



APPRAISAL OF THE LEGAL AND REGULATORY FRAMEWORKS GOVERNING CONSENT IN FAMILY MEDICAL MATTERS IN NIGERIA

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ABSTRACT

This paper, titled Appraisal of the Legal and Regulatory Frameworks Governing Consent in Family Medical Matters, the paper critically examines the legal structures regulating consent within the Nigerian healthcare system, with particular focus on women and children in the family context. Consent remains a fundamental principle in medical jurisprudence, as it is intrinsically linked to the protection of patients' fundamental rights, including dignity, privacy, and bodily integrity. The study underscores that beyond being a procedural requirement, consent: particularly informed consent constitutes a core element of lawful medical practice. Adopting a doctrinal research methodology, the paper undertakes a detailed analysis of relevant statutory and regulatory instruments. Key legislations examined include the Constitution of the Federal Republic of Nigeria 1999 (as amended), the Child's Rights Act 2003, the National Health Act 2014, and the Violence Against Persons (Prohibition) Act 2015. These statutes are interrogated to assess the extent to which they safeguard the autonomy and rights of women and children in medical decision-making within the family structure. The paper also explores judicial authorities to illuminate how Nigerian courts have interpreted and enforced the doctrine of consent in medical settings. Furthermore, the study provides conceptual clarifications of key terms such as consent, informed consent, and capacity, thereby establishing a solid analytical foundation. It identifies gaps and challenges within the existing framework, particularly in balancing parental authority, cultural influences, and individual autonomy. The paper concludes by offering recommendations aimed at strengthening legal protections and promoting a rights-based approach to medical consent in Nigeria.

KEYWORDS: *Consent, Family, Family Medicine and Medical Rights.*

1. INTRODUCTION

In common parlance, medical consent refers to consent to treatment, meaning that no individual may be subjected to any form of medical intervention, examination, or diagnostic procedure without first granting permission. Such permission must be based on adequate explanation provided by a clinician. This requirement applies universally, irrespective of the nature or invasiveness of the procedure, whether it involves a physical examination or any other form of clinical intervention.



The principle of consent constitutes a fundamental pillar of medical ethics and is firmly embedded within international human rights law.¹

Where consent is required in medical contexts, the notion of “informed consent” is particularly salient. In *Georgina Ahamefule v Imperial Medical Centre & Dr Alex Molokwu*², the Lagos State High Court addressed the legal consequences of administering an HIV test without prior informed consent or the provision of pre- and post-test counselling. The Court held that such unauthorized testing amounted to battery under the law of tort. Significantly, the decision was grounded strictly in common law principles of trespass to the person, rather than being framed in constitutional or human rights terms, notwithstanding the clear implications for privacy, autonomy, and personal dignity arising from the facts.

Beauchamp and Childress³, underscore informed consent as a core expression of autonomy within healthcare. It obliges medical practitioners to furnish patients with sufficient, comprehensible information regarding their diagnosis, available treatment options, attendant risks and benefits, as well as viable alternatives. Armed with this information, patients are positioned to make autonomous and reasoned healthcare decisions. Accordingly, medical consent occupies a foundational place in both legal and clinical discourse, constituting the bedrock of the fiduciary relationship between patient and healthcare provider.

From a constitutional perspective, the 1999 Constitution of the Federal Republic of Nigeria (as amended) provides the normative framework underpinning the doctrine of medical consent⁴. Section 34(1) guarantees respect for human dignity and prohibits torture, inhuman or degrading treatment, as well as medical or scientific experimentation without consent. This protection is further reinforced by Section 37, which safeguards the right to privacy, and Section 38(1), which enshrines freedom of thought, conscience, and religion.⁵

Consent, in this context, denotes a voluntary and informed agreement by a patient to undergo a medical procedure or intervention, made after full disclosure of its nature, risks, benefits, and available alternatives. The right to life operates as a central normative benchmark against which the validity, scope, and enforceability of medical consent are assessed. It ensures that consent is not treated as a mere procedural requirement but as a substantive safeguard of human rights,

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¹ NHS, ‘Consent to Treatment’ < <http://www.nhs.uk/conditions/consent-to-treatment/#....>> accessed 28 April 2025.

² (Unreported, Lagos State High Court, Suit No. ID/1627/2000, judgment delivered 27 April 2012).

³ T L Beauchamp and James F Childress, *Principles of Biomedical Ethics* (8th edn, Oxford University Press Oxford 2019) 107.

⁴ Constitution of the Federal Republic of Nigeria 1999 (as amended), s34(1).

⁵ CFRN, s37&38(1).



particularly aimed at protecting vulnerable groups, especially women and children from avoidable harm, coercion, and structural neglect within the healthcare system.⁶

Within any rigorous legal analysis of medical consent, the right to life assumes a foundational and determinative role, particularly when situated within a human rights framework as it pertains to Nigerian women and children. As the most basic and inalienable of rights, it informs and conditions the interpretation, content, and permissible limitations of medical consent, especially in clinical decisions that implicate survival, bodily integrity, and inherent human dignity⁷. Under Nigerian law, this right is expressly constitutionally guaranteed and further strengthened by binding international and regional human rights instruments. It consequently imposes both negative duties to refrain from arbitrary deprivation of life and positive obligations to adopt measures that protect and preserve life, including within healthcare delivery systems⁸.

