also in light of the fierce opposition they mounted against some aspects of the Bill they considered antithetical to societal, cultural and religious norms of Nigeria, it was essential they ensured that their efforts yielded fruit. In trying to guarantee this, CSOs informed government of their willingness to take a legal route if the Bill passed is not the same as the 'clean copy' transmitted by the National Assembly after concurrence by both Chambers, the Senate and the House of Representatives.

Furthermore, the Coalition made several advocacy visits to the President of the Senate, Speaker, House of Representatives and the Clerk to the National Assembly to ensure swift transmission of the Bill to the President for his assent. The Coalition also engaged with presidential aides to understand the thinking and policy direction of government. The most prominent aide, the Senior Special Assistant to President on the National Assembly Matters, Hon. Saudatu Sanni. She became a dependable ally of the Coalition, working through power blocks to fast-track the legislative process, the Bill's harmonisation and its transmission to the President. This was done alongside a vigorous media advocacy to increase public awareness on the Bill mounted by the Coalition.

Additionally, the Coalition also canvassed the support of prominent Nigerians, including former president Olusegun Obasanjo, and other international figures. Similarly, it held several press conferences, made numerous TV appearances, held strategic meetings with professional bodies and religious leaders, organised engagement meetings with leaders and members of associations including the Market Women Association. Furthermore, the Coalition produced and circulated advocacy letters and position papers on the Bill.

According to Hope Lukeson HERFON- HSRC Head of Secretariat:

> All these were done to forestall a repeat of what happened in the Sixth Assembly when the National Assembly passed the National Health Bill but was not assented to within the 30 days stipulated by the Constitution. As a result, time and resources expended in the bill process were lost and the Bill had to be re-introduced in subsequent Assemblies. The process was time, energy and resources consuming. We did not want to have to go through this process for the third time.

The Coalition also engaged international partners including DFID, USAID, WHO and the World Bank to help win presidential assent. Though difficult to assess the impact of their actions, they might well have contributed to the pressure, especially in light of the concerns held by many political leaders, particularly at the UN, about Nigeria's problems reaching MDG 4 and 5. As validated by the former National Programme Coordinator, Partnerships for Transforming Health Systems Phase 2 (PATHSII), Dr. Mike Egboh:

> I believe that the last visit to Chief Tony Anenih by the members of the Coalition may have been the main driver to the President's assent. We went to him with a strong advocacy message tied to the PDP achievements of President Goodluck Jonathan's government. The visit also came at a time when Nigerians were yearning for a change in leadership, and the ruling party was struggling to show its achievements and remain in power. They needed to back something popular, like the National Health Bill.

Additionally, professional bodies also played a significant role in advocating for presidential asset. For instance, the Nigerian Medical Association organised several meetings between its delegates and the President as well as other stakeholders in the Executive arm of government in order to ensure that the Bill was promptly assented to by President Goodluck Jonathan. The Bill received presidential assent on 31st October, 2014.

According to Dr. Ben Anyene, former Chairman, Health Reform Foundation of Nigeria:

> The bill was eventually passed but the road was tortuous. So many distractions. Several versions of the original surfaced. These versions were eventually harmonized just to allow for passage even though the Bill was far from being perfect but our argument was imperfect Bill is better than no Bill. And that amendments can be done later. So you can imagine the rapturous reception presidential assent to the Bill received from all of us that had been involved in the process all these years.

Similarly, as observed by Aloysius Chidebe (HERFON), "getting the President to sign was not a forgone conclusion and neither was it easy. Personal relationships with the president were explored. A member of the Coalition made it possible for us to meet with the political godfather to the President to prevail on him to sign."

Furthermore, as attested to by Dr. Laz Ude Eze, Co-Founder African Youth Initiative on Population, Health & Development (ANDENOID) a key lesson learnt during this process is that "the bill process in Nigeria is characterized by many obstacles and passage does not even necessarily depend on adherence to conventional processes. Instead, advocacy has to be unrelenting as one has to go the extra mile lobbying different stakeholders and actors to ensure success".

