ACHIEVING EQUITY IN ACCESS TO REPRODUCTIVE HEALTHCARE: LESSONS FROM COVID-19 CORPORATE SOCIAL RESPONSIBILITY INITIATIVES

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Abstract

Nigeria currently has very poor maternal health outcomes arising from inequitable provision of maternal health services. About 1 in 25 women are at a lifetime risk of dying from pregnancy related complications in Nigeria. Deaths occurred mostly from preventable causes which could be averted if women have access to maternal healthcare services (AMHC). Maternal Healthcare needs are peculiar to women and thus, this paper asserts that maternal health care issues need be addressed from a gendered and equity view point. This study adopts a doctrinal method relying on primary and secondary sources to justify AMHC. The study relies on the principles of equity of access in provision of health care services to highlight the need for enhanced AMHC. The study finds that AMHC has been fragmented and has not contributed significantly to reducing deaths arising from maternal causes in Nigeria. The study also finds that the concerted efforts made by corporate organizations to combat the COVID-19 pandemic yielded positive results and contributed significantly to reducing the negative impacts of the pandemic. The study evaluates the response of the Nigerian government and other stakeholders to ensure access to needed health care by COVID patients. The study concludes that the major lesson from the corporate social responsibility (CSR) Initiatives during COVID was the unified front put forward by corporate organizations to achieve a common goal of reducing the effects of the pandemic. The same approach has the potentials to save women from preventable deaths arising from maternal causes. The study recommends improved AMHC in Nigeria through concerted and unified CSR measures.

Keywords: Corporate Social Responsibility, Equity of Access, Maternal Health, Maternal Mortality, CSR Initiatives

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1. Introduction

The Corona Virus Disease (COVID 19) broke out late 2019 when the virus was first discovered in Wuhan, China. The virus spread across 216 countries leading to the declaration of the COVID-19 as a global pandemic by the World Health Organization (WHO) in March 2020.[1] The first case of COVID-19 was reported in Nigeria in February 2020. Between February and June, 2020 a total of 12, 486 cases have been confirmed with 354 recorded deaths.[1] The Nigerian government's swift response to the pandemic has been quite commendable as well as the response from corporate entities which floated corporate social responsibility (CSR) based programs to address the pandemic and alleviate the hardships occasioned by the pandemic.

The fact that some of the health issues which has not received the much-needed attention from government over the years have much higher morbidity and mortality rates invokes some level of curiosity leaving one to wonder why the government has not given the needed attention to address other health emergencies with the same swift response, vigour and commitment. Access to reproductive health care (ARHC) for instance remains a huge challenge for women in Nigeria.[2]

Available data reveals that the MMR in Nigeria stands at 993 per 100,000 live births.[3] Nigeria currently has very poor maternal health outcomes. In 2023, about 75,000 maternal deaths occurred in Nigeria, one of the highest across the globe.[4] About 1 in 25 women are at a lifetime risk of dying from pregnancy related complications in Nigeria.[5] These deaths are mostly from preventable causes which could have been adverted if women have access to maternal healthcare services (AMHC). Tasneem *et al*[6] reported enclampsia, pre-enclampsia and haemorrhage as the leading causes of maternal mortality in Nigeria. They noted that the above conditions are preventable if pregnant women have regular antenatal check-ups for early detection and if women have access to skilled birth attendants to assist

1. D Cucinotta and M Vanelli, —WHO Declares COVID-19 a Pandemic *Acta Biomed*. (2020) 91(1) 157-160. doi: 10.23750/abm.v91i1.9397. PMID: 32191675; PMCID: PMC7569573.

[2] AE Ogedegbe, O Adeagbo, BM Yankam, O Badru, MA Gadanya and LE Bain, _Two decades of women's sexual and reproductive health and rights in Nigeria: Successes, challenges, and opportunities' *African journal of reproductive health* (2025) 29(1) 25-37.

3 Trends in maternal mortality estimates 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: WHO; 2025.

4 ibid

[5] ibid

[6] S Tasneem, A Nnajı and MA Ozdal, _Causes of maternal mortality in Nigeria; a systematic review' *International Journal of Health Management and Tourism* (2019) 4(3) 200-210.

delivery. The number of maternal deaths arising from poor access to maternal healthcare services calls for concern and there is need for a holistic approach to resolving this crucial issue.

Whilst not attempting to downplay the severity of the COVID-19 pandemic, the focus of this paper is to make a case for increased commitment by government and stakeholders to address issues of equity in ARHC in Nigeria in the context of reproductive rights of women. Over the years, numerous excuses have been given by government for the failure of government to effectively guarantee ARHC for women including inadequate funds.[7] Majority of the related literature[8] on this subject area have not explored tackling the menace of maternal mortality from the perspective of the concerted efforts by the government and corporate organizations. The objectives of this study therefore are to discuss the concept of access in the context of reproductive health care; to justify ARHC for women relying on the principles of equity and vulnerability; to evaluate the response of the Nigerian government and other stakeholders' response to the COVID-19 pandemic and efforts to ensure access of COVID patients to needed health care; and to highlight the practicability of achieving improved ARHC for women in Nigeria through CSR measures.