In the Nigerian context, issues surrounding medical consent particularly in relation to women and children raises significant legal and human rights concerns. By way of illustration, the researcher's personal experience prior to undergoing a caesarean section is instructive. She was informed by her attending physician of the option of tubal ligation as a standard form of family planning. However, despite her informed preference and exercise of bodily autonomy, the medical team refused to proceed without the consent of her husband. While not an isolated occurrence, this episode exposes the persistent tension between individual autonomy and entrenched patriarchal socio-legal norms within Nigerian medical practice. It further raises critical questions regarding the extent of a woman's legal capacity to consent to medical procedures affecting her own body, as well as the corresponding duties imposed on healthcare professionals under Nigerian law.

2. LEGAL FRAMEWORK GOVERNING CONSENT FOR WOMEN IN NIGERIA

a) **The Constitution of the Federal Republic of Nigeria 1999 (as amended).**

The current Constitution of Nigeria was promulgated on 29 May 1999 and has since been amended multiple times. The Constitution of the Federal Republic of Nigeria (as amended) is regarded as the fundamental legal norm, with its provisions taking precedence over all other existing laws. The Constitution clearly states that it is 'Supreme and its provisions shall have binding force on all authorities and persons throughout the Federal Republic of Nigeria'⁹. Nigeria is a signatory to many international and regional treaties, including those related to human rights promotion and protection. For any treaty to have the force of law in Nigeria, such treaty must be enacted into law by the National Assembly¹⁰. In effect, the Constitution grants powers to the National Assembly to

⁶ African Charter on the Rights and Welfare of the Child arts 5, 14.

⁷ B A Garner, *Black's Law Dictionary* (11th edn, Thomson Reuters 2019) 1584.

⁸ CFRN 1999 (as amended) s33; African Charter on Human and Peoples' Rights art 4.

⁹ Constitution of the Federal Republic of Nigeria 1999 (as amended) (CFRN), s1.

¹⁰ CFRN 1999 (as amended), s12(1).



implement a treaty by making laws for every part of the Federation concerning matters not included in the Exclusive Legislative List.¹¹ The position of the law in such situations as buttressed in *Abacha&ors v Fawehimi*¹² is that the incorporated law is given the same ranking as other municipal laws.

The Constitution has two chapters that seek to protect the rights of people in Nigeria. These are Chapter II and Chapter IV of the Constitution. Chapter II of the Constitution deals with the Fundamental Objectives and Directive Principles of State Policy while Chapter IV deals with Fundamental Rights. Both chapters deal extensively with the rights of citizens.¹³ Chapter IV of the Constitution deals with fundamental rights which are justiciable and legally enforceable. This chapter of the Constitution deals with the right to life, the right to dignity of the human person, the right to personal liberty, and the right to a fair hearing.¹⁴ Other include the right to private and family life, the right to freedom of thought, conscience and religion, the right to freedom of expression and the press, the right to peaceful assembly and association, the right to freedom of movement, the right to freedom from discrimination, the right to acquire and own immovable property anywhere in Nigeria.¹⁵ The courts in *Ransome Kuti&Ors v. Attorney General of the Federation*,¹⁶ explained the nature of fundamental rights to mean:

*A right which stands above the ordinary laws of the land and which is antecedent to the political society itself. It is a primary condition for civilised existence and what has been done by our Constitution...is to have these rights in the Constitution so that the rights could be immutable to the extent of the non-immutability of the Constitution*¹⁷

However, the fundamental rights in sections 37 to 41 of the Constitution can be derogated and restricted ‘in the interest of defense, public safety, public order, public morality or public health or to protect the rights and freedom of other persons’¹⁸. The right to life contained in section 33 of the Constitution respectively cannot be derogated except in death resulting from acts of war or penalty for an offence known to law. Concerning the right to personal liberty contained in section 35 of the Constitution, the right cannot be derogated except if such measures are reasonably justifiable to deal with the situation that exists during that period of emergency.¹⁹

¹¹ Ibid, s12(2).

¹² *Abacha v Fawehinmi* (2000) LPELR-14(SC).

¹³ CFRN 1999 (as amended), Chpt II s13-24; Chpt IV, s33-46.

¹⁴ Ibid, s33-36.

¹⁵ CFRN, s37-41.

¹⁶ [1985] 2 NWLR (Pt 6) 211 at 257

¹⁷ Ibid, 229-230.

¹⁸ CFRN, s45(1)(a)(b).

¹⁹ CFRN, s45(2).



The Constitution provides for the Exclusive and Concurrent Legislative List.²⁰ The Exclusive Legislative Lists spells out the legislative competence of the federal government through the National Assembly while the Concurrent Legislative List enumerates matters that both the House of Assembly of a State (state governments) and the National Assembly (federal government) can legislate upon.²¹ Any matter not included in the Exclusive Legislative List and the Concurrent Legislative List falls within the exclusive legislative sphere of the states as residual matters.²² Considering that health is not an Exclusive or Concurrent matter, it is considered a residual matter within the legislative competence of the state under section 4(7)(c). However, a broad interpretation of item 60(a) of the Exclusive Legislative List which grants the federal government the power to establish and regulate authorities for the federation or any part of the federation, to ‘promote and enforce the observance of the Fundamental Objectives and Directive Principles contained in this Constitution’ can be said to extend the reach of the federal government to legislate on health care²³. In effect, the federal government can pass legislation that affects health care such as (health) insurance which also falls under the Exclusive Legislative List.