The role of CSOs in advocating for the Bill has not been restricted to the legislative stages leading to the passage and presidential assent of the Bill. An important role of the legislature is oversight of the executive. This includes not just oversight of policy but also of project. Policy oversight pertains to the scrutiny of executive plans and policies by the legislature. Project oversight, on the other hand, is the scrutiny of projects and activities for which appropriation was made for by the legislature. The sole purpose of both facets oversight is to ensure value for money, curb waste and reduce corruption thus ensuring good governance. Thus, in the period post presidential assent to the National Health Bill, Civil Society Organisations have mounted a robust advocacy to ensure compliance and proper implementation. For CSOs, the Health Act provides a framework for re-organizing, re-energizing and re-focusing healthcare delivery in Nigeria. This buttresses the role of CSOs in ensuring rigour in the oversight provided by the legislature. By working with the legislature through knowledge management activities and informed advocacy, CSOs continue to play a major role as stakeholders in the health sector by ensuring people's ownership of the Act, contributing to the full operationalization and accountability in the implementation of the National Health Law.

On its part, the Civil Society Legislative Advocacy Centre, CISLAC, was concerned mainly with resource allocation in the health sector and thus conceived of the Bill as a means of ensuring that healthcare is finally available to Nigerians hitherto excluded. At the drafting stage, therefore, CISLAC, worked with the National Assembly to improve the quality of the bill especially as it relates to matters of coordination and networking to ensure greater impact. The group argued that the absence of proper organisational framework in the health sector has been the main reason why many Nigerians have been denied healthcare. Additionally, post-presidential assent to the Bill, CISLAC has equally been involved in legislative advocacy to ensure effective oversight of the health sector in light of the Bill's provisions.

Similarly, the White Ribbon Alliance for Safe Motherhood strongly campaigned for the establishment of an implementation committee to monitor the actual operation of the Bill after it was passed into law by the President. Particularly, they advocated for modernisation of the health sector in Nigeria and increased funding in line with the Act which provides that one per cent of the consolidated revenue fund will be allocated to the health sector. Further to ensuring that this provision of the Act is adhered, the group also called for transparent management of health budget through constructive engagement with the private sector and civil society groups.

4.4 Influence of Indigenous CSOs/NGOs on the Process of the Enactment of the National Health Act 2014

It is evident from the discussions above that a lot of the advocacy for the National Health Bill was done by indigenous CSOs. Their success can be attributed mainly to their knowledge of the legislative processes and key actors both in the National Assembly and the executive arm of government. These indigenous CSOs explored all forms of relationships of individual members and groups towards the actualisation of the Bill.

As explained by the Head of HERFON- HSRC Secretariat, Hope Lukeson:

> We set up a front desk and stationed a contact person at the National assembly to study the process of sponsoring a bill, to identify strong senators and honourable members that can sway the National Assembly for us. These persons were identified and targeted for sensitization and enlightenment on the Bill by the Coalition members… [also] all the legislators with health background in both chambers (Senate and House) were targeted to support the Bill. These include the likes of Iyabo Obasanjo, Elumelu Ndudi, but especially Senator Okowa, etc. We

> also lobbied other legislators in both chambers, those who were sympathetic to the Bill or had some affiliation to the Coalition.

The success of the Coalition as a grouping of indigenous groups can, in part, be attributed to its ability to exploit linkages with in both the legislature and the executive. The coalition identified and nurtured champions in both the Senate and the House of Representatives to advocate for the passage of the Bill. Critically, the Coalition sponsored exchange of experience visits for these legislators to expose them to best practice in healthcare across sub-Saharan Africa and the potential benefits of health sector reform. The Coalition was successful in convincing the National Assembly of its value as a technical partner. It invested in research which in turn made its advocacy work evidence-based. Through this effort, the Coalition bridged knowledge gaps, undertook cost-benefit and 'landscaping analysis' and shared the outcome with all relevant stakeholders, including ordinary Nigerians.

Moreover, the Coalition actively participated in the several public hearings held on the Bill, starting in 2004. As Champions for Change's Theresa Effa explains, they were a resounding success:

> The Health Act saw the best public hearings of our time as all and sundry were given the opportunity to contribute…In a critical step, the coalition looked to influence the Universal Periodic Review (UPR) – a unique UN mechanism. Advocacy visits ware paid to selected UPR embassies reviewing Nigeria's human rights practices. The coalition urged them to make the passage of the National Health Bill top of their recommendations to the Nigerian government.

