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AFRICAN JOURNAL OF HEALTH LAW AND POLICY
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Editorial

We are delighted to present the inaugural issue of the *African Journal of Health Law and Policy*. This launch represents a significant milestone in African scholarly discourse on the intersections of law, policy, and healthcare. For too long, African voices have been underrepresented in the global conversation on health law and policy, with scholarship disproportionately reflective of contexts and concerns from North America and Europe. This journal is dedicated to centering African knowledge production, African health systems, African legal traditions, and African solutions to contemporary health challenges.

The articles in this inaugural issue exemplify the depth, relevance, and urgency of African health law scholarship. They address issues that are simultaneously deeply contextual to African health systems and globally significant. From questions of medical ethics and paediatric care to public health prevention and regulation, from the digital dimensions of healthcare security to access to justice, from the protection of patient dignity to the governance of emerging sectors, these contributions demonstrate the breadth and sophistication of contemporary health law scholarship on the continent.

Medical Ethics and Difficult Decisions

The examination by Ikhurionan and Olusegun of medical practitioners' knowledge and attitudes towards paediatric euthanasia opens a crucial conversation. In the African context, where resource constraints often make end-of-life care decisions particularly challenging, understanding the perspectives and knowledge gaps of healthcare providers is essential. This work contributes to the development of ethical frameworks that are responsive to African realities while maintaining professional standards and respect for life.

Public Health, Youth, and Policy Development

The contribution by Duyilemi and colleagues on gender differences in substance abuse risk among secondary school students addresses a pressing public health concern with significant policy implications. This evidence-based research provides the knowledge foundation necessary for formulating appropriate regulatory frameworks and targeted interventions. It exemplifies how health law scholarship must be grounded in empirical evidence from our own contexts and populations.

Digital Health and Sector-Specific Governance

Amadi's analysis of cybersecurity regulation in the Nigerian health sector addresses a gap that has become increasingly urgent as African healthcare systems digitalize. As patient data moves into digital spaces and health systems become interconnected, the need for robust, context-appropriate regulatory frameworks is critical. This work demonstrates how health law must evolve to address contemporary technological realities.

Access to Justice and Judicial Innovation

Sanu's comparative analysis of judicial accessibility for urgent medico-legal decisions across Nigeria, the United Kingdom, Canada, and the United States provides crucial insights. The ability of healthcare professionals and families to access timely judicial guidance on critical medical decisions is essential. This comparative approach enriches African legal analysis by learning from others while maintaining focus on African contexts.

Patient Dignity and Rights Protection

Onomrerhinor and Odesanmi critically examine the extent to which Nigerian health law protects the right to respectful care. This foundational inquiry into whether our legal frameworks adequately safeguard patient dignity is essential for improving health system quality and accountability. Their work reminds us that health law must ultimately serve human dignity and the well-being of those who experience our health systems.

Emerging Intersections: Health and Sports Governance

Edozien's proposal for strategic convergence between health law and sports law, culminating in a recommendation for a Nigerian National Sports Governance Bill, illustrates how health law scholarship must respond to evolving landscapes. Sports governance intersects with public health, occupational safety, pharmaceutical regulation, and disability rights. This forward-looking contribution points the way toward integrated regulatory approaches.

A Vision for African Health Law Scholarship

This inaugural issue reflects several commitments that will define this journal. First, we are committed to rigorous, evidence-based scholarship that grounds legal analysis in empirical reality. Second, we are committed to African-centred perspectives while remaining engaged in comparative and international dialogue. Third, we recognize that health law is inherently interdisciplinary, drawing on medicine, public health, ethics, policy studies, and social sciences. Fourth, we believe Health Law scholarship must ultimately serve the goal of more equitable, effective, and humane health systems.

As we launch this journal, we recognize the complex challenges facing African health systems: limited resources, competing priorities, institutional constraints, and the legacy of colonial and post-colonial governance structures. Health Law alone cannot solve these challenges. However, thoughtful legal analysis, informed by African contexts and committed to African priorities, can contribute meaningfully to health system strengthening, the protection of vulnerable populations, the promotion of professional standards, and the advancement of justice within healthcare.

We invite scholars, practitioners, policymakers, and students throughout Africa and beyond to engage with this journal. We seek articles that address the legal and policy dimensions of health in Africa, whether they focus on specific country contexts or comparative analyses. We welcome empirical research, doctrinal analysis, policy commentary, and work that bridges between law and other disciplines. We are particularly interested in work that addresses urgent contemporary challenges while contributing to foundational scholarly conversations.

To our authors in this inaugural issue: thank you for your scholarly contributions and for trusting us with your work. To our readers: We hope you find this journal valuable. To our editorial board and peer reviewers: your commitment to excellence in African scholarship is invaluable. As we move forward, we remain committed to creating a space where African health law scholarship can flourish, where African voices are loud and clear, and where law can serve the goal of healthier, more just, and more equitable societies.

Welcome to the *African Journal of Health Law and Policy*.

LeRoy Chuma Edozien
Editor-in-Chief

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Knowledge and Attitude of Medical Practitioners in Nigeria Regarding Paediatric Euthanasia

Paul E. Ikhurionan[a] and Olaitan O. Olusegun[b]

Abstract

Discussions about euthanasia have gained significant attention globally. In Nigeria, the legal stance on euthanasia is restrictive and undeveloped. This study investigated the knowledge and attitude of doctors at the University of Benin Teaching Hospital, Benin City, on paediatric euthanasia. The study was a questionnaire-based descriptive cross-sectional study carried out between July 2023 and August 2023. 254 doctors were recruited. Associations were compared using the chi-square/Fisher's exact test. Multivariate logistic regression was done to determine independent associations. The test was significant at p<0.05. The majority (124; 48.8%) of the study participants were age between 31 and 40 years. There were 149 (58.7%) males, giving a M:F ratio of 1.42:1. Two hundred and thirty-one (90.9%) doctors knew that euthanasia was not legal in Nigeria, but only 14 (5.5%) knew the relevant law on the topic. 76 (29.9%) believed that terminally ill children should be allowed to request an easy death. Only 77 (29.1%) respondents would offer euthanasia to children if it is legal. On bivariate analysis, age group, specialty and cadre were associated with approval of paediatric euthanasia. Multiple logistic regression highlighted the association of gender and specialty. Doctors in Nigeria are generally unaware of the law surrounding euthanasia.

Keywords: Attitude, Knowledge, Doctors, Pediatric Euthanasia

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1. INTRODUCTION

The term euthanasia is derived from two Greek words '*eu*' and '*thanatos*' meaning "Good death", a term which involves 'a premeditated act of ending a patient's life to alleviate severe suffering'.[1] It has become one of the newest and most controversial aspects of medical ethics. Care for terminally ill persons and palliative care are faced with several challenges including pain management and attending to psychosocial problems associated with dying.[2] A growing trend of euthanasia acceptance among the general population has been observed in many countries, indicating a growing support for personal autonomy regarding medical end-of-life decisions.[3] Thus, countries including Belgium, Colombia, the Netherlands, Luxembourg, Switzerland, Canada, New Zealand, Spain, Austria and Portugal have authorised euthanasia, with each jurisdiction including its 'eligibility criteria' and 'procedural safeguards' to ensure safe practices.[4] However, when the focus of these discussions shifts to the context of paediatric patients, the complexities and ethical dilemmas are magnified.

The legal landscape plays a crucial role in shaping attitudes towards euthanasia. Nigeria's legal stance on euthanasia is relatively restrictive, with no clear provisions for end-of-life decisions in paediatric cases. The Constitution of the Federal Republic of Nigeria guarantees the right to life of all citizens.[5] Similarly, the Criminal Code and Penal Code criminalize acts of killing or assisted suicide.[6] Under the Criminal Code, consent to death does not affect the criminal liability of the one who causes the death as a result of the sanctity of life, which is constitutionally guaranteed. Section 311 thus provides that 'A person who does any act or makes any omission which hastens the death of another person who, when the act is done, or the omission is made, is labouring under some disorder or disease arising from another cause, is deemed to have killed that other person'. Furthermore, section 326 provides that any person who counsels another to kill himself or aids another in killing himself is guilty of a felony and is liable to imprisonment for life.

The Code of Medical Ethics, a code of conduct guiding the practice and ethical decisions made by medical and dental practitioners in Nigeria,[7] found euthanasia contrary to the ethical code of the medical profession.[8] However, legal grey areas and a lack of specific guidelines can influence doctors' attitudes and decision-making processes. For example, the judgement by the Supreme Court that a person has right to reject life-sustaining treatment might reinforce conversations around right to life and right to terminate life.[9] The legal situation is more complicated for children as issues of consent and capacity to make decisions are paramount. Countries are more reluctant to enact legislations in this regard. In 2014, Belgium amended its law to allow terminally ill children of all ages to request euthanasia if they are in the final stages of the illness, with no available treatment, and are capable of discernment.[10] A similar legislation exists in the

[1] Nader Aghakhani, Béatrice Marianne Ewalds-Kvist and Sepideh Naseri, 'Euthanasia in End-of-Life Care: Ethical Compassion or Dilemma?' (2025) 14 Journal of Caring Sciences 214-216.
[2] Santoro D. Jonathan and Bennett Mariko, 'Ethics of End of Life Decisions in Pediatrics: A Narrative Review of The Roles of Caregivers, Shared Decision-Making and Patient Centered Values' (2018) 8 Behav Sci 42-46.
[3] Saadat, Payam, Reza Golpour and Seyede Fatemeh Shafaie, 'Attitude of Patients Towards Euthanasia Attending Neurology Clinic: A Pilot Study in Iran' (2018) 12 Journal of Clinical & Diagnostic Research 1-4.
[4] Isabelle Marcoux et al, 'Factors Associated with Evolution of the Use of Medical Assistance in Dying: Protocol for a Scoping Review', (2026) 15 JMIR Research Protocols e85963.
[5] (1999) Constitution of the Federal Republic of Nigeria, 1999, s33.
[6] Criminal Code Act. Nigeria; Chapter 77, Laws of the Federation of Nigeria. 1990.
[7] Olusegun, O.O. and Adejumo O.A., Legal Prescriptions for Medical Practitioners: A Handbook of Medico-Legal Issues and Rights Protection in Nigeria (Krafts Publishers, 2023) 17.
[8] See the MDCN Code of Medical Ethics, Rule 68.
[9] *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*. (2001) All N.L.R. 305.
[10] Emanuel, Ezekiel J et al., 'Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe' (2016) 316 *Jama* 79-90.

Netherlands for children above the age of 12, and between 1997 and 2004, 22 cases of neonatal euthanasia were reported in the country, amidst criticisms.[11]

Despite the great scientific and technological advances, medicine may not always have the answer to children's serious illnesses.[12] Many children suffer from chronic conditions, especially neurologic disorders, some of which have defied medical treatment and thus endure unbearable pain and psychological distress due to the condition. Similarly, globally, the prevalence of paediatric cancers, including Central Nervous System (CNS) tumours, has been rising in recent years.[13] Studying the death or suffering of children due to chronic diseases has become increasingly significant. Medical professionals often find themselves at the crossroads of preserving life and alleviating suffering, and their attitudes towards euthanasia can vary widely based on their personal values, professional ethics, and cultural beliefs. The emotional aspects of being responsible for making decisions that impact the lives of children with life-limiting illnesses can deeply influence doctors' attitudes and may drive them to explore alternative approaches to end-of-life care, including the consideration of euthanasia.

Some studies conducted to understand the views of doctors, nurses and students regarding euthanasia and paediatric euthanasia have provided conflicting conclusions.[14] An observational study to explore the attitude of doctors toward euthanasia in Delhi found that all the doctors consider active euthanasia as unethical.[15] However, psychiatrists and intensivists were more likely to endorse euthanasia compared to oncologists and haematologists. Although there was no significant difference between age groups and gender towards euthanasia, the doctors' sub-specialty significantly affected their opinion on the right to refuse life-sustaining treatment and preauthorization of a person's death should intolerable illness occur. While psychiatrists and intensivists supported the right to refuse life-sustaining treatment, oncologists and haematologists support legal preauthorisation of death.[16] Also, a cross-sectional study among Turkish oncologists reported that 43.8% of 80 oncologists did not object to euthanasia.[17] The reasons for objection by those who objected included that "Euthanasia was unethical" (46.7%); "It may be abused," (35.6%); "It was illegal," (31.1%); and that "It was against their religious tenets" (31.1%). Most (54.3%) of oncologists who answered the question of who should decide to perform euthanasia replied, 'the patients', while 42% said the families and doctors of the patients together. Twenty-eight (33.7%) of 83 doctors indicated that they had been asked to perform euthanasia.

In Nigeria, only a few investigations regarding this issue have been conducted. The prevailing attitudes of Nigerian doctors on this topic have implications not only for the medical community but also for the society at large. This study, therefore, aimed to evaluate the attitude of doctors in a tertiary hospital setting towards euthanasia in children. By exploring this topic, we gain insights that could inform medical education, policy development, and conversations within the medical

[11] Eduard Verhagen and John Lantos, 'The Dutch Model for Regulating Paediatric Euthanasia' (2025) Archives of Disease in childhood 110 (2025) 397-399.

[12] Filipa M. Silva et al., 'The Belgian Case of Euthanasia for Children, Solution or Problem? (2015) 23(3) Rev Bioética 475–484; Dorscheidt JHHM, 'The Legal Relevance of a Minor Patient's Wish to Die: A Temporality-Related Exploration of End-Of-Life Decisions in Pediatric Care' (2023) 45(1) Hist Philos Life Sci 1–24; Joel E. Frader, 'Surveying Euthanasia Practices: Methods and Morality' (2005)146(5) J Pediatr 584–585.

[13] See Su, Zhenjin, et al. 'Global, Regional, and National Childhood Brain and Central Nervous System Cancer Burden: An Analysis based on the Global Burden of Disease Study' (2025) 53 *Tropical Medicine and Health* 130-144, which emphasizes on the high prevalence rate of childhood cancers globally.

[14] Brouwer M et al., 'Should Pediatric Euthanasia be Legalized? (2018)141 Pediatrics 1–10; Kumar A et al, Euthanasia: A Controversial Entity Among Students of Karachi, (2017) 9(7). Singh S, Sharma D, Aggarwal V, Gandhi P, Rajpurohit S. Attitude of doctors toward euthanasia in Delhi, India. (2015) 01 Asian J Oncol. 49–54.

[15] Singh S, Sharma D, Aggarwal V, Gandhi P, Rajpurohit S. Attitude of Doctors toward Euthanasia in Delhi, India. (2015) 01 Asian J Oncol. 49–54.

[16] Ibid.

[17] Atillah S. Mayda, Erdem Ozkara and Funda Corapçioglu, 'Attitudes of Oncologists toward Euthanasia in Turkey' (2005) 3 Palliat Support Care. 221–225.

community, ultimately contributing to a more informed and empathetic approach to paediatric end-of-life care in Nigeria.

2. Method

2.1 *Place of Study*

The study was carried out at the University of Benin Teaching Hospital (UBTH), Benin City, Edo State. The UBTH is an 860-bedded tertiary hospital that provides health care in Edo State. It also serves as a referring centre for neighbouring states such as Delta, Ondo and Kogi states. The hospital provides specialty and sub-specialty care to children and adult populations. Terminally ill patients are cared for by primary care specialists (e.g., geriatrics, oncology, paediatric oncologist, etc.) with support from clinical psychologists, psychiatrists, and other support groups. The hospital has a legal department which provides legal clarifications on issues needing legal interpretation.

2.2 *Study Design*

The study was a descriptive cross-sectional study conducted between July 2023 and August 2023.

2.3 *Subjects*

The subjects included medical and dental doctors of all cadres providing clinical care to patients in UBTH. Doctors of other nationalities who work at the hospital were excluded from the study. Doctors who met the selection criteria were recruited consecutively into the study until the desired number was met.

2.4 *Data collection*

The relevant socio-demographic and clinical information were obtained using a self-administered semi-structured questionnaire. The questionnaire was organised into 3 sections, including sections on biodata; knowledge of paediatric euthanasia; attitude to paediatric euthanasia and clinical experience of paediatric euthanasia. The dependent variables were the knowledge and attitude of doctors regarding paediatric euthanasia. Independent variables included participant's age group, gender, specialty, religion and cadre. For the purpose of this study, the definition of euthanasia included vague terms like mercy killing and physician-assisted killing. The Penal Code and Criminal Code were accepted as correct answers for laws on euthanasia in Nigeria.

2.5 *Statistical analysis*

The collected data were organised, tabulated and statistically analysed using the International Business Machines Corporation (IBM) Statistical Package for the Social Sciences (SPSS) version 21.0 (SPSS for Window Inc; Chicago, LL, USA) Statistical Software. Descriptive characteristics such as gender, age groups, and cadre were presented as frequencies and percentages. Bivariate analysis was done using the chi-squared test. Multivariate analysis was done to determine sociodemographic factors associated with the knowledge and attitude of doctors to paediatric euthanasia. The level of statistical significance was accepted as $p<0.05$. Differences were considered to be statistically significant if their two-tailed p-value was less than 0.05.

3. Results

3.1 *Characteristics of study participants*

A total of 254 doctors were recruited for the study. The majority (124; 48.8%) of the study participants were aged between 31 and 40 years. There were 149 (58.7%) males and 105 (41.3%) females, giving a M:F ratio of 1.42:1. Nine (3.5%) of the participants were medical officers, and 47 (18.5%) were consultants. The main characteristics of the study sample are shown in Table 1.

Table 1: Characteristics of study participants

Variables	Frequency	Percentage
Age group		
20 - 30 years	59	23.2
31 - 40 years	124	48.8
41- 50 years	55	21.7
51 – 60 years	16	6.3
Gender		
Male	149	58.7
Female	105	41.3
Religion		
Christian	250	98.4
Muslim	3	1.2
Eckankar	1	0.4
Specialty		
Medicine	61	24.0
Surgery	24	9.4
Paediatrics	41	16.1
Obstetrics	34	13.4
Anaesthesia	10	3.9
Dentistry	33	13.0
Family medicine	23	9.1
Psychiatry	11	4.3
Others	17	6.7
Cadre		
Consultant	47	18.5
Senior Registrar	65	25.6
Registrar	87	34.3
Medical officer	9	3.5
House officer	46	18.1

3.2 *Knowledge of Euthanasia*

Two hundred and fifty (98.4%) of the study participants have heard of euthanasia, and 160 (63.0%) could correctly define it. The common definitions included 'deliberate termination of life of a patient by a medical doctor to ease the pain or suffering' in 48 (18.9%) of the respondents; 'mercy killing' in 74 (29.1%) of the doctors; painless killing of a patient with incurable illness" in 30 (11.8%) while 49 (19.3%) defined it as 'physician assisted suicide'. Seventy-four (29.1%) of the respondents correctly identified the forms of euthanasia as active and passive, while 68 (26.8%) identified only active euthanasia and 46 (18.1%) identified only passive euthanasia. Two hundred and thirty-one (90.9%) of the doctors knew that euthanasia was not legal in Nigeria, but only 14 (5.5%) knew the relevant laws on the topic.

3.3 *Attitude towards paediatric euthanasia*

One hundred (39.4%) doctors thought euthanasia was ethical, while 76 (29.9%) of the doctors believed that terminally ill children should be allowed to request an easy death. Seventeen (22.4%) of the 76 doctors who approved of euthanasia for terminally ill children suggested that consent be sought from everyone, including the child, father, mother, the doctor and the court. Twenty-two of them (28.9%) thought that consents should be given jointly by the fathers, the mothers and the child, while 14 (18.4%) thought that the consent from the parents alone (father and mother) should suffice. Eighty-six (33.9%) of the respondents believed that medical doctors should be allowed to give lethal doses of medications to terminally ill children.

As shown in Figure 1, the chief factors that doctors thought should be strongly considered regarding the ethics of paediatric euthanasia are the quality of life (83.1%), the patients' suffering

(78.7%), and medical prognosis (77.2%). The common paediatric conditions considered hopelessly and terminally ill by study participants were: Persistent vegetative state (67.7%); anaencephaly (62.6%); other congenital anomalies of the CNS (33.1%); CNS tumors (24%), and the Leukaemias (21.7%).

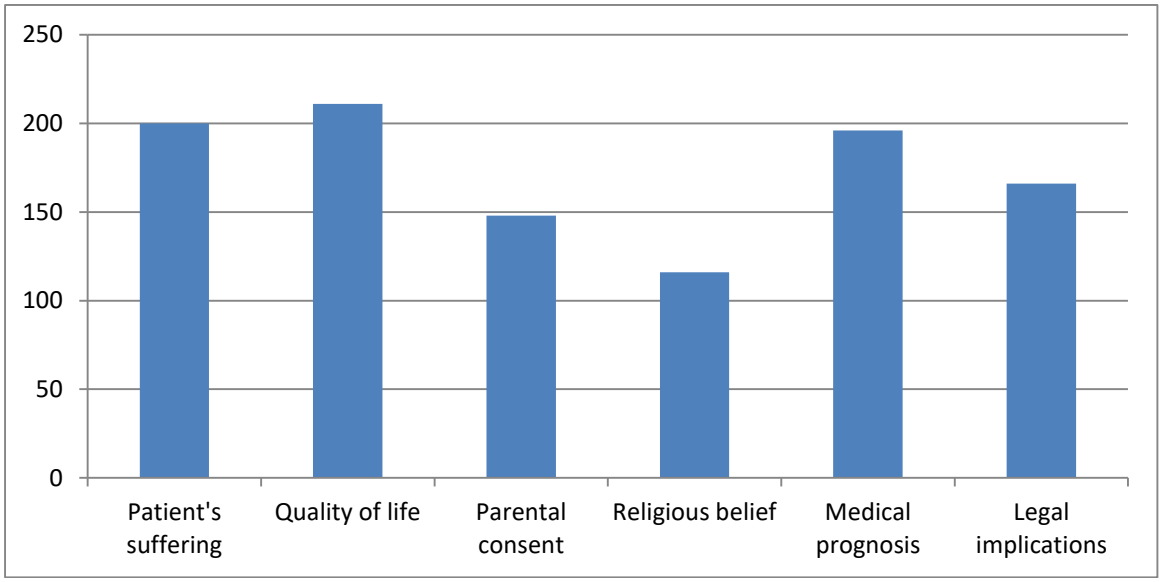

Figure 1: Factors to consider in evaluating ethical aspect of euthanasia (by frequency of response)

3.4 *Clinical Experience and Decision Making*

Only 77 (29.1%) of the respondents would offer euthanasia to children if it is legal. The most commonly cited reasons for being willing to offer paediatric euthanasia if legal were to end the child's suffering (45; 58.4%) and as respect for their autonomy (9/77; 11.7%). The majority of those who object to euthanasia, even when it is legal, cite religious (65/177; 36.7%) and ethical (32/177; 18.1%) reasons for their stance (Fig. 2). Twenty-one (8.3%) of the doctors recruited have been in a situation where a child requested to end his/her life so as to end his/her suffering. Of the doctors who have been in a situation where a child requested to end his/her life due to unbearable suffering eight (38.1%) either counselled or prayed with the patient; four (19.0%) reassured the patient and connected to support group; seven (33.3%) did nothing about the request and continued treatment; one (4.8%) invited the mental health team to review the child and only one (4.8%) connected the child to palliative care.