The Constitution does not expressly guarantee the right to healthcare as it is a social objective of the state as provided for in Chapter II of the Constitution. The Constitution provides that the State shall direct its policy towards ensuring that ‘the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused’ and that there are adequate medical and health care facilities for all persons.²⁴ Although not expressly catered for, other provisions of the Constitution that support the right to health and health care include the right to life, food, housing, the right to dignity of the human person, the right against discrimination and the right to work. This goes to buttress the indivisible and interdependent nature of human rights. It also goes to show the multi-sectoral nature of human rights.²⁵

b) National Health Act 2014

The National Health Act 2014 (NHA) is an Act of the National Assembly of the Federal Republic of Nigeria to provide a framework for the regulation, development and management of a national health system and set standards for rendering health services and related matters.²⁶ This is without prejudice to extant professional regulatory laws and protects, promotes and fulfils the rights of the people of Nigeria to have access to health care services.²⁷ Nigeria has ratified the International Covenant on Economic Social and Cultural Rights (ICESCR) and the provisions of the NHA are

²⁰ Ibid, Pt I Second Schedule; CFRN, pt II Second Schedule.

²¹ Ibid, Pt II of the second schedule.

²² Remigius Nwabueze, The Legal Protection and Enforcement of Health Rights in Nigeria’ in Collen M. Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Law Divide* (Cambridge University Press, 2014) 380.

²³ Ibid, 380-381.

²⁴ CFRN, s17(3)(c)(d).

²⁵ Obiajulu Nnamuchi, ‘Securing the Right to Health in Nigeria under the Framework of the National Health Act’ [2018] (37)(3) *Medicine and Law*, 480.

²⁶ National Health Act, 2014 (NHA), explanatory memorandum.

²⁷ NHA, s(1)(a)-(e).



similar concerning their emphasis on the use of available resources for the enjoyment of the highest standard of health. The quantum of resources available determines what is attainable or possible within a particular country. The NHA is the first comprehensive health legislation in Nigeria and identifies the right to health. It establishes the national health system and provides a framework for standards and regulation of health services in Nigeria. The standards set by the NHA are to provide the best possible health services within the limits of available resources for persons living in Nigeria and protect, promote and fulfil the rights of the people to have access to health care services.²⁸

It is important to mention that the NHA established the Basic Health Care Provision Fund to finance primary health care services to citizens.²⁹ The Basic Health Care Provision Fund is financed by the federal government's annual grant, grants by international donor partners and funds from any other source.³⁰ Money from the fund is distributed in percentages and is used to provide a basic minimum package of health services to citizens, in eligible primary or secondary health care facilities through the National Health Insurance Scheme (NHIS); provide essential drugs, vaccines and consumables for eligible primary health care facilities and emergency medical treatment.³¹ The National Primary Health Care Development Agency disburses all funds apart from that reserved for the NHIS. For States and Local Governments to qualify for a block grant from the fund, such states or local governments must contribute the fund in the manner prescribed in the NHA, must have applied the funds earlier disbursed following the provisions of the Act, must implement the national health policy, norms, standard and guideline prescribed by the National Council on Health.³²

Just like the Code of Medical Ethics in Nigeria for medical practitioners, the NHA still stresses the obligation of medical practitioners. Thus, a health care provider, health worker or health establishment is not to refuse a person emergency medical treatment for any reason.³³ A contravention of this provision is a punishable offence and attracts a fine of N100,000 or imprisonment not exceeding six months or both.³⁴ Except for psychiatric patients, a 'health care provider may refuse to treat a user who is physically or verbally abusive or who sexually harasses him or her, and in such a case the health care provider should report the incident to the appropriate authority'.³⁵ Concerning providing persons who are using health facilities with relevant information to enable them her make an informed medical decision, a health provider is obligated to give relevant information about his or her state of health and necessary treatment relating to the health status, the range of diagnostic procedure, benefit, risk, cost of associated options and the right to

²⁸ Ibid.

²⁹ NHA, s11(1).

³⁰ Ibid, s11(2)(a)-(c).

³¹ Ibid, s11(3)(a)-(e).

³² NHA, s11(4)-(6).

³³ Ibid, s20(1).

³⁴ NHA, s20(2).

³⁵ Ibid, s21(3).



refuse health services and its implication.³⁶ The health care provider concerned where possible, is to inform such a person in a language that he or she understands and in a manner which takes into account his or her level of literacy.³⁷

On the issue of confidentiality, the NHA also notes that information relating to a person's health status, treatment or stay in a health establishment is confidential.³⁸ Except, he or she consents to that disclosure in writing or a court order or any law requires that disclosure. In the case of a minor, such information can be disclosed upon the request of a parent or guardian. In the case of a person who is otherwise unable to grant consent, such disclosure can be made upon the request of a guardian or representative.³⁹ Here, the confidentiality clause can be breached by parents on behalf of all children, irrespective of age or capacity. Health information of minors can only be shared by obtaining the consent of the parent or guardian and not the minor.

These provisions notwithstanding, a health worker or any health care provider that has access to the health records may disclose such personal information as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties and where such access or disclosure is in the interest of the owner of the health records.⁴⁰ In all, the NHA does not have provisions on consent to medical treatment for mature minors. Although it refers to a health insurance scheme, it does not state how the funds are to be applied particularly where children are to become beneficiaries. It also limits the application of the Basic Health Care Provision Fund to government-owned health establishments.

c) Medical and Dental Practitioners Act, CAP M8 (LFN) 2004.