2. Access to Reproductive Health Care

The importance of healthcare can be traced to Aristotle's concept of *eudaemonia* meaning flourishing.[9] In the context of reproductive health, it means provision of all that is fundamentally necessary to a good life that aids reproduction. As such, reproductive health depends upon the extent to which poor and vulnerable groups can realize their rights to economic and social resources.[10] Menzel and Light stressing the importance of access in the healthcare context posits that access to medical services is necessary to individual

[7] MO Folayan, O Arije, A Enemo, A Sunday, A Muhammad *et al,* Factors associated with poor access to HIV and sexual and reproductive health services in Nigeria for women and girls living with HIV during the COVID-19 pandemic *African Journal of AIDS Research* (2022) 21(2) 171-182.

[8] Ogedegbe *et al* (n.2); Tasneem *et al* (n.6); AM Adesina and A. Adegboye, _Maternal mortality in Nigeria: trend, triggers and implications for sustainable development' *American Journal of Life Sciences* (2020) *8*(5) 135-143; EK Ekwuazi, CO Chigbu and NC Ngene, _Reducing maternal mortality in low-and middle-income countries' *Case Reports in Women's Health* (2023) *39*, e00542.

9. AJ Culyer, _Equity- Some Theory and its Policy Implications' *Journal of Medical Ethics* (2001) 27(4) 275-283.

10. NL Price and K Hawkins, _A Conceptual Framework for the Social Analysis of Reproductive Health' *Journal of Health, Population and Nutrition* (2007) 25(1) 24-36.

freedom, opportunities and self-responsibility just as access to the services of fire or police departments.[11]

The definition of what constitutes access is however fraught with many controversies. As far back as 1982, Daniels was of the view that access is a complicated notion which comprises of and is to be determined by various factors.[12] In the context of health care services, the fact that health care itself is non-homogeneous further compounds the problem of defining access. Ramsey describes the complexities in health care and difficulty in ascertaining priorities as one that is —incorrigible to moral reasoning‖[13] while Thomasma describes the healthcare system as a complex political, public policy and ethical issue.[14] The US Institute of Medicine defined access as the —timely use of personal health services to achieve the best possible outcome.‖[15] On their part, Oliver and Mossialos defined access to healthcare as the ability to secure and have needed information on a specified set of health services at a specified level of quality, subject to a specified maximum level of personal inconvenience and cost.[16]

The fact that access is a multi-dimensional concept[17] makes it difficult for scholars to reach a full consensus on its dimensions.[18] The factors that come into play in health care delivery will include process factors, factors of utilization as well as measures of satisfaction. The fact that health is affected by so many determinants also further complicates the discussion on access. Nevertheless, the fact is that poor ARHC is one of the primary causes of the high morbidity and mortality of women cannot be denied.

11. P Menzel and DW Light, _A Conservative Case for Universal Access to Health Care‘ *The Hastings Center Report*. (2006) 36(4) 36-45.
12. N Daniels, _Equity of Access to Health Care: Some Conceptual and Ethical Issues‘ *The Milbank Memorial Fund Quarterly Health and Society* (1982) 60(1) 51-81.
13. P Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven: Yale University Press, 1970), 240.
14. DC Thomasma, _Access to Health Care for the Elderly‘ *Business & Professional Ethics Journal* (1993) 12(2) 3-17.
15. ML Millman, *Access to Health Care in America (*Washington, DC: Institute of Medicine, National Academy Press, 1993), 18.
16. A Oliver and E Mossialos, _Equity of Access to Health Care: Outlining Foundations for Action‘ *Journal of Epidemiology and Community Health* (2004) 58(8) 655-658.
17. Y Choi, MS Fabic and J Adetunji, _Measuring Access to Family Planning: Conceptual Frameworks and DHS Data‘ *Studies in Family Planning* (2016) 47(2) 145-161.
18. J Mensah, _The Global Financial Crisis and Access to Health Care in Africa‘ *Africa Today* (2014) 60(3) 35-54.

The Committee on Economic, Social and Cultural Rights (CESR) identified availability, accessibility, affordability and qualitative as the principles of access.[19] This is similar to the view of access as summarized by Penchansky and Thomas. To them, access must include the Five As to wit: availability of services, commodities, personnel and resources to meet the user's needs; accessibility of the geographic location of facilities in relation to the user; accommodation of user's preferences by providers including hours and appointment schedules and walk-in services; affordability of provider's fee by users; and accountability of the provider in the context of user satisfaction.[20]

Ibiwoye and Adeleke emphasized the fact that cost among other factors remains the weightiest factor that impedes quality access to care in Nigeria.[21] This is not surprising in a country like Nigeria which ranks 157th in the Human Development Index (HDI) for 2018.[22] The HDI report reveals that 53.5% of the Nigerian population live below income poverty line of $1.90 USD per day.[23] Hence, the level of poverty in the country is unlikely to encourage out-of-pocket spending of limited funds on seeking needed health care.

Based on the foregoing, ARHC must therefore be such that encompasses availability, affordability, acceptability of needed healthcare services to the user's satisfaction without any hindrance or barrier.

