

Health Equity as a Justiciable Right in Nigeria: A Doctrinal Framework for Judicial Enforcement”

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Abstract

Despite the widespread recognition of the right to health across international, regional, and domestic human rights frameworks, courts have struggled to address persistent health inequities in a principled and consistent manner. This difficulty stems not from the non-justiciability of the right to health per se, but from a deeper doctrinal limitation: health equity is still predominantly treated as a policy aspiration rather than a legally enforceable standard. These disparities reflect in access, financing, geography, and health outcomes and reveal a persistent gap between normative legal commitments and their practical realization. This article argues that this conceptual mischaracterization has constrained judicial engagement with systemic disparities in access, financing, and health outcomes. Focusing on Nigeria, the article reconceptualizes health equity as a justiciable dimension of the right to health and develops a doctrinal framework for its judicial enforcement. Drawing on jurisdictions that adjudicate inequities within the right to health, it reinterprets and integrates the principles of non-discrimination, substantive equality, and reasonableness review into a structured, analytical model for adjudicating inequities in healthcare systems. On this basis, the article advances a set of enforceable standards as a judicial test that enables courts to identify and evaluate systemic health inequities as rights violations rather than mere policy deficiencies. By transforming health equity from a programmatic objective into an enforceable legal standard, the article offers a normative and doctrinal intervention that strengthens the capacity of courts to address structural injustice in healthcare.

Keywords: Health equity, Justiciability, Right to health, Substantive equality, and Socio-economic rights

1. Background and Context of the Study

The persistent inability of courts to address systemic health inequities exposes a fundamental limitation within the legal conception of the right to health. Although the right to health is firmly established in international, regional, and domestic human rights frameworks, its enforcement remains uneven, particularly in developing healthcare systems such as Nigeria.¹ While normative commitments in instruments such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and its interpretive guidance recognise State obligations to ensure access to healthcare services and underlying determinants of health, using standards of availability, accessibility, acceptability, and quality. yet, global and national realities reveal persistent and, in some instances, widening health inequities, revealing a persistent gap between legal recognition and practical enforcement. This disconnect highlights the gaps in access, financing, geographic distribution, and health outcomes, and are particularly pronounced in low- and middle-income countries

¹ WHO, 'Human rights' (2023) Available at: <<https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health#:~:text=The%20right%20to%20health%20is,It%20includes%20freedom%20and%20entitlements>> accessed 27 April 2026; Selemon Dessalegn Dibaba, 'The Human Right to Health: In International, Regional and National Legal Instruments' (2021) 9 (6) GSJ. See also, International Covenant on Economic, Social and Cultural Rights, adopted 16 Dec 1966 GA Res 2200 (XXI), 21 UN GAOR Supp (No 16) at 49 UN Doc A/6316 (1966) 993 UNTS 3 entered into force 3 Jan; WHO, 'Social determinants of health' <<https://www.who.int/health-topics/social-determinants-of-health?>> accessed 27 April 2026

(LMICs) where structural constraints limit effective realization of health rights.²

In Nigeria, the situation reveals the inability of existing legal frameworks to confront health inequities as matters of rights. Empirical evidence reveal significant inequalities in healthcare access across rural and urban populations, socio-economic groups, and geopolitical zones.³ For instance, maternal mortality rates remain among the highest globally, with marked disparities reflecting uneven access to skilled care and essential health services.⁴ Furthermore, the predominance of out-of-pocket (OOP) expenditure continues to expose households to catastrophic health spending, thereby deepening poverty and exclusion from healthcare services.⁵ Although the right to health is recognized within Nigeria’s legal and policy frameworks,⁶ its enforceability remains limited because constitutional provisions

² WHO, 'Social determinants of health' <<https://www.who.int/health-topics/social-determinants-of-health?>> accessed 27 April 2026.

³ N B Ezeaka and C C Ochuba and C E Bartholomew, 'Addressing Healthcare Inequalities in Nigeria: A Communication Perspective on Advocacy and Policy Implications' (2025) 4(4) *Journal of Advanced Research and Multidisciplinary Studies* 1-11 <DOI: 10.52589/JARMSAAQQDLCJ> accessed 27 April 2026

⁴ WHO, 'Maternal mortality' (2025) <<https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>> accessed 27 April 2026; Y Wei and others, 'Global, regional, and national levels of maternal mortality, 1990-2021: a systematic analysis for the Global Burden of Disease Study 2021' (2025) 30;25(1) 1359 *BMC Pregnancy Childbirth* <doi: 10.1186/s12884-025-08456-5> accessed 27 April 2026

⁵ WHO, 'Health financing' <Available at: <https://www.who.int/health-topics/health-financing?>> accessed 27 April 2026

⁶ O M Atoyebi, 'Right to Improved Health in Nigeria: A Critical Legal Appraisal' (2024) <<https://omaplex.com.ng/right-to-improved-health-in-nigeria-a-critical-legal-appraisal/>> accessed 27 April 2026

relating to health are often framed as non-justiciable directive principles, thereby constraining judicial intervention.⁷ Consequently, while legal recognition exists, its transformative potential is undermined by weak enforcement mechanisms and the absence of clear standards for addressing inequity. As a result, systemic inequities are rarely articulated or adjudicated as violations of rights, but are instead treated as failures of policy design or implementation.

This study argues that the failure to address health inequities within the adjudication of the right to health is rooted in the absence of a framework that renders equity judicially enforceable. This article develops a framework that integrates principles of non-discrimination, substantive equality and reasonableness review as a standard for adjudicating inequities in healthcare. This research focuses on Nigeria, examining how health equity, although widely acknowledged in public health discourse, can be translated into a justiciable legal standard within the adjudication of socio-economic rights.

2. Conceptual and Theoretical Framework

2.1 Concept of Health Equity

Health equity constitutes a central normative ideal within public health and human rights discourse, yet its legal articulation remains comparatively underdeveloped. This article conceptualizes health

⁷ Constitution of the Federal Republic of Nigeria 1999 (as amended) s 17(3)(d)

equity not merely as a policy aspiration, but as a justiciable threshold for identifying unjustifiable disparities in the enjoyment of the right to health. The World Health Organization (WHO) defines health equity as the absence of avoidable, unfair, or remediable differences in health among population groups.⁸ This definition underscores that disparities in health outcomes are not inherently problematic; rather, it is those disparities that are preventable and rooted in injustice that engage the principle of equity.⁹ In legal terms, this distinction provides a basis for distinguishing between permissible variation in health outcomes and inequities that may amount to violations of the right to health, particularly where such disparities arise from failures of state obligation. The implication of this is that, not all health disparities are legally relevant; only those traceable to structural disadvantage, institutional failure, or state omission engage responsibility under the right to health.