The Medical and Dental Practitioners Act (MDPA) is an Act of the National Assembly to establish the Medical and Dental Council of Nigeria for the registration of medical practitioners and dental surgeons and to provide for a Disciplinary Tribunal for the discipline of members.⁴¹ Considering that this study explores the idea of obtaining consent for medical treatment for mature minors, it is apt to review the MDPA in this regard. To administer treatment to a mature minor in a medical establishment, consent of the mature minor must be obtained by a 'medical practitioner' from the child. This study adopts the definition of 'medical practitioner' from the MDPA as defined in chapter two. The MDPA covers a range of provisions relevant to the practice of medicine in Nigeria.

³⁶ Ibid, s23(1)(a)-(d).

³⁷ Ibid, s23(2).

³⁸ Ibid, s26(1).

³⁹ Ibid, s26(2)(a)-(d).

⁴⁰ NHA, s27.

⁴¹ Medical and Dental Practitioners Act, Cap M8 LFN 2004 (MDPA).



It provides for offences and penalties for professional misconduct by medical practitioners.⁴² It establishes the Disciplinary Tribunal and Investigation Panel charged with the duty of considering and determining any case referred to it by the Medical and Dental Practitioners Investigation Panel any other case of which the Disciplinary Tribunal has cognizance.⁴³ These disciplinary measures are important as they help to ensure that medical practitioners uphold their professional ethics in dealing with adult, child patients generally as for women, this safeguards autonomy, particularly in reproductive health decisions (e.g., childbirth, surgeries, contraception). It ensures that no procedure, such as sterilization or cesarean section is done without voluntary, informed agreement. Violations can lead to professional sanctions. Thus, the Act promotes ethical medical conduct and protects women's constitutional rights to bodily integrity, privacy, and dignity in healthcare settings⁴⁴. No provision is made for how medical and dental practitioners are to cater to minor /patients or how they are to obtain their consent for treatment nor the type of permissible treatment they can give consent to. Nonetheless, the MDPA is still an important legislation for this study as it provides the foundation for the enactment of the Code of Medical Ethics by the Medical and Dental Council. The Code serves as the rules of professional conduct for medical practitioners in Nigeria.

d) Code of Medical Ethics in Nigeria 2008

This Code of Medical Ethics in Nigeria (the Code) is the rules of professional conduct for medical and dental practitioners in Nigeria, published by the Medical and Dental Council of Nigeria in 2008.⁴⁵ It guides the medical practitioner in the exercise of his or her skills in ways that uphold the ethics of the profession in Nigeria.

In dealing with consent, the confidentiality of patients must be protected by the medical practitioner. The Code in upholding the principles of medical confidentiality provides that all communications between the patient and the practitioner made in the course of treatment should be treated as confidential. The practitioner does not divulge information unless compelled by law or overriding common good, with the consent of the patient.⁴⁶ This helps to build trust in medical relationships and safeguards the patient's right to privacy regarding their medical status and history. Violation of this may result in professional misconduct leading to disciplinary actions against the medical practitioner. Also, medical practitioners are at liberty to choose whom they can render services but they must do so without discrimination in an emergency and to the best of their ability in the prevailing circumstance.⁴⁷ The ought to protect the autonomy, especially in sensitive areas such as maternal health, family planning, and surgical procedures for women, The Code does not provide for how confidentiality should be handled in cases of sexual abuse, substance abuse and

⁴² MDPA, s16,17.

⁴³ Ibid, s15(1)(3).

⁴⁴ Cap M8, LFN 2004.

⁴⁵ Code of Medical Ethics in Nigeria 2008 (CMEN), A-H.

⁴⁶ Ibid, rule 9f.

⁴⁷ CMEN, rule 9g.



mental health cases affecting children; however, the Code ensures that no treatment is given without clear, voluntary, and informed agreement. It also guards against coercion and gender-based discrimination, reinforcing women's rights to bodily integrity, dignity, and self-determination within the healthcare system. It is suggested that the medical practitioner exercises care in sharing information to avoid further abuse of the child, particularly in cases where the abuser is someone who is in legal care of the child.

The procedure for obtaining consent for major medical procedures, in ways that enhance the protection of the rights of patients is spelt out in rule 19 of the Code. This is what the Code refers to as 'informed consent' which has already been defined earlier. Informed consent is part of the general guidelines in medical and dental practice. A practitioner involved in a procedure requiring the consent of a patient, his or her relation or appropriate public authority must ensure that consent is obtained before such procedures are carried out whether they are invasive or not.⁴⁸ Explanations to the patient whose consent is needed should be simple, concise and unambiguous. Proper counselling should precede the signing of the consent form. Consent forms should be printed or written form with the name of the health establishment boldly indicated.⁴⁹ The Code identifies that persons below the age of 18 are mature enough to make certain medical decisions. Those between the ages of 16 years to 18 years can give consent. However, it does not match this with the CRA which still pegs the age of consent at 18 years. The health laws do not have provisions on medical consent for children and the Code do not state the law it refers to when it classifies children to provide consent to treatment. The Code does not clearly state the type or scope of permissible treatment these children can consent to, and neither does it reference the law in Nigeria from which it draws its position.

e) Violence Against Persons (Prohibition) Act 2015

The Violence Against Persons (Prohibition) Act 2015 is a significant legislation that aims to eliminate violence in private and public life, prohibit all forms of violence against persons, and provide maximum protection and effective remedies for victims and punishment of offenders. In the context of medical consent, the VAPP Act's provisions on informed consent and protection from violence are particularly relevant. For instance, the Act's definition of rape and other forms of sexual violence highlights the importance of obtaining informed consent in medical settings, particularly in cases involving vulnerable populations such as women and children⁵⁰. Medical professionals must ensure that patients provide informed consent before undergoing any medical procedure, and the VAPP Act's provisions on violence and abuse serve as a reminder of importance of respecting patients' autonomy and dignity.