3. Equity of Access in Provision of Healthcare Services

Equity as is known to law is based on principles developed by the courts of chancery to address unfairness and injustice. In the same token, the issue of equity in health care is one that is still evolving. One of the trending focuses of the World Health Organization is to address health inequity which is a major concern in both developed and developing countries.[24] Part of the measures to address the health inequity and ensure the closing of the

19. CESR General Comment No. 14. The Right to Highest Attainable Standard of Health (11/08/00) E/C.12/200/4. 22nd Session 25th April-12th May 2000.
20. R Penchansky and JW Thomas, _The Concept of Access: Definition and Relationship to Consumer Satisfaction *Medical Care* (1981) 19(2) 127-140.
21. A Ibiwoye and IA Adeleke, _Does National Health Insurance Promote Access to Quality Health Care? Evidence from Nigeria' *The Geneva Papers on Risk and Insurance Issues and Practice* (2008) 33(2) 219-233.
22. United Nations Development Programme, _Human Development Reports' available at http://hdr.undp.org/en/countries/profiles/NGA accessed 2/05/2025.
23. Ibid.
24. AJ Browne, CM Varcoe, ST Wong, VL Smye, J Lavoie *et al*, _Closing the Health Equity Gap: Evidence-based strategies for Primary Health Care Organizations' *International Journal for Equity in Health* (2012) 11(1) 59.

equity gap in health care delivery is the principle of Universal Health Coverage (UHC) under the United Nations Sustainable Development Goal No.3.[25]

According to Braveman and Gruskin, equity in health connotes striving to eliminate disparities in health between more and less-advantaged social groups occupying different positions in the social hierarchy.[26] This study adopts the definition of equity by Daniels as roughly equivalent to distributive fair or just.[27] This ensures a distributive justice in health care delivery. Berer in support of this view submits that need must be an important factor to be considered in distribution of healthcare services.

The need for equity of access in reproductive health care delivery is justifiable by the fact that more than 99 per cent of maternal deaths take place in certain developing countries.[28] Thus, equity of access in our context will simply mean that which aids fair and just distribution of healthcare services based on need. In the same vein, Muraleedharan puts forward the view that the society has the duty to provide a —just allocation of different types of health services, taking into account the competing claims of different types of health needs.‖ The necessity for stronger emphasis and commitment to a needs-based access was also emphasized by La Foucade and Scott.[29] Fried in discussing equity in health care specifically mentioned addressing issues like maternal and child health and ensuring access to health services that will make life tolerable for pregnant mothers and children as part of the decent minimum.[30]

Although healthcare provision may be considered an individual responsibility, Gibbard believes that the responsibility for healthcare provision can most effectively, reliably, and economically be discharged by government.[31]This view presupposes that it is the responsibility of government to guarantee access. This view emphasizing government‘s responsibility appears to be the basis for the decision in *Alyne da Silva Pimentel V Brazil*[32] where the government was accountable for the death of poor Afro-Brazilian woman who

25. United Nations, _Sustainable Development Goals Knowledge Platform available at https://sustainabledevelopmenn.org/ accessed 2/05/2025.
26. PA Braveman and S Gruskin, _Defining Equity in Health‘ *J Epidemiol Community Health* (2003) 57 254.
27. Daniels, (n. 12) 60.
28. M Berer, _Access to Reproductive Health: A Question of Distributive Justice‘ *Reproductive Health Matters* (1999) 7(14) 10.
29. AD La Foucade and EB Scott, _A Review of the Literature on Manifestations of Inequitable Access to Health Care: Lessons for the Caribbean‘ *Social and Economic Studies* (2006) 55(4) 107-132.
30. C Fried, _Equality and Rights in Medical Care‘ *Hastings Center Report* (1976) 6 29.
31. A Gibbard, _The Prospective Pareto Principle and Equity of Access to Health Care‘ *The Milbank Memorial Fund Quarterly. Health and Society* (1982) 60(3) 399-428.
32. Communication No.17/2008. Full text of the judgement. Available at http://www2.ohchr. org/english/law/docs/CEDAW-C-49-D-17-2008_en.pdf accessed 12/04/25.

died after multiple medical facilities failed to provide her with emergency obstetric care. The case which was brought before the Committee on Elimination of All Forms of Discrimination Against Women (CEDAW) in 2008 found that the failure to provide quality maternal health care constitutes a form of discrimination against women especially since only women require such services.

Closing the equity gap in ARHC is one of the most efficient ways to address health care needs of disadvantaged and vulnerable persons and in this context, maternal health needs of women.[33]

3.1 Equity versus Equality in Health Care

A likely question that requires answer in advocating for equity of access in healthcare is: Why equity, why not equality in ARHC? To stretch this question further, equity in access may in fact increase inequality in health as a category of persons will appear to be receiving more attention in terms of meeting their healthcare needs than others.

Asada in attempting to address the above questions holds the view that achieving health equality is an unachievable goal.[34] This is because health equality is weak and some major determinants of health are beyond control and thus, health equity is more attractive and can be more achievable.