A critical distinction must be drawn between equity and equality, as the conflation of these concepts has often impeded meaningful legal analysis. Equality, in its simplest sense, denotes sameness of treatment or distribution, whereas equity is concerned with fairness in both process and outcome. Thus, while equality may require identical allocation of healthcare resources, equity demands that such

⁸ WHO, 'Health equity' <https://www.who.int/health-topics/health-equity#tab=tab_1> accessed 27 April 2026

⁹ Elizabeth Fee and Ana Rita Gonzalez, 'The History of Health Equity: Concept and Vision' (2017) 14(3) <<https://www.primescholars.com/articles/the-history-of-health-equity-concept-and-vision-94924.html>> accessed 27 April 2026.

allocation be responsive to differing levels of need and structural disadvantage.¹⁰ Health equity, therefore, is fundamentally concerned with justice. It requires attention to avoidable disparities arising from social, economic, and institutional arrangements, and calls for corrective measures that prioritise those who are systematically disadvantaged.¹¹ Within a legal context, this shifts the focus from formal uniformity to substantive fairness, thereby providing a normative basis for judicial assessment of whether state action or inaction results in unjustifiable health disparities in violation of the right to health.¹²

2.2 Social Determinants of Health

Health inequities are produced not within healthcare systems, but through underlying social and structural conditions commonly described as the social determinants of health such as income inequality, education, housing, employment, environmental conditions, and access to basic services, all of which indirectly shape

¹⁰ 'How are Equity and Equality Different?' (2010) Just Health Action <<http://justhealthaction.org/wp-content/uploads/2010/05/JHA-Lesson-Plan-3-How-are-equity-and-equality-different-final.pdf>> accessed 27 April 2026; MPH@GW, The George Washington University online Master of Public Health program (2020) <<https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/>> accessed 27 April 2026

¹¹ Paula Braveman, 'Defining Health Equity' (2022) 114(6) *Journal of the National Medical Association* 593-600 <<https://doi.org/10.1016/j.jnma.2022.08.004>> accessed 27 April 2026

¹² Jensen N and Kelly A H and Avendano M, 'Health equity and health system strengthening – Time for a WHO re-think' (2022) 17(3) *Global Public Health*) 377–390 <<https://doi.org/10.1080/17441692.2020.1867881>> accessed 28 April 2026

health outcomes.¹³ However, within a legal context, their significance lies not merely in their explanatory value, but in their capacity to identify structural conditions that give rise to unequal enjoyment of the right to health. For instance, income is a primary determinant, as it directly influences access to healthcare services, nutrition, housing, and other essentials for health. Individuals with lower income levels are more likely to experience barriers to healthcare access and are disproportionately exposed to health risks.¹⁴ Education similarly plays a pivotal role,¹⁵ affecting health literacy, employment opportunities, and the capacity to make informed health decisions.¹⁶ Geography further compounds disparities,¹⁷ particularly in contexts such as Nigeria where rural populations often face limited access to

¹³ Davis M and Flores E, 'Health Equity Is Pursuing Social Justice in Health' (2022) 19 (1) *Journal of the American College of Radiology* 100; Prentice K R and Others, 'Defining health equity: A modern US perspective' (2024) 27(12) *IScience* <111326. <https://doi.org/10.1016/j.isci.2024.111326>> accessed 27 April 2026; Jensen N and Kelly A H and Avendano M, 'Health equity and health system strengthening – Time for a WHO re-think' (2022) 17(3) *Global Public Health* 377–390 <<https://doi.org/10.1080/17441692.2020.1867881>> accessed 28 April 2026

¹⁴ WHO, 'Social determinants of health' <https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1> accessed 28 April 2026

¹⁵ WHO, 'Social determinants of health' (2025) <<https://www.who.int/news-room/fact-sheets/detail/social-determinants-of-health>> accessed 28 April 2026; Zia Sherrell, 'What are social determinants of health?' *MedicalNewsToday* (2025) <<https://www.medicalnewstoday.com/articles/social-determinants-of-health>> accessed 28 April 2026

¹⁶ Braveman P and Gottlieb L 'The social determinants of health: it's time to consider the causes of the causes' (2014) 129 (2) *Public Health Rep* 19-31 <doi: 10.1177/003335491412915206> accessed 28 April 2026

¹⁷ Jon-Michial Carter, 'The Social Determinants of Health & How to Address them in Your Practice' (2025) *chartspan* <<https://www.chartspan.com/blog/social-determinants/>> accessed 28 April 2026

healthcare facilities, inadequate infrastructure, and a shortage of skilled health professionals.¹⁸ Gender also operates as a critical determinant, with women and girls frequently encountering structural barriers to healthcare, including socio-cultural constraints and unequal resource allocation.¹⁹ The doctrinal relevance is that social determinants provide the evidentiary and normative basis for distinguishing between natural variation in health outcomes and inequities attributable to state inaction or policy design.

These determinants collectively illustrate that health outcomes are not merely the product of individual choices but are significantly shaped by systemic inequalities.²⁰ When health disparities are traced to modifiable social and institutional arrangements, questions of state responsibility arise. Failures to address such determinants may constitute forms of omission that result in unjustifiable inequalities in

¹⁸ Hyacinth E Ichoku and Emmanuel O Nwosu, 'Social determinants and dynamics of health inequality in Nigeria' (2011) 49(3) *Economic and Financial Review* 47-70

¹⁹ Oduenyi C and Others, 'Gender discrimination as a barrier to high-quality maternal and newborn health care in Nigeria: findings from a cross-sectional quality of care assessment' (2021) 21(1) *BMC Health Serv Res* 198 <doi: 10.1186/s12913-021-06204-x> accessed 28 April 2026; Ernest Nzor, 'Women's health central to economic growth, sustainable reforms – FG ' The Guardian (12 January 2026) <<https://guardian.ng/features/health/womens-health-central-to-economic-growth-sustainable-reforms>> accessed 28 April 2026

²⁰ Nonye Benedeth Ezeaka and Chiamaka Chinazom Ochuba and Chinenye Evelyn Bartholomew, 'Addressing Healthcare Inequalities in Nigeria: A Communication Perspective on Advocacy and Policy Implications' (2025) 4(4) *Journal of Advanced Research and Multidisciplinary Studies* 1-11 <DOI: 10.52589/JARMSAAQQDLCJ> accessed 27 April 2026

access to healthcare and related services. Accordingly, social determinants of health provide a substantive basis upon which courts may assess whether disparities in health outcomes reflect permissible variation or legally cognisable violations of the right to health.

2.3 Equality Doctrine: From Formalism to Substantive Justice

Traditional approaches to equality, grounded in formal equality, require that like cases be treated alike and emphasise neutrality in law and policy, requiring that laws and policies apply equally to all individuals irrespective of their circumstances. While this approach ensures consistency, it often fails to account for pre-existing structural disadvantage and may inadvertently reinforce inequality in health outcomes.²¹ In contrast, substantive equality adopts a more nuanced and context-sensitive approach that recognises the unequal social and economic positions of individuals and groups. It requires that differential treatment be justified where necessary to achieve equitable outcomes, particularly for disadvantaged populations.²² Accordingly, substantive equality permits differential treatment where necessary to achieve fairness, particularly in favour of disadvantaged groups.²³ In legal terms, this aligns with judicial approaches that

²¹ Titia Loenen, 'The Conceptualization of Equality and Non-discrimination as Legal Standards: From Formal to More Substantive Equality' III (NIJHOF 2025) 38

²² British Columbia Human Rights, 'Substantive equality' <<https://bchumanrights.ca/glossary/substantive-equality/>> accessed 29 April 2026

²³ Ibid

assess whether state action is reasonable and proportionate in light of its impact on vulnerable groups.

