Public Health Activism and the Role of Civil Society in Good Governance: Some Reflections on the Nigerian Experience

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Abstract

This paper examines public health activism and the role of civil society in good governance in Nigeria. Using historical method spiced with empirical observation, the paper attempt to establish that public health activism by civil society in the areas of tobacco smoking control, HIV/AIDS, Tuberculosis and Ebola Virus Disease impacted positively in engineering good governance by public health policy actors in Nigeria. The good governance catalyzed by civil society activism in the public health sector contributed to significant improvement in public health safety and the effective management of epidemics and health emergencies as evidenced in the cases of HIV/AIDS, Tuberculosis and the containment of Ebola Virus Disease. Based on these findings, the paper concludes that civil society activism, if properly harnessed, holds the key to public accountability and good governance in Nigeria, and by extension, Africa's emerging democracies.

Keywords: Public health, activism, Good governance, Nigeria, Civil society.

Introduction

The safeguard of public health has been the overriding interests of states and the basis for the establishment of political institutions. The sanctity of public health is recognised by the United Nations Universal Declaration of Human Rights (1948) that everyone has right to a standard of living that is adequate for health and well-being of himself and his family. Article 12 of the International Covenant on Economic, Social, and Cultural Rights (2015), affirmed the rights of people to enjoy the highest attainable standard of physical and mental health. Good health is central to human existence because it is basic to human welfare and critical to social and economic development (National Strategic Health Development Plan 2009; Federal Ministry of Health 2013).

Governments all over the world have responsibility either solely or in conjunction with other non-state actors to provide, maintain, and guarantee adequate public health system. In societies where citizens hold government accountable, the legitimacy of government may depend on how well and how best it is able to maintain and improve the public health system. In many parts of the world, especially in Africa, the capacity of states to deliver and maintain adequate public health, particularly in the face of recurrent national and transnational emergencies has been on the decline.

In Nigeria, the public health system has been experiencing intense strain characterized by weak and inadequate services, frequent industrial actions by health personnel, corruption, lack or inadequate equipment and health infrastructures, poor management of epidemics and public health emergencies and non-availability of drugs etc., mostly due to poor funding and the lack of accountability mechanism. These, among other emerging challenges faced by the different levels of government in dealing with public health situations in Nigeria, has increasingly brought to the fore the roles of civil society.

In Asia and Latin America, Civil Society Organisations (CSOs) have been involved in mobilizing effective demand for services, building awareness of community needs and experimenting in innovative approaches to service delivery that are later replicated by the government sector (Kankya, Akandinda, and Rwabukwali, 2013: 1278). It is needless to state that a vibrant civil society is necessary for improving the quality of services, accountability, transparency, and commitment to good governance (Omede and Bakare, 2014). Because of the significant roles

civil society play in promoting good governance, the international community has long recognized them as *sine qua none* to global sustainable development (UNAID, 2015).

In the last two decades, the roles, visibility, and influence of civil society on Nigeria's public health system has been on the increase. The rising profile of civil society has been accelerated by the ascendancy of neo-liberalism and the failure of the Nigerian state to meet the expanding healthcare needs of the citizens (Igbuzor, 2010). The inextricable nexus between the public health sector, the well-being of citizens and socio-economic development has further expanded the responsibilities of civil society to engage, mobilize and catalyse policy actors in the public health system towards good governance. It is against this background that this paper reflects on Nigeria's experience of public health activism by CSOs and its impact on good governance.

Conceptual Clarification and Review

Civil society, like many other concepts in social sciences, is highly contested and has remained nebulous, ambiguous, and fluid. Definitions offered by scholars on civil society have tended to reflect their intellectual, environmental, and ideological standpoint. In spite of this, attempts have been made by scholars to describe a civil society in ways that appeal to different audiences.

Ikelegbe (2013), defines civil society as the association of citizens voluntarily bound together by common interests, civil and public purposes, and capable of voluntary collective and autonomous actions. It is an arena in which people take common action to pursue common objectives without the reward of profit or political power. This definition connotes that common interests are the basis for the formation as well as the bond that hold civil society together. Civil society could be a way of describing aspects of modern society as well as an ideal of what a good society should be like. Connor (cited in Ghaus-Pasha, 2004: 3) describe civil society as composed of autonomous associations which develop a dense, diverse, and pluralistic network. As it develops, civil society will 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. This implies that constituents of civil society have a diverse background and not necessarily homogenous group making it a complex movement. Shils (1991: 4), corroborate this notion when he asserts that civil society consists of three main components:

The first is a part of society comprising a complex of autonomous institutions-economic, religious, intellectual and political- distinguishable from the family, the clan, the locality and the State. The second is a part of society possessing a particular complex of relationships between itself and the State and a distinctive set of institutions, which safeguard the separation of State and civil society and maintain effective ties between them. The third is a widespread pattern of refined civil manners.