While critiquing and emphasizing the impossibility of approaching access from the perspectives of equality in health care, Gutmann and Muraleedharan also opines that the principle of equal access fails to guarantee equal results. Although access will inevitably be unequal, it is not necessarily unfair.[35] This is especially because needs are usually unevenly distributed. The impracticability of an even distribution of health needs was also established by Harris et al.[36]

Gutmann argued that discriminations in health care can therefore be permitted based upon type or degree of health need of populations.[37] This is even more so since it is unlikely at the end of the day to have an equally healthy population. The same position has been

33. Browne et al, (n.24) 69.
34. Y Asada, _Assessment of the Health of Americans: The Average Health-related Quality of Life and its Inequality Across Individuals and Groups' *Popul Health Metr* (2005) 3-7.
35. HT Engelhardt, _Health Care Allocations: Responses to the Unjust, the Unfortunate, and the Undesirable' in EE Shelp, ed. *Justice and Health Care* (Dordrecht: D. Reidel, 1981).
36. B Harris, J Goudge, JE Ataguba, D McIntyre, N Nxumalo *et al*, _Inequities in Access to Health Care in South Africa' *Journal of Public Health Policy* (2011) 32(1)102-123.
37. A Gutmann, _For and against Equal Access to Health Care' *The Milbank Memorial Fund Quarterly. Health and Society* (1981) 59(4) 542-560.

argued by Fried,[38] Gutmann[39] and Muraleedharran.[40] Their studies are in agreement that insisting on a right to equal access in health care is an anomaly in so far as other inequalities (in wealth, income etcetera) exists in the society.[41] Equal access will also not augur well for fairness especially in the context of those who indulge in voluntary health risks. Jacobs posits that an egalitarian perspective can never be used to justify a universal access to healthcare and favours a justice theory which adopts a right-based approach in justifying access to health care.[42]

From a seemingly extreme point of view, Norheim and Asada argue that health equality serves the purpose of levelling down health care services.[43] This means that those who currently have more access may be deprived of their access to ensure that they are on the same page with others. According to the authors, health equality if interpreted strictly may result in a situation whereby those who currently see may have to be made blind in order to assist the blind.[44] This view though a bit exaggerated, supposes that an attempt to use equality to create a balance in health care delivery may be detrimental to overall aggregate health concerns.

Based on the above, there is some huge consensus on the fact that equity in the context of health care is a normative concept which is subjective as opposed to equality which is empirical.[45]

There is thus need for healthcare policies which focus on not just horizontal equity which will aim at just improving overall access to health care by considering collective concerns but rather one that will balance both aggregate as well as distributive concerns based on respective needs[46] and evidencing a reflection on purpose and effect of such policy.[47]

38. Fried, (n.30) 30.
39. Gutmann, (n.37) 550.
40. VR Muraleedharan, _When Is Access to Health Care Equal? Some Public Policy Issues‘ *Economic and Political Weekly* (1993) 28(25) 1291-1296.
41. Fried, (n.23) 31.
42. L Jacobs, _Can an Egalitarian Justify Universal Access to Health Care?‘ *Social Theory and Practice* (1996) 22(3) 315-348.
43. OF Norheim and Y Asada, _The Ideal of Equal Health Revisited: Definitions and Measures of Inequity in Health should be Better Integrated with Theories of Distributive Justice *International Journal for equity in health* (2009) 8(1) 40.
44. Ibid.
45. W Chang, _The Meaning and Goals of Equity in Health‘ *Journal of Epidemiology & Community Health* (2002) 56488-491.
46. Norheim and Asada, (n.43) 43
47. J Anderson, P Roday, S Reimer-Kirkham, AJ Browne, KB Khan and MJ Lynam, _Inequities in Health and Health Care Viewed through the Ethical Lens of Critical Social Justice- Contextual Knowledge for the Global Priorities Ahead‘ *Advances in Nursing Science* (2009) 32(4) 282–294.

In sum, a health care service that is just, equitable and fair should be one which tailor's care in such a way that contexts of patient's needs are considered and effective plans are put in place and policies implemented to meet such needs. Such policy must necessarily be one that addresses inequalities and disparities in health as evidenced by the data and experiences indicative of poor life expectancy, quality of life, avoidable morbidities and mortalities.

3.2 Need for Equity of Access in Reproductive Healthcare in Nigeria

It is well established in the preceding section that for an argument for ARHC to be hinged on equity, the justification of the _need' must be apparent.[48] In Nigeria's response to the COVID-19 pandemic, equity evidently came into play as the government's priority was the reduction of the then rapidly growing spread of the coronavirus. The apparent need in the case of the COVID-19 pandemic was to curtail the spread of the highly contagious coronavirus and thus, reduce mortality rates. In the case of reproductive health care services for women, the drive for improved access to service is well apparent in the available statistics on maternal morbidity and mortality across the world and specifically, in Nigeria.

As noted earlier, Nigeria is the largest contributor to maternal mortality in the world with a woman's chance of dying from pregnancy and child birth complications being 1 in 25.[49] A total of 75, 000 deaths arising from maternal health issues were recorded in Nigeria in 2023 alone.[50] These deaths could have been averted if essential interventions could reach women on time and if the coverage and quality of healthcare services in Nigeria is improved significantly.

The issue of access to reproductive healthcare by women in Nigeria remains one that calls for genuine concern. The incessant violation and non-implementation of the reproductive rights is a major problem which has been and is still facing Nigeria. Although there have been numerous policy deliberations on this fundamental challenge, very little legal and institutional action has been taken by the government and major stakeholders in addressing this problem by taking practical and effective means to guarantee the right to ARHC and maternal health care services. The persistence of the problem is not farfetched from the

48. Culyer, (n.9) 278-279.
49. Trends in Maternal Mortality, (n.3).
50. Ibid.

unwillingness of the government to take legislative and other institutional measures to implement and facilitate the realisation of internationally recognized and guaranteed reproductive rights of women.

Whilst not downplaying the severity of the COVID-19 pandemic, the number of deaths recorded so far from the waves of the pandemic cannot be compared to number of maternal deaths arising from inability of women to ARHC.