The coalition held strategic sessions with the ministries of health and finance, NPHCDA, the National Health Insurance Scheme to get their buy-in and ownership. For example, the Federal Ministry of Health (FMOH) came to depend on the coalition to organise policy dialogues and sometimes provide technical support during public hearings on the Bill. The coalition worked to integrate government actors into the movement, helping the state to own the process. For example, the Coalition and FMOH have established a reference group to discuss the implementation of the Act. Efforts were made to engage other groups with influence on the president – forums were held with regulatory bodies, state ministers of health, and agencies such as the National Health Insurance Scheme and the National Primary Health Care Development Agency.

The Coalition's ability to forge compromise and consensus was its biggest success factor. It was able to do this horizontally among members, which created a sense of ownership among health professional associations and religious bodies, and vertically between the legislature, executive and the public. According to David Mark, Senate President during the 6th and 7th Assemblies, "we were not ready to allow the infighting of some health professional associations to stop the National Health Bill from being passed into law as that would be tantamount to disservice to Nigeria". The Coalition also brought together some of the major opponents to the Bill to the dialogue table. Recalling the Coalition's efforts, xxx stated that:

> ...when the Bill was smoothly passed by both the upper and lower chambers in August 2014, we [the Coalition] shifted our attention to the Catholic bishops. In a major breakthrough, several Bishops, headed by Cardinal John O. Onaiyekan, personally attended a meeting held by the coalition. The government delegation to the meeting was led by the Hon. Minister for Health, Prof. Onyebuchi Chukwu. For the first time, there seems to have been a number of areas in which the Catholic bishops and ourselves [Coalition] were able to find common ground, and there was a resolution to jointly move forward with the Bill.

Furthermore, to navigate diverse and politically volatile interests as well as the intricate legislative process, the Coalition adopted a strategy that eventually resulted in the successful passage of the Bill. These included: joint planning and resourcing; broadening the base of support; public mobilisation; engaging celebrities and international figures as champions; research and policy analysis; and engaging government and the legislative arm.

On joint planning and resourcing, the Health Reform Foundation of Nigeria (HERFON) served as the Coalition secretariat and developed the Coalition's yearly plans. They built a consensus around each member's core areas of expertise, experience and resources. The Coalition's success can also be attributed to its ability to broaden the support base and garner public support. They engaged key influencers including: the media, traditional and religious leaders, and professional medical associations. By so doing, they were able to address main concerns of stakeholders: Allied Health Professionals were concerned was the establishment of a tertiary commission to be headed by a medical doctor of more than ten years' experience; traditional and religious leaders had expressed reservations about some aspects of the Bill that were against their beliefs and teachings including trafficking in human ovarian eggs and sperms, and human organ pouching. Other interest groups to the Coalition include state

and local government officials and unions – including the Market Women Association and the Road Transport Workers Union. As Dr. Tunde Segun of E4A put it: "No other cause in this country has brought people of like-minds together this much."

Another critical success factor for the Coalition was public mobilisation through social media advocacy. Thus, in addition to public events and use of traditional media like TV and radio, the Coalition made use of social media. The Coalition held several Twitter chats and made effective use of the *#nationalhealthbill* hashtag to maximum effect in reaching out to millions numbers of Nigerians relying on social media for news and information. Also, the Coalition's use of celebrities and international figures in campaigning for the Bill helped in adding pressure on both the National Assembly and the President to expedite passage of the Bill as well as assent. Finally, the Coalition's was able to capture the interest of the public and the involvement of different indigenous Unions and Associations in its advocacy efforts. For instance, it was able to persuade the Market Women Association to support its campaign.

Even though indigenous CSOs led the advocacy for the National Health Bill, many international organisations were involved in the key stages of the process. The core funding for all major activities and events came primarily from HERFON, Save the Children, Partnership for Transforming Health Systems Phase II (PATH2) and Evidence for Action (E4A). Not only did organisations like DFID provide funding to HERFON and the Coalition, they also provided technical expertise, capacity building, and perspectives on international best practices. Thus, they helped to stimulate interest in the Bill, sustain advocacy for the Bill at the highest level and equip CSOs with the skills required to mount a successful advocacy on the Bill.