Within the context of the right to health, substantive equality provides the doctrinal bridge through which health equity becomes justiciable. It shifts judicial inquiry from whether individuals were treated equally in form, to whether state action or inaction has produced unjustifiable disparities in health outcomes. In doing so, it supplies a normative basis for evaluating whether distributive patterns in healthcare systems are compatible with constitutional and human rights obligations. The relevance of this distinction lies in its doctrinal implications. By aligning health equity with substantive equality, it becomes possible to frame inequities in healthcare not merely as policy concerns but as violations of legally enforceable principles of fairness and justice.

2.4 Justiciability in Human Rights Law

Justiciability refers to the capacity of a right or claim to be adjudicated and enforced by a court of law. It encompasses questions of legal recognition, enforceability, and institutional competence. In the context of socio-economic rights, including the right to health, justiciability has historically been contested on the basis of separation

of powers concerns and the perceived limitations of judicial capacity in matters involving resource allocation.²⁴

Notwithstanding these concerns, courts across various jurisdictions have developed doctrinal tools, such as reasonableness review, minimum core obligations, and non-discrimination principles, to facilitate the adjudication of socioeconomic rights within constitutionally accepted limits. These developments demonstrate that judicial enforcement of such rights can operate within structured legal principles without constituting institutional overreach.²⁵

The question of justiciability is particularly significant for health equity. If health equity is to be recognized as an enforceable component of the right to health, it must be expressed in terms that are sufficiently precise and capable of judicial application. This necessitates the development of clear standards and tests through which courts can assess whether disparities in healthcare constitute

²⁴ CN Kwoka, 'What Is Justiciability in Nigerian Constitutional Law?' (2025) Nigerian Lawyer Centre <<https://nigerianlawyerscenter.com/blog/what-is-justiciability-in-nigerian/>> accessed 29 April 2026; Will Chen, 'Justiciability' Lawprof <<https://lawprof.co/definition/justiciability/#:~:text=Justiciability>> accessed 29 April 2026

²⁵ Stanley Ibe, 'Beyond justiciability: Realising the Promise of Socio-Economic Rights in Nigeria' (2007) 1 *AHRLJ* 225-248; Marius Pieterse, 'Justiciable socio-economic rights as adaptive law for urban resilience' (2025) 25(3) *Human Rights Law Review* ngaf019 <<https://doi.org/10.1093/hrlr/ngaf019>> accessed 29 April 2026; Obinna James Edeh, 'The ECOWAS Court and the Justiciability of SocioEconomic Rights in Nigeria' (2018) <<https://rwi.lu.se/wp-content/uploads/2021/10/Obinna-James-Edeh-University-of-Nigeria-The-Ecowas-Court-and-the-Justiciability-of-Social-Economic-Rights-in-NigeriaRG.pdf>> accessed 29 April 2026

violations of legal rights.²⁶ This article builds on these developments to propose such a framework for the judicial operationalization of health equity.

2.5 Theoretical Anchors

2.5.1 Rights-Based Approach to Health

The rights-based approach to health conceptualises health not as a matter of charity or benevolence, but as a legal entitlement grounded in human dignity.²⁷ Under this approach, individuals are recognised as rights-holders, while the State bears corresponding obligations to respect, protect, and fulfil those rights.²⁸

2.5.2 Distributive Justice Theories

The theoretical foundations of health equity are further reinforced by principles of distributive justice. The work of John Rawls is particularly instructive in this regard. Rawls' theory of justice posits that social and economic inequalities are permissible only if they are arranged to the greatest benefit of the least advantaged members of

²⁶ Chidiobi Fabian OKWENE and Emmanuel Ibiam AMAH, 'From Directive Principles to Enforceable Rights: Legal Pathways for Enhancing the Justiciability of Socio-Economic Rights in Nigeria' (2026) AJLHR 10 (1)

²⁷ WHO, 'Human rights' (2023) <<https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health>> accessed 29 April 2026

²⁸ Meier BM and Evans DP and Phelan A, 'Rights-Based Approaches to Preventing, Detecting, and Responding to Infectious Disease' (2020) 82 Infectious Diseases in the New Millennium 217–53 <doi: 10.1007/978-3-030-39819-4_10. PMCID: PMC7226904> accessed 29 April 2026

society.²⁹ This “difference principle” supports the prioritisation of vulnerable groups within healthcare systems, thereby providing a philosophical justification for equity-oriented resource allocation.

3. Legal Foundations of the Right to Health

3.1 International Legal Framework

The right to health is firmly entrenched within international human rights law, most prominently through the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of the ICESCR recognises “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, thereby imposing binding obligations on States Parties to take deliberate, concrete, and targeted steps towards its realisation.³⁰ However, the normative content of this right has been most authoritatively elaborated in General Comment No. 14 of the United Nations Committee on Economic, Social and Cultural Rights.³¹ This interpretative instrument significantly advances the legal understanding of the right to health by clarifying both its scope and the nature of State obligations. It emphasises that the right to health is

²⁹ Wenar Leif, 'John Rawls' The Stanford Encyclopedia of Philosophy (Fall 2025 Edition) Edward N Zalta & Uri Nodelman (eds) <<https://plato.stanford.edu/archives/fall2025/entries/rawls/>> accessed 29 April 2026

³⁰ International Covenant on Economic, Social and Cultural Rights art 12

³¹ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art 12) adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4)

not to be construed narrowly as a right to be healthy, but rather as a right to a system of health protection that ensures equal opportunity for all to attain the highest possible standard of health.

A central contribution of General Comment No. 14 is the articulation of the AAAQ framework, which establishes four essential and interrelated elements of the right to health: Availability, Accessibility, Acceptability, and Quality. These elements collectively transform the right to health from an abstract entitlement into a structured normative standard capable of legal evaluation. Importantly, they also embed principles of equity within the right itself, particularly through the requirement of non-discrimination and the obligation to prioritise vulnerable and marginalised groups.³²

Furthermore, General Comment No. 14 introduces the concept of core obligations, which impose immediate duties on States irrespective of resource constraints. These include ensuring non-discriminatory access to healthcare, providing essential primary health services, and ensuring equitable distribution of health facilities.³³

³² End FGM, 'UN Committee on Economic, Social and Cultural Rights - General Comment No.14: The Right to the Highest Attainable Standard of Health 2000 (2016) <<https://www.endfgm.eu/resources/health/un-committee-on-economic-social-and-cultural-rights-general-comment-no.-14-the-right-to-the-highest-attainable-standard-of-health-2000>> accessed 29 April 2000

³³ Paragraph 43 and 44

Comparative Regional Human Rights Framework on the Right to Health

The recognition and enforcement of the right to health across regional human rights systems reveal a growing but uneven jurisprudential convergence towards its justiciability, particularly through the development of judicial standards addressing state obligations, vulnerability, and access to healthcare.