4. Legal Framework for Access to Reproductive Healthcare

The right to health has been recognized under international law as far back as 1948 in the United Nations Universal Declaration of Human Rights. Subsequently, the right has been reiterated in other international and regional human rights treaties. A very crucial aspect of the right to health which has gained notable recognition in recent times particularly in the international community and which aims to step down the tide of discrimination in provision of health services, is women's reproductive health rights. This right to health was well expounded by the United Nations CESR to necessarily include freedoms, entitlements and specifically, sexual and reproductive freedom to control one's body.[51] Thus, the right to health covers sexual and reproductive rights.

Reproductive health is as a state of complete physical, mental, social well-being in all matters relating to one's reproductive system, functions and processes.[52] Reproductive health —implies that people can have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice… and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant.‖[53]

Although the 1979 Convention on Elimination of all Forms of Discrimination against Women makes provisions for rights which have a bearing on women's reproductive

51. CESCR General Comment (n. 19).

52. NI Aniekwu, _A Legal Perspective on Reproductive Health and Gender-specific Human Rights in Nigeria' *Journal of Medicine and Biomedical Research* (2004) 3(1) 21-29.

53. UN, International Conference on Population and Development (ICPD) Programme of Action (POA) 1994, para 72 available at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf accessed 14/04/25; Beijing Declaration (1995), para. 94.

capabilities and access to facilities,[54] it was not until the year 1994 at the United Nations International Conference on Population and Development (ICPD) that the Programme of Action (POA) specifically pronounced reproductive rights of women as human rights.[55] Based on the above definition of reproductive health, we understand that one of the key indicators of reproductive health is the right of ARHC services to enable women safely go through pregnancy and childbirth.

In Nigeria, the reproductive health rights are not expressly guaranteed. However, the right can be inferred under the right to health guarantee under the laws. Sadly, the Nigerian Constitution does not recognise the right to health as one of the fundamental human rights contained under chapter four of the Constitution. Rather, chapter two simply recognises the provision of adequate medical and health facilities for all persons as a fundamental objective of the government which cannot be enforced against the government.[56] Notwithstanding the lapse in the Constitutional human rights provisions, the country has domesticated the 1981 African Charter on Human and Peoples Rights (ACHPR) and the regional treaty has thus become part of our laws. Article 16 of the ACHPR guarantees the right to health. Although, the 2003 Women's Protocol contains more detailed provisions on reproductive rights of women, the Protocol is yet to be domesticated in Nigeria pursuant to the provision of section 12(1) of the Constitution.

The 2014 National Health Act also recognises the right of citizens to access health care services. Section 1 of the Act establishes a National Health System which shall provide for persons living in Nigeria the best possible health services within the limits of available resources; set out the rights and obligations of health care services users; and protect, promote and fulfil the rights of the people of Nigeria to have access to health care services.[57]

Going by the interpretation of the right to health by the Committee on Economic Social and Cultural Rights (CESR), the right to health provisions adequately cover the guarantee of reproductive health rights of women including the right of access to healthcare services to enable women safely go through pregnancy and childbirth.

54. Articles 10-14
55. Principles 4 and 12; Also 1995 Beijing Declaration, Article 14 available at http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf accessed on 14/04/25.
56. Section 17 (3) (d)
57. National Health Act, Section 1 (c), (d) and (e).

The argument may also be put forward based on the principles of interrelatedness and indivisibility of rights, that the right to life of women gets threatened when their lives are put at risk due to inability to access healthcare services needed during pregnancy and child-birth. This view was put forward by Duru relying on what he termed an indirect approach to justiciability of Chapter two of the Constitution. He posits that the enforceability of Chapter II may also be dependent upon fundamental rights guaranteed in Chapter IV in some circumstances[58]. This approach though not tested in the context of right to health has been adopted by the court in the case of *Adewole v. Alhaji Jakande*[59] to give effect to the educational objective under Chapter II. The court held that the freedom of expression guaranteed under Chapter IV encompasses the right to establish schools in a bid to eradicate illiteracy. It is safe to we submit that a person whose life is at risk by reason of complications of pregnancy and who is unable to access needed reproductive health care cannot be said to be enjoying a right to life.

5. Efforts at Enhancing ARHC Services in Nigeria

Fragmented efforts have been made over the years to initiate programs to address poor ARHC in Nigeria. The National Primary Health Care Development Agency (NPHCDA) in 2009 introduced the Midwives Service Scheme (MSS) as a collaborative effort between the three tiers of government in Nigeria with the aim of addressing the unacceptably high maternal and child morbidity and mortality in the country.[60] The Community Health Influencers, Promoters and Services (CHIPS) Programme kicked off in 2018 and is to be implemented in across the 36 States and the Federal Capital Territory with the aim of reducing barriers to access by taking services closer particularly to pregnant women, women of childbearing age, new-born and children.

About 100, 000 CHIPS agents are expected to be trained to provide services which includes demand generation for PHC services, behaviour change communication, referral and community engagement; maternal new-born and reproductive sexual health among others.[61]

58. O Duru, _The Justiciability of the Fundamental Objectives and Directive Principles of State Policy under Nigerian Law‘ *Available at SSRN 2140361* (2012).
59. (1981) 1 NCLR 262.
60. NPHCDA. —Nigeria Midwives Services Schemel available at https://www.who.int/workforcealliance/forum/2011/hrhawardscs26/en/ accessed 25/02/22
61. Ibid.