It is needless to state that civil society is the sphere of social life outside the state, in which voluntary autonomous groups compete, collaborate, and cooperate over interests and preferences. It is the network of institutions by which citizens represent themselves, a realm of associational solidarity, activism and engagement, and a site of collective civic and public action (Ikelegbe, 2013: 6). Although the terms civil society, as explained above, is often used interchangeable with CSOs, there is a fundamental difference between the two. Where civil society is organized, it becomes CSO. It comes into existence when a group of people driven by common purpose come together in other to satisfy collective needs. According to Essien (2014), they can be in the form of associations, unions, mass organizations, networks, social organization, or social movement. CSOs, in their engagement with the state, play multiple roles in governance such as service provision, accountability demand from the state and market through representation and advocacy, building capacity of citizens to participate in governance, political education, political mobilization, legal aid, micro-credit services and childcare and reproductive health services to the people (Edwards and Foley, 2001; and Orji, 2014).

In Africa, due to a combination of factors, the capacity of states to maintain law and order and provide for the welfare of citizens is increasingly on the decline. As a result, great expectations are being placed on civil society to promote participation, empowerment, transparency, accountability, and good governance (Igbuzor, 2013: 3),

through their activism. It must be appreciated that the very existence of civil society by itself is not beneficial to society; their utility is found in their activism.

Activism involves a conscious social action either by individuals or group of people aimed at galvanizing, preventing, or influencing socio-cultural, environmental, political and/or economic reform on states with the desire to bring about positive changes in society. In other words, activism involves attempts to change the status quo, including targets such as social norms, imbedded practice, policies, or the dominance of certain social groups (Zoller, 2005: 344). Specifically, public health activism implies, at some level, a challenge to the existing order and power relationships that are perceived to influence some aspect of public health negatively or impede its promotion (Zoller, 2005: 344). It consists of movement by people and actions with the primary intent to promote, restore, or maintain public health. It includes efforts to influence determinants of health as well as more direct health-improving activities (Kankya et' al, 2013: 1277).

Public health activism are focused on a variety of issues within the rubrics of the health sector such as "health access movement" which focus on access to medical care; "constituency based health movement" which focus on health inequality among groups; and "embedded health movement" which focus on disease and illness experience, addressing "etiology, diagnosis, treatment and prevention (Brown, Zavestoski, McCormick, Mayer, Morello-Frosch and Altman, 2004: 50). Based on the foregoing, it is, therefore, safe to conclude that whatever sector civil society activism is targeted at, the ultimate objective is to ensure good governance. The big question then is, what is good governance?

Good governance, like the concept of civil society, has been defined differently by various authors. Babawale (2007), defines good governance as the exercise of political power to promote the public good and the welfare of the people. It embodies such principle as absence of lack of accountability in government, corruption, political repression, suppression of civil society, and denial of fundamental human rights. Furthermore, Babawale (2007) asserts that good governance is the presence of attributes such as transparency, accountability, demonstration of rationality in public policy, predictability, public access to information, respect for the rule of law and protection of civil liberties as well as press freedom in government business. Similarly, Ikotun (2004) observes that good governance has to do with performance in the management of state affairs for the purpose of enhancing human capacity, social well-being, and sustainable development in society.

According to Doornbos (20019: 4), good governance is used to invite judgment about how the country concerned was being governed: it enabled the raising of evaluative questions about proper procedures, transparency, quality and process of decision making, and other such matters. Thus, as Madhav (2007) rightly notes, good governance has much to do with the ethical grounding of governance and must be evaluated with reference to specific norms and objectives as may be laid down. The ethical grounding is better evaluated within the context of specific normative and/or legal framework. The United Nations Charter, in its preamble, for instance, unequivocally declared that the inherent dignity, equality and inalienable rights of all human beings is the foundation of freedom, justice and peace in the world (UN 1948). Thus, within the context of the United Nations, these values provides the ground norm to measure good governance.

Similarly, Article 3 of the International Covenant of Economic, Social and Cultural Rights provides that "States Parties to the present Covenant undertake to ensure the equal rights of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant" (ICESCR, 2015: 15). This means that any governance policy that aligned to those expressed in the Charter is "good governance." Conversely, any decision or policies within the jurisdiction of the United Nations that contravenes the intent of the Charter is "bad governance."

The Fundamental Objective and Directive Principle of State Policy of the 1999 Constitution of the Federal Republic of Nigeria laid out in Section 14(1) provides that, "the Federal Republic of Nigeria shall be a state based on the principles of democracy and social justice" (CFRN 1999 Constitution, as amended). This provision is strengthened in Section 16 (1 and 2) as follows:

The State shall, within the context of the ideals and objectives for which provisions are made in this Constitution…; (b) control the national economy in such manner as to secure the maximum welfare, freedom, and happiness of every citizen on the basis of social justice and equality of status and opportunity;… (2) The State shall direct its policy towards ensuring: (a) the promotion of a planned and balanced economic development; (b) that the material resources of the nation are harnessed and distributed as best as possible to serve the common good; (c) that the economic system is not operated in such a manner as to permit the concentration of wealth or the means of production and exchange in the hands of few individuals or of a group; and (d) that suitable and adequate shelter, suitable and adequate food, reasonable national minimum living wage, old age care and pensions, and unemployment, sick benefits, and welfare of the disabled are provided for all citizens (CFRN 1999 Constitution, as amended).