⁴⁸ Ibid, rule 19.

⁴⁹ Ibid.

⁵⁰ Violence Against Persons Prohibition Act 2015, s1.



Furthermore, the VAPP Act's prohibition of female genital mutilation (FGM) is also relevant to medical consent, as it highlights the need for medical professionals to be aware of and comply with laws and regulations that protects' rights⁵¹. In medical settings, patients may be vulnerable to abuse or exploitation, and the VAPP Act's provisions on protection orders and penalties for offenders provide a framework for protecting patients' rights and holding perpetrators accountable⁵². By understanding the act's provisions and their application to medical consent, medical professionals can better navigate complex ethical and legal issues that arise in their practice.

In addition, the VAPP Act's emphasis on protecting vulnerable populations, including women and children, underscores the importances of prioritizing patient-centered care and respecting patients' autonomy in medical decision-making⁵³. By so doing, medical professionals can help prevent violence and abuse, and promote a culture of respect and dignity in healthcare settings. Overall, the act's provisions provide a critical framework for promoting informed consent and protecting patients' rights in medical settings, and medical professionals must be aware of and comply with these provisions to ensure that patients receive high-quality care.

f) Criminal Code Act, CAP C8 LFN 2004

The Criminal Code Act, Laws of the Federation of Nigeria, 2004⁵⁴, is a foundational legal framework for criminal law, providing the basis for prosecuting violations of individual rights, including in matters of medical consent and the human rights of women and children within the family. While other statutes offer specific protections, the Criminal Code establishes the foundational criminal sanctions for acts that violate bodily integrity and personal safety.

The Act addresses medical consent by criminalizing any unauthorized medical procedure as an assault or battery. This is based on the common law principle of bodily autonomy. Sections 351, 352, and 353 define and criminalize assault and battery, meaning a medical procedure performed without 'valid consent' is an unlawful application of force. If such a procedure results in serious harm, the practitioner could be charged under Section 335 for causing "grievous harm." The defense of consent is crucial, but for it to be valid in a medical context, it must be "informed" meaning the patient understands the procedure, its risks, and alternatives. The absence of informed consent vitiates the defense, transforming a medical act into a criminal offense.⁵⁵

The Criminal Code is a key instrument for protecting women and children from violence and abuse within the family by criminalizing various offenses. Sections 357 to 362 cover assaults and

⁵¹ Ibid, s6.

⁵² Ibid, s30 and 42.

⁵³ Violence Against Persons Prohibition Act 2015, s4,5 and 14.

⁵⁴ Cap C.38 LFN 2004.

⁵⁵ F Adetunji, 'The Criminal Code Act and Its Role in the Legal Framework for Medical Consent in Nigeria' [2025] 12(3) *Law and Public Health Review* 78.



abductions against females, while Section 357 specifically defines and criminalizes rape. A contentious and widely criticized provision is Section 55(1)(d), which allows a husband to "correct" his wife, so long as it doesn't result in grievous harm. This section is often cited as a legislative relic inconsistent with modern human rights standards,⁵⁶ While Section 55(1)(d) purports to grant a husband a "right" to "correct" his wife, this right is a legal curiosity that is superseded by the law of assault and the ethical imperative of informed medical consent. The moment the "correction" causes a medical condition, the act transcends any semblance of a lawful right and becomes a criminal assault. For children, the Act provides significant protections. Section 218 addresses offenses like child defilement (sexual abuse of a minor) and cruelty, while Section 361 criminalizes the abduction of a child from their guardian. These provisions reinforce the legal responsibility of parents and guardians to provide a safe environment for children and serve as a criminal deterrent against abuse and exploitation.

g) The Child Rights Act, 2003

The Child Rights Act (CRA) 2003 is a comprehensive Nigerian statute enacted to safeguard and promote the rights and welfare of children. It defines a child as any individual under the age of eighteen and aligns with international standards, particularly the United Nations Convention on the Rights of the Child, to guarantee fundamental rights to survival, development, protection, and participation. The Act addresses critical areas of child welfare, including access to education, healthcare, and protection from abuse, neglect, and exploitation. It establishes a legal framework for the enforcement of these rights and prescribes sanctions for violations. Central to the CRA 2003 is the principle of the best interests of the child, which must guide all decisions and actions affecting children, ensuring that every Nigerian child is provided with a safe, nurturing, and supportive environment conducive to holistic development.⁵⁷ It provides that 'In every action concerning a child, whether undertaken by an individual, public or private body, institutions or service, court of law, or administrative or legislative authority, the best interest of the child shall be the primary consideration'.⁵⁸ The reason for the best interest principle is that young children rely on responsible authorities to represent their rights and interests in decisions that affect their individual and group well-being and capacities both as individuals and as a group.⁵⁹ A child is to be given the protection and care necessary for his/her well-being. This will take into account the rights and duties of parents, legal guardians, individuals or institutions responsible for the care and protection of the child⁶⁰. Just like the African Charter on the Rights and Welfare of the Child (ACRWC), the CRA

⁵⁶ G Olabisi, 'Assessing the Criminal Code Act's Provisions on the Human Rights of Women and Children in Nigeria: A Call for Reform' [2025] 20(1) *Nigerian Journal of Family Law* 45.

⁵⁷ Child Rights Act 2003, (CRA), s1.

⁵⁸ *Ibid*, s1.