Across the African human rights system, the right to health is expressly protected under Article 16 of the African Charter on Human and Peoples’ Rights, which requires States to take necessary measures to protect the health of their populations and ensure access to medical services.³⁴ The African Commission on Human and Peoples’ Rights has progressively expanded its scope of this provision through an integrated interpretation linking health to rights to life, dignity and a satisfactory environment. In *Social and Economic Rights Action Center (SERAC) v Nigeria*, the Commission held that State failure to prevent environmental degradation and ensure access to basic health-related conditions constitutes a violation of the right to health.³⁵ This jurisprudence reflects an emerging recognition that health rights extend beyond clinical care to encompass the underlying determinants of health although equity is not yet articulated as an independent justiciable standard.

³⁴ African Charter on Human and Peoples’ Rights art 16

³⁵ *Social and Economic Rights Action Center (SERAC) and Another v. Nigeria* (Communication 155/96)

A similar pattern of indirect but evolving protection is evident within the European human rights system. Although the European Convention on Human Rights does not contain an explicit right to health³⁶, the European Court of Human Rights has developed protective jurisprudence through the right to life³⁷ and the prohibition of inhuman or degrading treatment.³⁸

In this context, failures in healthcare provision may engage state responsibility where they result in serious harm or loss of life.³⁹ Additionally, the European Social Charter explicitly recognises the right to health and imposes obligations regarding public health protection and access to healthcare services.⁴⁰ This dual framework has enabled incremental judicial engagement with health-related claims, but it has not yet produced a coherent doctrine of health equity, as disparities are generally addressed indirectly rather than as a standalone violation. The European approach is thus characterised by indirect enforceability, where health-related claims are adjudicated through adjacent civil and political rights. While this has enabled some degree of judicial intervention, it has also limited the

³⁶ Convention for the Protection of Human Rights and Fundamental Freedoms 213 UNTS 222

³⁷ art. 2

³⁸ art. 3

³⁹ *L.C.B. v United Kingdom* no 23413/94 (09 June 1998); *Cyprus v Turkey* no 25781/94 (10 May 2001)

⁴⁰ European Social Charter (revised) [1996] CETS No 163 (Revised ESC) art 11

development of a coherent doctrine of health equity, as disparities are rarely addressed as standalone violations.⁴¹

By contrast, the Inter-American human rights system has adopted a more explicit and progressive approach to socio-economic rights. While the American Convention on Human Rights primarily focuses on civil and political rights,⁴² the Protocol of San Salvador explicitly recognises the right to health and obliges States to ensure access to essential healthcare services.⁴³

The Inter-American Court of Human Rights has strengthened this framework by interpreting the right to health in conjunction with rights to life and personal integrity. further interpreted the right to health in conjunction with the right to life and personal integrity, thereby strengthening its enforceability. In several decisions, the Court has emphasized State obligations to ensure access to healthcare, particularly for vulnerable populations, and has recognised the structural dimensions of health inequalities.⁴⁴ This jurisprudence

⁴¹ Marija Milenkovska, 'The Protection of the Right to Health Under Article 2 of the European Convention on Human Rights' (2012) 3 (10) *Mediterranean Journal of Social Sciences*

⁴² American Convention on Human Rights (adopted 22 November 1969, entered into force 18 July 1978) 1144 UNTS 123 (ACHR) art 26

⁴³ Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ('Protocol of San Salvador') (adopted 17 November 1988, entered into force 16 November 1999) OAS Treaty Series No 69, art 10

⁴⁴ Mac-Gregor Eduardo Ferrer, 'Impact of the Inter-American Jurisprudence on Economic, Social, Cultural, and Environmental Rights' in Armin von Bogdandy and others (eds), *The Impact of the Inter-American Human Rights*

demonstrates increasing attention to structural inequality and vulnerability, thereby offering valuable insights for the development of a justiciable framework for health equity.

Taken together, these regional approaches reveal a converging jurisprudential trend: despite doctrinal and institutional differences, courts and supervisory bodies increasingly recognise positive state obligations, apply standards of reasonableness or proportionality, and acknowledge the structural dimensions of health-related harm. However, while this convergence strengthens the justiciability of the right to health, health equity itself remains insufficiently articulated as an independent legal standard. This gap underscores the need for a structured framework through which health inequities may be directly assessed as violations of enforceable rights rather than indirect policy concerns.

3.3 The Implicit Nature of Equity

A careful examination of international and regional human rights frameworks reveals that while health equity is not always expressly articulated as a standalone legal right, it is deeply embedded within existing legal principles and obligations. In particular, doctrines of non-discrimination and the protection of vulnerable groups serve as

System: Transformations on the Ground (New York 2024 online edn, Oxford Academic 22 Feb 2024)
<<https://doi.org/10.1093/oso/9780197744161.003.0012>> accessed 29 April 2026; Pedro Villarreal, 'The Direct Justiciability of the Right to Health at the IACtHR – What is the Added Value?' *Völkerrechtsblog* 22 October 2018 <[doi: 10.17176/20181022-165043-0](https://doi.org/10.17176/20181022-165043-0)> accessed 29 April 2026

the primary conduits through which equity considerations enter the legal architecture of the right to health.

At the international level, the principle of non-discrimination has immediate and cross-cutting application. Article 2(2) of the ICESCR obliges States to guarantee that rights are exercised without discrimination of any kind, including on grounds such as race, sex, socio-economic status, or place of residence.⁴⁵ This obligation has been interpreted expansively in General Comment No. 14 to require not merely formal equality, but substantive equality in access to healthcare and underlying determinants of health.⁴⁶ Importantly, the non-discrimination principle extends beyond prohibiting direct exclusion to addressing indirect and systemic forms of disadvantage. This includes disparities arising from socio-economic inequalities, geographic marginalisation, and structural barriers within healthcare systems. In this regard, non-discrimination functions as a proxy for equity, as it requires States to identify and rectify patterns of unequal access and outcomes that disproportionately affect certain groups.

Closely linked to this is the emphasis on vulnerable and marginalised groups.⁴⁷ International human rights law consistently imposes

⁴⁵ International Covenant on Economic, Social and Cultural Rights, art 2(2)

⁴⁶ CESCR General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12) adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4)

⁴⁷ CESCR General Comment No 14 paragraph 43(f)

heightened obligations on States to prioritise individuals and communities who are at greater risk of health deprivation. General Comment No. 14 for example, explicitly identifies groups such as women, children, persons living in poverty, and rural populations as requiring special attention in the design and implementation of health policies. Similarly, regional bodies, including the African Commission on Human and Peoples' Rights, have underscored the duty of States to adopt targeted measures to address the needs of disadvantaged populations.⁴⁸

Notwithstanding this embeddedness, a critical doctrinal limitation persists. The principle of equity, though functionally present, remains conceptually diffuse and legally under-specified. It is often subsumed within broader categories such as non-discrimination or reasonableness, rather than articulated as an independent and enforceable standard. As a result, courts tend to address inequities indirectly, without identifying them as violations of a distinct legal obligation grounded in equity.

This lack of explicit doctrinal articulation has significant consequences. It limits the ability of litigants to frame claims in terms of systemic inequity, constrains judicial reasoning, and ultimately weakens the enforceability of the right to health. Without a clearly defined legal standard, equity risks remaining a normative aspiration

⁴⁸ Social and Economic Rights Action Center (SERAC) v Nigeria (2001)

rather than a justiciable right. Accordingly, the central argument in this article is that health equity, though already embedded within existing legal frameworks, must be doctrinally crystallized and operationalized as a distinct, reviewable standard. Only through such articulation can courts effectively engage with structural disparities and transform the implicit promise of equity into a concrete and enforceable legal obligation.