This constitutional provisions form the basis for evaluating good governance in Nigeria. Thus, good governance involves public perception of public policy compliance with stated objectives and established rules in ways that promote public good and welfare. Accordingly, Ogundiya (2010) asserts that good governance must relate to performance capacity of a government or the ability of leaders to steer changes desired by majority of citizens. By implication, the failure of governance could mean failure of leadership. Governance is said to be good when it achieves the desired goal of the state in terms of better welfare for people, social justice and the rule of law, security of lives and properties, enhanced political participation, among others. As Gberevbie, Oyeyemi, and Excellence-Oluye (2014: 85) rightly pointed out, accountability, transparency, and responsiveness on the part of government and its officials are the hallmark of good governance in any society.

Methodology

This paper adopt historical method for the purpose of generating data necessary for this research paper. Historical research relies on a wide variety and repository of facts which can be derived from primary or secondary sources as well as oral tradition. However, in this paper, evidence was derived from both primary and secondary sources. The primary sources include the use of public records, legal documents, and newspapers. Secondary sources comprised materials found in textbooks, encyclopedias, journal articles, newspapers, and magazines. In addition to these, the paper also draws on the author's personal observation and experience. The method of data analysis involved the use of prose, analytical deduction, descriptive statistical tools, and narratives.

Nigeria's Public Healthcare Context

Nigeria is a federation consisting of 36 States, a Federal Capital Territory (FCT) and 774 Local Government Areas (LGAs), with a population of 171 million people (UNICEF, 2013). Public healthcare in Nigeria is provided in three levels; the primary, secondary and tertiary, all of which are managed by the Local, State and Federal Governments, respectively (Yunusa, Irinoye, Suberu, Garba, Timothy, Dalhatu and Ahmed, 2014: 28). At the top is the Federal Government, which is responsible for tertiary healthcare and the formulation of national health policies (Nwakeze and Kandala, 2011). Both the National Health Policy (NHP) of 1988 and the Revised National Health Policy (RNHP), enunciated in 2004, are founded on Primary Health Care (PHC), as the bedrock for achieving sustainable public healthcare for Nigerians.

The major goal of PHC is to attain a comprehensive healthcare service through the provision of safe drinking water and sanitation, adequate nutrition, reproductive health, health education, maternal and child health, family planning, provision of essential drugs, disease control and immunization against infectious diseases. Despite the elaborate scope of the Nigeria's NHP document and its operation for nearly three decades, the country's health indicators are among the worst in the world as many of the health-related MDGs targets (ended in 2015) were not achieved.

Nigeria shoulders 10% of the global disease burden with persisting high prevalence of communicable and rising prevalence of non-communicable diseases. Life expectancy at birth is 49 years, while the disability adjusted life expectancy at birth is 38.3 years; vaccine-preventable diseases, as well as infectious and parasitic diseases,

continue to exact their toll on the health and survival of Nigerians (Omoluabi, 2014: 15). Key health indicators show that Nigeria has an estimated infant mortality rate of 75 per 1000 live births, child mortality rate of 88 per 1000 live births, under-five mortality of 157 per 1000 live births and a maternal mortality of 820 per 100,000 live births in 2008 (Egharevba, Imhonopi and Iruonagbe, 2015: 6). The infant and child mortality rate is worse than the Sub-Saharan African average and one of the highest in the world (UNICEF, 2013; Pharm Access Foundation, 2015). The main causes of infant and child deaths are pneumonia, diarrhea, malaria, and neonatal causes, compounded by under-nutrition and vaccine-preventable diseases (UNICEF, 2013: 3). In 2012, World Bank Development indicator database shows Nigeria's health indices as presented below:

Table 1: Nigeria's Public Health Indices

S/No.	Index	Nigeria's Figure	Ranking among Countries
1	Access to Sanitation	33%	115th of 129
2	Birth rate, crude per 1000 people	40.51	20th of 195
3	Children underweight rate	11%	14th of 95
4	Contraception	15%	77th of 89
5	Dependency ratio per 100	90	20th of 166
6	Drug access	1%	141st of 163
7	Expenditure per capital	$23	155th of 186
8	Hospital beds/1000 people	1.67%	98th of 149
9	Infant mortality rate	70.49%	33rd of 149
10	Life expectancy at birth	49yrs	170th of 194
11	Probability of reaching 65 years	42.1%	126 of 159
12	Total expenditure on health	4.7%	135 of 185 as % of GDP
13	Water availability	2,514 cubic (mtrs)	115 of 165

Source: Adapted from Egharevba, Imhonopi, and Iruonagbe (2015).