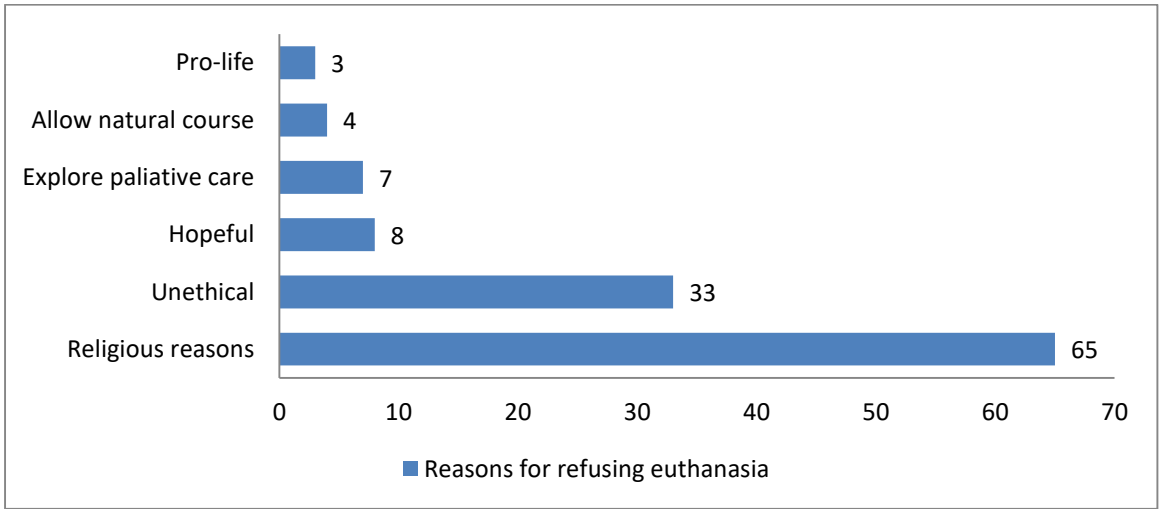

Figure 2: Reasons for declining approval of paediatric euthanasia (by frequency of response)

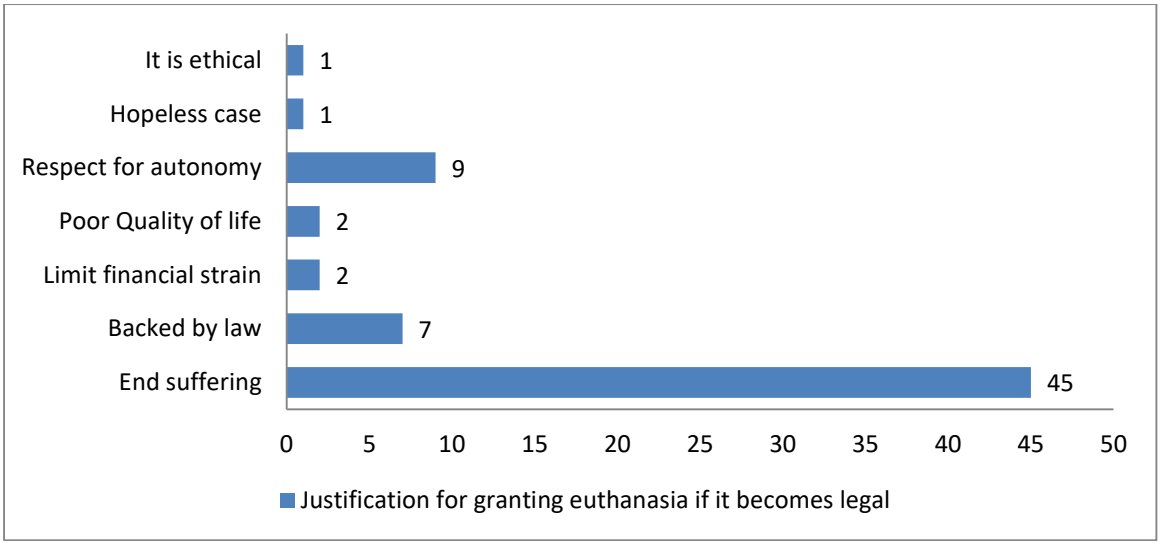

Figure 3: Justification for approving paediatric euthanasia (by frequency of response)

3.5 *Bivariate analysis*

On bivariate analysis, age group, specialty and cadre were associated with the belief that doctors should be allowed to give a lethal dose of medications to terminally ill children (Table 2).

Table 2: Factors associated with approval of legalization of paediatric euthanasia

Variables	Yes	No	χ^2	p
Age Group				
20-31	28	31	8.440	**0.029***
31-40	39	85		
41-50	17	38		
50-60	2	14		
Gender				
Male	56	93	2.234	0.135
Female	30	75		
Religion				
Christianity	84	166	2.492	0.682
Eckankar	0	1		
Islam	2	1		
Specialty				
Anaesthesia	3	7	26.617	**<0.001***
Dentistry	15	18		
Family medicine	10	13		
Medicine	26	35		
O &G	15	19		
Paediatrics	5	36		
Psychiatry	0	11		
Surgery	6	18		
Others	6	11		
Cadre				
House Officers	25	21	12.083	**0.015***
Medical officers	2	7		
Registrar	28	59		
Senior Registrar	21	44		
Consultants	10	37		

Table 3: Factors associated with willingness to offer euthanasia to children if legal

Variables	**Yes**	**No**	χ^2	**p**
Age				
20-30	20	39	5.255	0.162
31-40	42	82		
41-50	10	45		
51-60	4	12		
Gender				
Male	51	98	3.189	0.074
Female	25	80		
Religion				
Christianity	73	177	4.152	0.081
Eckankar	1	0		
Islam	2	1		
Specialty				
Anaesthesia	3	7	5.429	0.719
Dentistry	11	22		
Family medicine	7	16		
Medicine	19	42		
O &G	10	24		
Paediatrics	10	31		
Psychiatry	1	10		
Surgery	7	17		
Others	8	9		
Cadre				
House Officers	16	30	2.531	0.664
Medical officers	4	5		
Registrar	26	61		
Senior Registrar	19	46		
Consultants	11	36		

3.6 *Multivariate analysis*

Multiple logistic regression analyses mostly confirmed the results of the bivariate analyses shown earlier and particularly highlighted the association of gender and specialty in approval of paediatric euthanasia and willingness to offer it if legal. Female doctors had significantly lower odds of approving of euthanasia than male doctors. Dental surgeons and family physicians had about four times the odds of approving euthanasia compared to surgeons (Table 4). Concerning willingness to offer euthanasia if it was legal, female doctors were significantly less likely to offer euthanasia (Table 5).

Table 4: Doctors should be allowed to give lethal dose of medications to terminally ill children

Variables	Yes	No	OR	95% CI	p
Age Group					
20-31	28	31	3.016	0.364 - 25.009	0.306
31-40	39	85	2.619	0.390 - 17.567	0.322
41-50	17	38	3.478	0.578 - 20.922	0.578
50-60	2	14	1		
Gender					
Female	56	93	0.479	0.254 - 0.903	**0.023**
Male	30	75	1		

Religion					
Christianity	84	166	0.390	0.031 - 4.988	0.469
Eckankar	0	1	0.001	<0.001 - 0.001	-
Islam	2	1	1		
Specialty					
Anaesthesia	3	7	1.867	0.338 - 10.306	0.474
Dentistry	15	18	4.007	1.144 - 14.043	**0.030**
Family medicine	10	13	4.299	1.104 - 16.740	**0.035**
Medicine	26	35	2.466	0.769 - 7.914	0.129
O &G	15	19	2.954	0.856 - 10.191	0.086
Others	6	11	3.217	0.714 - 14.494	0.128
Paediatrics	5	36	0.556	0.138 - 2.241	0.409
Psychiatry	0	11	0.001	<0.001 - 0.001	0.997
Surgery	6	18	1		
Cadre					
Consultant	10	37	0.791	0.232 - 2.697	0.707
House Officers	25	21	2.663	0.738 - 9.614	0.135
Medical officers	2	7	0.536	0.090 - 3.187	0.493
Registrar	28	59	0.681	0.307 - 1.510	0.344
Senior Registrar	21	44	1		

Table 5: Willingness to offer euthanasia to children if legal included

Variables	Yes	No	OR	95% CI	p
Age Group					
20-31	20	39	2.926	0.453-18.899	0.259
31-40	42	82	3.163	0.624-16.032	0.164
41-50	10	45	0.931	0.211-4.106	0.925
50-60	4	12	1		
Gender					
Female	51	98	0.532	0.028-0.991	**0.047**
Male	25	80	1		
Religion					
Christianity	73	177	0.130	0.010-1.673	0.118
Eckankar	1	0	-	-	-
Islam	2	1	1		
Specialty					
Anaesthesia	3	7	1.359	0.246-7.517	0.725
Dentistry	11	22	1.801	0.517-6.270	0.355
Family medicine	7	16	1.904	0.477-7.593	0.362
Medicine	19	42	1.238	0.384-3.988	0.720
O &G	10	24	1.248	0.360-4.318	0.727
Others	10	31	3.336	0.795-14.007	0.100
Paediatrics	1	10	1.230	0.384-3.998	0.744
Psychiatry	7	17	0.434	0.360-4.318	0.481
Surgery	8	9	1	0.043-4.415	
Cadre					
Consultant	16	30	1.483	0.421-5.221	0.540
House Officers	4	5	1.235	0.352-4.333	0.742
Medical officers	26	61	2.095	0.443-9.910	0.351
Registrar	19	46	0.766	0.345-1.701	0.513
Senior Registrar	11	36	1		

4. Discussion

Our study provided evidence that almost all doctors who responded to the questionnaire have heard about euthanasia. However, there are varying views on its definition, and most of the respondents did not know the legal framework guiding euthanasia in Nigeria. Majority of the doctors believed that euthanasia is unethical, but about a third of respondents believe that doctors should be allowed to give lethal doses to terminally ill children. A third of doctors will offer euthanasia to children if it were legal. There was no significant difference seen in the attitude of doctors of different age group toward euthanasia, although younger doctors strongly endorsed euthanasia. Female doctors were less willing to either approve of the legalization of euthanasia or offer it if legal. Family physicians and dentists were more willing to approve of the legalization of paediatric euthanasia in Nigeria.

It is evident from our study that doctors do not have sufficient knowledge of the legal framework governing euthanasia in Nigeria. Although many doctors have heard of euthanasia and could define it, many could not tell the position of the Nigerian law regarding euthanasia. Our findings resonate with the observations of Adejumo *et al*[18] and Archibong and colleagues[19] in two separate studies evaluating the knowledge of medical doctors on the National Health Act and the laws regulating clinical and medical laboratories in Nigeria, respectively. They reported that although doctors were aware of these legal statutes, many of them had not read them. This observation may be due to the fact that medical professionals do not have sufficient training in health laws and health-related legal proceedings.

About three-fifth of the doctors consider euthanasia to be unethical in our study. This position is held by a number of doctors, including Leiva and colleagues, who believe that euthanasia amounts to medicalization of suicide.[20] Opinions of health professionals on the ethics of euthanasia vary widely between countries. Previous studies have reported that doctors from low- and medium-income countries were less likely than their counterparts from high-income countries to find limiting or withdrawing life-sustaining treatment justifiable.[21] The same argument may hold for ethical positions on paediatric euthanasia. About three in ten doctors believe that terminally ill children should be allowed to request for an easy death while one-third of the respondents believe that doctors should be allowed to give lethal doses to terminally ill children. This finding of our study is in consonance with the study carried out in Finland in the year 2022 by Piili *et al* in which 25% of doctors surveyed fully agreed with the legalization of euthanasia.[22] The reason for the growing support for euthanasia among doctors is not apparent. However, the absence of adequate end-of-life care in Nigeria and poor quality of life for terminally ill children might be remotely responsible. It has been argued that the provision of quality hospice and palliative care for terminally ill persons is preferred to euthanasia by patients.[23] Some others suggest that euthanasia or medical assistance in dying can be integrated into palliative care for completeness.[24]

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[18] Adejumo O, Madubuko C, Adejumo O, Junaid O, Owolade S. 'Knowledge of the National Health Act among Physicians in two Tertiary Hospitals in Southern Nigeria' (2022) 5(2) Babcock Univ Med J. 85–91.

[19] Archibong F, Atangwho A, Ayuk A, Okoye I, Atrogor M, Okokon I. Medical Law: Exploring Doctors' Knowledge on the Laws Regulating Clinical and Medical Laboratories in Nigeria. (2019) 28(4) Niger J Med. 386–392.

[20] Rena Leiva, Gordon Friesen and Timothy Lau, 'Why Euthanasia is Unethical and Why We Should Name it as Such' (2018) 64 World Med J. 33–37.

[21] Schembs L, Racine E, Shevell M, Jox RJ. 'Physicians' Attitudes Towards Ethical Issues and End- Making for Pediatric Patients with Unresponsive Wakefulness Syndrome: An International Survey' (2023) Jan. Dev Med Child Neurol. 1–10.

[22] Piili RP, Louhiala P, Vänskä J, Lehto JT. Ambivalence toward Euthanasia and Physician-Assisted Suicide Has Decreased Among Physicians in Finland. (2022) 23 BMC Med Ethics 1–8.

[23] Ulrichová M. Euthanasia and the Needs of the Terminally Ill Merits and Risks of Voluntary Workers in Hospices. (2016) 217 Procedia - Soc Behav Sci. 657–68.

[24] Davies D. Medical assistance in dying: A paediatric perspective. (2018) 23 Paediatr Child Heal. 125–30. Hanson SS. Pediatric Euthanasia and Palliative Care Can Work Together. (2015) 33 Am J Hosp Palliat Med. 421–4.

Physicians' gender has been shown from previous works to influence their opinion on the legalisation of euthanasia. In the index study, female doctors were less likely to approve of the legalization of paediatric euthanasia than males. This is in agreement with the findings of Piili *et al* among Finnish physicians.[25] The attachment of females to children and their nurturing tendencies might explain the observed difference in opinion. Similarly, the opinion of doctors regarding legalization of paediatric euthanasia might differ according to specialties. Dental surgeons and Family Physicians were significantly more likely to approve of paediatric euthanasia than those from the surgical specialties in this study. Peretti-Watel and colleagues have previously reported that General Practitioners and neurologist were significantly more likely to approve of the legalization of euthanasia than oncologists.[26] While the reason for this observation is not apparent, it is believed that Family Physicians might have approved of legalization of euthanasia due to their better understanding of how the challenge of having a terminally ill child affects the family function and dynamics compared to other specialties. These are core concepts of family physician training; they consider the influence of illness on the family while attending to patients.

Only about a third of doctors would offer euthanasia to children if it is legal. The observation of the index study suggests that other factors besides the legal regulations affect the decision to offer euthanasia. This agrees with the observation of van den Ende *et al* in Netherland where euthanasia is legal.[27] They reported that 35 (32.1%) of the 109 doctors surveyed who have received requests for physician-assisted death declined the request. They found religious reasons and inability to fulfil the due care criteria, which requires the doctor to be convinced of unbearableness and lack of prospects for improvement as the common reason for decline. Similarly, this study observed that religious and ethical reasons underscored the refusal of doctors to grant euthanasia even if it were legal. Female doctors were significantly less likely to offer euthanasia even if it was legal than their male counterparts. The reason for the observation is not far-fetched. Females are generally more attached and willing to care for suffering children than males.

It is not surprising that persistent vegetative state (also known as unresponsive wakefulness syndrome) and anencephaly ranked top on the list of conditions considered hopeless and terminally ill. A previous study among paediatric neurologists and developmental paediatricians reported that 85.0% of them found the withholding of life-sustaining treatment from patients with persistent vegetative state to be justifiable.[28] The reasons for justifying the withholding or limitation of life-sustaining treatment were severe comorbidity, intense suffering and absence of recovery prospects. This is similar to the findings of this study that poor quality of life, severe suffering and poor medical prognosis were the chief considerations in determining the ethics of euthanasia.

Our study observed that the cadre of the doctors was not associated with their attitude to paediatric euthanasia on multivariate analysis; however, younger doctors of lower cadre were more likely to approve of euthanasia for terminally ill children on bivariate analysis. The findings of our study agree with the report of previous studies.[29] It is likely that younger doctors' approval of paediatric euthanasia as an end to the patients' suffering might be due to inexperience with bereavement and its effect on families. Whereas the suffering of the child might cease with euthanasia, the family continues to suffer guilt, especially knowing that they directly consented to the ending of the child's life. This sentiment might be responsible for the observed difference. Similarly, doctors of lower cadre who may not be responsible for making decisions on life-

[25] Ibid, no,16

[26] Peretti-Watel P, Bendiane MK, Pegliasco H, Lapiana JM, Favre R, Galinier A, et al. Doctors' opinions on euthanasia, end of life care, and doctor-patient communication: Telephone survey in France. (2003) 327(7415) Br Med J. 595–6.

[27] van den Ende C, Bunge EM, Eeuwijk J, van de Vathorst S. Exploring doctors' reasons for not granting a request for euthanasia: a mixed-methods study. (2022) 6 BJGP Open. 1–10

[28] Ibid, n15

[29] Ibid, n16

sustaining care, might also have approved of paediatric euthanasia solely because of the strain caring for a terminally ill child places on the medical team and hospital facility.

About a tenth of the doctors surveyed had been in a situation where a child asks for death on account of unbearable suffering. This observation is comparable with the finding of Grassi and colleagues among Italian doctors.[30] Of this number, less than one-twentieth had referred their patient to palliative care. This finding brings to the fore the primordial state of paediatric palliative care in Nigeria. Most hospitals that manage terminally ill children do not have hospice and palliative care facilities. Although the benefits of paediatric palliative care are indisputable, the understanding and utilization of palliative care in children with terminal illness and their families is still at an early stage.[31] Paediatric palliative care is poorly developed in low-income countries, and available services are generally precarious and fragmented, hence the poor utilization by doctors who manage terminally ill children.[32] Previous authors have argued that the increase in demand for euthanasia is reflective of the poor state of hospice and palliative care generally.[33] Policy makers must begin to consider the building of facilities and training of personnel with competencies for end-of-life care among children with terminal illnesses.

4.1 *Limitations*

This study had a few limitations. First, the use of only a quantitative approach to explore human behaviour and attitude has its limitations, because responses are restricted to only the options provided in the questionnaire. Inclusion of a qualitative approach could have provided an opportunity to understand in detail the reasons for doctors' choices and opinions. Secondly, the study explored an aspect of end-of-life care (euthanasia) without considering the experience of the doctors in paediatric end-of-life issues. Respondents' choices may have been influenced by their personal and professional experience in the matters.

5. Recommendations

It is recommended that legal statutes regulating doctors' practices should be taught during the course of medical education and frequently communicated to doctors. Policy makers should revise the current curriculum of medical education and incorporate training on health law and policy at both the undergraduate and postgraduate levels. Also, there should be collaboration between professional medical associations and legal associations to help bridge the knowledge gap.

6. Conclusion

Doctors in Nigeria are generally unaware of the legal regulations surrounding euthanasia. If the findings of this study represent the position of the generality of healthcare professionals in Nigeria, it can be concluded that most of them view euthanasia as unethical and only about one-third of Nigerian doctors support the legalization of paediatric euthanasia. The global discourse regarding end-of-life decisions for children, particularly sparked by the legalization of paediatric euthanasia in Belgium, may lead to enhancements in, and increased accessibility to, high-quality palliative care for paediatric patients.

[30] Grassi L, Agostini M, Magnani K. Attitudes of Italian doctors to euthanasia and assisted suicide for terminally ill patients. (1999) 354(9193) Lancet 1876–7.
[31] Ibid.
[32] Ibid.
[33] Ibid, n6; Massey C. Failure to Reform Experimental Treatment Accessibility Leads Push for Legalization of Assisted Suicide and Euthanasia in a Surprising New Group of Individuals — Children. (2018) 6(1) Child Fam Law J 63-102.

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Gender Differences in Substance Abuse Risk and Knowledge among Secondary School Students in Ondo, Southwestern Nigeria: Evidence for Health Policy Formulation and Regulatory Framework Development

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Abstract

Substance abuse among adolescents is a growing public health concern in Nigeria, with important implications for health policy and adolescent healthcare regulation. Despite evidence that gender influences substance use patterns, awareness, and vulnerability, gender-specific data among secondary school (SS) students remain limited. This study examined gender differences in substance abuse risk, knowledge, and associated factors among SS students in Ondo, Ondo State, Nigeria. Mixed-methods design was employed involving 304 senior SS students selected through multistage random sampling. Quantitative data were collected using a structured questionnaire and the Drug Abuse Screening Test (DAST-10), while qualitative data were obtained through gender-balanced focus group discussions. Data were analysed using JASP and ATLAS.ti. Social media (37.3%) led as source of substance-related information. Females demonstrated greater awareness of cannabis (91.7%), tramadol (78.7%), codeine (92.3%), and emerging drugs, whereas males more frequently recognized alcohol (60.9%) and cigarettes (72.2%). Parental educational level and information sources were significantly associated with substance abuse risk ($p<0.001$). Qualitative findings revealed stricter supervision of female boarding students, reducing exposure opportunities compared with males. The findings highlight the need for gender-responsive substance abuse policies, strengthened regulation of digital content, school-based awareness programs, and community interventions that address socioeconomic determinants of adolescent substance abuse.

Keywords: Gender; Substance-abuse; Secondary-school-students; Health policy; Regulatory frameworks; Nigeria; DAST-10

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1. INTRODUCTION

Substance abuse among adolescents has emerged as a major global public health challenge with significant consequences for physical health, mental well-being, academic performance, and future productivity.[1] Traditionally viewed as a problem primarily affecting older adults, substance misuse is now increasingly prevalent among younger populations, including secondary school students.[2] In Nigeria, the situation is particularly concerning; recent data indicate a rising trend in the use of alcohol, cannabis, prescription opioids, and emerging synthetic substances among adolescents and youths.[3] Prevalence estimates vary widely across regions, with reported rates ranging from 20% to 40% among students and young adults.[3] This escalating burden places substantial pressure on the healthcare system and underscores critical gaps in existing health policies, regulatory frameworks, and school-based prevention strategies.

Despite increasing recognition of adolescent substance use as a policy priority, the gender dimension of the problem remains insufficiently understood and inadequately addressed in health law and policy frameworks. Although gender differences in drug use have been documented—historically with more males than females involved—recent global assessments highlight the persistent underrepresentation of women and girls in drug-use epidemiological research and evidence-based health policy discussions.[4] This evidence gap directly constrains the development of gender-responsive prevention and intervention programmes mandated by international health frameworks, particularly in low-resource settings where cultural, social, and institutional factors shape adolescent behaviour differently for males and females. Furthermore, the absence of gender-disaggregated data limits the capacity of policymakers and health authorities to design and implement targeted regulatory interventions.