4. Justiciability: Doctrine and Controversies

4.1 What Makes a Right Justiciable?

The concept of justiciability lies at the heart of any attempt to translate normative commitments into enforceable legal obligations. A right is considered justiciable where it is capable of being adjudicated by a court of law through the application of identifiable legal standards.⁴⁹ In this regard, three interrelated criteria are particularly instructive: precision, enforceability, and institutional competence.

First, precision requires that a right be sufficiently defined to permit judicial interpretation and application.⁵⁰ Vague or indeterminate norms are often regarded as unsuitable for adjudication, as they risk

⁴⁹ CN Kwoka, 'What Is Justiciability in Nigerian Constitutional Law?' *supra* at footnote 24

⁵⁰ JAJA Tonye Clinton, 'Judicial Interpretation of Legislation as a Source of Rules of Legislative Procedure and Legislative Drafting: a Comparative Study of United Kingdom and Nigerian Court Cases on Legislative Drafting' (2016) 9 *Comparative Law Review* 149-201
<<https://apcz.umk.pl/CLR/article/view/CLR.2015.007>> accessed 29 April 2026

conferring excessive discretion upon courts. This concern has historically been invoked to resist the justiciability of socio-economic rights, including aspects of the right to health. However, developments in international law, particularly the elaboration of standards such as the AAAQ framework, demonstrate that such rights are capable of meaningful specification.

Secondly, enforceability concerns the capacity of courts to grant effective remedies in the event of a violation. A right that cannot be enforced risks remaining purely aspirational. In the context of socio-economic rights, enforceability has often been questioned on the basis that such rights entail positive obligations and resource allocation. Nevertheless, courts have increasingly adopted remedies that focus on structural compliance, such as declaratory orders and supervisory jurisdiction, thereby mitigating concerns about overreach.⁵¹

Thirdly, institutional competence addresses whether courts are the appropriate forum for resolving disputes involving complex policy considerations. Critics argue that issues of healthcare allocation fall within the domain of the executive and legislature. Yet, this argument overlooks the fundamental role of courts in safeguarding rights and ensuring that State action conforms to constitutional and legal standards. Rather than displacing policy-making functions, judicial

⁵¹ Mike JH, 'Enhancing the Right to Health in Nigeria through Judicial Intervention' (2023) 67(3) *Journal of African Law* 409-430 <doi:10.1017/S0021855323000116> accessed 30 April 2026

review can operate as a mechanism of accountability, ensuring that decisions are reasonable, non-discriminatory, and consistent with legal obligations.⁵²

Taken together, these criteria indicate that the justiciability of the right to health, and by extension, health equity, does not depend on the absence of complexity, but on the availability of structured legal standards through which courts can evaluate disparities in access, outcomes, and state action.

4.2 Core Doctrinal Tools

The evolution of socio-economic rights jurisprudence has been facilitated by the development of a set of core doctrinal tools that enable courts to engage with complex rights without exceeding their institutional mandate. These tools are central to the operationalisation of the right to health.

The principle of non-discrimination is foundational. As an immediately binding obligation, it requires States to ensure equal access to healthcare and prohibits both direct and indirect forms of

⁵² Alicia Ely Yamin and Luciano Bottini Filho and Camila Gianella Malca, 'Advancing the right to health: from exhortation to action' (2023) Geneva: World Health Organization <https://cdn.who.int/media/docs/default-source/council-on-the-economics-of-health-for-all/whocouncil-economics-health4all_insight_no5.pdf> accessed 30 April 2026; YAMIN Alicia Ely and FILHO Luciano and MALCA Camila Gianella, 'Analysing governments' progress on the right to health' 102 (5) Bulletin of the World Health Organization 307-313

discrimination.⁵³ Its significance lies in its capacity to address systemic inequalities, thereby providing an entry point for the adjudication of equity-related claims.

Reasonableness review has emerged as a key standard. Under this approach, courts assess whether State policies and actions are reasonable in light of constitutional obligations. This does not entail substituting judicial judgment for that of policy-makers; rather, it involves evaluating whether measures are comprehensive, coherent, and responsive to the needs of vulnerable groups.⁵⁴ In this way, reasonableness review enables courts to evaluate whether state measures adequately address structural inequalities in healthcare access and outcomes.

The doctrine of minimum core obligations further strengthens enforceability by identifying essential levels of rights that must be immediately realised.⁵⁵ In the context of the right to health, this includes access to basic healthcare services and essential medicines. While the precise content of the minimum core may be contested, its normative function is to establish a baseline below which State conduct is presumptively unlawful. It therefore provides a benchmark against which inequities in access to essential health services may be assessed as *prima facie* violations.

⁵³ CESCR General Comment No 14 para 12(b)

⁵⁴ Syrett K, 'Evolving the Right to Health: Rethinking the Normative Response to Problems of Judicialization' (2018) 20(1) Health Hum Rights 121-132

⁵⁵ CESCR General Comment No 14 para 43

Finally, the principle of progressive realisation acknowledges that full realisation of socio-economic rights may be achieved over time, subject to resource constraints.⁵⁶ However, it imposes an obligation on States to take deliberate and concrete steps towards this goal, and prohibits retrogressive measures without adequate justification. Importantly, progressive realisation does not negate justiciability; rather, it provides a framework within which courts can assess the adequacy of State efforts.⁵⁷ Courts may therefore assess whether disparities persist due to illegitimate constraints or result from unreasonable or unjustified state inaction.

A seminal illustration of the justiciability of socio-economic rights, particularly in relation to the doctrine of progressive realisation, is the decision of the Constitutional Court of South Africa in *Minister of Health v Treatment Action Campaign*.⁵⁸ The case concerned the government’s policy restricting access to Nevirapine, a drug capable of preventing mother-to-child transmission of HIV, to a limited number of pilot sites. The Court held that the policy was unreasonable and inconsistent with the State’s constitutional obligations. Crucially, its reasoning was grounded in the principle of progressive realization, as enshrined in the South African Constitution. The Court emphasized that while the State is not required to achieve the full realization of

⁵⁶ art. 2(1) ICESCR; CESCR General Comment No 3 para 1

⁵⁷ Syrett K, 'Evolving the Right to Health: Rethinking the Normative Response to Problems of Judicialization' (2018) 20(1) Health Hum Rights 121-132

⁵⁸ *Minister of Health and Others v Treatment Action Campaign and Others* (No 1) [2002] ZACC 16, 2002 (5) SA 703 (CC)

socio-economic rights immediately, it is nonetheless under a duty to take reasonable, deliberate, and concrete steps towards their fulfilment. The restriction of a life-saving intervention, particularly where it was available and medically effective, constituted a failure to meet this obligation.