Malaria is the most important public health challenge and is responsible for 60% of outpatient visits to health facilities in Nigeria. Over 90% of Nigerians are at risk of malaria, with over 100 million cases per year and about 300,000 deaths. The Federal Ministry of Health estimates a financial loss of approximately $8.4 million per year. (Pharm Access Foundation, 2015: 11). In spite of the tremendous response over a period of two decades, HIV/AIDS epidemic has remained a major challenge with an adult prevalence of 4.1% and 3.14 million infected persons. This figure ranked Nigeria third after India and South Africa (Nigeria Global Health Initiative Strategy,

2011). In 2005 alone, there were about 220,000 HIV/AIDS related deaths in Nigeria. Also, Nigeria is among the 30 countries in the world with a high burden of Tuberculosis (TB), TB/HIV coinfections and drug-resistant TB with an estimated prevalence of 322 cases per 100,000 population with only 15% of the total burden being notified in 2015 (Onyedum, Alobu and Ukwaja 2017).

According to the Nigeria Global Health Initiative Strategy (2011), despite the considerable investment in the health sector over the years, there are marked inequities in the distribution of health services and resources between the rural areas and the urban centres. Similarly, there are infrastructural decay, inefficient management, weak referral systems, poor coverage and integration, unavailability or shortage of essential drugs and other health commodities, poor supervision, and widespread poverty. As a result, the public sector healthcare system is unable to provide basic, cost-effective services for the prevention and management of common health problems, especially at LGA, Ward, and community levels (Nigeria Global Health Initiative Strategy, 2011: 9).

The PHC, which is supposed to be the cornerstone of Nigeria's public healthcare system, caters for less than 20% of the target population (Abdulraheem, Olapipo, and Amodu, 2012), with about 20% of the 30, 000 PHC facilities not working (Aregbeshola and khan, 2017). In fact, since the introduction of the National Health Insurance Scheme (NHIS), in 2004, not up to 10% of the total population of the country have been captured in the scheme. Over 90% of those currently enrolled in the scheme are federal government employees. Most of the federating states and private sector employees are yet to be integrated into the programme. Professor Yusuf Usman, the suspended Executive Secretary of the NHIS confirmed this when he said that 90% of Nigerians eligible for the scheme had not been covered (Onyeji, 2018).

The deplorable state of health facilities and the lack of confidence in the country's public healthcare system, has resulted in high rate of foreign travels for medical treatment abroad by those who can afford the cost, including top government functionaries. The common destination for medical tourism by Nigerian patient include Germany, the United States, the United Kingdom, Switzerland, and lately, India. It is estimated that no fewer than 3,000 Nigerians travel to Indian, alone, every year (Omoluabi, 2014). According to Dr. Theophilus Ndubuaku, the National Secretary, Academic Staff Union of Research Institutions (ASURI), Nigeria loses $1. 35 billion annually to medical tourism which is more than the approximately $95 million allocated the health sector in the 2018 budget representing 3.9% of the total budget of $23.8 billion (Akor, 2018).

One of the major factors that accounted for the deplorable state of the public healthcare system in Nigeria is consistent underfunding of the health sector (Oyewunmi and Oyewunmi, 2014). Health sector funding has always fallen below the benchmark of 11% of GDP, as recommended by the World Health Organization (WHO). For instance, funding allocated to the health sector was 4.5% in 2009, 3.5% in 2010, 5% in 2012, 5.5% in 2013, 4.4% in 2014, 5.5% in 2015, 4.2% in 2016 and 4.1 in 2017, respectively (Omoluabi, 2014; Otaru and Nwaosu, 2015 and Onyeji, 2017). The provision of healthcare at PHC level is largely the responsibility of local governments with the support of state ministries of health (Abdulraheem, Olapipo, and Amodu, 2012: 5), yet, the Local Government is the least funded and less organized tier of government in Nigeria. Thus, primary healthcare has not been properly funded and organized, thereby creating a weak base for the healthcare system (Pharm Access Foundation, 2015).

The problem is further compounded by corruption and diversion of significant percentage of funds appropriated for the health sector into private pockets through fraud, sharp practices, mismanagement, and poor medical governance. Over the years, these, among others, have resulted in infrastructural decay, obsolete equipment, frequent industrial unrest, incessant strike actions, and inadequate and demoralize personnel leading to emigration of doctors and other health workers abroad in search of "better opportunities". It is estimated that about 2,392 and 1,529 Nigerian doctors practice in the United States and the United Kingdom, respectively, as at 2005. In 2010, the figure rose to 5,000 in the United States (Eme, Uche and Uche, 2014) and by 2017, about 35, 000 medical doctors from Nigeria were said to be practicing either in the United States or the United Kingdom (Okogba, 2017). The foregoing context, therefore, provided the incentives for civil society intervention and activism in Nigeria.

Some Reflections on the Nigerian Experience

Anti-Tobacco campaign is perhaps one of the public health concern that has enjoyed long period of public health activism by CSOs in Nigeria. It is arguably one of the public health issue in which civil society engagement with government took longer time before eliciting appropriate political and policy response. CSOs that have been active in the tobacco smoking control activism include: the Environmental Rights Action (ERA)/Friends of the Earth, Nigeria (FoEN), All Consumers Movement Union (ANCOMU), Doctors Against Tobacco (DAT), People Against Drug Dependence and Ignorance (PADDI), Nigerian Tobacco Control Alliance (NTCA), Citizens Centre, Educare Trust, The Nigerian Heart Foundation (NHF), Coalition Against Tobacco (CAT), and the Nigerian Cancer Society (NCS).