⁵⁹ United Nations Committee on the Rights of the Child, General Comment No 7 (2005) Implementing Child Rights in Early Childhood CRC/C/GC/7/Rev.1, 13.

⁶⁰ CRA, s2.



bestows on the child the rights necessary for development, and responsibilities and in addition, extends the applicability of fundamental rights in Chapter IV of the 1999 Constitution (as amended) to the child.⁶¹

Various state states of the federation have domesticated this federal legislation thereby giving the CRA a binding force in these states while some states are still grappling with the importance of the legislation. One problem is that the 1999 Constitution of Nigeria does not situate issues concerning children within the legislative competence of the federal legislature which is the National Assembly but within that of the federating States as part of residual matters. Any law from the federal legislature on issues not within their legislative competence is null and void and this is the position with the CRA.⁶² The remedies to situations will be for States to adopt such a law as a state law⁶³.

Another problem is the application of the CRA with Islamic law in Northern Nigeria and the conflict between provisions.⁶⁴ Cultural diversity, social values and religious inclination was not given due consideration before enacting the CRA and some provisions have formed a direct attack on Islamic principles and practices⁶⁵. Abubakar and Musa suggest that for a Nigerian child to be better protected, each state should be allowed to enact their respective child rights law which is in tandem with their local customs and peculiarities.⁶⁶ Although these challenges exist, the Constitution which is the *grundnorm* and applicable to all persons irrespective of age, sex or religion still applies to children and also provides human rights protection for all children in Nigeria⁶⁷. This is so even for children in states that do not have the CRA domesticated as state laws.

These authorities collectively form the core legal and regulatory framework governing medical consent for women and children in Nigeria.

3. Consent and Capacity of Children under Nigerian Law.

While parents retain custodial authority over their children, this authority is accompanied by clearly defined rights and duties owed to the child. Chief among these are responsibilities relating to care,

⁶¹ Ibid, 11.

⁶² *Chief Saatsaha Thaddeus Yenge v Attorney General of the federation* (2023) LPELR-61122(CA) Per Jamilu Yammama Tukur, JCA (P 15 - 16 Paras C - C); A N Nwazuoke, 'Status of the Girl Child in Nigeria and the Child Rights Act 2003' [2003] (5)(1) *Nigerian Bar Journal* 116.

⁶³ Nwazuoke(n47) 117; Patricia Imade Gbobo and O.W Igwe, 'Child Rights Law and Practice in Nigeria: A Lesson from South Africa' [2021] (17)(1) *UNIZIK Law Journal*, 97-113.

⁶⁴ Abubakar Isa Bappa, 'The Child Rights Act 2003: Understanding its Peculiarities and Conflict in its Application in Northern states of Nigeria' in Prof Yusuf Aboki (ed), *Nigeria's March Towards Global Political Stability: An assessment of her laws and statutes. Legal Essays in Honour of Senator Bala Mohammed* (Micro Media Computers, A publication of the department of public law, Ahmadu Bello University Zaria-Nigeria 2013) 232.

⁶⁵ Ibid, 246.

⁶⁶ G Abubakar and I Musa, 'Examining the Legal Basis for the Promotion and Protection of the Rights of the Child in Nigeria' [2020] (1) *International Journal of Law and Clinical Legal Education*, 83-90.

⁶⁷ E S Nwauche 'Child Marriage in Nigeria (II): Legal and Unconstitutional' [2015] (15) *African Human Rights Law Journal*, 421-432.



welfare, and upbringing, which are expressly known and codified under the Child Rights Act (CRA).⁶⁸ These statutory responsibilities frame the context within which decisions affecting children, including medical decisions are to be made. At the international level, the United Nations Convention on the Rights of the Child 1989 (UNCRC) reinforces this framework by obligating State Parties to respect the responsibilities, rights, and duties of parents in a manner that is consistent with the evolving capacities of the child, while ensuring that parents provide appropriate direction and guidance to enable children to exercise their rights. This obligation is not limited to biological parents but extends to members of the extended family, legal guardians, or other persons legally responsible for the child in accordance with local custom and law.⁶⁹ A combined reading of the UNCRC and the CRA reveals a clear normative intention: the exercise of rights and duties by parents and children alike must be calibrated to the child's evolving capacity, age, and ability, and mediated through appropriate or necessary parental guidance. This principle has direct relevance to the question of children's legal capacity to consent to medical treatment, as it challenges rigid assumptions of incapacity based solely on chronological age. The scope and meaning of these concepts, particularly those reflecting Article 5 of the UNCRC have been authoritatively clarified by the Committee on the Rights of the Child (CRC).⁷⁰ The Committee explains that Article 5 is designed to strike a careful balance between parental authority and children's autonomy, while underscoring the obligation of States to safeguard children's rights within the context of the family, documented as the fundamental unit of society and the natural environment for the growth and well-being of children.⁷¹ Parents and guardians therefore bear an ongoing obligation to adjust the level and nature of guidance they provide, taking into account the child's wishes, interests, decision-making ability, and understanding of consequences. As children acquire greater knowledge and experience, parental guidance should gradually transform from directive instruction to advice, dialogue, and ultimately mutual engagement. This transition does not occur at a fixed age but evolves progressively as children are encouraged to express their views, which must be given increasing significance.⁷²

The CRA reinforces this position through its emphasis on both age and ability. It recognizes that children's intellectual and cognitive capacities develop over time and that age serves as an important, though not an exclusive indicator of capacity.⁷³ This aligns with established theories of cognitive development, which link age with stages of reasoning and decision-making competence. By coupling age with ability, the CRA rejects a purely chronological approach to capacity and implicitly acknowledges the emergence of child autonomy. Consequently, a child who is properly

⁶⁸ Child Rights Act 2003, s 14–17.