In Nigeria, adolescent substance abuse has been linked to peer pressure, easy access to drugs, poor parental supervision, and limited awareness of long-term health consequences.[5] These factors are amenable to policy intervention through strengthened regulatory controls, school health policies, and community health initiatives. Understanding adolescents' knowledge, perceptions, and risk exposure is essential for informing legislative and regulatory responses. While quantitative studies have provided insights into prevalence and demographic associations, qualitative approaches are vital for uncovering the institutional, social, and gender-specific vulnerabilities that policies must address.[6] Additionally, research demonstrates that knowledge

[1] Eric Chikweru Amadi and Gift Onyinyechi Akpelu, "Effects of Drug Abuse on the Academic Performance of Secondary School Students in Emohua Local Government Area of Rivers State" (2021) 6(1) International Journal of Innovative Healthcare Research 5.

[2] Temitope O Kolawole, Adenike O Ogunyemi and Anthonia R Lucas, "Prevalence of Substance Use and Knowledge of its Effects among Secondary School Students in Lagos, Nigeria" (2025) 31(0) South African Journal of Psychiatry, article e2370.

[3] Abubakar I Jatau and others, "The Burden of Drug Abuse in Nigeria: A Scoping Review of Epidemiological Studies and Drug Laws" (2021) 42 Public Health Reviews, article 1603960.

Ifeoma Ajibola and others, "Prevalence, Pattern and Determinants of Substance Abuse among Youths in a Rural Community of Osun State, Southwest Nigeria" (2023) 23(4) African Health Sciences 563

[4] Cristina Buccelli and others, "Gender Differences in Drug Abuse in the Forensic Toxicological Approach" (2016) 265 Forensic Science International 89.

[5] Chinedu O Elom and others, "Impact of Drug Abuse on the Mental Health of Secondary School Students in Abakaliki, Ebonyi State, Nigeria" (2025) 8(3) International Journal of Innovative Research in Science Studies 4362.

Ayanda Khoza and Hoope N Shilubane, "Substance Use and Associated Factors Among In-School Adolescents in South Africa" (2021) 14(1) Open Public Health Journal 435.

[6] Ibid, n8; Chioma O Ofiaeli and others, "Knowledge and Indulgence in Substance Abuse among Adolescents in Anambra State, South-East Nigeria" (2022) 22(1) African Health Sciences 227.

about substance abuse alone does not necessarily prevent misuse among adolescents, highlighting the need for integrated policy approaches that combine awareness initiatives with structural and institutional safeguards.[7]

Given the rising burden of adolescent substance abuse in Nigeria[8] and the critical gap in gender-specific evidence needed to inform health policy and school health governance, this study addresses an urgent policy research priority. It examines gender differences in substance abuse knowledge, exposure, and associated risk factors among senior secondary school students in Ondo, Ondo State—findings essential for evidence-based policy formulation. Specifically, the study: (1) assesses gender-specific patterns in substance abuse knowledge to inform curriculum and health education policy; (2) determines associations between gender and substance abuse risk to support targeted prevention policy frameworks; (3) explores social, personal, and institutional factors influencing substance use to identify policy and regulatory intervention points; and (4) identifies gender-sensitive strategies that can be integrated into school health policies, health legislation, and adolescent protection frameworks.

Overall, this study seeks to generate robust, gender-disaggregated evidence that can inform evidence-based health policy, strengthen school health governance, enhance regulatory frameworks, and support the development of targeted, gender-responsive interventions aligned with Nigeria's health priorities and international adolescent health standards.

2. METHODOLOGY

2.1 *Study Design and Setting*

A total of 304 senior secondary school students, aged 15 to 20 years, were recruited from selected schools within a local government area in Ondo State, Nigeria, to participate in a mixed-methods study, which commenced with a quantitative phase and concluded with a qualitative phase. A multi-stage sampling technique was employed. After obtaining ethical approval from the University of Medical Sciences' Ethics and Research Committee and permission to conduct research from the Ondo West Local Government Education Authority, the names of all secondary schools in the area were obtained. The schools' names were written on slips of paper, placed in envelopes, and randomly drawn. Six schools were selected through this process, with assent provided by the school principals on behalf of the students.

2.2 *Study Phases*

This study was conducted in two stages:

Stage I: Quantitative Phase

A survey examined the prevalence of knowledge about drug abuse among selected secondary schools. A self-developed, structured questionnaire was administered, covering a wide range of topics including demographics (age, sex, ethnicity, parental education level, class, etc.), knowledge and awareness of substance abuse, types of substances used, substance use history, usage patterns, consequences of drug use, and attitudes and beliefs regarding substance abuse.

[7] Ibid, n8

[8] Jaya B Rajamani and others, "Prevalence of Substance Use among Adolescents Residing in Urban Slums of Vellore: A Cross-Sectional Study" (2024) 13(11) Journal of Family Medicine and Primary Care 4831. Keitumetse E Mokwena and Nobuhle J Setshego, "Substance Abuse among High School Learners in a Rural Education District in the Free State Province, South Africa" (2021) 63(1) South African Family Practice, article a5302.

In addition, the Drug Abuse Screening Test (DAST-10) was employed to assess the risk of drug abuse among the students.

Stage II: Qualitative Phase

The study employed focus group interviews, guided by an interviewer-assisted questionnaire, to further assess the prevalence of drug abuse and explore associated factors among students. A gender-balanced group of participants was selected using a binary sampling approach, whereby students across classes were asked to pick an enclosed slip of paper marked either YES or NO; those who selected YES were recruited into the focus group sessions. During these face-to-face discussions, participants provided in-depth perspectives on substance abuse, its underlying causes, and potential control measures. All sessions were recorded, with participants' identities protected by concealing their names.

2.3 *Data Analysis*

Quantitative data were processed using JASP (version 0.95.10), while qualitative responses were analyzed with ATLAS.ti using the following steps:

1. Coding: peer influence, stress coping, family background, gender differences
2. Categorization: risk factors, protective factors
3. Network view: illustrating how peer influence connects to adolescents and gender differences
4. Interpretation: [male participants tended to emphasize peer pressure, whereas female participants highlighted academic stress and recreational motivations.]

3. RESULTS

3.1 *Sociodemographic Distribution of Participants*

Most respondents were less than 15 years old, and in Senior Secondary school level (42.9%), with equivalent gender distribution, and of Yoruba ethnic extraction (85.5%). Most of the respondents became aware of substance abuse from social media (37.3%), and most of the respondents attributed other reasons, such as sexual drive and other unknown reasons, for the abuse of substances (33.1%). Additionally, most of the respondents obtained substances through other crooked means (74.3%). The majority of the respondents had different levels of abuse knowledge (Low 32.0%, Moderate level 16.3%, and Substantial level 8.9%) (Table 1)

Table 1: Sociodemographic characteristics of the participants

Variable	Frequency(N)	Percentage (%)
Age group (year)		
< 15	145	42.9
15	67	19.8
16-25	126	37.3
Gender		
Male	169	50
Female	169	50

Ethnicity		
Yoruba	289	85.5
Igbo	35	10.4
Hausa	6	1.8
Others	8	2.4
Family Settings		
Monogamy	274	81.1
Polygamy	44	13.0
Separated	20	5.9
Source of information about drugs		
Friend	77	22.9
Social Media	126	37.3
School	80	23.7
Family Member	28	8.3
Other	25	7.4
Reasons for taking drugs		
Peer influence	65	19.2
Poor academic performance	46	13.6
Neighbour	71	21.0
Family Dysfunction	44	13.0
Other reasons	112	33.1
Reasons for continual drug usage		
Feeling of being high	85	25.4
Enhancing Fearlessness	74	21.9
Euphoria and happiness	70	20.7
Other	108	32.0
Knowledge of Abuse level		
No Abuse	55	16.3
Low	145	32.0
Moderate	108	16.3
Substantial	30	8.9
Other crook Mean of getting substance		
YES	251	74.3
NO	81	25.7

3.2 *General Distribution of Substances among Participants*

Most of the substances were available and known to the majority of respondents (Table 2): Cannabis (77.2%), Alcohol (55.6%), Tramadol (71.9%), Codeine (79.1%), Cigarette (67.5%).

Table 2: Distribution of Substance Abuse

Substance	Frequency	Percentage
Cannabis		
Yes	261	77.2
No	77	22.8
Alcohol		
Yes	188	55.6
No	150	44.4
Tramadol		
Yes	243	71.9
No	95	28.1
Codeine		
Yes	267	79.1
No	71	21.0
Cigarette		
Yes	288	67.5
No	110	32.5
Others		
Yes	209	61.8
No	129	38.2

3.3 *Frequency Distribution of Substance across the Level of Abuse*

Codeine is at risk of being substantially and moderately abused, while cannabis and alcohol have the lowest abuse risk (Table 3).

Table 3: Substance-based distributions of the level of substance abuse

Substance	DAST ABUSE LEVEL			
	NO	LOW	MODERATE	SUBSTANTIAL
	N(%)	N(%)	N(%)	N(%)
Cannabis				
YES	50(19.2)	114(43.7)	75(28.7)	22(8.4)
NO	5(6.5)	31(40.3)	33(42.9)	6(10.4)
Alcohol				
YES	30(16)	83(44.1)	61(32.4)	14(7.4)
NO	25(16.7)	62(41.3)	47(31.3)	16(10.7)
Tramadol				
YES	42(17.3)	103(42.4)	78(32.1)	20(8.2)
NO	13(13.7)	42(44.2)	30(31.6)	10(10.7)
Codeine				
YES	48(18.0)	112 (41.9)	83(31.1)	24(9.0)
NO	7(9.9)	33(46.5)	25(35.2)	6(8.5)
Cigarette				
YES	32(14.0)	100(43.9)	78(34.2)	18(7.9)
NO	23(20.9)	45(40.9)	30(27.3)	12(10.9)

Others				
YES	35(16.7)	86(41.1)	68(32.5)	20(9.6)
NO	20 (15.5)	59(45.7)	40(31.0)	10(7.8)

3.4 *Gender-Based Distribution of the Level of Risk of Awareness of Substance Abuse*

Males (75%) had a substantial risk of substance abuse compared to females (25%), while female respondents demonstrated a low risk of substance abuse (Table 4).

Table 4: Gender-based distributions of Substance abuse

Substance	**Male**	**Female**
	N(%)	N(%)
Cannabis		
Yes	106 (62.7)	155 (91.7)
No	63(37.7)	14 (8.3)
Alcohol		
Yes	103 (60.9)	85 (50.3)
No	66 (39.1)	84 (49.7)
Tramadol		
Yes	110 (65.1)	133(78.7)
No	59 (34.9)	36 (21.3)
Codeine		
Yes	111(65.7)	156(92.3)
No	58(34.3)	13 (7.7)
Cigarette		
Yes	122 (72.2)	106 (62.7)
No	47(27.8)	63(37.3
Others		
Yes	81(47.9)	128 (75.7)
No	88(52.1)	41 (24.3)

Table 5: Gender-based distribution of the level of substance abuse

Gender	ABUSE LEVEL			
	NO ABUSE	LOW	MODERATE	SUBSTANTIAL
	N(%)	N(%)	N(%)	N(%)
Male	22(13.0)	72(42.6)	55(32.5)	20(11.8)
Female	33(19.5)	73 (43.2)	53(31.4)	10(5.9)

3.5 *Association between Selected Sociodemographic Distributions and the Level of Knowledge Risk of Abuse among Respondents*

There is a significant association between the level of substance risk and respondents' parents ' educational level (χ^2 = 32.20, p = 0.000) and source of substance abuse information (χ^2 = 23.38, p = 0.03) (Table 6). However, there is no significant association between the level of substance risk and age group (χ^2 = 5.71, p = 0.455).

Table 6: Association between distribution of age group and level of Abuse among the respondents

			ABUSE LEVEL				X	p
			LOW ABUSE	MOD ABUSE	NO ABUSE	SUBST ABUSE		
age group	<15	N	62	51	23	9	5.718	0.455
		%	42.8%	35.2%	15.9%	6.2%		
	16-22	N	53	39	18	16		
		%	42.1%	31.0%	14.3%	12.7%		
	15	N	30	18	14	5		
		%	44.8%	26.9%	20.9%	7.5%		

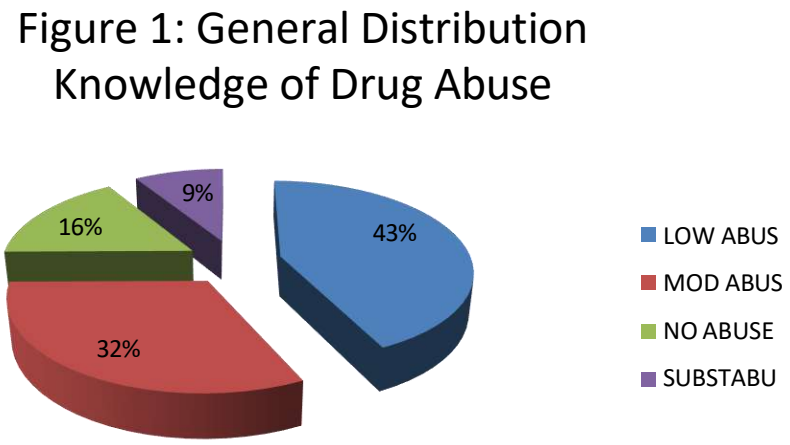
Table 7: Association of distribution of knowledge substance abuse level and educational level

		Distribution of Level of Abuse				X	P
		LOW ABUSE	MOD ABUSE	NO ABUSE	SUBSTANCE ABUSE		
Tertiary	N	8	3	2	5	32.199	0.000
	%	44.4%	16.7%	11.1%	27.8%		
Secondary	N	71	69	14	13		
	%	42.5%	41.3%	8.4%	7.8%		
Primary	N	64	35	39	12		
	%	42.7%	23.3%	26.0%	8.0%		

Table 8: Association of distribution of substance Abuse knowledge and the Source of information of substance abuse

		ABUSE LEVELS				X	p
		LOW ABUSE	MOD ABUSE	NO ABUSE	SUBST. ABU		
Peer Influence	n	32	14	12	7	23.381	0.025
	%	49.2%	21.5%	18.5%	10.8%		
Poor Academic Performance	n	23	13	9	1		
	%	50.0%	28.3%	19.6%	2.2%		
Neighbour	n	23	32	8	8		
	%	32.4%	45.1%	11.3%	11.3%		

Family Dysfunction	n	19	14	3	8		
	%	43.2%	31.8%	6.8%	18.2%		
Others	n	48	35	23	6		
	%	42.9%	31.3%	20.5%	5.4%		



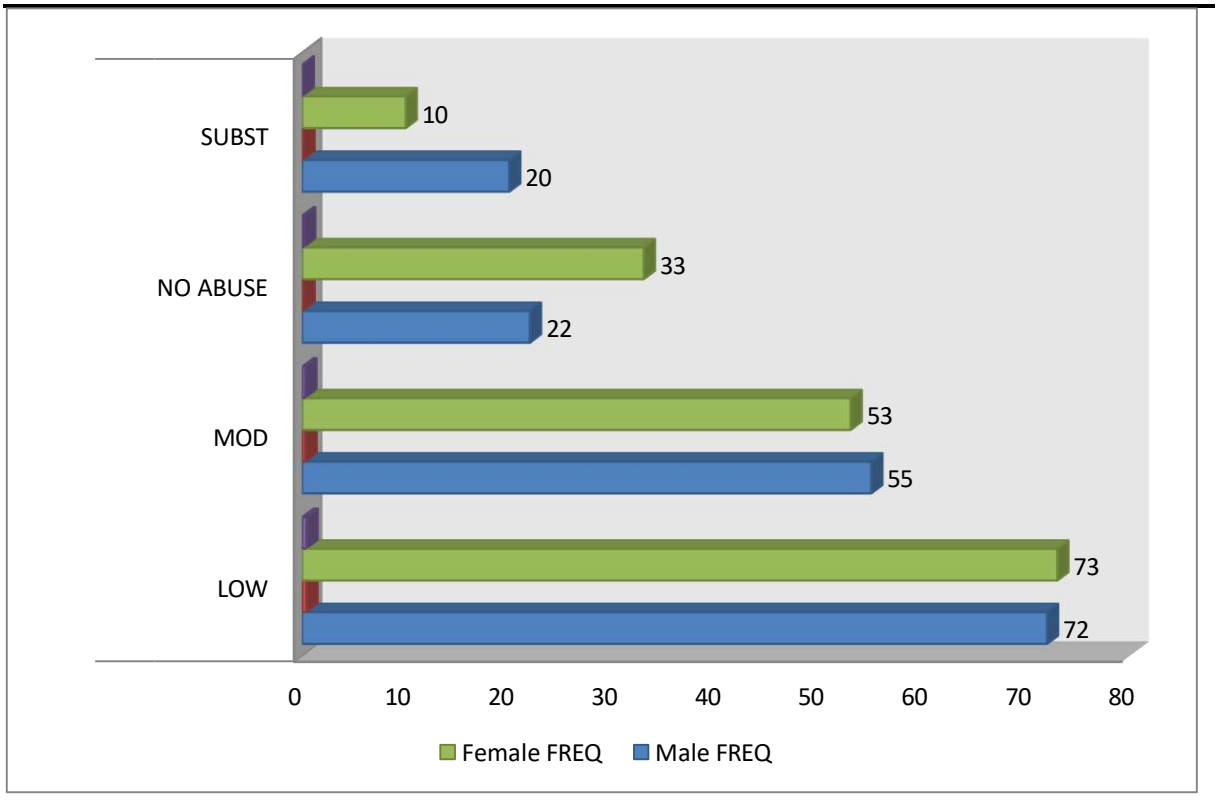


Figure 2: Gender: Gender-based distribution of the level of substance abuse knowledge

4. DISCUSSION

This study assessed the prevalence of substance abuse among secondary school students stratified by gender, explored associated factors, and identified evidence-based strategies to inform health policy and prevention frameworks. The findings reveal critical gaps in current health regulation, school health governance, and legislative frameworks that must be addressed through coordinated policy reform.

4.1 *Social Media as a Primary Information Source: Policy and Regulatory Implications*

A striking finding was that social media constituted the leading source of substance-related information (37.3%), with profound implications for digital health governance and regulatory oversight. Research has established that social media content significantly influences substance use behaviours among Nigerian students, underscoring the urgent need for targeted legislative and regulatory interventions to reduce exposure to substance-related content.[9] This finding highlights a critical policy gap: the absence of comprehensive digital health regulatory frameworks governing substance-related online content targeting adolescents. Current health policies in Nigeria do not adequately address the oversight of social media platforms frequented by secondary school students, nor do they establish clear accountability mechanisms for the moderation of content. Policymakers must consider: (1) strengthening existing media regulation frameworks to include substance-related content; (2) establishing digital health literacy standards within school curricula; and (3) engaging telecommunications regulators and platform providers in evidence-based policy dialogue.

4.2 *Gender-Specific Knowledge Disparities and Policy Implications*

The study revealed significant gender differences in substance awareness, with females demonstrating greater recognition of cannabis (91.7%), tramadol (78.7%), codeine (92.3%), and emerging drugs, while males more frequently recognized alcohol (60.9%) and cigarettes (72.2%). Historically, substance abuse research and policy frameworks have been male-centric;[10] however, the evolving epidemiology documented here, and corroborated by increasing prevalence rates among women, demands gender-responsive legislative reform. These findings necessitate immediate policy action: (1) gender-disaggregated substance abuse prevention curricula tailored to knowledge gaps; (2) school health policies that address gender-specific vulnerability patterns; and (3) health authority guidelines ensuring equal emphasis on emerging drug threats across gender categories. Current national drug control policies lack gender-specific implementation strategies, representing a significant governance gap that constrains effective prevention.

4.3 *Risk Factors and Preventive Policy Framework*

The analysis identified multiple drivers of substance abuse - peer influence, limited parental oversight, family dysfunction, stress coping mechanisms, and curiosity - all of which are amenable to policy-level intervention. The significant association between parental educational level and substance risk (p=0.000) indicates that health policies must integrate socioeconomic and educational determinants.

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[9] Shamsudeen F Agberotimi and Eniola O Olumuji, "Substance-Reference Content, Social Media and Substance Use among University Students in Abeokuta, Nigeria" (2025) 11(1) Cogent Social Science, article 2525996.
[10] Wan Sulaiman WS and others, "Exploring Gender Differences in the Vulnerability Towards Drug Abuse among Adolescents in Malaysia" (2021) 6(1) Psikohumaniora: Jurnal Penelitian Psikologi 1.

This finding supports evidence-based recommendations for: (1) coordinated health-education policy linking school-based substance prevention to community health worker programs; (2) family-centred health policies that address parental capacity and supervision; and (3) mental health service integration within school health systems to address stress and emotional distress, a critical gap in current school health governance frameworks in Nigeria.

Notably, the study found that knowledge of substance abuse did not necessarily prevent misuse. This suggests that awareness campaigns alone are insufficient policy responses. Effective prevention requires integrated, multi-sectoral policy approaches combining education with structural and institutional safeguards, a principle that is underutilized in current Nigerian health policy frameworks.

4.4 *Qualitative Findings: Institutional Controls and School Health Governance*

Qualitative analysis revealed stark differences in perceived substance abuse prevalence between male and female students, with female boarding students reporting limited exposure due to stricter institutional controls. This finding has important implications for school health policy and governance: it demonstrates that institutional safeguards (such as regular monitoring, clear disciplinary frameworks, and environmental design) can measurably reduce substance access among adolescents. However, these controls are inconsistently applied across school types (day vs. boarding), revealing governance gaps.

Policy recommendations include: (1) establishing standardized school health policies governing substance abuse prevention, monitoring, and disciplinary procedures across all educational institutions; (2) strengthening accountability mechanisms for school administrators in policy compliance; (3) training school health personnel and teachers in evidence-based substance abuse prevention and harm reduction; and (4) creating transparent reporting systems for substance-related incidents to inform health surveillance and policy evaluation.

4.5 *Gender-Based Vulnerability Patterns and Targeted Policy Responses*

The analysis identified notable gender disparities in substance abuse patterns and severity. Male students demonstrated higher prevalence and severity of drug use, often linked to societal expectations and reduced parental oversight. Female students, while less involved overall, showed engagement patterns often connected to relationships and economic vulnerability, suggesting the need for targeted interventions addressing gender-specific risk pathways. These findings require gender-responsive health policies that: (1) acknowledge and address differential vulnerability patterns; (2) incorporate gender considerations into school health curricula and prevention strategies; and (3) integrate substance abuse prevention with gender-based violence and protection frameworks.

4.6 *Emerging Synthetic Drugs: Regulatory and Legislative Gaps*

Qualitative findings identified emerging designer drugs ("Ice," "Skushi") and novel substances alongside traditional drugs, revealing a critical regulatory challenge. The rapid emergence of synthetic substances outpaces current drug scheduling and regulatory mechanisms in Nigeria.[11] This gap necessitates: (1) strengthened pharmaceutical regulation governing precursors and legitimate drug distribution; (2) coordinated legislative efforts across health, law enforcement, and border agencies; (3) enhanced drug surveillance systems to detect and respond to emerging

[11] Abdulrahman Lawal and others, "Prevalence and Factors Associated with Substance Abuse among Adolescents in Public and Private Secondary Schools in Katsina State, Nigeria" (2025) 25 BMC Public Health 531

threats; and (4) proactive policy mechanisms enabling rapid regulatory response to new psychoactive substances.