The anti-tobacco campaign by CSOs in Nigeria did not only focused on creating awareness and sensitization of the public on the adverse effects of tobacco smoking on public health but also exposed the negative corporate practices by Tobacco companies. CSOs adopted several strategies, including public lectures, roundtables, advocacy for change in excise tax rate regimes. For example, In January 2017, the Federal Government of Nigeria listed tobacco as a luxury goods and raised import duty on tobacco from 20 percent to 60%. The ERA/FoEN urged the government to impose a minimum of 150% special levies on all tobacco products in order to reduce its consumption in Nigeria (*ThisDayLive,* 2017; *Nigerian Current*, 2017).

Since 1990, Nigeria has consistently marked the World No Tobacco Day (WNTD), driven by civil society until late 2000, when the Ministry of Health began to organize the event (Drope, 2011). Efforts were made to facilitate the enactment of effective policies that will create the needed supportive environment to enable Nigerians enjoy healthy lives; and be protected from the greed of tobacco transnational corporations such as the British American Tobacco [BAT] (Ekine, 2008). More recently, CSOs have used litigation as instrument of activism on tobacco control in Nigeria. On the 30 April 2017, the ERA/FoEN with the former Attorney General and Commissioner of Justice, Lagos State, Prof Yemi Osinbajo (now Vice President, Federal Republic of Nigeria), instituted a legal proceedings against five tobacco companies namely; British American Tobacco-Nigeria (BATN), International Tobacco Limited, BAT, BAT (Investment) Limited and Philip Morris International (PMI), in order to recoup the sum of N2.5 trillion expended on sick victims of tobacco products (Drope, 2011).

In spite of many years of civil society campaign against smoking of tobacco, successive governments have occasionally raised alarm over increasing rates of smokers in the country, but consistently failed to take concrete measures to enforce tobacco smoking control. Thus, the quantity-specific excise tax on cigarettes of 40 percent of the price and 5 percent import duty was maintained for a long period of time. It was not until 1990 that the Federal Government took a significant policy measure on tobacco control with the promulgation of the Tobacco Smoking (Control) Decree 20, 1990 (later converted to "Tobacco Control Act 1990 CAP. T 16" in 2001, following the return to democracy), after years of civil society activism. In 1999, government took further steps on tobacco control when a National Smoking Cessation Committee was constituted. These, among other series of action, led to the enforcement of a ban on tobacco advertisement by the Advertising Practitioners Promotion Control (APCON), of Nigeria in 2002.

In 2004, Nigeria signed the Framework Convention on Tobacco Control (FCTC), and paid its voluntary FCTC contribution to the World Health Organisation (WHO), up to 2007. The Federal Government also stopped the establishment of a multi-million dollars tobacco factory by the Imperial Tobacco Group in Osun State as a demonstration of its commitment to tobacco control (Drope, 2011). In Abuja, the Federal Capital Territory (FCT), tobacco smoking in public places was banned on the 1st June 2008 (Ekine, 2008). When the Tobacco Control Bill went through the first reading in the National Assembly, BATN made frantic and desperate efforts to quash the Bill. However, vigorous campaign by CSOs led to the eventual passage of the Bill by the Senate on the 11th March 2011 and subsequently signed into law in 2015, as the National Tobacco Control Act, 2015.

The increasing global trend towards democratization has opened up the political space for CSOs to play a more active policy influencing roles. The promise of democracy becomes a reality when people's voices are heard by policy makers and when groups (especially marginalized sectors of society) begin to participate in the

marketplace of competing interests (Gausha-Pasha, 2004: 17). In Nigeria, civil society activism has contributed significantly to the rising profile of good governance practice in the public health sector. The HIV/AIDS response in Nigeria, for instance, made huge progress because of the significant contributions of CSOs. Since HIV/AIDS became a public health concern in Nigeria in the 1980s', CSOs have been critical in ensuring successful implementation of quality HIV services, more significant stakeholders' input into HIV policymaking as well as increased focus on the human rights of key population and people living with HIV (UNAID, 2015: 1), at all levels of government. Currently, seven states namely; Lagos, Benue, Cross River, Kaduna, Ogun, Enugu, and Nasarawa have passed HIV anti-discrimination laws (National Agency for the Control of AIDS, 2016).

In 2001, as part of the commitment to reverse the HIV epidemic, the United Nations endorsed the Greater Involvement of People Living with HIV, known as the GIPA Principle. The principle emphasizes the rights of people living with HIV to self-determination, creating enabling environment for people living with HIV, ...and improving the overall quality and effectiveness of the AIDS response (UNAID, 2015). This development further opened the space for public health activism by CSOs such as the International Community of Women Living with HIV (ICW), International Planned Parenthood Federation (IPPF), and the Global Network of People Living with HIV (GNP+), in addressing the evidence gap on HIV-related discrimination and stigmatization. The activities of these civil society groups significantly contributed to the reduction of discrimination and stigmatization of people living with HIV and AIDS (Awofeso, 2011).