The Subsidy and Reinvestment Programme (SURE-P) was another national effort introduced by government with the aim of ensuring that the savings from the partial removal or reduction of subsidy is utilised for the benefit of Nigerians.[62] This is similar to efforts put in place by the previous administration of Sani Abacha which set up the defunct Petroleum Trust Fund (PTF) with the aim of investing saved funds in specific projects[63] and the Olusegun Obasanjo administration which came up with the National Economic Empowerment and Development Strategy (NEEDS).[64]

The SURE-P Maternal and Child Health (MCH) program was to enhance ARHC from the SURE-P savings. The SURE-P MCH Programme was established under the social safety net programmes. According to the World Bank, the SURE-P MCH was aimed at saving lives of mothers and their babies by improving access to reliable health services and increasing the demand for maternal and child health services.[65] Amakom and Nsofor *et al* noted that in addition to improving access, the reduction of maternal morbidity and mortality and attainment of Millennium Development Goals (MDG) Nos. 4 and 5 was part of the aim of the SURE-P MCH.[66] The two main components of the programme was to improve both use of services and supply of services to pregnant women. [67]

According to Onugha, SURE-P augmented the Midwives Service Scheme (MSS) which was established in 2009 and driven by the NPHCDA to improve access to reproductive health care services for pregnant women. Amakom corroborating Onugha agreed that SURE-P MCH planned to scale up the MSS by expanding it to more PHCs across the

62. OC Nwosu and E Ugwuerua, _Analysis of Subsidy and Reinvestment Programme (SURE-P) and Youth Empowerment in Nigeria 2012-2014' *IOSR Journal of Humanities and Social Science* (2014) 19(12) 25-32.
63. MA Gado and A Sanusi, _An Assessment of the Prospects and Challenges of Subsidy Re-Investment and Empowerment Program (SURE-P) of Former President Goodluck Jonathan on Nigerians' *Global Journal of Applied Management and Social Sciences* (2018) 14 166-178.
64. SO Uhunmwuangho and EO Akintoye, _An Appraisal of the State Fund and Empowerment Programme in Nigeria' *AFRREV IJAH: An International Journal of Arts and Humanities* (2016) 5(3) 150-160.
65. World Bank, _Nigeria Subsidy Reinvestment and Empowerment Programme (SURE-P): Maternal and Child Health Initiative' <https://www.worldbank.org/en/programs/sief-trust-fund/brief/nigeria-subsidy-reinvestment-and-empowerment-programme-sure-p> accessed 28 May 2024.
66. U Amakom, _Subsidy Reinvestment and Empowerment Programme (SURE-P) Intervention in Nigeria: An Insight and Analysis' *Afriheritage Policy Discussion Paper* (2013) 2 1-73 <https://www.africaportal.org/publications/subsidy-reinvestment-and-empowerment-programme-sure-p-intervention-nigeria-insight-and-analysis/> accessed 27/05/23.
67. Ibid; IM Nsofor, AN Ezeokoli, KO Akabike, I Anya and C Ihekweazu, An Evaluation of the Maternal and Child Health Project of the Subsidy Reinvestment and Empowerment Programme (SURE-P MCH) March–May 2015' <http://epiafric.com/wp-content/uploads/2019/05/An-Evaluation-of-the-Maternal-and-Child-Health-Project-of-the-Subsidy-Reinvestment-and-mpowerment-Programme-SURE-P-MCH.pdf> accessed 1 January 2024.

country and specifically to areas where they are most needed.[68] The MSS was initially funded largely from the debt relief granted to Nigeria by the Paris Club but upon inception of SURE-P, more funds were committed to the Scheme under the SURE-P Programme.[69] The SURE-P MCH which addresses both demand and supply issues in access was initially launched in 500 public PHC facilities and their catchment areas across the 36 States and the Federal Capital Territory (FCT) in 2012 but was later scaled up to cover 1,000 PHC Centres in 2013.[70] Chukwuma and Bossert reported that between 9 and 16 facilities were selected to receive the intervention from each of the 36 states. The selection criteria include location in a rural area; a catchment population of more than 10000 residents; provision of maternal and child health services; availability of minimum equipment and basic infrastructure; and opening hours of 24hours daily.[71]The SURE-P Maternal Health Program has however not been sustained.

Another national program worthy of note is the National State Health Investment Project (NSHIP) which is a RBF program being funded by the World Bank via an International Development Association credit of 150 million USD to Nigeria.[72] NSHIP is however being implemented by the National Primary Healthcare Development Agency (NPHCDA) in only few states to improve the access of women to better quality health services and in response to accelerating the rate of meeting the SDGs, particularly, Goal No. 3 and thus, targets maternal, child and other primary health care services.[73] The NPHCDA provide technical assistance to the state primary health care development agencies (SPHCDA) who contracts selected primary and secondary healthcare facilities to deliver a pre-defined package of mother and child health services toward improving quality of care and enhancing equity in