4.7 *Evidence-Based Policy Recommendations*

Synthesizing these findings, the following policy interventions are recommended:

1. Digital Health Governance: Develop comprehensive regulatory frameworks addressing substance-related content on social media, with clear accountability measures for platform providers and content moderation standards aligned with adolescent protection principles.
2. Gender-Responsive School Health Policies: Establish standardized, gender-sensitive school health policies governing substance abuse prevention, monitoring, and response, with enforcement mechanisms and regular policy evaluation.
3. Curriculum Reform: Integrate evidence-based, gender-disaggregated substance abuse education into secondary school curricula, emphasizing emerging drugs and addressing gender-specific knowledge gaps.
4. Integrated Mental Health Services: Strengthen school health systems to include accessible mental health and psychosocial support services, addressing stress and emotional distress as protective factors.
5. Parental and Community Engagement: Develop health policies connecting school-based prevention with community health initiatives and parental support programs, particularly targeting low-educational-background families.
6. Regulatory and Law Enforcement Coordination: Enhance pharmaceutical regulation, border security, and drug trafficking prevention through multi-sectoral policy coordination and evidence sharing.
7. Health Surveillance and Monitoring: Establish standardized substance abuse surveillance systems collecting gender-disaggregated data to inform policy evaluation and adaptive management.
8. Teacher Training and Accountability: Develop professional development standards for teachers and school health personnel in substance abuse prevention, with clear accountability mechanisms.

4.8 *Limitations and Policy Implications*

While this study provides critical evidence for policy formulation, findings are limited to one state and may not generalize across Nigeria's diverse socioeconomic and institutional contexts. Policymakers should commission multi-site surveillance studies to establish national epidemiological baselines and inform federal health policy frameworks.

5. CONCLUSION

This study reveals significant gender-based disparities in substance abuse awareness, knowledge, and risk exposure among secondary school students. These disparities are inadequately addressed in current health policies and regulatory frameworks. The prominent role of social media, the association between socioeconomic factors and risk, and the demonstrated effectiveness of institutional controls all point toward actionable policy priorities. These findings provide an evidence base for urgent health policy reform, including digital health governance, gender-responsive school health policies, curriculum integration, mental health

service strengthening, and multi-sectoral coordination. Implementation requires commitment from health authorities, educational institutions, legislative bodies, and community stakeholders to translate evidence into protective policy frameworks that safeguard adolescent health.

Acknowledgement

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Towards a More Robust Legal Framework for Cybersecurity in the Nigerian Health Sector: Recommendations for Sector-Specific Regulation

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Abstract

The digitalization of healthcare services in Nigeria has necessitated robust legal frameworks to protect health information systems from cyber threats. This paper examines the legal and regulatory framework governing cybersecurity in the Nigerian health sector, evaluating the adequacy of existing legislation, including the National Health Act 2014, the Nigeria Data Protection Act 2023, and the Cybercrimes (Prohibition, Prevention, etc.) Act 2015 (as amended in 2024). A critical analysis of primary and secondary sources reveals that while Nigeria has made significant strides in establishing broad legal frameworks for cybersecurity in healthcare, substantial gaps remain in enforcement mechanisms, technical capacity, sector-specific regulations, and harmonization of overlapping laws. The paper recommends comprehensive amendments to strengthen cybersecurity provisions specifically tailored to the healthcare sector's unique vulnerabilities and operational requirements.

Keywords: Cybersecurity; Health sector; Data protection; Nigeria; protection of health information systems.

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1. INTRODUCTION

The healthcare sector has undergone a significant digital transformation, with electronic health records (EHRs), telemedicine platforms, and health information management systems becoming integral to modern healthcare delivery.[1] This digitalization, while enhancing healthcare access and efficiency, has exposed the sector to unprecedented cyber threats ranging from data breaches to ransomware attacks targeting critical health infrastructure.[2] The healthcare sector processes vast amounts of sensitive personal data, making it particularly attractive to cybercriminals and necessitating robust legal protections.

Despite serving one of Africa's largest economies and its most populous nation, Nigeria's healthcare infrastructure remains fragmented, with significant disparities between urban and rural healthcare facilities.[3] The increasing adoption of digital health technologies, accelerated by the COVID-19 pandemic, has outpaced the development of comprehensive cybersecurity frameworks specifically designed for healthcare settings.[4] This gap between technological advancement and legal protection creates vulnerabilities that threaten patient privacy, data integrity, and healthcare service continuity.

The Nigerian government has recognized the need to develop sector-specific cybersecurity regulations for industries such as healthcare, given their unique challenges and risks, with experts urging the adoption of tailored cybersecurity standards that address their specific needs.[5] The legal framework governing cybersecurity in Nigeria's health sector comprises multiple statutes, regulations, and policies that operate at various levels of specificity and enforcement. Understanding this complex regulatory landscape is essential for healthcare providers, policymakers, and legal practitioners seeking to ensure compliance while protecting patient data and critical health infrastructure.

This paper provides a comprehensive analysis of the legal framework regulating cybersecurity in the Nigerian health sector. It examines the primary legislation, including the National Health Act 2014, the Nigeria Data Protection Act 2023, and the Cybercrimes Act, evaluating their adequacy in addressing contemporary cyber threats to healthcare systems. The paper further considers subsidiary regulations, enforcement mechanisms, and practical implementation challenges, then offers recommendations for legislative and regulatory reform.

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[1] World Health Organization, 'Global Strategy on Digital Health 2020-2025' (WHO 2021) 15

[2] K Varma, 'Healthcare Under Attack: Why Is Cybersecurity Now Critical?' (IT News Africa, March 2026) https://www.itnewsafrica.com/2026/03/healthcare-under-attack-why-is-cybersecurity-now-critical/ accessed 22 March 2026; Ponemon Institute, '2024 Healthcare Cybersecurity Report' (Ponemon Institute 2024) https://www.proofpoint.com/us/resources/threat-reports/ponemon-healthcare-cybersecurity-report accessed 22 March 2026.

[3] N Ravi, C Thomas and J Odogwu, 'How to Reload and Upgrade Digital Health to Serve the Healthcare Needs of Nigerians' (2024) 5 *Frontiers in Digital Health* 1225092; O I Eze, A Iseolorunkanmi and D Adeloye, 'The National Health Insurance Scheme (NHIS) in Nigeria: Current Issues and Implementation Challenges' (2024) 4 *Journal of Global Health Economics and Policy* e2024002.

[4] C Onyemelukwe and D Bhadmus, 'Nigeria Data Protection Act 2023: Relevant Provisions for Healthcare Delivery in Nigeria' (Health Ethics and Law Consulting 2024) https://healthlaw.com.ng/wp-content/uploads/2024/03/Nigeria-Data-Protection-Legislation-and-the-Health-Sector-1.pdf accessed 22 March 2026.

[5] Deloitte Nigeria, 'Nigeria Cybersecurity Outlook 2024' (Deloitte 2024) https://www.deloitte.com/ng/en/services/risk-advisory/perspectives/Nigeria-Cybersecurity-Outlook-2024.html accessed 22 March 2026.

2. The Constitutional Foundation for Privacy and Data Protection

The foundation of Nigeria's data protection and cybersecurity framework lies in the Constitution of the Federal Republic of Nigeria 1999 (as amended). Section 37 of the Constitution guarantees Nigerian citizens a fundamental right to privacy in their homes, correspondence, telephone conversations, and telegraphic communications.[6] This constitutional provision establishes the bedrock principle that personal information, including health data, deserves legal protection from unauthorized access and disclosure.

However, the Constitution's privacy provisions are notably broad and lack the specificity required for the digital age. The Constitution neither defines the scope of privacy nor contains detailed privacy provisions.[7] This lack of definitional clarity has necessitated the development of more specific statutory frameworks to operationalize constitutional privacy protections in healthcare and other sectors. The constitutional right to privacy has been interpreted by Nigerian courts as encompassing informational privacy, which extends to the protection of personal data, including health information.[8]

The constitutional framework provides the normative foundation upon which sector-specific cybersecurity laws are built. All subsequent legislation governing cybersecurity in healthcare must align with constitutional privacy guarantees, and any limitations on these rights must satisfy constitutional requirements of reasonableness and proportionality.[9]

3. The National Health Act 2014: Sector-Specific Provisions

The National Health Act 2014 represents Nigeria's first comprehensive legislation establishing a regulatory framework for the health system. The Act provides a framework for the regulation, development and management of a health system and sets standards for rendering health services in Nigeria.[10] Critically, Part III of the Act addresses the rights and obligations of users and healthcare personnel, including specific provisions relating to health records protection and confidentiality.

3.1 *Obligation to Keep Records*

Section 25 of the National Health Act mandates that persons in charge of health establishments must ensure that health records containing prescribed information are created and maintained for every user of health services.[11] This obligation establishes the foundational requirement for health data management in Nigeria, creating a legal duty to document patient information systematically. The provision implicitly recognizes that proper record-keeping is essential for quality healthcare delivery while simultaneously creating cybersecurity obligations to protect these records from unauthorized access.

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[6] Constitution of the Federal Republic of Nigeria 1999 (as amended) s 37.

[7] R I Opara, 'The Legal Framework for Information Security in the Age of Digital Identity in Nigeria' (2024) 1(2) *East African Journal of Law, Policy and Globalization* 1.

[8] Constitution of the Federal Republic of Nigeria 1999 (as amended), s 37; *Godfrey Nya Eneye v MTN Nigeria Communication Ltd* Suit No FHC/ABJ/CS/717/2013 (Federal High Court, Abuja); *Ezugwu Anene v Airtel Nigeria Ltd* Suit No FCT/HC/CV/545/2015 (High Court of the Federal Capital Territory, Abuja).

[9] Constitution of the Federal Republic of Nigeria 1999 (as amended) s 45

[10] National Health Act 2014, preamble.

[11] ibid, s 25.

3.2 *Confidentiality Requirements*

The cornerstone of health data protection in the National Health Act is Section 26, which provides comprehensive confidentiality protections. Section 26(1) states that 'all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential.'[12] This provision imposes a strict legal obligation of confidentiality on all healthcare providers and workers who have access to patient information.

Section 26(2) enumerates limited exceptions to the confidentiality requirement, permitting disclosure only where: (a) the user consents in writing; (b) a court order or law requires disclosure; (c) in the case of minors, with parental or guardian consent; (d) for persons unable to grant consent, upon request of a guardian or representative; or (e) where non-disclosure represents a serious threat to public health.[13] These exceptions balance patient privacy rights against legitimate public interests and legal requirements, providing healthcare providers with clear guidance on when disclosure is permissible.

3.3 *Protection of Health Records*

Section 29 of the National Health Act specifically addresses cybersecurity concerns by requiring persons in charge of health establishments to implement control measures preventing unauthorized access to health records and securing storage facilities and systems.[14] This provision explicitly recognizes the importance of cybersecurity measures in protecting health information. Section 29(2) creates a comprehensive criminal offence framework, prohibiting various acts, including:

a. Falsifying records by adding, deleting, or changing information
b. Creating, changing, or destroying records without authorization
c. Failing to create or change records when required
d. Providing false information for inclusion in records
e. Copying records without authorization
f. Connecting personal identification elements with health condition information without authorization
g. Gaining unauthorized access to records or record-keeping systems
h. Intercepting information transmitted between systems
i. Connecting unauthorized computer systems to health record systems
j. Modifying or impairing operating systems or programs used for health records.[15]

Violations of Section 29(2) constitute criminal offences punishable by imprisonment for up to two years, a fine of ₦250,000, or both.[16] While these provisions represent significant progress in recognizing cybersecurity as a legal imperative in healthcare, the penalties have been criticized as inadequate given the potentially catastrophic consequences of health data breaches.[17]

[12] ibid s 26(1).
[13] ibid s 26(2).
[14] ibid s 29(1).
[15] ibid s 29(2).
[16] ibid s 29(2).
[17] O Enabulele and JE Enabulele, 'Nigeria's National Health Act: An Assessment of Health Professionals' Knowledge and Perception' (2016) 57(5) *Nigerian Medical Journal* 260

3.4 *Access Rights and Complaints Mechanisms*

Sections 27 and 28 of the National Health Act establish frameworks for appropriate access to health records by patients and healthcare providers, while Section 30 creates mechanisms for patients to lodge complaints about privacy violations.[18] These provisions ensure that cybersecurity measures do not impede legitimate access to health information while providing accountability mechanisms for breaches.

3.5 *Evaluation of the National Health Act's Cybersecurity Provisions*

The provisions of the National Health Act represent a bold sector-specific regulation, offering a viable template for safeguarding privacy concerns in Nigeria.[19] However, several limitations merit consideration. First, the Act predates the current sophistication of cyber threats facing healthcare systems. Enacted in 2014, the legislation does not adequately address contemporary challenges such as ransomware attacks, sophisticated phishing campaigns targeting healthcare workers, or vulnerabilities in interconnected medical devices.[20]

Second, the penal sanctions appear inadequate, particularly the financial sanctions, in light of immeasurable loss, reputational erosion, technological advancement, and the emergence of sophisticated security and privacy issues.[21] A maximum fine of ₦500,000 (approximately $350) provides insufficient deterrence against cybersecurity violations that could compromise thousands of patient records or disrupt critical healthcare services.

Third, the Act lacks detailed technical standards or guidelines for implementing cybersecurity measures. While it mandates control measures to prevent unauthorized access, it does not specify minimum security requirements such as encryption standards, access control protocols, incident response procedures, or regular security audits.[22] This absence of technical specificity leaves healthcare providers without clear guidance on compliance requirements and makes enforcement challenging.

4. The Nigeria Data Protection Act 2023

The Nigeria Data Protection Act 2023 (NDPA), which received Presidential assent on 13 June 2023, represents Nigeria's first comprehensive principal legislation specifically addressing data protection.[23] The Act establishes the Nigeria Data Protection Commission (NDPC) as the primary regulatory authority responsible for enforcing data protection provisions across all sectors, including healthcare.[24]

[18] National Health Act 2014, ss 27, 28, 30.

[19] T Ilori, 'Privacy and Security in Nigeria's Healthcare Sector' (Lexology, 22 October 2018) https://www.lexology.com/library/detail.aspx?g=bffdbd12-8032-40cf-bf68-a8c1913399c2 accessed 22 March 2026.

[20] OA Ogundimu and others, 'Safeguarding Electronic Health Records (EHRs) and Medical Devices: Cybersecurity Threats and Countermeasures in Nigeria' (2025) 25(2) *World Journal of Advanced Research and Reviews* 2249.

[21] Ilori (n 19); National Health Act 2014 (Nigeria) s 30.

[22] Clarense Security, 'Nigeria's Data Protection Laws: NDPA & the National Health Act' (clarensec.com, 2024) https://clarensec.com/blog/data-protection-laws.html accessed 22 March 2026.

[23] Nigeria Data Protection Act 2023, preamble.

[24] ibid s 5.

4.1 *Scope and Applicability to Healthcare*

The NDPA applies to all forms of personal data processing, whether by automated means or manual processing, making it directly applicable to healthcare providers who collect, store, and process patient information.[25] Section 2 of the Act provides that it applies extraterritorially to data controllers and processors who do not reside or operate in Nigeria but process personal data of data subjects in Nigeria, ensuring comprehensive coverage of health data processing activities.[26]

The health sector is composed of myriad actors who deal with a variety of data, including public and private hospitals, pharmacies, laboratories, public health insurance schemes, health maintenance organisations, and clinical research organisations, as well as digital healthcare businesses providing electronic medical records solutions and telemedicine platforms.[27] All these entities fall within the NDPA's regulatory scope and must comply with its provisions regarding personal data processing.

4.2 *Principles of Data Processing*

The NDPA establishes fundamental principles for personal data processing that are particularly relevant to healthcare. Section 4 requires that personal data be processed lawfully, fairly, and transparently; collected for specified, explicit, and legitimate purposes; adequate, relevant, and limited to necessary purposes; accurate and kept up to date; retained only as long as necessary; and processed securely using appropriate technical and organizational measures.[28] These principles align with international data protection standards and impose significant obligations on healthcare providers to implement robust cybersecurity measures.

4.3 *Sensitive Personal Data*

Health information is classified as sensitive personal data under the NDPA. Section 1 defines 'Health status' as sensitive personal data, recognizing the heightened privacy and security concerns associated with health information.[29] The processing of sensitive personal data is subject to stricter requirements, including the need for explicit consent and enhanced security measures to prevent unauthorized access or disclosure.[30]

4.4 *Data Controllers and Processors of Major Importance*

The Act introduces a new category of entities known as 'Data Controllers or Processors of Major Importance' (DCPMI), defined as those processing personal data of more than 5,000 data subjects in a six-month period or operating in specified sectors, including healthcare.[31] This designation has significant implications for healthcare facilities, as most hospitals, health insurance schemes, and digital health platforms would qualify as DCPMIs.

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[25] ibid s 2(1).
[26] ibid s 2(2).
[27] Onyemelukwe and Bhadmus (n 4); Ilori (n 19).
[28] Nigeria Data Protection Act 2023, s 4.
[29] ibid s 1 (definition of 'Health status').
[30] ibid s 30; Onyemelukwe and Bhadmus (n 4).
[31] KPMG Nigeria, 'Nigeria Data Protection Act 2023: A Review' (KPMG 2023) https://assets.kpmg.com/content/dam/kpmg/ng/pdf/nigeria-data-protection-act2023_kpmg-review.pdf accessed 22 March 2026.

DCPMIs face enhanced regulatory obligations, including mandatory appointment of a Data Protection Officer (DPO) with expert knowledge of data protection law and practices, registration with the NDPC within six months of the Act's commencement, and filing of annual Compliance Audit Returns.[32] For healthcare facilities, these requirements necessitate significant investments in compliance infrastructure, data protection impact assessments, transparent privacy policies, and procedures for managing patient consent and handling data subject rights requests.[33]

4.5 *Cybersecurity Requirements*

While the NDPA does not use the term 'cybersecurity' explicitly, its provisions impose clear cybersecurity obligations on data controllers and processors. The General Application and Implementation Directive (GAID) requires every company to conduct periodic compliance audits of their data processing activities to mitigate the risk of data breaches through appropriate technical and organisational measures.[34]

Section 13 of the NDPA mandates the implementation of appropriate technical and organizational measures to ensure data security, prevent data loss, damage, or unauthorized access, and maintain the confidentiality and integrity of personal data.[35] For healthcare providers, this translates to requirements for encryption of patient data, secure access controls, regular security assessments, staff training on data handling protocols, and incident response procedures.

4.6 *Data Breach Notification*

The NDPA establishes a comprehensive data breach notification framework. Upon discovering a data breach, data controllers must notify the NDPC without undue delay and, where feasible, within 72 hours of becoming aware of the breach.[36] Additionally, where the breach is likely to result in a high risk to the rights and freedoms of data subjects, the controller must also notify affected individuals.[37] These provisions ensure timely responses to cybersecurity incidents affecting patient data.

4.7 *Enforcement and Penalties*

The NDPA grants the NDPC significant enforcement powers, including the authority to conduct investigations, issue compliance orders, and impose administrative penalties for violations.[38] Penalties for data breaches or misuse of patient data can be significant, with operating an unlicensed digital health service potentially resulting in a fine of not less than ₦5,000,000, imprisonment for not more than two years, or both.[39] Patients aggrieved by violations of their data rights can lodge complaints with the NDPC, which may issue compliance orders including

[32] Nigeria Data Protection Act 2023, ss 32, 44; Nigeria Data Protection Act General Application and Implementation Directive (GAID) 2025, arts 8–10.
[33] Onyemelukwe and Bhadmus (n 4); Nigeria Data Protection Act 2023, ss 26, 35, 38; GAID 2025, art 7.
[34] Nigeria Data Protection Commission, 'General Application and Implementation Directive' (NDPC 2023) para 4.2
[35] Nigeria Data Protection Act 2023, s 13.
[36] ibid s 32(1).
[37] ibid s 32(2).
[38] ibid ss 35–40.
[39] ibid, s 48(2)(b).

warnings, directives to uphold data rights, or cease and desist orders, as well as pursue civil remedies in court.[40]

4.8 *Relationship with the National Health Act*

The NDPA does not repeal the National Health Act, with both statutes continuing to apply to health data protection, and where inconsistencies exist, the provisions of the NDPA prevail.[41] This creates a complementary regulatory framework where the National Health Act provides sector-specific health data protections while the NDPA establishes broader data protection principles applicable across all sectors, including healthcare. Healthcare providers must ensure compliance with both statutes, navigating their overlapping but distinct requirements.

5. The Cybercrimes (Prohibition, Prevention, etc.) Act 2015 (as amended 2024)

The Cybercrimes (Prohibition, Prevention, etc.) Act 2015, as amended by the Cybercrimes (Prohibition, Prevention, etc.) Amendment Act 2024, provides the primary criminal law framework for prosecuting cybercrimes and protecting critical information infrastructure in Nigeria.[42] The Act's objectives include providing an effective legal framework for the prohibition, prevention, detection, prosecution, and punishment of cybercrimes; ensuring protection of critical national information infrastructure; and promoting cybersecurity and the protection of computer systems, networks, and data.[43]

5.1 *Protection of Critical National Information Infrastructure*

Part II of the Cybercrimes Act addresses the protection of Critical National Information Infrastructure (CNII). Section 3 empowers the President, on the recommendation of the National Security Adviser, to designate certain computer systems, networks, and information infrastructure vital to national security or economic and social well-being as constituting CNII.[44]

The National Cybersecurity Policy designates the healthcare sector as a National Critical Information Infrastructure.[45] This designation has profound implications for cybersecurity obligations in the health sector. The Designation and Protection of Critical National Information Infrastructure Order 2024 specifically identifies healthcare as a critical sector requiring heightened protection.[46]

5.2 *Offences against Critical Infrastructure*

Section 4 of the Cybercrimes Act criminalizes offences against CNII. Any person who, without authorization and for fraudulent purposes, accesses or tampers with CNII commits an offence.[47]

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[40] ibid ss 43, 48(2); Nigeria Data Protection Commission, 'Frequently Asked Questions' (NDPC, 2024) https://www.ndpc.gov.ng/faqs/ accessed 22 March 2026.

[41] AG Nienaber McKay and others, 'The Regulation of Health Data Sharing in Africa: A Comparative Study' (2024) 11(1) *Journal of Law and the Biosciences* lsad.

[42] Cybercrimes (Prohibition, Prevention, etc) Act 2015; Cybercrimes (Prohibition, Prevention, etc) Amendment Act 2024.

[43] Cybercrimes (Prohibition, Prevention, etc) Act 2015, s 1.

[44] ibid s 3.

[45] National Cybersecurity Policy and Strategy (Federal Republic of Nigeria 2014) Part 7.5.

[46] Designation and Protection of Critical National Information Infrastructure Order 2024.

[47] Cybercrimes (Prohibition, Prevention, etc) Act 2015, s 4(1).