A number of CSOs have been active in mobilizing stakeholders and promoting good governance in the management of the HIV pandemic in Nigeria. CSOs such as the HIV/AIDS Network, the Network of People Living with HIV/AIDS (NEPWHAN), and the Nigeria Youth Network on HIV/AIDS (NYNETHA), have focused primarily on representing their members, facilitating access to government support and gaining inclusion of their interests in policy priorities. Others like the Planned Parenthood Federation of Nigeria (PPFN), the Initiative for Equal Rights, Health Reform Foundation of Nigeria (HERFON), Civil Society Network for HIV and AIDS (CISHAN), and Journalists against AIDS (JAAIDS), adopted mixed approach of advocacy and service delivery. These CSOs were involved at different levels of the national multi-sectoral strategy such as the review of National HIV/AIDS Policy, participation in the National Strategic Plan (NSP) development, interface with the House of Representatives Committee on HIV/AIDS as well as advocacy and participation in the review of the National Strategic Framework (NSF). They also actively participated in the planning and budgeting process for the NSP on HIV both at the state and national level (GARPR, 2014: 32)

The contributions of CSOs in tackling the HIV and AIDS epidemic in Nigeria has been significant. Their activism have influenced some remarkable policy and legislative measures in the country. While CSOs activism prevented the enactment of the Same Sex Marriage (Prohibition) Bill by President Goodluck Jonathan in 2014, they, however, succeeded in pushing for the HIV Anti-Discrimination Act 2012 to be signed into law. Similarly, HIV criminalization was removed from the anti-discrimination and stigma Bill and signed into law in February 2015 (Williamson and Rodd, 2016). Furthermore, there were significant policy response by the different tiers of government as well as marked efforts at improving health facilities. The NSP on HIV is updated every 5 years as a matter of national policy. The most recent NSP ended in 2015 (Williamson and Rodd, 2016).

Unlike HIV/AIDS and breast cancer, public health activism by CSOs on TB control in Nigeria has been on the low ebb before 1999. Public health campaign on TB has mostly been limited to occasions of World TB Day. This attitude is also reflected in government commitment and funding allocation to TB control and treatment programmes across the country. However, the growing awareness of the inextricable connection between HIV and TB and the need to mainstream TB into HIV/AIDS intervention dramatically increased and expanded civil society commitment to TB control. CSOs such as Ummah Support Group, Global HIV/AIDS Initiative Nigeria (GHAIN), and Living Hope Care Organisation (LIVHORG), have been providing educational and necessary adherence support to TB/HIV co-infected members (Public Health Watch, 2006).

Increased public knowledge on TB control as integral part of comprehensive HIV/AIDS care gave further impetus to civil society activism on TB control in Nigeria. These campaign by civil society has led to improved government

response on TB control. Former President Olusegun Obasanjo, who assumed office in 1999, for instance, demonstrated great political commitment to TB control through active participation in high-level meetings of the Stop TB Partnership, African Heads of States, the African Union, and the World Economic Forum (Public Health Watch, 2006: 150). The government demonstrated its will to combat TB when it adopted the Amsterdam Declaration and enunciated federal policy on TB control. President Obasanjo also hosted the Summit of African Heads of State on TB, HIV/AIDS, and malaria in 2001, and +5 Summit in 2006 culminating in the Abuja declaration to combat TB, HIV/AIDS, and malaria (Public Health Watch, 2006).

During the Ebola Virus Disease (EVD) outbreak in a number of West Africa countries, civil society groups mounted a sustained campaign and pressure on the Nigerian government to initiate and take preventive measures to avoid the transmission of the EVD into Nigeria. Social media such as Facebook pages, twitter feeds, and other social media sites/platforms were particularly useful sources in public health activism. The Nigerian Government, in spite of its fore knowledge that the virus was spreading, neglected to put in place concrete preventive strategies.

The EVD entered Lagos, Nigeria on the 20th July 2014, through an infected Liberian diplomat, Patrick Sawyer. Patrick Sawyer was on his way to Calabar, Cross River State, for a conference of the Economic Community of West African States [ECOWAS] (BPSR, 2015: 31). This happened at a time when the Nigerian Medical Association (NMA), were on a nationwide industrial action against the government. After an initial refusal, it later called off its members from the industrial action following appeals from different segments of the Nigerian populace and civil society groups (Oyewunmi and Oyewunmi, 2014). The First Consultant Medical Centre, Obalende, Lagos (a private medical hospital) on suspicion that Patrick Sawyer was infected with EVD confined him to the hospital, despite claim of human rights violation and threat of legal action.