68. Amakom, (n.66) 51.
69. EO Onugha, _Scaling up Nigeria's Midwives Service Scheme and Reducing Inequality Gaps in Maternal Mortality' *Open Journal of Obstetrics and Gynecology* (2017) 7(8) 880.
70. World Bank, _The SURE-P Maternal and Child Health Project in Nigeria' <http://pubdocs.worldbank.org/en/284981453222884744/Policy-brief-Nigeria-SURE-P-MCH-IE.pdf> accessed 28 October 2024.
71. A Chukwuma and TJ Bossert, _The Impact of Health Service Delivery on Political Support: Evidence from the Nigerian Subsidy Re-investment and Empowerment Programme' (2018) <https://www.researchgate.net/profile/Adanna_Chukwuma2/publication/325477752_The_Impact_of_Health_Service_Delivery_on_Political_Support_Evidence_from_the_Nigerian_Subsidy_Re-investment_and_Empowerment_Programme/links/5b10514a0f7e9b4981006bec/The-Impact-of-Health-Service-Delivery-on-Political-Support-Evidence-from-the-Nigerian-Subsidy-Re-investment-and-Empowerment-Programme.pdf.> accessed 1 December 2024.
72. Ibid.
73. Y Ogundeji, _Can Performance Based Financing Improve Quality of Healthcare in Nigeria?' (2016) <https://afhea.org/docs/presetationspdfs/Yewande%20Ogundeji%20%20Can%20RBF%20improve%20quality%20and%20access%20to%20care%20in%20Nigeria% 20- %20Copy.pdf> accessed 12 November 2024.

health.[74] Fee waivers and vouchers be incorporated into the NSHIP programme consistent with the Basic Healthcare Provision Scheme to provide maternal health services at no charge to all by 2021.[75]

It is noteworthy that minimal and individual efforts have also been made by corporate organizations targeting reduction of maternal mortality in Nigeria. The Mobile Telephone Networks (MTN) Foundation's Mother and Child Health (MCH) Initiative[76] is one that the government can leverage on to partner with the service providers and map out larger strategies for improving access to maternal health care services. The MTN MCH contributes to keeping mothers and children under five alive through medical Outreaches; awareness and Advocacy; upgrade of existing facilities; and Maternal, nutrition and Health Support programmes. The objective is to drastically reduce the prevalence of deaths of women and children by providing access to quality health care for less privileged women and children in the society. Launched in 2017, the first phase of the project was expected to cover Ogun, Oyo, Abia, Cross River, Kaduna and Niger States. The MTN Audrey Care subscription plan includes a pregnancy insurance, which provides cover for a free ultrasound scan and insures against premature delivery, among a host of other benefits. The Audrey care service also gives access to free Audrey Packs which includes a selection of maternal and new-born healthcare products, such as diapers, baby cream, baby soap, disinfectants, etcetera, from reputable brands.[77]

Access Bank's W Initiative which seeks to provide maternal health support for women is also worthy of mention.[78]

What is clear is that efforts have been fragmented across states and as such, it has not translated to significant reduction in the high maternal mortality ratio in Nigeria. The above makes apparent the need for holistic and novel approaches which will aid coordinated and concerted efforts towards the enhancement of ARHC in Nigeria.

74. World Bank, _Nigeria: Project Information' <https://www.rbfhealth.org/rbfhealth/country/nigeria> accessed 12 November 2025.
75. Federal Ministry of Health, NHIS, NPHCDA, _Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund' (2016).
76. MTN Foundation, _Mother and Child Health', <https://foundation.mtnonline.com/causes/mother-and-child-health/> accessed 12/11/19 ; MTN AudreyCare, https://mtnbusiness.com.ng/mtnaudreycare accessed 12 November 2024.
77. Ibid
78 W Initiative, available at h ttps://www.accessbankplc.com/sustainable-banking/our-community-investment/the-w-initiative accessed 07/05/2026.

6. Exposition to Corporate Social Responsibility (CSR) Approaches in Response to the COVID-19 Pandemic

Prior to the coronavirus outbreak, the Canadian government in partnership with the Lagos State government under the Global Partnership Programme funded the establishment of a biosecurity laboratory after the Ebola outbreak in Nigeria. Chevron also donated a Molecular Biology Laboratory to the Lagos University Teaching Hospital.[79] This shows that gaining support for tackling health emergencies when well projected and coordinated has always held some promise.

After the discovery of the index case of COVID-19 in Nigeria, the government was swift to constitute a Presidential Task Force (PTF) on COVID-19 in March 2020 to coordinate and oversee Nigeria's multi-sectoral inter-governmental efforts to contain the spread and mitigate the impact of the COVID-19 pandemic in Nigeria.[80] The PTF mandate include coordination of national and state-level activities to curtail the spread of the virus. The PTF in discharge of its mandate has coordinated treatment centres; sensitization and awareness campaigns; establishment of diagnostic laboratories; and recommended interventions, funding and technical support for states in combating the spread of COVID-19. The PTF works in conjunction with the National Centre for Disease Control (NCDC).