5. Conclusion: Lessons Learnt and Way Forward

This chapter has reviewed the contribution of civil society organisations to the passage of the National Health Act through various forms of legislative advocacy. As clearly shown, the role of CSOs spanned the various stages of the legislative process from First Hearing through to Presidential Assent. Furthermore, it has been shown that CSO engagement with the legislation continued post-assent through monitoring and tracking. Through their research too, CSOs have continued to assist the National Assembly in the exercise of its health oversight functions.

The role played by the various CSOs, regardless of their philosophical leaning, demonstrated that when CSOs are engaged in developing and reviewing national health plans, they can assist in identifying or sharpening national priorities and consequently help improve health outcomes. However, the ability of CSOs to be involved in health policy planning depends to a large extent to the prevailing political context. In the case of Nigeria, participation by CSOs in shaping the health policy at the national level was quite robust.

Some of the key lessons learnt and success factors identified include knowledge of the legislative process, ability to leverage on existing relationships and networks, and partnership with international partners, among others. The coalition's strategy of building rapport with government, giving it ownership of the process and acting as an ally rather than a critic proved highly effective in getting the Bill through. For instance, it was able to aggregate the interests of a diverse mix of national and international organisations with a focus on maternal, new-born and child health; as well as unusual alliances, such as with religious leaders and the Market Women Associations. Furthermore, from the onset, the Coalition developed clear objectives, and activities that contributed towards achieving those objectives. Also, given the irregular nature of the legislative calendar, the Coalition identified and worked with highly motivated partners who provided long-term institutional support and funding.

On the other hand, the Coalition experience several setbacks and incorporated the lessons learnt into its subsequent efforts. For instance, according to HERFON, the coalition failed to anticipate the dissatisfaction of some organisations and stakeholders to some sections of the Bill, notably the cost of setting up a tertiary commission and the leadership of the National Health Commission being given exclusively to medical doctors, not other competent professionals. This contributed the President's refusal to sign in 2011

However, despite the important role played by CSOs and their potential in informing and strengthening health policy in Nigeria, a lot remains to be done by way of strengthening their capacity to effectively engage in policy advocacy. This requires adept knowledge of government policy processes and structures around health in order to engage in any meaningful way. Similarly, more effective engagement with the National Assembly requires an understanding of the legislative process which can be characterised by a series of obstacles that collectively constitute a formidable barrier to the passage of a legislation (Dear & Patti, 1981).

There is also the need to put in place a framework that incorporates CSOs in health development and reform. Such a framework would formalize the relationships of CSOs with government and assist towards promoting accountability. In many countries, governments do not really agree that civil society has the right to be involved

in policy dialogue, or only pay lip service to it. In those cases, in particular, but in general as well, civil society involvement in policy process is often based on personal/individual relationships between civil society representatives and government officials. This underscores the need to formalise the relationship between the government and CSOs in Nigeria. In this regard, government can share health policy and planning documents with CSOs well in advance to allow for broader consultation by CSOs especially those operating at the sub-national level.

On its part, despite progress made by the National Assembly in engaging CSOs on the National Health Bill, a lot remains to be done to foster a more productive relationship between CSOs and the parliament. Often, engagement between the two has been antagonistic where NASS views CSOs with suspicion and tags them as "troublemakers" while CSOs regard NASS and its processes as opaque. The National Assembly can expand the frontier of its engagement with CSOs beyond the conventional means of public hearings and involve CSOs in its committee meetings and oversight activities. In particular, National Assembly oversight functions can benefit from the research and data generated by CSOs. Research is recognized as a fundamental ingredient for action, and it is essential for development because it informs policies and programs (Eisenberg, 2001; Neufeld & Johnson, 2001).

Furthermore, using the NHB as a case in point, CSOs can expand the reach of the National Assembly and serve as a barometer to test public opinion on policy issues. This is because some CSOs are embedded in various communities in which they work and often give voice to these communities.

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