Importantly, the Court did not interpret progressive realization as a license for inaction or minimal compliance. Rather, it clarified that the doctrine imposes positive and continuous duties on the State, including the obligation to remove unjustifiable barriers to access and to expand the reach of essential healthcare services. The government's failure to extend access to Nevirapine beyond pilot sites, despite clear evidence of need and feasibility, was therefore found to be inconsistent with the requirement of reasonableness within progressive realization. The decision illustrates how courts can apply the doctrine of progressive realization through a standard of reasonableness to address inequities in access to essential healthcare. It demonstrates that judicial review can identify and remedy structural disparities without displacing the policy-making role of the State.

5. Health Equity as a Justiciable Standard

5.1 Reframing Health Equity

The central contention of this study is that health equity must be repositioned from the realm of policy aspiration to that of enforceable legal obligation. While public health discourse has long recognised

equity as a foundational value, its legal marginalisation has significantly constrained its transformative potential. This disconnect is neither inevitable nor justified; rather, it reflects a failure of doctrinal articulation rather than an absence of normative or legal basis.

International human rights law already embeds equity-oriented principles within the right to health. General Comment No. 14 explicitly requires States to ensure equitable distribution of health facilities, goods, and services, thereby recognising that disparities in access and outcomes are subject to legal scrutiny.⁵⁹ Similarly, the obligation of non-discrimination under Article 2(2) of the ICESCR imposes an immediate duty to eliminate both direct and indirect forms of inequality in healthcare access.⁶⁰ Moreover, global policy frameworks such as the Sustainable Development Goals (SDGs), particularly Goal 3 (good health and well-being) and Goal 10 (reduced inequalities), reinforce the centrality of equity in healthcare systems.⁶¹ Although these instruments are often framed in policy terms, their widespread adoption reflects an emerging consensus that inequity is not merely undesirable but unjustifiable.

⁵⁹ General Comment No. 14: The Right to the Highest Attainable Standard of Health

⁶⁰ International Covenant on Economic, Social and Cultural Rights, art 2(2)

⁶¹ UN General Assembly, 'Transforming our world: the 2030 Agenda for Sustainable Development' (21 October 2015) A/RES/70/1

The task, therefore, is not to create new rights, but to reconstruct existing legal doctrines in a manner that renders equity explicit, actionable, and reviewable. This requires situating health equity within established principles such as non-discrimination, substantive equality, and reasonableness review. By situating health equity within established doctrines of non-discrimination, substantive equality and reasonableness review, it becomes possible to articulate it as a judicially enforceable standard capable of guiding courts in the assessment of systemic disparities in healthcare.

5.2 Three Core Obligations of Health Equity

To operationalise health equity within a legal framework, it is necessary to distil it into concrete and enforceable obligations. This study proposes three interrelated dimensions through which health equity may be judicially articulated: horizontal equity, vertical equity, and structural equity.

(a) Non-discrimination (Horizontal Equity)

Horizontal equity requires that individuals and groups in similar circumstances receive equal treatment.⁶² This principle is firmly

⁶² R Raine and others, 'Evaluating health-care equity' in R Raine and others (eds) *Challenges, solutions and future directions in the evaluation of service innovations in health care and public health* (NIHR Journals Library 2016) *Health Services and Delivery Research*, No 4 (16) Essay 5 <<https://www.ncbi.nlm.nih.gov/books/NBK361257/>> accessed 30 April 2026; Wagstaff A and van Doorslaer and Paci P, 'On the measurement of horizontal

grounded in international human rights law and has been consistently affirmed as an immediate and non-derogable obligation. In the healthcare context, horizontal equity prohibits arbitrary or unjustified disparities in access to services, treatment, or outcomes among comparable populations. For instance, differential access to healthcare based on socio-economic status or geographic location, where not objectively justified, constitutes a violation of this principle.⁶³

The normative basis for this obligation is well established. General Comment No. 14 underscores that health facilities must be accessible to all, “especially the most vulnerable or marginalised sections of the population, without discrimination”.⁶⁴ Thus, horizontal equity provides a clear entry point for judicial enforcement, as it translates directly into identifiable legal violations. This makes it a critical doctrinal entry point for assessing health inequities, particularly where disparities disproportionately affect identifiable groups.

inequity in the delivery of health care' (1991) 10 (2) J Health Econ 169–205 <[https://doi.org/10.1016/0167-6296\(91\)90003-6](https://doi.org/10.1016/0167-6296(91)90003-6)> accessed 1 May 2026

⁶³ Iguel San Sebastián and Paola A Mosquera and Nawi Ng and Per E Gustafsson, 'Health care on equal terms? Assessing horizontal equity in health care use in Northern Sweden' (2017) 27(4) European Journal of Public Health 637–643 <<https://doi.org/10.1093/eurpub/ckx031>> accessed 1 May 2026; Kien V D and others, 'Horizontal inequity in public health care service utilization for non-communicable diseases in urban Vietnam' (2014) 7(1) Global Health Action <<https://doi.org/10.3402/gha.v7.24919>> accessed 1 May 2026

⁶⁴ CESCR General Comment No 14 para 12(b)

(b) Priority to Disadvantaged Groups (Vertical Equity)

Vertical equity extends beyond equal treatment to require differential and preferential measures in favour of disadvantaged groups.⁶⁵ It recognises that identical treatment may perpetuate inequality where underlying conditions are unequal.⁶⁶ This principle finds support in both international and regional frameworks. The Committee on Economic, Social and Cultural Rights has repeatedly emphasised the obligation of States to prioritise vulnerable populations, including women, children, rural communities, and persons living in poverty.⁶⁷ Similarly, the African Commission has underscored the need for targeted interventions to address structural disadvantage in cases such as *SERAC v Nigeria*.

As a justiciable standard, vertical equity enables court to assess whether State measures adequately prioritize disadvantaged groups,

⁶⁵ Kapiriri L and Razavi S D 'Equity, justice, and social values in priority setting: a qualitative study of resource allocation criteria for global donor organizations working in low-income countries' (2022) 21(1) International journal for equity in health 17 <<https://doi.org/10.1186/s12939-021-01565-5>> accessed 1 May 2026

⁶⁶ Raine R and others, 'Evaluating health-care equity' In: Raine R and others, solutions and future directions in the evaluation of service innovations in health care and public health: NIHR Journals Library 2016 May (Health Services and Delivery Research No 4 16) Essay 5 <10.3310/hsdr04160-69> accessed 1 May 2026; Norheim OF and Others, 'Guidance on priority setting in health care (GPS-Health): the inclusion of equity criteria not captured by cost-effectiveness analysis' (2014) 12 (18) Cost Eff Resour Alloc <<https://doi.org/10.1186/1478-7547-12-18>> accessed 1 May 2026

⁶⁷ General comment No 20: Non-discrimination in economic, social and cultural rights (art 2 para 2 of the International Covenant on Economic, Social and Cultural Rights)

and to identify failures where policies disproportionately neglect populations facing structural barriers to healthcare access.

(c) Resource Allocation Reasonableness (Structural Equity)

Structural equity concerns the fair and rational allocation of healthcare resources across populations and regions.⁶⁸ It addresses systemic disparities that arise from policy decisions, budgetary priorities, and institutional arrangements. The principle of reasonableness, as developed in socio-economic rights jurisprudence, provides a doctrinal basis for assessing such allocation. Courts are not required to determine the optimal distribution of resources; rather, they assess whether State decisions are reasonable in light of constitutional obligations and the needs of affected populations.