Additionally, intentional acts that directly or indirectly hinder or interfere with the performance or functioning of CNII constitute criminal offences.[48]

Attacks on sectors designated as critical national infrastructure are punishable by imprisonment for not less than 15 years without an option of fine.[49] This severe penalty reflects the critical importance of protecting healthcare infrastructure from cyber threats that could disrupt essential health services or compromise patient safety.

Section 10 specifically addresses tampering with critical infrastructure by employees. It makes it an offence for any person employed by a private organization or health institution who commits unauthorized acts or intentionally permits tampering with critical infrastructure computer systems, with penalties including a fine of ₦2,000,000 or imprisonment for three years.[50]

5.3 *Other Relevant Offences*

Beyond CNII protection, the Cybercrimes Act criminalizes various activities relevant to healthcare cybersecurity:

a. **Unlawful access to computers** (Section 6): Unauthorized access to computer systems, punishable by imprisonment for up to three years or a fine of ₦7,000,000 or both.[51]
b. **System interference** (Section 8): Intentionally hindering or interfering with computer system functioning, with penalties of up to five years imprisonment or ₦10,000,000 fine.[52]
c. **Interception of electronic messages** (Section 14): Unlawful interception of emails and other electronic communications, punishable by two years imprisonment or ₦1,000,000 fine.[53]
d. **Computer-related forgery and fraud** (Sections 16-17): Creating false electronic documents or using computers to commit fraud, with penalties ranging from five to seven years imprisonment.[54]

These offences provide criminal law mechanisms to prosecute individuals who breach healthcare cybersecurity, whether through hacking, data theft, or fraudulent manipulation of health records.

5.4 *Reporting Obligations*

Section 21 of the Cybercrimes Act mandates that a cyber attack or threat must be reported to the Nigeria Computer Emergency Response Team (NgCERT) within seven days, with failure to report punishable by a fine of ₦2,000,000 and denial of internet service.[55] This mandatory reporting

[48] ibid s 4(2).
[49] F E Eboibi and O M Ogorugba, 'Rethinking Cybercrime Governance and Internet Fraud Eradication in Nigeria' (2022) 26(S2) *Academy of Strategic Management Journal* 1-14, 3; K Okafor, 'An Appraisal of the Legal Regime for Cyber Security in Nigeria' (*Gravitas Review of Business and Property Law*, 2024) https://gravitasreview.com.ng/product/appraisal-legal-regime-for-cyber-security-nigeria/ accessed 22 March 2025.
[50] Cybercrimes (Prohibition, Prevention, etc) Act 2015, s 10.
[51] ibid s 6.
[52] ibid s 8.
[53] ibid s 14.
[54] ibid ss 16–17.
[55] ibid s 21.

requirement ensures that cybersecurity incidents affecting healthcare facilities are documented and can be addressed systematically by national cybersecurity authorities.

5.5 *The 2024 Amendments*

The Cybercrimes (Prohibition, Prevention, etc.) Amendment Act 2024 introduced significant updates to strengthen Nigeria's cybersecurity framework. Key amendments relevant to healthcare include expanded definitions of critical infrastructure, establishment of sectoral Computer Emergency Response Teams (CERTs) and Security Operations Centers (SOCs), and enhanced penalties for cybercrimes.[56] The Amendment Act recognizes the evolving nature of cyber threats and aims to address gaps in the original 2015 legislation.

5.6 *Evaluation*

The Cybercrimes Act provides essential criminal law mechanisms for prosecuting cybersecurity violations affecting healthcare. The designation of healthcare as critical infrastructure and the severe penalties for attacks on CNII demonstrate recognition of the sector's importance. However, critics note that the Act unnecessarily limits its scope to the protection of Critical National Information Infrastructure and does not sufficiently provide for the broad framework addressing areas not related to CNII.[57]

Furthermore, underreporting remains a debilitating factor for estimating the cost and extent of cybercrime and deprives the industry of shared common knowledge.[58] The seven-day reporting requirement, while commendable, may not capture the full scope of cybersecurity incidents in healthcare, as many facilities lack the capacity to detect and document breaches effectively.

6. Subsidiary Regulations and Guidelines

Beyond the primary legislation, several subsidiary regulations and guidelines impact cybersecurity in the Nigerian health sector:

6.1 *National Cybersecurity Policy and Strategy (2014)*

[56] Cybercrimes (Prohibition, Prevention, etc.) Amendment Act 2024, ss 3, 5, 11; Designation and Protection of Critical National Information Infrastructure Order 2024. For commentary see Tech Hive Advisory, 'Nigeria Cybercrimes (Prohibition, Prevention, etc.) Act Amendment: Charting Future Direction' (Tech Hive Advisory Africa, 2024) https://www.techhiveadvisory.africa/insights/nigeria-cybercrimes-prohibition-prevention-etc-act-amendment-charting-future-direction accessed 22 March 2026.

[57] O A Onadeko and A F Afolayan, 'A Critical Appraisal of the Cybercrimes Act, 2015 in Nigeria' (paper presented at the 29th International Conference of the International Society for the Reform of Criminal Law, Halifax, Nova Scotia, Canada, July 2016) https://www.isrcl.com/wp-content/uploads/2021/05/Onadeko-Afolaya-A-critical-appraisal-of-the-cybercrimes-act-in-Nigeria.pdf accessed 22 March 2026; see also Tech Hive Advisory, 'Nigeria Cybercrimes (Prohibition, Prevention, etc.) Act Amendment: Charting Future Direction' (Tech Hive Advisory Africa, 2024) https://www.techhiveadvisory.africa/insights/nigeria-cybercrimes-prohibition-prevention-etc-act-amendment-charting-future-direction accessed 22 March 2026.

[58] M T Ladan, *Introduction to Cyberlaw and Cybersecurity in Nigeria* (2nd edn, Ahmadu Bello University Press 2019); F E Eboibi and O M Ogorugba, 'Rethinking Cybercrime Governance and Internet Fraud Eradication in Nigeria' (2023) 26(S1) *Journal of Legal, Ethical and Regulatory Issues* 1; B M Kuada and others, 'Comprehensive Analytical Review of Cybercrime and Cyber Policy in West Africa' (2025) 12 *Journal of Electrical Systems and Information Technology* art 15.

Nigeria's National Cybersecurity Policy and Strategy, adopted in February 2015, provides the overarching policy framework for national cybersecurity efforts.[59] Part 7.5 of the Policy specifically identifies healthcare as one of Nigeria's national critical infrastructures requiring protection.[60] The Policy emphasizes collaboration between government, the private sector, and citizens to safeguard digital ecosystems and calls for the development of robust legal frameworks to address cybercrime and protect critical infrastructure.[61]

6.2 *Designation and Protection of Critical National Information Infrastructure Order 2024*

This Presidential Order operationalizes Section 3 of the Cybercrimes Act by formally designating key sectors, including healthcare, as CNII.[62] The Order mandates implementation of unified strategies and security measures to mitigate risks, ensuring these vital infrastructures remain resilient against emerging threats.[63] The Office of the National Security Adviser (ONSA) is tasked with leading CNII protection through the development of a Critical National Information Infrastructure Protection Plan (CNIIPP) and the establishment of a Trusted Information Sharing Network (TISN) for cross-sector collaboration.[64]

6.3 *Nigeria Data Protection Regulation 2019*

Although superseded by the NDPA 2023 as principal legislation, the Nigeria Data Protection Regulation (NDPR) 2019 issued by NITDA remains in force where its provisions do not conflict with the NDPA.[65] The NDPR provides additional guidance on data protection implementation and continues to inform compliance practices in healthcare and other sectors.

6.4 *Digital Health Services Bill 2025*

The Digital Health Services Bill 2025, which had its first reading before the House of Representatives on 19 March 2025, aims to establish a comprehensive legal framework for regulating Nigeria's rapidly growing digital health sector.[66] The Bill mandates that all digital health service providers comply with the Nigeria Data Protection Act 2023 and implement robust cybersecurity measures to safeguard patient data from unauthorized access and breaches.[67] If enacted, this legislation would provide sector-specific cybersecurity requirements for digital health platforms, telemedicine services, and health technology providers.

7. Enforcement Mechanisms and Institutional Framework

[59] National Cybersecurity Policy and Strategy (Federal Republic of Nigeria 2014).
[60] ibid Part 7.5.
[61] A Akande and O Nweke, 'Leapfrogging or Lagging?: Highlighting Critical Information Infrastructure Protection Challenges and Opportunities in Nigeria' (2024) 10(3) *Journal of Cybersecurity* 287.
[62] Designation and Protection of Critical National Information Infrastructure Order 2024.
[63] ibid.
[64] ibid, paras 3–4; Pavestones Legal, 'Safeguarding Nigeria's Critical National Information Infrastructure; Cybercrimes (Prohibition, Prevention, etc.) Amendment Act 2024, s 3; Review of a New Order' (Mondaq, 2 December 2024) https://www.mondaq.com/nigeria/security/1552562 accessed 22 March 2022.
[65] Nigeria Data Protection Regulation 2019.
[66] Y Abiodun, 'Nigeria's Digital Health Services Bill 2025: A New Dawn for Healthcare Regulation' (*Proshare*, 22 March 2025) https://www.proshareng.com/articles/Nigerian-Health-Sector/Digital-Health-Services-Bill-2025/72485 accessed 16 March 2026.
[67] ibid.

7.1 *Nigeria Data Protection Commission*

The NDPC, established under the NDPA, serves as the primary data protection authority responsible for enforcing data protection and cybersecurity provisions across all sectors, including healthcare.[68] The Commission's powers include conducting investigations, issuing compliance orders, imposing administrative sanctions, and collaborating with other regulatory agencies.[69] In an ongoing enforcement action issued in August 2024, the NDPC found Fidelity Bank guilty of data breach and violations, demonstrating the Commission's active enforcement approach.[70]

7.2 *Office of the National Security Adviser*

The Office of the National Security Adviser (ONSA) coordinates national cybersecurity efforts and oversees the protection of critical information infrastructure.[71] For healthcare as designated CNII, ONSA plays a crucial role in developing security strategies, facilitating inter-agency cooperation, and ensuring implementation of cybersecurity measures.[72]

7.3 *Nigeria Computer Emergency Response Team (ngCERT)*

Established under the Office of the National Security Adviser, ngCERT serves as Nigeria's coordination center for managing cyber incidents.[73] Healthcare facilities must report cyber attacks and threats to ngCERT within seven days as mandated by the Cybercrimes Act.[74] The 2024 amendments established sectoral CERTs and SOCs to enhance incident response capabilities in critical sectors, including healthcare.[75]

7.4 *Federal Ministry of Health*

The Federal Ministry of Health plays a regulatory role in healthcare cybersecurity through its mandate to develop health policies and standards.[76] However, coordination between the Ministry and cybersecurity authorities remains underdeveloped,[77] creating potential gaps in sector-specific implementation.

7.5 *Challenges in Enforcement*

Despite this institutional framework, enforcement of cybersecurity regulations in Nigerian healthcare faces significant challenges. These include limited technical capacity among enforcement agencies, insufficient resources for monitoring and compliance verification, lack of

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[68] Nigeria Data Protection Act 2023, s 5.
[69] ibid ss 6–8.
[70] Nigeria Data Protection Commission, 'Enforcement Actions and Compliance Updates' (NDPC 2024) https://www.ndpc.gov.ng accessed 16 March 2026.
[71] Office of the National Security Adviser (ONSA), *National Cybersecurity Policy and Strategy (NCPS) 2021* (ONSA) 9–10.
[72] ibid.
[73] Cybercrimes (Prohibition, Prevention, Etc.) Act 2015, s 42(c); Office of the National Security Adviser, *National Cybersecurity Strategy Action Plan* (ONSA, November 2017) Appendix D; Nigerian Computer Emergency Response Team (ngCERT), 'About ngCERT' https://cert.gov.ng accessed 24 March 2026.
[74] Cybercrimes (Prohibition, Prevention, etc) Act 2015, s 21.
[75] Cybercrimes (Prohibition, Prevention, etc) Amendment Act 2024.
[76] National Health Act 2014, s 2.
[77] International Institute for Strategic Studies, *Cyber Capabilities and National Power*, vol 2 (IISS, 2023) 78; T Okeke and others, 'Evaluating the Impact of Cybersecurity Strategy' (2025) 13(4) *International Journal of Innovative Information Systems and Technology Research* 198, 201.

clear jurisdictional boundaries between multiple regulatory authorities, and inadequate awareness among healthcare providers regarding their cybersecurity obligations.[78]

8. Gaps and Inadequacies in the Current Legal Framework

8.1 *Absence of Healthcare-Specific Cybersecurity Standards*

While there are overarching laws such as the NDPA and the Cybercrimes Act, the legal landscape lacks sector-specific cybersecurity regulations that address healthcare's unique challenges, with experts calling for tailored cybersecurity standards addressing specific needs.[79] The healthcare sector faces distinctive cybersecurity challenges, including interconnected medical devices, legacy systems, real-time operational requirements, and life-critical services that cannot be interrupted for security updates.[80] Current legislation does not provide technical standards or operational guidelines specifically designed for these healthcare-specific contexts.

8.2 *Inadequate Penalties*

As previously noted, penalties under existing legislation appear inadequate relative to the potential harm from healthcare cybersecurity breaches. The ₦250,000 maximum fine under Section 29 of the National Health Act and even the ₦2,000,000 penalty for failing to report cyber incidents provide insufficient deterrence against sophisticated cybercriminals who can profit significantly from healthcare data theft or ransomware attacks.[81]

8.3 *Limited Technical Guidance*

The legislation establishes broad principles requiring implementation of 'appropriate' security measures but provides limited technical guidance on what constitutes adequate cybersecurity for healthcare contexts.[82] Healthcare providers lack clear standards regarding encryption requirements, access control mechanisms, incident response protocols, vulnerability management, security testing, and audit requirements specific to health information systems.

8.4 *Regulatory Fragmentation and Overlap*

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[78] Andersen (Nigeria), 'Cybersecurity Risks in Healthcare: Addressing Africa's Digital Health Vulnerabilities' (Andersen Nigeria, 3 December 2024) https://ng.andersen.com/cybersecurity-risks-in-healthcare-addressing-africas-digital-health-vulnerabilities accessed 24 March 2026; O Adediran and I Okon, 'Challenges of Data Privacy Enforcement in Nigeria: A Regulatory Perspective' (2023) 5(2) *Journal of Cybersecurity and Data Protection* 45.

[79] ICLG, 'Cybersecurity Laws and Regulations Report 2025: Nigeria' (International Comparative Legal Guides, 2024) https://iclg.com/practice-areas/cybersecurity-laws-and-regulations/nigeria accessed 24 March 2026; PO Nweke and O Izuagie, 'Securing AI-Driven Healthcare Systems in Climate-Resilient Infrastructure: A Framework for Sustainable Public Health in Nigeria' (2025) 2(1) *Multidisciplinary Journal of Engineering, Technology and Sciences* 1.

[80] ISO, 'Healthcare Cybersecurity: Diagnosing Risks, Prescribing Solutions' (International Organization for Standardization, 2024) https://www.iso.org/healthcare/cybersecurity accessed 24 March 2026.

[81] National Health Act 2014, s 29; Cybercrimes (Prohibition, Prevention, Etc.) Act 2015, s 22; CYFIRMA, 'Cyber Threat Assessment on Nigeria' (CYFIRMA Research, October 2025) https://www.cyfirma.com/research/cyber-threat-assessment-on-nigeria accessed 24 March 2026.

[82] Nigeria Data Protection Act 2023, s 24; Cybercrimes (Prohibition, Prevention, Etc.) Act 2015, s 6; ICLG, 'Cybersecurity Laws and Regulations Report 2025: Nigeria' (International Comparative Legal Guides, 2024) https://iclg.com/practice-areas/cybersecurity-laws-and-regulations/nigeria accessed 24 March 2026.

Healthcare cybersecurity in Nigeria is governed by multiple overlapping statutes, creating potential confusion and compliance challenges. The National Health Act, NDPA, Cybercrimes Act, and various subsidiary regulations operate simultaneously, sometimes with unclear jurisdictional boundaries between the NDPC, Federal Ministry of Health, and ONSA.[83] This fragmentation can hinder effective enforcement and create uncertainty for healthcare providers regarding compliance requirements.

8.5 *Weak Incident Response and Recovery Frameworks*

While the Cybercrimes Act mandates the reporting of cyber incidents to ngCERT, the legislation provides limited guidance on incident response protocols, recovery procedures, business continuity planning, or post-incident remediation requirements specific to healthcare settings where service disruption can have life-threatening consequences.[84]

8.6 *Insufficient Address of Emerging Technologies*

Current legislation does not adequately address cybersecurity challenges posed by emerging healthcare technologies, including artificial intelligence systems, Internet of Medical Things (IoMT) devices, blockchain-based health records, and cloud-based health platforms.[85] As healthcare increasingly adopts these technologies, regulatory frameworks must evolve to address their unique security implications.

8.7 *Limited Resources and Capacity*

Implementation of cybersecurity measures in Nigerian healthcare is hampered by resource constraints. Many healthcare facilities, particularly in the public sector and rural areas, lack the financial resources, technical expertise, and infrastructure necessary to implement robust cybersecurity programs as required by law.[86] The legislation does not provide mechanisms for supporting capacity building or resource allocation to assist healthcare facilities in meeting cybersecurity obligations.

8.8 *Weak Public-Private Collaboration*

While the National Cybersecurity Policy calls for collaboration between the government and the private sector, practical mechanisms for information sharing, threat intelligence exchange, and coordinated incident response between healthcare providers and cybersecurity authorities remain underdeveloped.[87]

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[83] National Health Act 2014; Nigeria Data Protection Act 2023; Cybercrimes (Prohibition, Prevention, Etc.) Act 2015; National Cybersecurity Policy and Strategy (Office of the National Security Adviser, 2021); OA Salihu, 'Regulating the Future: The Current State and Prospects of Artificial Intelligence Policy in Nigeria' (SSRN, 31 March 2025) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=5117653 accessed 24 March 2026.

[84] Cybercrimes (Prohibition, Prevention, Etc.) Act 2015, s 37; Nigeria Data Protection Act 2023, s 40.

[85] White & Case LLP, 'AI Watch: Global Regulatory Tracker — Nigeria' (White & Case, 2025) https://www.whitecase.com/insight-our-thinking/ai-watch-global-regulatory-tracker-nigeria accessed 24 March 2026.

[86] Andersen (Nigeria) (n 78); OJ Okpabi, 'Nigeria's Cybersecurity Crisis: Unmasking the Digital Threat Landscape' (Mr. Plan ₿ Publication, June 2025) https://medium.com/mr-plan-publication/nigerias-cybersecurity-crisis-unmasking-the-digital-threat-landscape accessed 24 March 2026.

[87] Office of the National Security Adviser, *National Cybersecurity Policy and Strategy* (ONSA, 2021); Nweke and Izuagie (n 79) 1.

9. Comparative Perspectives: International Standards

Nigeria's healthcare cybersecurity framework can be evaluated against international standards and comparative jurisdictions:

9.1 *General Data Protection Regulation (GDPR)*

International compliance regimes like the EU's GDPR profoundly influence Nigeria's cybersecurity laws by driving adoption of global best practices, with Nigerian organizations, particularly those with multinational operations, implementing cross-border data protection measures that comply with both Nigerian law and international standards such as GDPR.[88] GDPR's comprehensive approach to data protection, including health data, provides relevant comparative insights. GDPR imposes strict requirements for processing health data as a special category of personal data, mandates data protection impact assessments for high-risk processing, requires breach notification within 72 hours, and provides significant penalties of up to 4% of annual global turnover or €20 million.[89]

While Nigeria's NDPA adopts similar principles, GDPR's enforcement mechanisms, technical guidance, and jurisprudence provide more detailed frameworks that could inform the strengthening of Nigerian healthcare cybersecurity regulation.

9.2 *Health Insurance Portability and Accountability Act (HIPAA)*

The United States' HIPAA establishes comprehensive security and privacy rules specifically for healthcare contexts.[90] HIPAA requires covered entities to implement administrative, physical, and technical safeguards; conduct regular risk assessments; maintain audit controls; ensure workforce training; establish incident response procedures; and implement business associate agreements for third-party service providers.[91] HIPAA's healthcare-specific technical standards and detailed compliance requirements provide models that Nigeria could adopt in developing sector-specific healthcare cybersecurity regulations.

9.3 *ISO/IEC 27001 and Healthcare Standards*

Many organizations in highly regulated sectors like healthcare adopt international standards, such as ISO/IEC 27001 for information security management, with these becoming standards that Nigerian organizations aim to align with.[92] Healthcare-specific standards like ISO 27799 provide guidance for protecting health information. Nigeria could strengthen its framework by incorporating or referencing these international standards as baseline requirements for healthcare cybersecurity.

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[88] MC Diyoke and ST Edeh, 'Data Protection in the Digital Age: A Comparative Analysis of Nigeria's NDPA and the EU's GDPR' (2024) *Proceedings of the 13th International Conference on Information & Communication Technologies and Development* (ACM, 2024) https://dl.acm.org/doi/10.1145/3700794.3700799 accessed 24 March 2026.

[89] Regulation (EU) 2016/679 (General Data Protection Regulation) arts 9, 33, 35, 83.

[90] Health Insurance Portability and Accountability Act of 1996 (HIPAA) Pub L No 104-191, 110 Stat 1936.

[91] 45 CFR Parts 160, 162, and 164 (HIPAA Security Rule).

[92] ISO/IEC 27001:2022, *Information Security, Cybersecurity and Privacy Protection — Information Security Management Systems — Requirements* (International Organization for Standardization, 2022); Maxicert, 'ISO/IEC 27001 Certification in Nigeria' (Maxicert, October 2025) https://maxicert.com/nigeria-obtain-iso-27001-certification accessed 24 March 2026.

10. Recommendations

Based on the analysis of Nigeria's healthcare cybersecurity legal framework and its identified gaps, the following recommendations are proposed:

10.1 *Enactment of Healthcare-Specific Cybersecurity Regulations*

Nigeria should introduce dedicated, sector-specific cybersecurity regulations for healthcare that address the unique vulnerabilities of health information systems. These regulations should prescribe detailed technical standards covering encryption, access controls, authentication mechanisms, and network security, with specific requirements for medical devices, telemedicine platforms, and electronic health records. They should also mandate regular risk assessments, security audits, incident response planning, business continuity protocols, and enforceable standards for third-party health technology vendors. Simultaneously, the Digital Health Services Bill 2025 should be prioritised and enacted to provide comprehensive regulatory coverage of the rapidly expanding digital health sector.

10.2 *Strengthening of Penalties and Enforcement Mechanisms*

The penalty regime for cybersecurity violations in healthcare must be substantially strengthened to achieve meaningful deterrence. Maximum fines under the National Health Act should be raised to levels comparable to those under the Nigeria Data Protection Act — at minimum ₦5,000,000 — and a tiered penalty structure should be introduced that calibrates sanctions to the severity of the breach, the number of patients affected, and whether the violation was negligent or intentional. Organisational sanctions, including suspension of operating licences and mandatory corrective oversight, should apply to repeat offenders, and the Nigeria Data Protection Commission should be empowered with a clearer mandate and adequate resources to enforce compliance orders effectively across healthcare contexts.