Following the confirmation of the index case, rapid actions were taken by both the Federal and Lagos State Governments. Former President Goodluck Jonathan immediately declared the event a public health emergency and approved the release of N1.9 billion (USD $11.5 million). This include a grant of N200 million to each state for the implementation of EVD containment programs, including the creation of additional isolation centers, contact tracing, case management, among others (BPSR 2015). A number of CSOs such as HAPPYNigeria, Community Life Project (CLP), Media Rights Agenda (MRA) and Civil Society Legislative Advocacy Centre (CISLAC), complimented government efforts, especially in sharing information and disseminating best practices through seminars and sensitization campaigns to increase public awareness on prevention and care. Others like the International Emergency Management Society (TIEMS)-Nigeria/West African Chapter, canvased for transparency and accountability in the management of the N1.9 billion (US $11.5 million), Special Intervention Fund (SIF), released by the Federal Government (*Premium Time*, 2014).

It is needless to say that the role played by CSOs in raising public awareness on the danger of the EVD galvanized the Federal, State Governments and other stakeholders to provide strong and decisive leadership at both the national and sub-national levels to contain the EVD. It is also worthy of note that Former President Goodluck Jonathan, the former Governors of Lagos and Rivers State, Babatunde Fashola and Rotimi Amaechi, and the then Minister of Health, Prof. Onyebuchi Chukwu, demonstrated excellent leadership qualities by eschewing their party and political differences to work together. Government adopted several strategies such as intensive public awareness and sensitization campaign, screening for all arrivals/departures at land, air and sea borders, banning of transportation of corpses, delay in the reopening of school, training and retraining of medical personnel and the provision of personal protective equipment to health workers (BPSR 2015).

Challenges Confronting Civil Society in Public Health Activism in Nigeria

In spite of the immense contributions of civil society to good governance in the Nigeria's public health sector through activism, CSOs are confronted with many challenges that militate against their effective functioning. Some of the challenges are discussed below:

CSOs have found it increasingly difficult to secure funds for their activities because their limited sources of funds are increasing insufficient to meet growing public needs and expanding potential areas of intervention. Other factors contributing to this situation are increase in the number of CSOs, lack of government investment in CSOs, and the changing political agendas of the donors from which the CSOs derive much of their funding (Ogbogu and Idogho, 2016: 305). As a result, local CSOs face several funding constraints in mobilizing the citizens to engage the government on public health reforms. Specifically, these challenges range from difficulty in mobilizing funds to set up and maintain advocacy groups for building and sustaining the momentum behind initiatives, to the cost of maintaining a reliable communication infrastructure in a country like Nigeria with unreliable power sources (Songonuga, 2015).

Closely related to poor and inadequate funding is the problem of donor influence or control on CSOs' activities. Due to limited local funding sources, most Nigerian CSOs look beyond the national borders to fund their activities leading to donor-dependence on external sources (Omede and Bakare, 2014; Okafor, 2006; and Ikelegbe, 2013). This has created donor-driven CSOs and donor-driven areas of focus since it is the donor that controls the purse strings-regardless of what issues the average citizen may actually be interested in advancing (Ottaway, 2000: 270). For instance, international funding for HIV/AIDS control from 2006 to 2012 has been on service delivery roles of preventing and mitigating the effects of HIV/AIDS rather than policy analysis and advocacy (Williamson and Rodd, 2016). CSOs with keen interest in advocating for better government services, improved policies and accountability demand in HIV/AIDS responses received little funding (Williamson, 2013; Williamson and Rodd, 2016; and Ogbogu and Idogho, 2016). Such donors compelled local CSOs to comply with programmes such as standard accounting system, minimum service packages, programme monitoring mechanism, reporting standard, site inspection, and budget review in order to keep them aligned with donor priorities. In the very few cases where federal funding occurs, the CSOs seems to be an extension of the federal or state patronage system (Songonuga, 2015: 92).

Poor funding and donor demand on CSOs in Nigeria affect their independent development and ability to contribute significantly to national development. To address these challenges, CSOs should look inward by expanding their membership base across the country and source funding through contributions by members. Another way is to seek legislative measures that would create a consolidated trust fund from where registered CSOs could apply for funds. This will reduce the dependence of CSOs on the government and foreign donors, enhance their independence and legitimacy in dealing with the state and other stakeholders including international donors. Also, donor agencies can channel their funding toward grassroots associations and professionalize them in a manner that fosters their ability to balance foreign funding with local interests (Ottaway, 2000).

Similarly, because most external funds for CSOs to drive public healthcare response in Nigeria has been on programme and project implementation, most local CSOs lack a deep understanding of public health issues beyond implementation. Thus, the ability of CSOs to engage fully in policy analysis, policy development, and their capacity to influence policy process is limited. In other words, local CSOs lack the technical grasps, advocacy skills, and networking resources necessary for successful health reform advocacy (Williamson and Rodd, 2016). Thus, donors should be willing, therefore to support holistic development of local CSOs, and deepen their understanding of networking and collaborative programming (Ogbogu and Idogho, 2016), through workshop, conferences, and training, etc.