The Central Bank of Nigeria (CBN) also opened a CBN COVID-19 Relief Fund account.[81] The CBN called on corporate organizations to make donations to the Fund which is intended to be used to fight the corona virus. As at 17th April, 2020, a total sum of N25,893,699,791.00 had been raised from individuals and corporate organizations with up to two billion Naira received from a single individual to the Fund.[82] These contributions were made at a time when less than five hundred cases had been recorded in Nigeria with 17 deaths.[83] Contributions were made by various companies totalling about 107[84] under the auspices of the Private Sector Coalition against COVID-19 (CA-COVID). Apart from cash

79. G Salau, COVID-19 Corporate Donations: Bazaar or absence of strategic CSR. https://guardian.ng/features/covid-19-corporate-donations-bazaar-or-absence-of-strategic-csr-2/ accessed 20/04/26

80. https://statehouse.gov.ng/covid19/objectives/ accessed 20/04/26

81. Central Bank of Nigeria. https://www.cbn.gov.ng/Out/2020/CCD/covid%20contributions.pdf accessed 2/07/20.

82. Channels Television. https://www.channelstv.com/2020/04/18/donations-to-nigerias-covid-19-relief-fund-top-n25bn/ accessed 20/04/26

83. ibid

84. EA Benson, Updated: List of all companies and billionaires that have contributed to COVID-19 relief fund https://nairametrics.com/2020/04/18/list-of-all-companies-and-billionaires-that-have-contributed-to-covid-19-relief-fund/ accessed 20/04/26

donations, donations of medical supplies, food relief materials and medical equipment were also made by companies as part of their corporate social responsibility efforts. Furnished isolation centres were donated in Lagos and Onne Port. Most of these donations were done without much pressure or goading.[85]

On 14th April, 2020, the European Union announced a EUR 50m contribution to Nigeria to assist with implementation of a national coordinated response to the COVID-19 pandemic.[86] On 17th April, 2020, the United States through its United States Agency for International Development and the Department of State also announced a total funding of $21.4m made to Nigeria to prevent and mitigate the spread and effect of COVID-19.[87] By 23rd April, 2020, the federal government was reported to have released $2.7 million to support the NCDC and promised an additional $18 million to tackle the coronavirus disease in Nigeria.[88]

7. Lessons from the COVID-19 CSR Initiatives

The major lesson from the CSR Initiatives during COVID was the unified front put forward by corporate organizations to achieve a common goal of reducing the effects of the pandemic. Whilst equity of access was evident in the response of government to the COVID-19 pandemic in Nigeria, same cannot be said of government's response both legal and non-legal, to the issue of right of ARHC for women. The government's response in constituting the PTF on COVID-19, release of funds, coordination of donations by the CBN among others shows that the government clearly appreciates the need for swift and concerted efforts in tackling the spread of the virus. This cannot be said for the government's response to maternal deaths over the years.

Also, the formation of the Private Sector Coalition against COVID-19 reflects the power of concerted rather than isolated piecemeal individual efforts in addressing societal challenges. The coming together of about 107 corporate organizations under this coalition

85. Salau, (n. 79).

86. European Union. EU Boosts Nigeria's COVID-19 Response with N21 Billion Contribution. https://eeas.europa.eu/delegations/nigeria/77571/eu-boosts-nigeria%E2%80%99s-covid-19-response-n21-billion-contribution_en accessed 20/04/26

87. United States Embassy and Consulate in Nigeria. U,S Assistance to fight COVID0-19 in Nigeria reaches $21.4m https://ng.usembassy.gov/u-s-assistance-to-fight-covid-19-in-nigeria-reaches-21-4-million/ accessed 20/04/26

88. Chatham House. Nigeria's Political Leaders Need to Win Trust to Tackle COVID-19. https://www.chathamhouse.org/expert/comment/nigeria-s-political-leaders-need-win-trust-tackle-covid-19?gclid=CjwKCAjwxev3BRBBEiwAiB_PWF7iRScrv0DuVyqsbM4ExvZhg8gvwOZ998y3q4o8M8Wvh53KZuhiIBoCu-UQAvD_BwE accessed 20/04/26

to pull funds and achieve a common goal, within a short period of time is equally commendable. While organizations like MTN and Access Bank and a few others are making individual efforts to improve AMHC, it is believed that collective efforts to form a coalition against maternal mortality, similar to the CA-COVID will go a long way to achieve holistic and significant results in improving AMHC and reducing maternal mortality in Nigeria.

8. Conclusion and Recommendations

The study discussed the concept of access in the context of reproductive health care and established the existence of a right to ARHC under existing international human rights frameworks. The study justified ARHC for women relying on the principles of equity and vulnerability. It however found that efforts aimed at improving AMHC in Nigeria has been fragmented and has not contributed significantly to reducing deaths arising from maternal causes in Nigeria.

The study further evaluated the response of the Nigerian government and other stakeholders to ensure access to needed health care by COVID-19 patients during the pandemic. It found that the concerted efforts made by corporate organizations to combat the COVID-19 pandemic yielded positive results and contributed significantly to reducing the negative impacts of the pandemic.

In the context of enforcing socio-economic rights, the issue of economic realities of states has always been a limiting factor, the COVID-19 pandemic has however shown that this appears not to be a cogent limiting factor once the need and urgency involved is well-appreciated. The decline in the fortunes of most countries and organizations during the pandemic did not in any way deter the government and organizations from going all out to take needed measures to curtail the spread of the virus.

Progressive realisation of the right to health in the ARHC context lends credence to the need for government to rethink their strategies for combating maternal deaths and re-evaluate the severity of the situation regarding maternal mortality, appreciate the need for sincere and practical interventions and take realistic steps to combat the challenge leveraging on concerted CSR efforts and initiatives as was done in the fight against COVID-19. With strong political will and unified corporate sector buy-in and support to

form a coalition against maternal mortality, the increasing tide can be stemmed and lives of women prevented from avoidable deaths