10.3 *Establishment of Technical Standards and Harmonization of the Regulatory Framework*

The Federal Ministry of Health, in collaboration with the NDPC and ONSA, should develop comprehensive technical guidelines establishing minimum security baselines calibrated to the size and type of healthcare facility, data sensitivity classifications, secure interoperability standards, and cybersecurity requirements for telemedicine platforms. Alongside this, the existing regulatory fragmentation must be resolved by clearly delineating roles and responsibilities among the NDPC, Federal Ministry of Health, ONSA, and other relevant agencies, establishing formal inter-agency coordination mechanisms and information-sharing protocols, amending the National Health Act to align with NDPA provisions, and creating a unified compliance framework that integrates requirements across multiple statutes.

10.4 *Enhancement of Capacity Building and Resource Allocation*

Addressing Nigeria's healthcare cybersecurity capacity deficit requires dedicated resource mobilisation. A Healthcare Cybersecurity Fund should be established to support public health facilities in meeting security requirements, complemented by regional centres of excellence offering technical assistance and training. Cybersecurity training and certification should be mandated for healthcare IT personnel and Data Protection Officers, and standardised, accessible security assessment tools should be developed for resource-constrained facilities. Tax incentives

or subsidies for cybersecurity infrastructure investment would further encourage compliance across the sector.

10.5 *Development of Incident Response Frameworks and Promotion of Information Sharing*

A robust incident management ecosystem is essential to healthcare cybersecurity resilience. Although the Critical National Information Infrastructure Order 2024 designates healthcare as a critical sector, it neither establishes a dedicated healthcare-specific incident response mechanism nor has its provisions been meaningfully implemented.[1] A dedicated Healthcare-CERT should therefore be established to coordinate sectoral incident response, supported by standardised playbooks, mandatory disaster recovery drills, business continuity testing, and formalised mutual aid agreements between healthcare facilities. A healthcare cybersecurity information-sharing platform and public-private partnerships bringing together government agencies, healthcare providers, and cybersecurity experts would further strengthen the sector's collective defences.

10.6 *Addressing Emerging Technologies and Conducting Regular Legal Reviews*

The regulatory framework must anticipate rather than lag behind technological change. Specific security standards should be developed for Internet of Medical Things devices and artificial intelligence systems used in healthcare, alongside frameworks for securing cloud-based health records and addressing the cybersecurity implications of blockchain in health information management. Privacy-by-design and security-by-design principles should be embedded in all new health technology deployments. To sustain the framework's relevance over time, periodic legislative reviews should be institutionalised, benchmarked against international standards, and informed by regular stakeholder consultations with healthcare providers, patients, and cybersecurity experts, ensuring that the law keeps pace with evolving threats, technologies, and enforcement realities.

11. Conclusion

Nigeria has made commendable progress in establishing legal frameworks for cybersecurity in the health sector through the National Health Act 2014, the Nigeria Data Protection Act 2023, and the Cybercrimes Act as amended in 2024. These statutes, together with subsidiary regulations, create a multi-layered regulatory framework addressing health data confidentiality, data protection principles, and critical infrastructure protection. The designation of healthcare as critical national infrastructure and the establishment of the Nigeria Data Protection Commission as an enforcement authority demonstrate recognition of cybersecurity's importance.

However, significant gaps remain in the adequacy of these legal frameworks. The absence of healthcare-specific cybersecurity standards, inadequate penalties, limited technical guidance, regulatory fragmentation, weak incident response mechanisms, and insufficient capacity all undermine effective protection of Nigeria's health information systems. Current legislation has not kept pace with the rapid evolution of cyber threats and the increasing digitalization of healthcare services.

The healthcare sector's unique characteristics, including life-critical operations, interconnected medical devices, legacy systems, and highly sensitive personal data, necessitate tailored regulatory approaches that the current general cybersecurity and data protection frameworks do not fully provide. International comparative frameworks such as GDPR and HIPAA demonstrate the value of comprehensive, sector-specific standards with detailed technical requirements and robust enforcement mechanisms.

Addressing these gaps requires comprehensive legal and regulatory reform. Priority actions include enacting healthcare-specific cybersecurity regulations with detailed technical standards, strengthening penalties to provide effective deterrence, harmonizing the fragmented regulatory framework, enhancing capacity building and resource allocation, developing robust incident response frameworks, addressing emerging technologies, and promoting public-private collaboration.

As Nigeria continues its digital health transformation, robust legal frameworks for cybersecurity are not merely desirable but essential for protecting patient privacy, maintaining healthcare service continuity, and ensuring public trust in the health system. The recommendations proposed in this article provide a roadmap for strengthening Nigeria's healthcare cybersecurity legal framework to meet contemporary challenges and position the sector for secure digital innovation.

The imperative for reform is urgent. Healthcare cybersecurity is not a technical issue alone but a fundamental right to privacy, patient safety, and public health concern that demands comprehensive legal protection. Nigerian policymakers, healthcare regulators, and stakeholders must act decisively to close existing gaps and create a robust, enforceable, and effective legal framework that safeguards the nation's health information infrastructure against evolving cyber threats.

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Judicial Accessibility for Urgent Medico-Legal Decisions: A Comparative Analysis of Nigeria, the United Kingdom, Canada, and United States

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Abstract

In the clinical environment, time is often the most critical determinant of patient outcomes. When consent for urgent medical intervention is withheld or unavailable, the judiciary must function as a responsive safety net capable of rendering decisions within hours rather than days. This article examines the profound disparity in judicial accessibility for urgent medical decisions between Nigeria and three comparator common law jurisdictions: the United Kingdom, Canada, and the United States. It argues that Nigeria's current legal infrastructure, characterized by systemic delays, the absence of specialized fast-track procedures, and a lack of 24/7 judicial availability, critically undermines the constitutional guarantees of the right to life and the right to health. Through a functionalist comparative analysis, the article identifies transferable institutional models, including the UK's duty judge system, Ontario's multidisciplinary Consent and Capacity Board, and the American emergency motion culture. It further engages with the National Mental Health Act 2021 as a case study in the gap between legislative aspiration and implementation, drawing on recent data indicating that approximately 50 million Nigerians live with mental health conditions while fewer than 350 psychiatrists serve the population. The article concludes with targeted recommendations for procedural and institutional reform, including the establishment of specialized health law divisions, a 24/7 duty judge system, and state-level Medical Consent and Capacity Boards adapted from the Canadian model.

Keywords: Emergency care, urgent medical intervention; judicial accessibility

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I. INTRODUCTION

In the clinical environment, time is often the most critical determinant of patient outcomes. For medical practitioners, the necessity of obtaining legal authorization for urgent interventions (ranging from life-saving blood transfusions for minors to the withdrawal of life-sustaining treatment) presents a profound ethical and legal dilemma when consent is withheld or unavailable. In many developed jurisdictions, the judiciary serves as a responsive and accessible arbiter, capable of rendering decisions within hours or even minutes. However, in Nigeria, the judicial system is frequently perceived as a bottleneck rather than a safety net. This paper examines the profound disparity in judicial accessibility for urgent medical decisions between Nigeria and three selected common law jurisdictions: the United Kingdom, Canada, and the United States.

1.1 *Comparative Methodology*

The selection of the UK, Canada, and the US as comparator jurisdictions is predicated on several methodological rationales. First, all four nations share a common law heritage, providing a consistent doctrinal baseline for analyzing judicial intervention. Second, these jurisdictions represent a spectrum of institutional responses to medical emergencies: the UK's centralized judicial *'duty judge'* system, Canada's specialized quasi-judicial tribunal (the Consent and Capacity Board), and the US's procedurally fast-tracked *'emergency motion'* culture.

This study employs a functionalist comparative method, an approach pioneered by Ernst Rabel and refined by scholars such as Konrad Zweigert, Hein Kötz, and Ralf Michaels [1] . The functionalist method directs the comparatist to focus not merely on formal legal rules (*'law in books'*) but on how different legal systems solve identical practical problems (*'law in action'*). The foundational premise of functionalism is that legal systems, despite doctrinal differences, often develop functionally equivalent responses to universal social problems. Rather than asking whether Nigeria possesses institutions doctrinally identical to the UK's Court of Protection or Canada's Consent and Capacity Board, the functionalist asks: how does each system address the universal problem of securing timely judicial authorization for urgent medical interventions?

The mechanism that renders such a comparison possible is the identification of functional equivalence as the *tertium comparationis* [2] . As Michaels explains, institutions are deemed comparable if they fulfil similar functions in their respective legal systems, irrespective of doctrinal differences in structure or nomenclature[3]. This approach is particularly valuable where

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[1] See generally Zhu Shuli, 'Struggling Between Ideal and Reality: A Historical Review of Functionalism in Comparative Law' (2012) 3 Peking University Law Journal 509, 517–18 (discussing Rabel's foundational 1924 lecture); Konrad Zweigert and Hein Kötz, *An Introduction to Comparative Law* (Tony Weir tr, 3rd edn, Clarendon Press 1998) ch 3; Ralf Michaels, 'The Functional Method of Comparative Law' in Mathias Reimann and Reinhard
Zimmermann (eds), *The Oxford Handbook of Comparative Law* (Oxford University Press 2006) 339.

[2] Ralf Michaels, 'The Functional Method of Comparative Law' in Mathias Reimann and Reinhard Zimmermann (eds), *The Oxford Handbook of Comparative Law* (Oxford University Press 2006) 339, 340. See also Johannes Veigel, 'Die funktionale Methode bei der Rechtsvergleichung' (2021) 30 *Juridica International* 1, 4 (describing *tertium comparationis* as the "social problem" that forms the basis of functional comparison).

[3] Ralf Michaels, 'The Functional Method of Comparative Law' in Mathias Reimann and Reinhard Zimmermann (eds), The Oxford Handbook of Comparative Law (2nd edn, OUP 2019) 345

constitutional guarantees (such as the right to health or the right to life) may be located in different institutional sites across jurisdictions. By prioritizing procedural rules and judicial practice directions alongside substantive statutes, this analysis seeks to identify 'functional equivalents' that could be adapted to the Nigerian context.

1.2 *Theoretical Framework: Access to Justice and the Right to Health*

The analysis is grounded in Access to Justice theory, which posits that legal rights are illusory without effective, timely, and affordable mechanisms for their enforcement[4]. In the context of medical emergencies, 'access' is redefined by the temporal dimension: a remedy that arrives after a patient has suffered irreversible harm is no remedy at all. Furthermore, this paper frames judicial accessibility as a prerequisite for the justiciability of the right to health. While Chapter II of the Nigerian Constitution contains the right to health in a non-justiciable form, the judiciary has increasingly derived a justiciable right to health from the fundamental right to life (Section 33)[5]. This theoretical nexus implies that the state's failure to provide a responsive judicial forum for life-saving medical decisions constitutes a procedural violation of the right to life itself.

2.0 The Nigerian Landscape: Statutory Aspirations vs Judicial Realities

The legal framework for health rights in Nigeria is anchored in the Constitution of the Federal Republic of Nigeria 1999 (as amended) [6] and the National Health Act [7] . Section 33 of the Constitution guarantees the right to life, while Section 20 of the National Health Act prohibits healthcare providers from refusing emergency medical treatment. Despite these robust statutory provisions, the practical enforcement of these rights in urgent scenarios remains fraught with difficulty.

A Nigerian medical practitioner seeking an urgent court order, particularly after hours or during weekends, confronts significant procedural hurdles. The process typically involves filing an *ex parte* motion in a High Court, permitted for matters of 'extreme urgency' under various High Court Rules (e.g., Federal High Court Rules 2019, Order 26;[8]Lagos State High Court Rules 2019, Order 42[9] . However, these rules require physical filing at the court registry during official working hours (Monday to Friday, 8:00 am to 4:00 pm). The absence of a formal 24/7 'duty judge' system means that securing a prompt hearing outside regular hours depends on the discretion of the Chief Judge and availability of court staff, leading to unpredictable and often fatal delays.

The Supreme Court's decision in *Esabunor v Faweya*[10] illustrates these tensions. While the Court affirmed the state's power to override parental religious objections to life-saving blood transfusions for a minor, the protracted litigation history -culminating in a Supreme Court judgment -reveals a process fundamentally ill-suited for emergency room realities.

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[4] Mauro Cappelletti and Bryant Garth, *Access to Justice and the Welfare State* (European University Institute 1981). See also Richard Moorhead and Pascoe Pleasence, 'Access to Justice after Universalism: Introduction' (2003) 30(1) *Journal of Law and Society* 1, 2, citing Cappelletti and Garth; Joint Committee on Human Rights, *Enforcing Human Rights* (HL Paper 669, HC 669, Session 2017–19, 19 July 2018) para 12, citing *Airey v Ireland* (1979) 2 EHRR 305 ('practical and effective, not theoretical and illusory').

[5] Abacha v. Fawehinmi (2000) 6 NWLR (Pt. 660) 228 (SC)

[6] Constitution of the Federal Republic of Nigeria 1999 (as amended)

[7] National Health Act 2014

[8] Federal High Court (Civil Procedure) Rules 2019, Order 26

[9] Lagos State High Court (Civil Procedure) Rules 2019, Order 42

[10] [2019] 7 NWLR (Pt 1671) 316

The **National Mental Health Act 2021** (NMHA) represents a landmark legislative attempt to modernize Nigeria's approach to mental health governance, replacing the colonial Lunacy Act of 1958[11]. Section 44 creates a **Mental Health Assessment Committee**, a tribunal-style body with jurisdiction to review involuntary admissions, assess capacity, and protect the rights of persons with mental disabilities[12].However, the Act is silent on how to secure urgent authorization for medical interventions when time is critical. It establishes no procedures for emergency applications outside regular court hours, nor does it mandate timeframes for the Assessment Committee to render decisions in urgent cases. This omission reflects a broader pattern: substantive rights proclaimed without the procedural infrastructure necessary to render them immediately enforceable.

3.0 Comparative Jurisdictional Analysis

3.1 *United Kingdom: The 24/7 Judicial Safety Net*

The United Kingdom provides the most sophisticated model for judicial accessibility in medical cases. The Mental Capacity Act 2005[13]establishes a framework for decisions involving adults who lack capacity, centered on the 'best interests' principle. For children, the Children Act 1989[14]and the High Court's inherent jurisdiction provides the legal basis for intervention.

Crucially, the UK judiciary is structured for 24/7 responsiveness. The Court of Protection and the Family Division maintain an 'urgent business' system. Practice Direction 10B outlines the procedure for serious medical treatment cases. Outside standard hours, a duty judge is always available via a dedicated emergency telephone line to hear applications and grant orders, often within the hour. For example, in a matter heard before Ms Justice Harris in October 2024 concerning the forced conveyance of a patient with renal failure, the court convened an urgent remote hearing on a Friday, with a further hearing held just three days later [15] . This responsiveness ensures the legal system operates at the speed of medicine.

Notable cases demonstrating this include *Great Ormond Street Hospital v Yates*[16] and *Tafida Raqeeb v Barts Health NHS Trust*[17].The UK model thus offers a functional equivalent centered on judicial availability: legal authority is never more than a telephone call away.

3.2 *Canada: Quasi-Judicial Efficiency through the Consent and Capacity Board*

Ontario's **Consent and Capacity Board (CCB)** offers a distinctive model of quasi-judicial efficiency bridging informal mechanisms and the formal court system. Established under the *Health Care Consent Act 1996* (HCCA),[18] the Board conducts hearings under the HCCA, *Mental*

[11] National Mental Health Act 2021
[12] National Mental Health Act 2021, s 44
[13] National Mental Health Act 2021, s 44
[14] Children Act 1989
[15] Claire Martin, 'An urgent case: Renal failure and an application for forced "extraction and conveyance" to hospital' (Open Justice Court of Protection, 31 October 2024) <https://openjusticecourtofprotection.org/2024/10/31/an-urgent-case-renal-failure-and-an-application-for-forced-extraction-and-conveyance-to-hospital/> accessed 27 January 2026

[16] [2017] EWHC 1909 (Fam)

[17] [2019] EWHC 2531 (Admin).
[18] Health Care Consent Act 1996, SO 1996, c 2, Sched A, s 70(1)

Health Act, *Substitute Decisions Act 1992*, and related legislation[19]. Its primary responsibilities include reviewing involuntary status in psychiatric facilities, adjudicating capacity issues, and determining disputes concerning consent to treatment and admission to care facilities[20].

3.2.1 Multidisciplinary Composition

The CCB's distinguishing feature is its multidisciplinary composition. Board members are appointed by the Lieutenant Governor in Council and comprise three categories: psychiatrists, lawyers, and public members. [21] Hearing panels are typically constituted with a lawyer, a psychiatrist, and a community member.[22] For most cases, the Board sits in panels of three[23]. This structure serves both substantive and procedural functions: the legal member ensures adherence to natural justice; the medical member brings clinical insight; the public member enhances accessibility and legitimacy.

3.2.2 Statutory Timeframes

The CCB's procedural architecture is designed for speed. Section 75 of the HCCA mandates that hearings must commence within **seven calendar days** of receiving an application[24]. The Board must issue its decision within **one calendar day** of the hearing's conclusion[25]. When written reasons are requested, as they may be within 30 days, they must be issued within four business days[26] . These statutory timeframes transform the theoretical right to review into a practical remedy. Hearings average approximately two hours,[27]conducted in the facility where the subject resides or receives treatment[28].

3.2.3 Information Access and Procedural Fairness

Before a hearing, a patient's lawyer is entitled to examine and copy all medical records at the patient's expense[29]. All parties may examine documents to be used at the hearing, with copies

[19] Public Appointments Secretariat, 'Consent and Capacity Board' (Ontario.ca) <https://www.pas.gov.on.ca/Home/Agency/263> accessed 27 January 2026

[20] Consent and Capacity Board, 'Overview' (ccboard.on.ca)

[21] Consent and Capacity Board, 'Overview' (ccboard.on.ca)

<https://www.ccboard.on.ca/scripts/english/publications/overviewhtml.asp> accessed 27 January 2026

[22] Public Appointments Secretariat, 'Consent and Capacity Board' (Ontario.ca)

[23] N.15

[24] Health Care Consent Act 1996, SO 1996, c 2, Sched A, s 75(2); Ferencz v Vissers 2016 ONCA 552 at para 3

[25] Health Care Consent Act 1996, SO 1996, c 2, Sched A, s 75(3)

[26] N. 15

[27] N. 15

[28] Consent and Capacity Board, 'Overview' (ccboard.on.ca) <https://www.ccboard.on.ca/scripts/english/publications/overviewhtml.asp> accessed 27 January 2026

[29] Consent and Capacity Board, 'Preparing for a Board Hearing: Information for the Incapable Person or Patient' (ccboard.on.ca) <https://www.ccboard.on.ca/scripts/english/publications/overviewhtml.asp> accessed 07 February 2026

provided at nominal cost[30]. If an alleged incapable person appears without representation, the Board may direct Legal Aid Ontario to arrange counsel[31], or appoint *amicus curiae* to assist in ensuring procedural fairness[32].

3.2.4 Remedial Powers and Judicial Review

The Board's powers are comprehensive: reviewing findings of incapacity, considering appointment of representatives, reviewing substitute decision-maker compliance, and providing directions regarding patient wishes[33]. Under the *Mental Health Act*, it reviews involuntary status, community treatment orders, and findings of incapacity to manage property[34]. Any party may appeal to the Ontario Superior Court within seven days[35].

3.2.5 The Supreme Court's Endorsement in Rasouli

In *Rasouli v Sunnybrook Health Sciences Centre*[36], the Supreme Court affirmed the CCB's centrality in resolving end-of-life disputes. The majority held that withdrawal of life support constitutes 'treatment' under the HCCA, requiring consent[37], and endorsed the CCB as the appropriate forum when consent is withheld. The Court observed that the CCB process was 'working just fine,' with hearings convened quickly and decisions rendered the day following hearing[38].

3.3. *United States: Procedural Fast-Tracking*

In the United States, judicial accessibility is facilitated through federal statutes and procedural rules. The Emergency Medical Treatment and Labor Act (EMTALA)[39] mandates that hospitals

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[30] Consent and Capacity Board, 'Preparing for a Board Hearing: Information for the Health / Residential Facility Manager or Administrator' (ccboard.on.ca) <https://www.ccboard.on.ca/scripts/english/publications/overviewhtml.asp> accessed 10 February 2026

[31] Ibid

[32] Whaley Estate Litigation Partners, 'Consent and Capacity Board' (welpartners.com) <https://welpartners.com/practiceareas/consentcapacityboard.php> accessed 10 February 2026

[33] Ontario Ministry of Health and Long-Term Care, 'Consent and Capacity Board' (webarchive.bac-lac.gc.ca, 2008) <https://webarchive.bac-lac.gc.ca/web/20080223052346/http://www.health.gov.on.ca/english/public/program/mentalhealth/consent.html> accessed 05 February 2026

[34] Whaley Estate Litigation Partners, 'Consent and Capacity Board' (welpartners.com) <https://welpartners.com/practiceareas/consentcapacityboard.php> accessed 05 February 2026

[35] Consent and Capacity Board, 'Overview' (ccboard.on.ca) <https://www.ccboard.on.ca/scripts/english/publications/overviewhtml.asp> accessed 07 February 2026

[36] [2013] 3 SCR 341

[37] Lisa Feldstein, 'What does the Rasouli decision mean for families in Ontario?' (CanLII Connects, 12 September 2013) <https://canliiconnects.org/fr/commentaires/37445> accessed 14 February 2026

[38] Lisa Feldstein (n.28)

[39] Emergency Medical Treatment and Labor Act (EMTALA) 42 USC § 1395dd

provide stabilizing treatment regardless of ability to pay, creating a legal environment where the duty to treat is paramount.

When disputes require judicial intervention, the US system utilizes **Temporary Restraining Orders (TROs)** under Rule 65(b) of the Federal Rules of Civil Procedure[40]. TROs can be issued *ex parte* where 'immediate and irreparable injury' will result. State courts exercise *parens patriae* powers to protect minors or incapacitated adults, allowing rapid intervention. Notable cases such as *Cruzan v Director, Missouri Department of Health* [41]and *Schiavo ex rel Schindler v Schiavo*[42] exemplify the judiciary's role in complex medical-legal issues.

3.4 *The Canadian Model as Functional Equivalent for Nigeria*

For Nigerian policymakers, the CCB model offers transferable insights. Its multidisciplinary composition addresses concerns about judicial lack of clinical expertise. Its statutory timeframe - seven days to hearing, one day to decision -create enforceable deadlines preventing systemic delays. Its status as an independent tribunal provides specialization that generalist courts cannot achieve, while remaining publicly funded and accessible at no cost[43].

Notably, Nigeria need not create such mechanisms from scratch. The National Mental Health Act 2021 already provides for a Mental Health Assessment Committee with jurisdiction to review involuntary admissions and assess capacity [44] . This Committee, if properly constituted and funded, could serve as a prototype for broader Medical Consent and Capacity Boards, its jurisdiction expanded to cover all treatment decisions involving questions of capacity or consent, its procedures amended to mandate rapid timeframes.