⁶⁹ United Nations Convention on the Rights of the Child 1989, art 5.

⁷⁰ Committee on the Rights of the Child, *General Comment No 20 on the Implementation of the Rights of the Child during Adolescence* (2016) 4.

⁷¹ UNCRC 1989, Preamble; CRC General Comment No 20 (n19).

⁷² CRC General Comment No 12 (n22) 88.

⁷³ Child Rights Act 2003, s19–20.



nurtured may acquire sufficient rationality and understanding to make informed decisions including medical decision prior to attaining the age of majority.

4. Regulatory and Ethical Guidelines in Medical Practice

Regulatory and ethical guidelines in medical practice in Nigeria are structured to ensure that healthcare delivery complies with professional standards, respects patient autonomy, and satisfies legally enforceable duties of care. The principal regulatory authority is the Medical and Dental Council of Nigeria (MDCN), established under the Medical and Dental Practitioners Act.⁷⁴ The MDCN issues the Code of Medical Ethics in Nigeria (2008), which provides detailed guidance on informed consent, confidentiality, and professional conduct. Under this Code, a medical practitioner is required to obtain the voluntary and informed consent of a patient before any medical intervention, except in limited emergency circumstances. This obligation includes disclosing relevant information about the patient's condition, the nature and purpose of the proposed treatment, its risks, and any available alternatives.

Statutory support for these ethical obligations is found in the National Health Act 2014, particularly sections 20–23, which codify the doctrine of informed consent and affirm the right of patients to participate actively in decisions concerning their health.⁷⁵ The Act further requires that information be communicated in a manner that is appropriate to the patient's level of understanding, thereby ensuring that consent is both informed and meaningful. In practice, healthcare institutions complement these provisions through internal policies and clinical protocols that guide practitioners in obtaining and documenting consent in accordance with legal and ethical standards. Ethically, medical practice in Nigeria is grounded in the principles of autonomy, benevolence, non-maleficence, and justice. These principles require healthcare providers to respect the decision-making capacity of patients, act in their best interests, avoid harm, and ensure fairness in the distribution of medical care. Although cultural and family influences may sometimes shape healthcare decisions, the prevailing legal framework affirms that a competent adult particularly a woman, retains ultimate authority over her medical choices.

5. CHALLENGES OF MEDICAL CONSENT IN NIGERIA AS IT RELATES TO WOMEN AND CHILDREN

A Patriarchal and Cultural Interference with Women's Autonomy

Persistent influence of patriarchal cultural norms undermines the autonomy of women in making healthcare decisions. In many medical scenario, healthcare providers still require the consent of a husband or male relative before carrying out certain procedures on women, particularly reproductive or family planning procedures such as tubal ligation, caesarean-related interventions, or contraceptive services. This practice directly conflicts with the legal principle that every

⁷⁴ Medical and Dental Practitioners Act, Cap M8, Laws of the Federation of Nigeria 2004.

⁷⁵ National Health Act 2014, s20–23.



competent adult possesses the right to determine what shall be done to his or her body. Consequently, women are frequently deprived of the opportunity to exercise independent medical choices, despite constitutional guarantees of dignity, privacy, and personal liberty. Such interference weakens the doctrine of informed consent and reinforces gender inequality within healthcare administration.

B Inadequate Disclosure of Medical Information by Healthcare Providers

Another major challenge is the failure of many healthcare practitioners to provide adequate and comprehensible information before obtaining consent from patients. Informed consent requires that a patient be fully apprised of the nature of the treatment, its risks, benefits, possible complications, and available alternatives. However, in practice, many patients especially women and children are subjected to procedures without sufficient explanation or counselling. The decision in *Georgina Ahamefule v Imperial Medical Centre & Dr Alex Molokwu* illustrates this concern, where an HIV test was conducted without prior informed consent or counselling. Such inadequate disclosure undermines patient autonomy and exposes individuals to medical interventions they may not have willingly accepted if properly informed. The challenge is worsened by low literacy levels, language barriers, and poor communication between doctors and patients.

C Weak Enforcement of Legal and Human Rights Protections

Although the Constitution of the Federal Republic of Nigeria 1999 (as amended) guarantees rights relating to dignity, privacy, and freedom from non-consensual medical experimentation, enforcement remains significantly weak. Many victims of medical rights violations lack awareness of their legal entitlements or the financial means to seek redress in court. Furthermore, healthcare institutions often lack effective accountability mechanisms to sanction medical practitioners who violate consent requirements. Consequently, breaches of informed consent frequently go unreported or unresolved. The absence of strong institutional enforcement allows unlawful medical practices to persist, particularly against vulnerable groups such as women and children who may already face social and economic disadvantages.

D Challenges Relating to Consent for Children and Minors

Medical consent involving children presents complex legal and ethical difficulties in Nigeria. Since minors are generally considered incapable of giving legally valid consent, decisions are ordinarily made by parents or guardians. However, situations frequently arise where parental decisions conflict with the best interests or urgent medical needs of the child. In some cases, religious or cultural beliefs may lead parents to refuse life-saving treatments for their children. This creates uncertainty regarding the extent to which medical practitioners may intervene without parental consent in order to preserve the child's right to life. The absence of comprehensive statutory guidelines governing children's medical consent further compounds this challenge and leaves healthcare professionals uncertain about the lawful course of action in emergency situations.