While CSO activism on HIV/AIDS, EVD containment and Tobacco control have enjoyed relatively higher media coverage, reporting on TB issues has been mainly event-driven. This is in spite of the growing awareness of the linkage between TB and HIV/AIDS epidemic. Reports on TB are mostly featured during or near World TB Day. Such stories mostly focus on government spending on TB control and the availability of free TB treatment (Ogundipe. 2006). Press coverage of CSOs engagement with government on TB control has been generally low. Even the media has not played significant "watchdog" role on government TB response, particularly in reviewing policies and evaluating the impact of programme implementation. There has been little investigative reporting

on controversial matters such as the federal health budget, and insufficient government contributions to TB programmes (Ogundipe, 2006).

Poor media coverage of CSO-TB activism in Nigeria has been attributed to insufficient knowledge by editors and journalist of TB, in addition to difficulties in obtaining information on the implementation of TB programmes from government officials and other stakeholders. By contrast, HIV/AIDS reporting enjoy wider information sources. To close the gap and increase media coverage of CSO engagement with government on TB and other public health matters, there is need for targeted efforts to educate and mobilise media owners, editors, and journalist on the economic and social effects of TB and other public health epidemic on Nigeria. Media training should focus on improving skills for investigative reporting; assessing government policy, budgets, and spending; and monitoring government policy vis-à-vis international commitments (Ogundipe, 2006: 53). Equally, the Public Information Act has to be effectively implemented, so that information and data is available on government operations and activities (Ikelegbe, 2013: 64).

Another important challenge is the concentration of CSOs in major cities and urban centers such as Lagos, Abuja, Kano, Port Harcourt, and Kaduna, etc., at the expense of the rural areas. This has narrowed membership base and weakened the links between CSOs and their primary constituencies (Kankya et al 2013). Okafor (2006) observes that since most CSOs in Nigeria are externally funded and locally managed, as opposed to funding by members from the grassroots population, the founders/CEOs run the affairs of CSOs with few effective internal checks by the local community. The lack of transparency as well as mismanagement and conversion of donor funds into personal use by some CSOs have all combined to create mutual suspicion and mistrust between CSOs and the grassroots population whose interests they want to advance. The exclusion of grassroots population from the ranks of the CSOs have often presented a challenge when the need to mobilize the citizens to engage the government on public health reforms and other matters arises. Similarly, many of these ethical issues have tended to weaken CSOs' moral right to engage the state effectively.

The above challenges can be addressed through the enactment of relevant laws that would provide regulatory framework for CSOs. Such laws should provide for the establishment of a regulatory agency dedicated to ensuring smooth operations of CSOs in Nigeria without necessarily compromising their independence. Similarly, the laws should ensure that ownership of CSOs is broadened to accommodate community participation. This implies that rather than sitting atop specified constituencies, the constituencies should be actively and adequately represented in the leadership, membership, and work of the CSOs (Ikelegbe, 2013: 64). In the same vein, their funding, expenditures, and activities should be subject to public scrutiny either quarterly or annually as may be deemed expedient by the law.

Although, CSOs have made their mark in the fight against HIV/AIDS, TB, the containment of EVD and tobacco control, their response is still fragmented. Relationships between CSOs is characterized by mistrust and competition with limited collaboration and partnerships (Ogbogu and Idogho, 2016). Sometimes, this division reflect ethnic and religious cleavages; and often culminate into unnecessary disagreement among CSOs on appropriate and timely courses of action. The mistrust and competition among them also affect their access and sharing of vital information and data that would otherwise help them make informed collective decision. Petty jealousy and limited cooperation among CSOs have affected their capacity to engage and sustain a successful public health reform activism in Nigeria.

Founders/CEOs of CSOs should see themselves as partners in progress (not competitors), who have social and moral responsibility to intermediate between the state and society as well as advance and protect the interests of the citizens. This is possible through the forging of constructive partnership among the various CSOs. Furthermore, through recruitment of diverse segments of the Nigerian society, particularly, grassroots population into leadership and membership ranks would dilute the "founders' syndrome" and the personification of CSOs. This would consequently douse tension and sense of competition among CSOs in Nigeria.

5.0 Conclusion and Recommendations

There is no gain saying that civil society activism on public health in Nigeria has contributed significantly to good governance in the health sector. Civil society, apart from their roles in creating the platform for citizens to demand accountability from government and other public health stakeholders, were critical in providing a wide range of experience, knowledge, as well as insights into gaps in health service delivery. Similarly, they play key roles in the identification of practical and political challenges that are crucial for attaining improved public healthcare for Nigerians. Activist roles by CSOs were significant in galvanizing policy changes, greater transparency and accountability of governments and other public health sector managers. The positive impact of civil society activism on public healthcare delivery system and the management of epidemiological emergencies as evidenced by the successes of the anti-tobacco campaign, the management HIV/AIDS, TB control and the containment of the EVD in Nigeria.

Despite the myriad of challenges faced by civil society in Nigeria, the successes recorded in anti-tobacco campaign, HIV/AIDS and TB response, and the containment of EVD in Nigeria is a testament to the fact that civil society activism if properly harnessed holds the key to public accountability and good governance in Africa's emerging democracy. In the vein, successes of civil society engagement with policy actors in Nigeria's public health sector can be further develop into a model of state-society relations that can be exported to sister African countries and other parts of the world.

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