2.0 Identifying the Gaps: Why Nigeria Lags Behind

The disparity between Nigeria and these jurisdictions is rooted in the political economy of health and challenges of legal transplantation. Nigeria has adopted substantive laws of its common law counterparts, but failed to transplant accompanying procedural infrastructure and judicial culture. Key factors include:

1. **Absence of Specialized Fast-Track Procedures:** Nigeria lacks a dedicated 'duty judge' system or quasi-judicial body like Canada's CCB for medical emergencies.
2. **Judicial Congestion and Generalism:** High Court judges are overwhelmed with diverse caseloads. Without specialized health law divisions, medical emergencies proceed at the same pace as non-urgent civil matters.
3. **Logistical and Technological Barriers:** Lack of a 24/7 emergency judicial hotline and reliance on physical filing create insurmountable barriers during weekends and public holidays.
4. **Cultural and Religious Sensitivities:** Fear of litigation and lack of clear, rapid judicial authorization lead physicians to delay treatment or act without legal cover.

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[40] Federal Rules of Civil Procedure, Rule 65
[41] 497 US 261 (1990)
[42] 403 F 3d 1223 (11th Cir 2005)
[43] Consent and Capacity Board, 'Overview' (ccboard.on.ca)

<https://www.ccboard.on.ca/scripts/english/publications/overviewhtml.asp> accessed 27 January 2026

[44] National Mental Health Act 2021, s 44

5. **Political Economy and Funding:** Chronic underfunding of the judiciary limits adoption of modern court management systems and training of specialized personnel.

The implementation trajectory of the National Mental Health Act 2021 offers a sobering case study. More than three years after enactment, and nearly two years after it was signed into law in January 2023, critical institutional infrastructure remains unestablished[45]. The Department of Mental Health Services within the Federal Ministry of Health, envisaged as the coordinating hub, has yet to be operationalized[46]. The National Mental Health Fund remains unfunded[47]. Only Lagos and Ekiti states have domesticated the Act[48].

The scale of unmet need underscores urgency. According to the World Health Organization, approximately 50 million Nigerians (one in four citizens) live with mental health conditions[49]. Depression and anxiety are most common, with an estimated seven million affected by depressive disorders and nearly five million by anxiety disorders[50]. Yet the country has fewer than 350 psychiatrists serving a population of over 200 million -a ratio of 0.1 per 100,000, far below the global average of nine per 100,000[51]. Approximately 98 per cent of mental health costs are borne directly by patients, and nine out of ten Nigerians who need mental health services cannot access them[52].

This implementation deficit underscores a central thesis: legal rights, however elegantly drafted, are illusory without institutional capacity to enforce them. To date, no empirical study

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[45] 'Stakeholders advocate dedicated budgets, partnerships to bridge Nigeria's mental health gap'

Premium Times (Abuja, 3 September 2025) <https://www.premiumtimesng.com/health/health-news/818525-stakeholders-advocate-dedicated-budgets-partnerships-to-bridge-nigerias-mental-health-gap.html> accessed 21 February 2026

[46] Lara Adejoro, '16 months after presidential assent, FG yet to establish mental health dept' *The Punch* (Lagos, 8 June 2024) <https://healthwise.punchng.com/16-months-after-presidential-assent-fg-yet-to-establish-mental-health-dept/> accessed 12 February 2026

[47] N42

[48] N.42

[49] 'Medical Experts: 50 Million Nigerians Battling Mental Illness, 75% Untreated' *THISDAYLIVE* (Abuja, 16 October 2025) <https://www.thisdaylive.com/2025/10/16/medical-experts-50-million-nigerians-battling-mental-illness-75-untreated/> accessed 12 February 2026

[50] 'Over 40M Nigerians suffer mental illness — YALI tasks states to domesticate Act' *Daily Post* (11 October 2025) <https://dailypost.ng/2025/10/11/over-40m-nigerians-suffer-mental-illness-yali-tasks-states-to-domesticate-act/> accessed 12 February 2026

[51] N.41

[52] N. 41

has quantified emergency medical applications filed in Nigerian courts or the average time required to obtain judicial authorization. This data gap itself reflects a system that does not recognize urgent medical-legal disputes as meriting special attention.

3.0 Addressing Potential Counterarguments

1. **Concerns about Judicial Overreach into Clinical Discretion:** The judiciary's role is not to dictate medical treatment but to adjudicate legal and ethical dilemmas --disputes over consent, capacity, or best interests. Courts rely heavily on expert medical evidence, ensuring oversight complements clinical judgment.
2. **Resource Constraints within the Nigerian Judiciary:** A duty judge system primarily involves re-allocation and rotation of existing judicial personnel, not creation of new infrastructure. The societal cost of delayed urgent care - in preventable morbidity, mortality, and litigation - far outweighs investment in responsive mechanisms.
3. **3. Risks of Forum Abuse in Emergency Applications:** This risk is mitigated through stringent safeguards: requiring robust affidavits of urgency, imposing costs for frivolous applications, and ensuring *ex parte* orders are strictly interim and subject to prompt review.

4.0 Recommendations for Reform in Nigeria

1. **Establishment of Health Law Divisions:** High Courts in major metropolitan areas should establish specialized divisions or designate judges with health law expertise to handle medical cases, ensuring familiarity with ethical and clinical dimensions.
2. **Implementation of a 24/7 Duty Judge System:** The National Judicial Council should mandate rotation of duty judges available 24/7 for emergency medical applications via a dedicated, secure communication line. The UK experience demonstrates urgent remote hearings can be convened rapidly, with complex applications resolved within days[53].
3. **Statutory Fast-Tracking:** Amendments to the National Health Act or High Court Rules should mandate that applications for urgent medical interventions be heard within 24 hours of filing, creating enforceable deadlines. Ontario's statutory timeframes provide a proven model balancing urgency with procedural fairness[54].
4. **Quasi-Judicial Boards:** Nigeria should establish state-level Medical Consent and Capacity Boards adapted from the Canadian model, multidisciplinary in composition, subject to strict statutory timeframes. The National Mental Health Act 2021's Mental Health Assessment Committee[55] could serve as a prototype, its jurisdiction expanded to cover all treatment decisions involving capacity or consent, its procedures amended to mandate rapid timeframes.
5. **Enhanced Role for Hospital Ethics Committees:** Hospital Ethics Committees should be strengthened through statutory recognition and legal protection for members, serving as

[53] Claire Martin (n. 11)

[54] Health Care Consent Act 1996, SO 1996, c 2, Sched A, s 75(3)
[55] Health Care Consent Act 1996, SO 1996, c 2, Sched A, s 75(2); Ferencz v Vissers 2016 ONCA 552 at para 3

preliminary filters, and ensuring that only genuinely contested matters reach courts. Regular training should be conducted for members of HECs to update them on developments in the medico-legal field as related to their institutional mandate.

6. **Public Awareness and Stakeholder Engagement:** Reform must be accompanied by comprehensive public awareness campaigns educating healthcare providers, patients, and families about legal rights and enforcement mechanisms. The Young African Leaders Initiative has urged state governments to domesticate the Mental Health Act and prioritize investment in mental health services [56] .The Association of Psychiatrists in Nigeria has called for integration of mental health into primary care, curriculum reform, and measures to stem migration of mental health practitioners[57].

5.0 Conclusion

The right to health and the right to life, enshrined in Nigeria's Constitution, remain largely aspirational without a judicial system capable of responding to the urgent realities of medical practice. While the UK, Canada, and the US have developed sophisticated, responsive mechanisms ensuring law is accessible in times of medical crisis, Nigeria remains hampered by systemic delays and a lack of specialized infrastructure. The National Mental Health Act 2021 exemplifies this gap: its Mental Health Assessment Committee remains largely unimplemented, its department unestablished, and its procedural framework silent on urgent timelines[58]. The scale of unmet need, 50 million Nigerians living with mental health conditions, fewer than 350 psychiatrists, nine in ten unable to access care, underscores the urgency[59].

The judiciary must evolve into an active partner in the delivery of life-saving healthcare. By adopting a 24/7 duty judge system, establishing specialized health law divisions, and building upon the statutory foundation of the NMHA 2021 to create fully functional Medical Consent and Capacity Boards, Nigeria can transform its judicial landscape. This reform is not merely a procedural enhancement; it is a fundamental imperative to ensure the justiciability of health rights and prevent judicial delay from becoming a *de facto* death sentence. In the intersection of law and medicine, an accessible and responsive judiciary is not a luxury, but a matter of fundamental human rights and survival.

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[56] 'YALI urges states to address bottlenecks in implementation of Mental Health Act' *The Guardian* (Lagos, 10 October 2025) <https://guardian.ng/features/health/yali-urges-states-to-address-bottlenecks-in-implementation-of-mental-health-act/> accessed 13 February 2026

[57] 'Association advocates mental health integration into PHC' *News Agency of Nigeria* (Abuja, 11 May 2025) <https://nannews.ng/2025/05/11/association-advocates-mental-health-integration-into-phc/> accessed 13 February 2026

[58] No. 41; No. 42

[59] Ibid

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Respectfulness of Care: To What Extent is Nigerian Health Law Protective?

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Abstract

Respectfulness of care encompasses dignity, privacy, autonomy, and compassionate communication, and this is increasingly being recognized as central to quality, patient-centered healthcare delivery. International human rights instruments highlight these as fundamental rights, but the extent to which national legal systems protect and enforce them vary considerably across jurisdictions. Using legal analysis, this paper critically examines the extent to which Nigerian health law protects respectfulness of care in healthcare delivery. It examined selected provisions in the Constitution, statutes, ethical codes and policy framework, including professional regulatory codes and relevant international human rights instruments ratified by Nigeria. It finds that although Nigerian health law offers some protection for respectful care, particularly in privacy, consent, confidentiality, and non-discrimination, gaps remain in enforcement, justifiability and public awareness. Many protections are policy-based rather than legally binding, limiting effectiveness, and there are persistent deficiencies in implementing consent and confidentiality in clinical practice. The paper recommends strengthening enforcement of existing legislation, expanding statutory recognition and improving public and professional awareness as necessary steps to enhancing legal protection of respectful healthcare delivery. It concludes that only by taking these steps will the present structural and legal limitations in respectfulness of care, which hinder effective protection of patients' rights in health care delivery, be addressed.

Keywords: Respectful care, health law, patient rights, Nigeria, medical law, healthcare ethics

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1. INTRODUCTION

Respectfulness of care is a central element of quality healthcare and human rights-based practice. It embodies ethical and legal obligations to treat patients with dignity, fairness, and compassion, to protect privacy, to ensure consent, and to foster effective communication in clinical interactions. These principles reflect broader human rights norms embedded in instruments such as the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights.[1]

International health organizations such as the World Health Organization (WHO) emphasize respectful care as essential for quality health systems. Respectful maternity care, in particular, is identified as a critical component of safe motherhood and effective maternal and newborn services. WHO's Standards for improving quality of maternal and newborn care emphasize respectful, dignified, and non-discriminatory care as central to clinical quality.[2]

In many jurisdictions, these principles are reinforced through legal and regulatory frameworks that define and protect patient rights. Health law serves as an important mechanism for accountability within healthcare delivery, protecting individuals from neglect, discrimination, and abuse. In Nigeria, healthcare governance is shaped by a framework of constitutional provisions, statutory laws, professional regulations, and policy instruments**.** Key legal instruments include the Constitution of the Federal Republic of Nigeria 1999 (as amended), the National Health Act 2014**,** and the Patients' Bill of Rights (2018). Professional standards, particularly the Code of Medical Ethics for Medical Practitioners[3] and the Nursing and Midwifery Council of Nigeria Code of Professional Conduct, further regulate clinical practice.[4] In addition**,** international human rights instruments ratified by Nigeria provide normative guidance for the protection of patient rights within the healthcare system.

However, despite the existence of these legal protections, persistent concerns remain regarding the practical enforcement of patient rights and the extent to which Nigerian health law adequately safeguards respectfulness of care. Challenges such as weak enforcement mechanisms, limited awareness of patient rights, and structural deficiencies in the healthcare system may undermine the effectiveness of these legal provisions. For example, clinical studies report that many practitioners fail to obtain valid consent, and a lack of proper disclosure remains widespread.[5]

This paper examines the extent to which Nigerian health law protects respectfulness of care in healthcare delivery and identifies gaps that may hinder the realization of respectful healthcare practices. It is divided into six sections. The first section is the introduction. The second conceptualizes respectfulness of care in health care delivery. The third examines the legal framework for protecting respectful care in Nigeria. The fourth section discusses their limitations and the challenges to the protection of the right to respectfulness of care using practical

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[1] United Nations, Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217 A(III)). Universal Declaration of Human Rights | United Nations, World Health Organization, 'Standards for Improving Quality of Maternal and Newborn Care in Health Facilities' (WHO 2016), White Ribbon Alliance, *Respectful Maternity Care: The Universal Rights of Childbearing Women* (2011)

[2] World Health Organization, *Standards for Improving Quality of Maternal and Newborn Care in Health Facilities* (WHO 2016).

[3] Medical and Dental Council of Nigeria, *Code of Medical Ethics in Nigeria* (2004) Document 269473210 | PDF accessed 12th April 2026.

[4] Nursing and Midwifery Council of Nigeria, *Code of Professional Conduct* https://nmcn.gov.ng/code-of-conduct/ accessed 12th April 2026.

[5] A J Gogos, R B Clark & M M Bismak, 'When Informed Consent Goes Poorly: A Descriptive Study of Medical Negligence Claims and Patient Complaints' *The Medical Journal of Australia* (2011) 195(6): 340- 344

illustrations of disrespectful care in Nigerian hospitals and compares the Nigerian situation with what obtains in other jurisdictions like South Africa and the United Kingdom. The fifth and sixth sections contain the paper's recommendations and conclusion, respectively.

2. Conceptualizing Respectfulness of Care in Health Law

Respectfulness of care refers to healthcare interactions that uphold patient dignity, autonomy, privacy and emotional well-being. It extends beyond technical clinical competence to include interpersonal behaviours and ethical obligations that shape patient experiences.[6] Consideration for the patient's dignity is central to respectfulness of Care. Human dignity and respect in health care means treating individuals with honor, privacy and empathy, and valuing their autonomy and preferences.[7]

In health care delivery, dignity is the inherent and unassailable value intrinsic to all individuals. It is shaped by a number of factors, including respect for the patients' values, beliefs, culture, and morality.[8] Autonomy in respectful care means honoring a patient's right to self-determination, dignity and control over their own body and decisions. It involves moving away from paternalistic models where health care providers dictate care and towards a partnership where the patient is empowered to make informed choices free from coercion, violence or discrimination.[9] Privacy in respectful care means recognizing and upholding the patient's right to personal space, bodily modesty, confidentiality and autonomy. Ensuring that the patient feels safe, valued and in control when caring for them. It is a foundational element of dignity that involves both physical discretion and the protection of personal information of the patient.[10]

From a legal and human rights standpoint, respectful care means providing healthcare in a manner that upholds the patient's fundamental dignity, autonomy, privacy, and confidentiality, while ensuring freedom from harm, mistreatment, and discrimination. It is considered a universal human right, not merely a standard of quality, that protects the patient-provider relationship.[11] Thus, respectful care can be understood through several key rights commonly recognized in health law, such as: right to dignity and respectful treatment, right to privacy and confidentiality, right to information and consent, right to participate in healthcare decisions and right to equitable and non-discriminatory care. These rights reflect fundamental principles embedded in international human rights law and healthcare ethics. When incorporated into national legal systems, they provide mechanisms for protecting patients against disrespectful or abusive treatment in healthcare settings.

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[6] S B Frampton, S Guastello & M J Lepore, 'Compassion as the foundation of Patient-Centered Care: The Importance of Compassion in Action' *Journal of Comparative Effectiveness Research* (2013) 2(5):443-455

[7] X Sun, G Zhang, Z Yu, K Li & L Fan, 'The Meaning of Respect and Dignity For Intensive Care Unit Patients: A Meta-Synthesis of Qualitative Research. *Nursing Ethics* (2024):31(4):652–669.

[8] L Buonaccorso, S Soncini, MC Bassi, D Mecugni & L Ghirotto, 'Training Healthcare Professionals to Dignity-in-care: A Scoping Review. *Nurse Education Today* (2024) 146:106543.

[9] PK Tully, RL Molina, J Quist-Nelson, L Wangerien, K Harris, AL Weiseth, JK Edmonds, 'Supporting Patient Autonomy Through Respectful Labor and Childbirth Healthcare Services, *Seminars in Perinatology* (2025) 49(3):152048

[10] AE Muhammed, 'The Importance of Respect and Privacy in Caregiving: Maintaining Patient Dignity'G, available at https://medium.com/@animot777/the-importance-of-respect-and-privacy-in-caregiving-456285c78434 accessed 21 April 2026

[11] AG Cantor, RM Jungbauer, AC Skelly AC, et al. 'Respectful Maternity Care: Dissemination and Implementation of Perinatal Safety Culture To Improve Equitable Maternal Healthcare Delivery and Outcomes' [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2024 Jan. (Comparative Effectiveness Review, No. 269.) Executive Summary. available at: https://www.ncbi.nlm.nih.gov/books/NBK599318/ accessed 20 April 2026

3. Nigerian Legal Framework for Protecting Respectful Care

3.1 *Constitutional Protection of the Right to Health*

The Constitution of the Federal Republic of Nigeria 1999 (as amended) provides the foundational legal framework for human rights protection, including norms relevant to respectful healthcare. Although healthcare is not explicitly recognized as a fundamental right, several provisions indirectly support patient dignity and equitable treatment. Section 33 guarantees the *right to life*, imposing a duty on the state to safeguard conditions necessary for its preservation, including access to essential healthcare services. Section 34 protects the *dignity of the human person*, prohibiting inhuman or degrading treatment and reinforcing the obligation to treat patients with respect. Section 42 guarantees *freedom from discrimination*, ensuring equitable access to healthcare regardless of personal characteristics. Additionally, Section 17(3)(d) obligates the state to provide adequate medical and health facilities. Although this falls within the Directive Principles of State Policy and is generally non-justiciable, these constitutional provisions collectively establish a normative basis for human dignity, bodily integrity, and respectful care. Their limited enforceability, however, constrains patients' ability to seek judicial redress for violations of these standards.

3.2 National Health Act (2014)

The National Health Act (2014) represents one of the most comprehensive legal instruments regulating healthcare delivery in Nigeria. The Act establishes standards for health service provision and outlines certain rights of healthcare users. Key provisions relevant to respectful care include Sections 26 and 27, which state:

> *26 (1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential.*
> *(2) Subject to section 27 of this Act, no person may disclose any information contemplated in subsection (l) unless—*
> *(a) the user consents to that disclosure in writing;*
> *(b) a court order or any law requires that disclosure;*
> *(c) in the case of a minor, with the request of a parent or guardian.*
> *(d) in the case of a person who is otherwise unable to grant consent upon the request of a guardian or representative: or*
> *(e) non-disclosure of the information represents a serious threat to public health.*
> *27. A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties, where such access or disclosure is in the interest of the user.*

From the above provision, all information concerning a patient's health status and treatment must be confidential. Disclosure is restricted except with consent, by court order, or where serious public health risks justify non-disclosure. This section establishes the patient's right to confidentiality. Although the Act does not elaborate detailed procedural standards, its ethical imperatives support the principle that patients must consent before interventions. Under the Act, patients are entitled to relevant health information, though practice often falls short. The Act also emphasize humane, patient-centered treatment. However, despite these statutory provisions, enforcement mechanisms remain weak. The Act lacks strong compliance and monitoring

frameworks, and many patients are unable to secure legal remedies when their rights are violated.

3.3 *Patients' Bill of Rights (2018)*

The Patients' Bill of Rights (PBoR) was introduced in 2018 by the Federal Ministry of Health and the Consumer Protection Council. The Patients' Bill of Rights outlines the rights and responsibilities of patients in the healthcare system. It aims to promote patient autonomy, dignity, and well-being by establishing standards for healthcare providers to follow.[12] It provides patients with information on how they reasonably expect to be treated during the course of their hospital stay. The Bill of Rights outlined 12 rights that patients are entitled to. They include:

i. Right to relevant information in a language and manner the patient understands, including diagnosis, treatment, other procedures, and possible outcomes.
ii. Right to timely access to detailed and accurate medical records and available services.
iii. Right to transparent billing and full disclosure of any costs, including recommended treatment plans.
iv. Right to privacy and confidentiality of medical records.
v. Right to clean, safe, and secure healthcare environments.
vi. Right to be treated with respect, regardless of gender, race, religion, ethnicity, allegations of crime, disability or economic circumstances.
vii. Right to receive urgent, immediate and sufficient intervention and care, in the event of an emergency.
viii. Right to reasonable visitation in accordance with prevailing rules and regulations.
ix. Right to decline care, subject to prevailing laws and upon full disclosure of the consequences of such a decision.
x. Right to decline or consent to participation in medical research, experimental procedures or clinical trials.
xi. Right to quality care in accordance to prevailing standards.
xii. Right to complain and express dissatisfaction regarding services received.

The aim of the PBoR is to empower patients and promote accountability within healthcare institutions. However, scholars argue that the PBoR functions primarily as a policy document rather than a legally binding statute, limiting its enforceability in practice. This undermines its impact, as hospitals and providers are not always compelled to integrate its standards into enforceable institutional policies.[13]

3.4 *Professional Ethical Codes*

Professional regulatory bodies also contribute to the protection of respectful care through ethical guidelines. Examples include: the Code of Medical Ethics for Medical Practitioners and Nursing and Midwifery Council of Nigeria Code of Professional Conduct. These codes require healthcare

[12] B Ifeoluwayimika, B Akinleye & M J Aiyedatiwa, 'The Patients Bill of Rights and Its Legal, Ethical and Socio Legal Challenges: Are There Failed Promises?' *African Journal of Law, Ethics and Education* (2025) 8(2):1-25

[13] Nigeria Health Watch, 'Patients' Bill of Rights; Game Changer or Another Policy Paper?' Available at https://articles.nigeriahealthwatch.com/patients-bill-of-rights-game-changer-or-another-policy-paper/#:~:text=What%20is%20the%20Patients'%20Bill,a%20non%2Dbinding%20declaration%E2%80%9D. accessed 20 April 2026

professionals to maintain patient confidentiality, obtain consent, and treat patients with dignity and compassion. However, enforcement is often dependent on professional disciplinary processes rather than judicial mechanisms, which limits legal accountability.[14]

S/N	Legal/Policy Instrument	Year	Key Provisions Relevant to Respectful Care	Legal Status
1	Constitution of the Federal Republic of Nigeria	1999	Sections 33 & 17: Right to life, health facilities; Directive Principles support dignity & health	Partially justiciable (sections 33 enforceable; 17 non-justiciable)
2	National Health Act	2014	Patient confidentiality, informed consent, access to health information, dignity in healthcare	Statutory law, enforceable but weak compliance mechanisms
3	Patients' Bill of Rights (PBoR	2018	Right to information, privacy, respectful treatment participation, complaint/redress	Policy document; not fully legally binding
4	Code of Medical Ethics	2008	Patient dignity, confidentiality, consent, professional communication	Ethical standard; enforceable via professional disciplinary bodies
5	Nursing and Midwifery Council Code of Professional Conduct	2004	Compassionate care, patient advocacy, confidentiality, respectful communication	Ethical standard; enforceable via professional disciplinary bodies
6	WHO Respectful Maternity Care Standards	2018	Dignity, privacy, autonomy, non-discrimination in maternity care	International guidance; advisory in Nigeria

4. Limitations and Challenges to the Protection of the right to Respectfulness of Care in Nigeria

Empirical accounts from Nigerian healthcare settings reveal persistent patterns of disrespectful care, manifesting in environmental neglect, poor communication, breaches of confidentiality, and unprofessional conduct by health workers.[15] At the General Outpatient Department of Lagos State University Teaching Hospital, patients were subjected to overcrowded and poorly maintained conditions, with little regard for their comfort or dignity. Such conditions raise concerns under the right to dignity protected by the Constitution of the Federal Republic of Nigeria 1999, which

[14] G P Dafiel & I J Agada, 'Regulating Ethical Standards in African Healthcare;
Legal Complexities for Medical Practitioners and Institutions in Nigeria' Journal of Legal Studies, Humanities and Political Sciences (2026) 13:1-14.