E Socio-Economic Inequality and Limited Access to Quality Healthcare

Poverty, illiteracy, and inadequate healthcare infrastructure also constitute serious impediments to meaningful medical consent in Nigeria. Many patients, particularly women in rural communities, lack sufficient education or awareness to fully understand complex medical information presented to them. In overcrowded or underfunded hospitals, medical personnel may prioritize expediency over proper patient counselling, thereby reducing consent to a mere formality rather than an informed and voluntary decision-making process. Additionally, fear of losing access to medical care may compel economically disadvantaged patients to accept procedures without questioning healthcare providers. This socio-economic imbalance significantly undermines the voluntariness required for valid consent and perpetuates systemic inequality within healthcare delivery.

6. CONCLUSION

In conclusion, while Nigerian law clearly prioritizes dignity, autonomy, and welfare, its practical implementation requires strengthening. It is suggested that Nigeria adopt clearer statutory guidelines on third-party and adolescent consent, standardize informed consent protocols across healthcare institutions, enhance judicial and institutional capacity for timely intervention, intensify professional training on rights based medical practice, and promote public legal education to eliminate unlawful spousal or parental veto over competent decision-making. Such reforms are essential to consolidating a coherent, rights centered framework for medical consent consistent with constitutional mandates and international human rights standards. The analysis concludes that progressive consent regimes are characterized by a structured balance between autonomy and protection, clarity in statutory drafting, and meaningful judicial and professional guidance. The study concludes that medical consent in Nigeria is not merely a procedural requirement but a substantive exercise of autonomy and human rights that remains fragile in the face of entrenched patriarchal and cultural barriers. Women's reproductive autonomy and children's capacity to participate meaningfully in medical decision making are inadequately protected, exposing gaps between statutory rights, judicial interpretation, and practical realities.

The study underscores the necessity for the adoption of a coherent, rights-oriented and capacity-sensitive statutory framework that unequivocally safeguards women's independent medical decision-making and appropriately acknowledges the evolving capacities of minors. Particular emphasis is placed on the harmonization of legislative provisions governing healthcare, criminal responsibility, and child protection, as well as the need for clearer judicial direction to ensure consistent protection of patient autonomy and more definite standards governing consent and capacity. Professional disciplinary frameworks must be actively enforced, and healthcare facilities should report violations to regulatory bodies for timely action. By combining statutory authority, judicial enforcement, and institutional accountability, Nigeria can transform informed consent from a formalistic requirement into a substantive safeguard of autonomy, dignity, and health rights for vulnerable groups, particularly women and children.



7. RECOMMEDATIONS

A. Enact Comprehensive Legislation on Medical Consent

There is a pressing need for the Nigerian legislature to enact a comprehensive statutory framework specifically regulating medical consent and informed consent in healthcare practice. Although constitutional provisions and common law principles provide some protection, the absence of a unified legislation creates uncertainty and inconsistency in medical practice. Such legislation should clearly define the elements of valid consent, the scope of disclosure required of healthcare practitioners, and the legal consequences of non-compliance. It should further codify patients' rights to autonomy, dignity, privacy, and bodily integrity in line with international human rights standards. Particular emphasis should be placed on safeguarding the rights of women and children, who are often vulnerable to coercive or discriminatory medical practices.

B. Strengthening Patient Autonomy and Elimination of Spousal Consent Requirements

Medical institutions and healthcare professionals should recognize and uphold the legal capacity of competent adult women to independently consent to medical procedures affecting their bodies. The practice of requiring spousal approval before carrying out procedures such as tubal ligation, contraception, or other reproductive health interventions undermines constitutional guarantees of dignity, privacy, and personal liberty. Hospitals should therefore adopt institutional policies expressly prohibiting discriminatory consent practices rooted in patriarchal or cultural assumptions. Regulatory bodies such as the Medical and Dental Council of Nigeria should also issue binding ethical guidelines reaffirming that the consent of a competent adult patient is sufficient in law.

C. Mandatory Training and Ethical Reorientation of Healthcare Providers

Continuous legal and ethical training should be made mandatory for all healthcare practitioners in Nigeria. Such training should focus on informed consent, patients' rights, medical ethics, constitutional obligations, and international human rights standards applicable to healthcare delivery. Many violations of medical consent arise from ignorance of legal obligations or deeply entrenched cultural attitudes within the healthcare system. Regular workshops, seminars, and professional certification programs would therefore enhance compliance with ethical standards and reduce incidents of unauthorized medical procedures and testing.

D. Improved Access to Remedies and Enforcement Mechanisms

Effective mechanisms should be established to ensure that victims of medical consent violations can easily seek redress. This includes strengthening hospital complaint units, medical disciplinary tribunals, and judicial remedies for breaches of patients' rights. Courts should also adopt a more rights-based approach in adjudicating medical consent disputes, recognizing violations not merely as tortious wrongs but also as infringements of constitutionally guaranteed human rights such as dignity, privacy, and freedom from degrading treatment. Legal aid services and human rights



organizations should equally provide support for vulnerable women and children who may lack the resources to pursue legal claims.

E. Public Awareness and Sensitization Campaigns

Government agencies, civil society organizations, and healthcare institutions should intensify public enlightenment campaigns on the importance of informed medical consent and patients' rights. Many patients remain unaware that they possess the legal right to refuse treatment, demand adequate information, or challenge unauthorized medical interventions. Public education through media campaigns, community outreach programs, and healthcare awareness initiatives would empower citizens particularly women and children to make informed healthcare decisions and hold medical practitioners accountable for violations of their rights.