In *Minister of Health v Treatment Action Campaign*,⁶⁹ the South African Constitutional Court emphasised that State policies must be comprehensive, coherent, and responsive to the needs of vulnerable groups. This approach enables courts to scrutinise systemic inequities without encroaching upon the domain of policy-making. Structural equity therefore provides a framework for addressing disparities in healthcare infrastructure, funding, and service delivery, particularly in

⁶⁸ Patricia Jakowski, 'Health Equity Definition, Measures & Importance' (2025) Study.com <study.com/academy/lesson/health-equity-definition-measures-importance.html> accessed 1 May 2026

⁶⁹ *Minister of Health v Treatment Action Campaign*

contexts such as Nigeria where regional and socio-economic inequalities are pronounced.⁷⁰

Structural equity therefore provides a doctrinal basis for judicial scrutiny of systemic disparities in healthcare infrastructure, funding and service delivery.

5.3 A Judicial Framework for the Assessment of Health Equity

Building on the foregoing obligations, this study proposes a structured judicial test for assessing claims of health inequity. This test is designed to translate abstract principles into operational legal criteria capable of guiding judicial decision-making.

(a) Avoidability Test

The first inquiry is whether the disparity in question is avoidable or unjustifiable. This reflects the core definition of health equity as the absence of preventable and unfair differences. Courts should distinguish between disparities arising from unavoidable factors and those attributable to State action or inaction, including policy failure,

⁷⁰ Chai Y and Others, 'Equity and trends in the allocation of health human resources in China from 2012 to 2021' *Arch Public Health* 82, 175 <<https://doi.org/10.1186/s13690-024-01407-0>> accessed May 1 2026; Ying Liu and Others, 'Regional healthcare resource allocation and decision-making: Evaluating the effectiveness of the three-stage super-efficiency DEA model' (2024) 10(23) *Heliyon* <<https://doi.org/10.1016/j.heliyon.2024.e40312>> accessed 1 May 2026

structural neglect, or inequitable resource allocation. This aligns with WHO guidance on identifying unjust health inequalities.⁷¹

(b) Disproportionality Test

The second inquiry examines whether the disparity disproportionately affects vulnerable or marginalised groups. This incorporates principles of substantive equality and vertical equity. Evidence of disproportionate impact, such as higher maternal mortality rates in rural areas or limited access to healthcare among low-income populations, would support a *prima facie* finding of inequity.⁷²

(c) Reasonableness Test

The final inquiry assesses whether the State has taken adequate and reasonable measures to address the disparity. This reflects established jurisprudence on socio-economic rights and ensures that courts evaluate State action rather than substitute their own judgment. Relevant considerations may include the existence of policies, their implementation, and their responsiveness to the needs of affected populations. This approach is consistent with judicial practice in cases such as *Treatment Action Campaign*. This ensures that judicial review

⁷¹ WHO, 'Health equity' <<https://www.who.int/health-topics/health-equity?>> accessed 1 May 2026

⁷² Ezeaka NB and Ochuba CC and Bartholomew C, 'Addressing Healthcare Inequalities in Nigeria: A Communication Perspective on Advocacy and Policy Implications' (2025) 4(4) *Journal of Advanced Research and Multidisciplinary Studies* 1-11 <DOI: 10.52589/JARMSAAQDLCJ> accessed 1 May 2026

remains focused on the adequacy of State measures, rather than substituting judicial judgment for policy decisions.

Taken together, these three enquiries provided a structured and coherent framework through which courts can assess claims of health inequity. The test integrates principles of non-discrimination, substantive equality, and reasonableness review, thereby ensuring consistency with established consistency with established socio-economic rights jurisprudence while enabling the direct adjudication of systemic disparities in healthcare.

6.0 Application to Nigeria: Structural Health Inequity Domains

6.1 Primary Healthcare Access

Primary healthcare (PHC) constitutes the foundational tier of any functional healthcare system, serving as the first point of contact between individuals and the health system.⁷³ In Nigeria, however, the PHC system remains a major site of structural health inequity, reflecting disparities in access, distribution, and service delivery that are capable of legal characterization.

⁷³ WHO, 'Primary health care' <<https://www.who.int/health-topics/primary-health-care>> accessed 1 May 2026; White F, 'Primary health care and public health: foundations of universal health systems' (2015) 24(2) Medical principles and practice: international journal of the Kuwait University, Health Science Centre 103–116 <<https://doi.org/10.1159/000370197>> accessed 1 May 2026

Rural neglect remains one of the most persistent dimensions of this inequity. A significant proportion of Nigeria’s population resides in rural areas, yet access to healthcare infrastructure in these regions is markedly limited. Facilities are often distant, understaffed, and poorly equipped, resulting in delayed or foregone treatment. These patterns are well documented in empirical studies highlighting disparities in healthcare accessibility across rural and urban populations.⁷⁴

Closely related to this is the unequal distribution of healthcare facilities. Health infrastructure remains disproportionately concentrated in urban and economically advantaged regions, particularly in southern Nigeria, while northern and rural regions are comparatively underserved. This imbalance reinforces geographic and socio-economic inequalities, as access to healthcare becomes contingent upon location.⁷⁵

The weakness of first-contact healthcare systems further compounds these disparities. Many PHC facilities suffer from inadequate staffing,

⁷⁴ AM Yaqoob and KK Salman, 'An Empirical Investigation into Measurement and Determinants of Healthcare Access in Rural Nigeria: A Multidimensional Perspective' (2026) <medRxiv 2026.02.13.26346240> accessed 1 May 2026; Adomi S and others, 'Equity of Healthcare Access in Nigeria: A Scoping Review' (2024) 24(3) The Nigerian Health Journal 1345-1354 <<https://doi.org/10.60787/tnhj.v24i3.891>> 1 May 2026; Fang W and Others, 'Urban–Rural Disparities in Geographic Healthcare Accessibility: A Comparative Study of Nigeria and Zambia' (2026) J Urban Health <<https://doi.org/10.1007/s11524-026-01077-z>> accessed 1 May 2026

⁷⁵ AM Yaqoob and AA Salisu and Obumneke Ezie, 'Income-related inequalities and inequities in access to inpatient healthcare in rural Nigeria' <medRxiv 2026.02.12.26346153> accessed 1 May 2026

poor equipment, and limited funding, leading to low-quality service delivery and diminished public trust. As a result, patients often bypass primary care altogether, placing additional strain on higher-level facilities and exacerbating inequities for those unable to access alternative care.⁷⁶

From a doctrinal standpoint, these conditions reflect failures across horizontal, vertical, and structural dimensions of equity. The persistence of such disparities underscores the need to reframe primary healthcare access not merely as a policy concern, but as a justiciable issue capable of assessment under the proposed framework of horizontal, vertical, and structural equity.

6.2 Maternal and Child Health

Maternal and child health outcomes in Nigeria provide a stark illustration of systemic inequities within the healthcare system. Nigeria continues to account for a disproportionately high share of global maternal and under-five mortality, with many of these deaths arising from preventable causes.⁷⁷ A defining concern is the

⁷⁶ Ogah P and others, 'Primary health care in Nigeria: best practices and quality of care in Nigeria' (2024) 24 (963) BMC Health Serv Res <<https://doi.org/10.1186/s12913-024-11406-0>> accessed 1 May 2026; Ugochukwu Uzoechina Nwokoro and others, 'Determinants of primary healthcare services utilisation in an under-resourced rural community in Enugu State, Nigeria: a cross-sectional study' (2022) 42(209) Pan African Medical Journal <[doi: 10.11604/pamj.2022.42.209.33317](https://doi.org/10.11604/pamj.2022.42.209.33317)> accessed 1 May 2026

⁷⁷ WHO, 'Maternal mortality' (2025) <<https://www.who.int/news-room/fact-sheets/detail/maternal-mortality?>> accessed 1 May 2026

persistence of preventable mortality. Maternal deaths are frequently linked to conditions such as haemorrhage and infection, while child mortality is driven by diseases that are largely avoidable through basic interventions. The continued prevalence of such outcomes reflects structural deficiencies in access, infrastructure, and service delivery rather than medical inevitability.⁷⁸ These disparities reveal a clear failure to prioritise vulnerable populations and ensure equitable access to essential healthcare services, thereby engaging core principles of non-discrimination and substantive equality.

Applying the proposed judicial framework, these outcomes satisfy the threshold of avoidability, as the underlying causes are well understood and preventable through established interventions. They also demonstrate clear disproportionality, disproportionately affecting women, children, and low-income populations. The persistence of such conditions further raises questions of reasonableness, particularly in light of the State’s obligation to prioritise vulnerable groups and ensure access to essential healthcare services. Accordingly, maternal and child health disparities constitute a paradigmatic case of justiciable health inequity

⁷⁸ Mordecai Oweibia and others, 'Maternal and Child Health Trends in Nigeria: A Scoping Review of NDHS 2018 vs. NDHS 2023' (2025) <medRxiv 2025.05.18.25327864> accessed 1 May 2026

6.3 Geographic Inequity

Geographic inequity remains a defining feature of Nigeria's health system, with access and outcomes varying significantly based on location. The urban–rural divide continues to shape patterns of healthcare access. Urban areas benefit from greater availability of facilities, personnel, and infrastructure, while rural populations face barriers such as distance, cost, and limited service availability. These disparities contribute to lower utilisation rates and poorer health outcomes in rural communities.⁷⁹

Regional disparities further deepen these inequities. Northern regions, particularly the North-East and North-West, consistently record poorer health indicators compared to southern regions. These differences are attributable to a combination of historical underinvestment, socio-economic disadvantage, and governance challenges. Such patterns demonstrate that geographic location operates as a determinant of health, raising serious concerns regarding the equitable distribution of healthcare resources.⁸⁰

⁷⁹ Fang W and others, 'Urban–Rural Disparities in Geographic Healthcare Accessibility: A Comparative Study of Nigeria and Zambia' (2026) *J Urban Health* <<https://doi.org/10.1007/s11524-026-01077-z>> 1 May 2026

⁸⁰ Chima V and others, 'Regional variations in child health deprivation and its associated factors in Nigeria' (2025) 5(8) *PLOS Global Public Health* e0003796 <<https://doi.org/10.1371/journal.pgph.0003796>> accessed 1 May 2026

From a doctrinal perspective, geographic disparities in healthcare access and outcomes engage in all three dimensions of the proposed framework. The persistence of such disparities suggests avoidable inequities arising from unequal distribution of healthcare infrastructure and services. The disproportionate impact on rural populations and historically disadvantaged regions supports a finding of inequity. Finally, these patterns raise questions as to whether State resource allocation decisions meet the standard of reasonableness, particularly where longstanding regional imbalances remain unaddressed.

6.4 Financial Protection

Financial barriers constitute a critical dimension of health inequity in Nigeria, significantly affecting both access to and utilisation of healthcare services. The healthcare system is characterised by high levels of out-of-pocket expenditure, with individuals bearing a substantial share of healthcare costs. This financing structure places disproportionate pressure on low-income households and undermines equitable access to care. Such expenditure often results in financial hardship and deepens existing poverty where healthcare costs exceed a significant proportion of household income⁸¹

⁸¹ Edward Odunyemi Adedokun, ‘The Implications of Health Financing for Health Access and Equity in Nigeria’ (2022) Healthcare Access, IntechOpen <<https://doi.org/10.5772/intechopen.98565>> accessed 1 May 2026; Okechukwu Chime Ogbodo, ‘Trends and Challenges of Health Care Financing in Nigeria’

A further consequence is poverty-driven exclusion from healthcare. Many individuals are unable to seek or continue treatment due to financial constraints, effectively denying them access to essential services. This dynamic perpetuates a cycle in which ill-health and poverty reinforce one another. These conditions raise fundamental questions regarding compliance with the obligation to ensure economic accessibility of healthcare, a core component of the right to health.

Within the proposed framework, financial barriers to healthcare constitute a clear instance of justiciable inequity. The exclusion of individuals from essential services due to cost satisfies the avoidability criterion, as alternative financing mechanisms are well established. The disproportionate burden on low-income populations reflects structural inequality, thereby engaging principles of substantive equality. Moreover, the persistence of high out-of-pocket expenditure raises serious concerns regarding the reasonableness of State measures to ensure economic accessibility which a core component of the right to health.

Taken together, these domains – maternal and child health, geographic access, and financial protection, all demonstrate that health inequities in Nigeria are not isolated or incidental, but systemic and structurally embedded. When assessed through the proposed

judicial framework, these disparities reveal patterns of avoidable harm, disproportionate impact, and insufficiently reasonable State action. This underscores the viability of treating health equity as a justiciable standard capable of guiding judicial intervention in addressing systemic inequalities within the healthcare system.

7. Conclusion

This article has argued that health equity is not merely a normative aspiration, but a concept that is both definable and legally enforceable. The foundations for its enforcement already exist within international and regional human rights law, particularly through doctrines of non-discrimination, substantive equality, and reasonableness. The major challenge, therefore, lies not in the absence of legal basis, but in articulating and applying health equity as a distinct justiciable standard.

The analysis highlights the need to move from normative recognition to enforceable obligation. The continued marginalisation of equity within legal doctrine has allowed systemic disparities, especially in Nigeria, to persist without meaningful accountability. Addressing this gap requires a deliberate doctrinal shift that places equity at the centre of the right to health. In response, this article has advanced a structured framework for judicial enforcement, of health equity, grounded in non-discrimination, prioritisation of disadvantaged groups, and reasonableness in resource allocation, supported by a

212

clear three-part judicial test. By translating abstract commitments into concrete standards of review, this framework provides courts with a coherent method for identifying and addressing inequities as violations of legal rights rather than mere policy shortcomings. This approach demonstrates that equity can be translated into practical and reviewable legal standards.

Ultimately, recognising health equity as a justiciable component of the right to health has significant implications for both legal doctrine and practice. It enables courts to engage more directly with structural disparities in healthcare systems, strengthens accountability for inequitable outcomes, and enhances the transformative potential of the right to health. In doing so, it offers a pathway for aligning legal commitments with lived realities, particularly in jurisdictions where health inequities remain deeply entrenched.