[15] AO Olajide, C Ndikom, E O Ogunmodede, O O Bello, T A Awotunde, E O Famutimi, G O Adeniran, D Taiwo, R Oyekale & D T Esan, 'A Cry for Dignity: Verbal, Physical and Emotional Abuse Experienced by Postpartum Women in Nigerian Healthcare, *Journal of Forensic and Legal Medicine*, (2025) 109: 102802.

prohibits degrading treatment.[16] Vulnerable patients, including nursing mothers, were reportedly unable to access appropriate seating, reflecting systemic shortcomings in patient-centered care.

Beyond environmental concerns, significant communication gaps were observed. Patients were reported to have received prescriptions without adequate explanation, undermining the principle of informed consent.[17] This practice is inconsistent with the standards set out in the Patients' Bill of Rights, which guarantees patients the right to relevant information and participation in decision-making. The failure to provide adequate information not only compromises clinical outcomes but also violates ethical and legal obligations of care.[18]

Confidentiality breaches also emerged as a critical issue. A patient at the Nigerian Institute of Medical Research alleged unauthorised disclosure of his HIV status after receiving targeted pharmaceutical advertisements.[19] If established, such conduct would contravene the Nigerian Data Protection Regulation 2019, which mandates the lawful processing and protection of personal data, particularly sensitive health information. It would also violate the patient's right to privacy, as protected under the Constitution. In addition, patients frequently reported dismissive attitudes and reluctance by healthcare providers to respond to questions. This undermines the right to be treated with respect and to receive adequate information, as recognised under both ethical standards and the Patients' Bill of Rights.[20]

Instances of verbal abuse further illustrate the erosion of respectful care. Reports of healthcare workers using harsh and humiliating language towards patients, particularly nursing mothers, constitute clear violations of the right to dignity and freedom from degrading treatment under Nigerian law. Such behaviour may also amount to professional misconduct under applicable regulatory codes governing healthcare practitioners.[21]

Notably, variations in compliance were observed across institutions. Federal health facilities demonstrated relatively better adherence to patients' rights, including visible display of the Patients' Bill of Rights and improved patient-provider interactions. However, gaps remain, particularly among non-clinical staff, highlighting the need for comprehensive institutional accountability.[22]

Overall, these findings demonstrate that disrespectful care in Nigeria is not merely an ethical concern but also a legal and human rights issue, implicating constitutional protections, statutory regulations, and policy frameworks. Addressing these challenges requires stronger enforcement mechanisms, improved awareness, and institutional reforms to ensure that patients' rights are consistently upheld in practice.

From the above, it is evident that despite legal provisions, several barriers limit the effectiveness of the enforcement of the right to respectful health care in Nigeria. One of the challenges is weak enforcement mechanisms**.** Many patient rights provisions lack clear mechanisms for enforcement. Patients find it difficult to pursue legal remedies due to procedural barriers and limited access to legal representation. Another is low awareness of patient rights**.**

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[16]T Obayendo, 'How Nigerian Health Workers Violate Patients' Rights with Impunity' (*Africa-China Reporting Project*, 15 February 2022) available at https://africachinareporting.com/how-nigerian-health-workers-violate-patients-rights-with-impunity/ accessed 12 April 2026

[17] Ibid

[18] Ibid

[19] Ibid

[20] Ibid

[21] J Orpin, S Puthussery, R Davidson & B Burden, 'Women's Experiences of Disrespect and Abuse in Maternity Care Facilities in Benue State, Nigeria' *BMC Pregnancy Childbirth* (2018) 18(1): 213.

[22] Ibid

Many patients are unaware of their legal rights within the healthcare system and this limit their ability to demand respectful care. In addition, there are constraints in the Nigerian health care system**.** For instance, structural challenges such as workforce shortages, inadequate funding and poor infrastructure undermine the delivery of respectful care.[23] Cultural and paternalistic practices also limit or act as a barrier to the enjoyment of respectful care. Long-standing medical paternalism and social norms hinder patient autonomy and consent practices.

Therefore, although the Nigerian health law provides normative recognition of respectful care principles, practical protection is limited. Key rights are articulated but enforcement is weak and the general perception is that legal remedies are cumbersome due to low public awareness. The absence of a robust enforcement mechanisms constrains the realization of patient right to respectful health care.

Comparative perspectives from jurisdictions such as South Africa and the United Kingdom illustrate the advantages of embedding patient rights within justiciable statutory frameworks and establishing independent oversight bodies that monitor compliance. In South Africa, the constitutional rights to dignity and health can be found in Sections 10, 24, 26, 27 and 29[24] and they are frequently invoked in litigation often by way of mandamus that is, mandatory interdicts, to compel public health authorities to act when systemic failures result in a violation of these rights. The courts thus pay a critical role in enforcing these rights, particularly when the state fails to provide adequate medical care, including in instances of HIV/AIDS treatment, mental health and emergency care.[25]

In the UK, the NHS Constitution and common law duties provide a robust framework for respectful healthcare by entrenching dignity, compassion, and patient-centred care as legal or quasi-legal entitlements, rather than mere aspirations. These frameworks can be interpreted to ensure that respect is central to every interaction, holding professionals accountable through both statutory mechanisms and tort law[26]

Nigeria could use some lessons for the above jurisdiction. A good place to start would be aligning legal standards with international benchmarks, including the WHO Respectful Maternity Care Charter and WHO *Standards for Improving Quality of Maternal and Newborn Care*. These can offer normative guidance for enhancing legal protections. Other steps are highlighted in the next section.

5. Recommendations

Strengthening the protection of respectful care in Nigeria will require a multifaceted approach. As a result, this paper recommends the following:

[23] B Ifeoluwayimika, B Akinleye & M J Aiyedatiwa, 'The Patients Bill of Rights and Its Legal, Ethical and Socio Legal Challenges: Are There Failed Promises?' African Journal of Law, Ethics and Education (2025) 8(2):1-25

[24] Constitution of the Republic of South Africa. December 16, 1996 (as amended to February 1, 2013) (South Africa [za] Act No, 108 of 1996, GG Vol 378, No 17678, Main Text, Chapter 2 Bill of Rights (ss 7-39)

[25] South African Human Rights Commission, 'Access to Health Care' available at https://www.sahrc.org.za/home/21/files/FINAL%20Access%20to%20Health%20Care%20Educational%20Booklet.pdf#:~:text=The%20right%20to%20have%20access%20to%20health,one%20may%20be%20refused%20emergency%20medical%20treatment, Accessed 20 April 2026

[26] Landmark Chambers, 'The purpose and effect of the NHS Constitution' available at https://www.landmarkchambers.co.uk/wp-content/uploads/2018/06/HG-17-08-30-The-purpose-and-effect-of-the-NHS-constitution-formatted.pdf accessed 20 April 2026

The first is the integration of the Patients' Bill of Rights into Statutory Law**.** This will elevate the Patients' Bill of Rights from a policy framework into binding legislation which would significantly enhance its enforceability. Currently, while the PBoR articulates key entitlements such as dignity, informed consent, privacy, and non-discrimination, it lacks direct legal sanctions for violations. It is pertinent therefore that its provision be codified by the National Assembly so that it can create clear legal obligations for healthcare providers and institutions, provide justiciable rights that patients can enforce in court, enable regulatory bodies to impose penalties for breaches and harmonize patient protection standards across federal and state health systems. This reform would align Nigeria's domestic legal framework with international human rights standards, particularly those articulated by the United Nations in the context of the right to health.

The Second should be the establishment of independent health rights oversight bodies. The creation of independent oversight institutions, such as a Health Ombudsman or Patient Rights Commission, would strengthen accountability mechanisms within the health sector. Such bodies could be empowered to receive and investigate complaints from patients and families, conduct independent audits of healthcare facilities, issue binding recommendations or sanctions and facilitate alternative dispute resolution where appropriate. Independence from healthcare providers and government interference is critical to ensure credibility and public trust. These bodies could complement existing regulators such as the Medical and Dental Council of Nigeria and nursing councils.

The third is to enhance public and provider awareness. A major barrier to the realization of respectful care is the limited awareness of rights and obligations among both patients and healthcare providers. Addressing this requires sustained education efforts such as public awareness campaigns via media, community outreach, and civil society organizations to inform citizens of their healthcare rights, integration of patients' rights education into school curricula and community health programmes, capacity-building initiatives for healthcare workers on legal and ethical responsibilities. Improved awareness will empower patients to demand respectful care and provide incentives for equipping providers to deliver it consistently.

Fourth, there should be mandatory continuous training**.** Respectful care should be embedded as a core professional competency. This requires mandatory, ongoing training for all healthcare workers, including medical ethics and professionalism, effective communication and interpersonal skills, patients' rights and legal responsibilities and cultural competence and non-discrimination Regulatory bodies could tie such training to licensure and revalidation requirements which will ensure that practitioners remain up to date. Embedding respectful care into continuing professional development will foster a culture of accountability and patient-centered practice.

6. Conclusion

Respectful care is a critical component of quality healthcare delivery and patient-centered practice. Although Nigerian health law contains several provisions aimed at protecting patient dignity, privacy, and autonomy, current legal frameworks provide only partial protection. Significant gaps remain in enforcement, legal recognition, and institutional accountability. Addressing these challenges will require statutory legal reforms, improved enforcement mechanisms, alignment with international frameworks, and greater public awareness of patient rights.

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Towards Strategic Convergence of Health Law and Sports Law: Proposal for a Nigerian National Sports Governance Bill

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Abstract

The intersection of health law and sports law is an underexplored dimension of public law scholarship and policy development. This paper examines how these two historically distinct legal domains could converge to shape athlete welfare, public health outcomes, and sporting governance in Nigeria. It examines the structural, normative, and institutional arrangements through which health law principles are embedded within (or conspicuously absent from) sports regulation, with reference to the National Sports Commission Act, the National Institute for Sports Act, the National Health Act 2014, and allied health legislation, as well as the National Sports Industry Policy. The paper further analyses how this intersection exemplifies intersectoral collaboration as a mechanism for advancing population health, drawing on the Health in All Policies (HiAP) framework. Finally, it proposes a Nigerian National Sports Governance Bill and evaluates the place of health law within this Bill, identifying critical lacunae and offering reform recommendations. The paper argues that a coherent legal architecture integrating health and sports law is not merely desirable but constitutionally mandated, and that the proposed Nigerian National Sports Governance Bill will present a transformative opportunity to embed health governance at the heart of Nigerian sports administration.

Keywords: Sports law; Health law; Health in All Policies; Sport governance; Social determinants of health

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1. INTRODUCTION

Law, as a means of maintaining social order, seldom operates within hermetically sealed disciplinary boundaries. The reality of governance demands that legal frameworks interact, overlap, and mutually reinforce one another across sectors. Few intersections illustrate this principle as vividly as the confluence of health law and sports law. Sport, by its very nature, is a health-laden enterprise: it generates physical injury, mental health challenges, and occupational risks, and simultaneously serves as one of the most potent vectors of public health promotion.

In Nigeria, this intersection has evolved in a fragmented and largely reactive manner. The country's sports governance architecture, anchored by the National Sports Commission Act,[1] the National Institute for Sports Act,[2] and various state-level legislation, has historically prioritised the organisational dimension of sport (and, recently, the commercial dimension[3]), largely subordinating the health and welfare of athletes to subsidiary considerations. Meanwhile, Nigeria's health law framework, considerably strengthened by the National Health Act 2014[4] and ancillary legislation, has not been systematically extended to the specific context of sport.

This fragmentation carries real consequences. Nigerian athletes, from grassroots competitors to professional footballers, operate within a legal vacuum regarding occupational health protections, access to sports medicine, anti-doping governance, mental health support, and post-career medical care. The absence of coherent legal integration between health and sports law means that accountability mechanisms are diffuse, enforcement is weak, and the potential of sport as a vehicle for population health improvement remains largely underappreciated and unrealised. The intersection of health law and sports law is an underexplored dimension of public law scholarship and policy development.

This paper undertakes a systematic analysis across five substantive sections: the conceptual foundations of health law and sports law; the nature and mechanisms of their intersection in Nigeria; the intersectoral collaboration paradigm and its application to population health; a health law analysis of a proposed Nigerian National Sports Governance Bill; and finally, reform recommendations for a coherent, rights-respecting legal architecture.

2. Conceptual Foundations: Health Law and Sports Law Defined

2.1 *Health Law: Scope and Normative Architecture*

Health law is a multi-dimensional field encompassing the legal rules, regulatory frameworks, and institutional arrangements that govern the organisation, financing, delivery, and quality of healthcare, as well as the protection and promotion of public health. It integrates constitutional rights jurisprudence, administrative law, contract law, tort law, criminal law, and international law. Gostin defined public health law as "the study of the legal powers and duties of the state, in collaboration with its partners, to ensure the conditions for people to be healthy."[5]

In Nigeria, the constitutional foundation of health law is found in Section 17(3)(d) of the 1999 Constitution (as amended), which provides that the State shall direct its policy towards ensuring

[1] National Sports Commission Act 2023

[2] National Institute for Sports Act (Cap N62, LFN 2004), s 3.

[3] Exemplified by the current administration's 'Renewed Hope Initiative for Nigeria's Sports Economy (RHINSE)'. See NSC Launches Renewed Hope Initiative For Sports Economy Accessed 1 May 2026.

[4] National Health Act 2014 (Act No 8 of 2014), s 1.

[5] Gostin, Lawrence O., "A Theory and Definition of Public Health Law" (2008). O'Neill Institute Papers. 8. https://scholarship.law.georgetown.edu/ois_papers/8

that adequate medical and health facilities are provided for all persons at all times.[6] While classified under Chapter II (the non-justiciable Fundamental Objectives and Directive Principles of State Policy) the courts have increasingly interpreted this provision as illuminating the justiciable rights to life under Section 33 and dignity under Section 34.[7] In *SERAP v Federal Republic of Nigeria*, the ECOWAS Community Court of Justice affirmed that constitutional policy objectives could be deployed interpretively to give content to enforceable socio-economic rights obligations.[8]

The National Health Act 2014 constitutes the centrepiece of Nigerian health law. It establishes a framework for the regulation of health services, defines patients' rights and obligations, mandates emergency treatment, prohibits harmful health practices, and establishes the Basic Minimum Package of Health Services.[9] The National Health Insurance Authority Act 2022 creates a mandatory contributory health financing system.[10] Complementary legislation, including the Tobacco Control Act 2015 and the Food and Drugs Administration and Control Act, further constitute the multi-statute framework of Nigerian health law.[11]

2.2 *Sports Law: Scope and Normative Architecture*

Sports law encompasses the body of legal rules and regulatory norms governing sporting activity, sporting organisations, and the legal relationships arising therefrom. It draws upon contract law, tort law, labour law, intellectual property law, criminal law, and international law.

In Nigeria, the sports law framework derives from a multiplicity of sources. The National Sports Commission Act establishes the apex regulatory body for sports administration with powers to formulate and implement sports policy, develop and manage sports facilities, and regulate national sports federations.[12] The National Institute for Sports Act establishes the National Institute for Sports as the centre for sports science, coaching education, and athlete development.[13] Nigeria is a signatory to the UNESCO International Convention Against Doping in Sport (2005) and is bound by the World Anti-Doping Code through the National Anti-Doping Centre.[14] Nigerian sports governance also operates within a private regulatory layer comprising national sports federations and international governing bodies, whose rules frequently exercise more immediate practical authority than domestic legislation.[15]

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[6] Constitution of the Federal Republic of Nigeria 1999 (as amended), s 17(3)(d).

[7] Ibid, ss 33–34.

[8] See: *The Registered Trustees of the Socio-economic and Accountability Project (SERAP) v. Nigeria & UBEC.* ECOWAS Court App No ECW/CCJ/APP/07/10, where the ECOWAS Community Court held that the failure to ensure access to education implicated constitutional health and dignity obligations.

[9] Ibid, s 4 (Basic Minimum Package of Health Services).

[10] National Health Insurance Authority Act 2022, s 3 (establishing the NHIA and dissolving the former NHIS).

[11] Tobacco Control Act 2015; Food and Drugs Administration and Control Act (Cap F33, LFN 2004).

[12] National Sports Commission Act 2023

[13] National Institute for Sports Act (Cap N62, LFN 2004)

[14] *World Anti-Doping Code* (WADA, 2021 edn) art 2 (anti-doping rule violations). WADC

The National Anti-Doping Act 2025 allows the National Anti-Doping Organization (NADO) to coordinate all anti-doping strategies in compliance with the provisions of the World Anti-Doping Code (WADC).

[15] See FIFA-Commentary-on-the-FIFA-Regulations-for-the-Status-and-Transfer-of-Players-2023-edition.pdf (Accessed 1 May 2026) and World Athletics Competition Rules (2024) Book of Rules | Official Documents, both of which bind Nigerian national federations through their respective membership obligations.

3. The Intersection of Health Law and Sports Law in the Nigerian Context

3.1 *Anti-Doping Law as a Health-Sports Law Interface*

Anti-doping regulation represents perhaps the most developed point of intersection between health law and sports law in Nigeria. Doping is simultaneously a sports integrity issue, a criminal matter, and a profound public health concern. The health implications of anabolic steroid abuse, erythropoietin misuse, blood doping, and stimulant consumption have been extensively documented, ranging from cardiovascular complications and liver damage to psychiatric disorders and sudden death. As Loland and McNamee have argued, anti-doping rules are ultimately grounded in an ethical commitment to athlete health protection and not merely sporting purity.[16]

The Nigeria Anti-Doping Act, 2025 domesticates the *International Convention Against Doping in Sport*, bringing domestic governance into closer conformity with the World Anti-Doping Code and establishing the Nigeria Anti-Doping Centre (NADC), a fully independent body tasked with overseeing drug testing, enforcing anti-doping rules, and managing compliance among Nigerian athletes.[17] An official authorization allowing an athlete to use a prohibited substance or method for legitimate medical reasons without facing anti-doping sanctions. ('Therapeutic Use Exemption' (TUE)) requires the input of pharmacists, physicians, and sports medicine practitioners, and bridges the governance frameworks of Health, Sport, and Youth Development.

3.2 *Occupational Health and Safety of Athletes*

The classification of athletes as workers is a matter of considerable legal complexity in Nigeria. Professional footballers in the Nigeria Professional Football League occupy a hybrid position. They are engaged under contracts that exhibit employment characteristics, yet sports governance has not fully incorporated them into the protective ambit of labour law and occupational health regulation.

The Employees' Compensation Act 2010, administered by the Nigeria Social Insurance Trust Fund, theoretically covers all employees in Nigeria, including professional athletes, given the broad statutory definition of "employee".[18] However, enforcement of occupational health and safety norms in Nigerian sports contexts is largely nominal. Football clubs routinely operate without on-site medical personnel, without adequate pitch safety standards, and without formalised injury management protocols meeting the requirements of the Factories Act.[19] That Act, which governs workplace health and safety, has never been systematically applied to sports facilities and training grounds. At the National Industrial Court of Nigeria (NICN), which exercises jurisdiction over occupational health and safety matters under Section 254c of the Constitution,[20] no decided case has yet systematically analysed the occupational health dimensions of athletes' employment. These indicate that there is a significant jurisprudential lacuna in matters of occupational health and safety of sportsmen and women.

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[16] S Loland and M McNamee, "Clean Sport, Athlete Rights, and the Significance of Anti-Doping Rules" (2019) 7 *International Journal of Sport Policy and Politics* 1, 9.

[17] "A Bill for an Act to Domesticate and Enforce in Nigeria the International Convention against Doping in Sports, Establish the Nigeria Anti-Doping Centre to implement Nigeria's obligation to the World Anti-Doping Code International Standards and for Related Matters, 2024" was signed into law by President Bola Tinubu in 2025. See: A Closer Look at Nigeria's New National Anti-Doping Law: The Nigeria Anti-Doping Act, 2025 - News Digest Accessed 2 May 2026.

[18] Employees' Compensation Act 2010, s 2 (definition of "employee"); s 7 (employer notification obligations to NSITF).

[19] Factories Act (Cap F1, LFN 2004), s 47 (health, safety and welfare requirements); s 2 (definition of "factory" which, on its proper construction, encompasses sports facilities with an engaged workforce).

[20] Constitution of the Federal Republic of Nigeria 1999 (Third Alteration) Amendment Act 2010, s 254C (conferring jurisdiction on the NICN over occupational health and safety matters).

3.3 *Sports Medicine, Healthcare Access, and the Right to Health*

Access to quality sports medicine sits at the cusp of health law and sports law. No specific statutory framework governs the practice of sports medicine as a specialty, the accreditation of sports medicine facilities, or the minimum medical standards applicable to sports events. The National Health Act 2014, in Section 1, establishes the right of every person to access healthcare services;[21] Section 20 mandates health establishments to ensure the availability of emergency medical treatment.[22] Applied to the sports context, these provisions impose obligations on event organisers, sports facilities, and sports regulatory bodies to ensure the availability of emergency medical care at sporting events. Stadium disasters that have occurred in Nigeria highlight the life-or-death importance of integrating NHA emergency care obligations into the operational requirements for sports event licensing.[23]

3.4 *Mental Health in Sport: A Neglected Intersection*

The mental health of athletes, an issue that has gained global prominence following high-profile disclosures by international sports figures, remains conspicuously absent from Nigeria's sports law framework. It appears not to have been recognised that mental health is as much a part of athletic welfare as physical fitness. The Mental Health Act 2021, enacted after decades of inadequacy under the colonial-era Lunacy Act, provides a modern statutory basis for mental health care in Nigeria.[24] Yet no linkage exists between this statute and the sports governance architecture.

This gap is particularly consequential given the well-documented mental health pressures experienced by athletes: performance anxiety, post-retirement adjustment disorders, the psychological sequelae of concussion, and the mental health impacts of sexual harassment and abuse. The IOC Mental Health Toolkit for Elite Athletes provides a normative template for integrating mental health protections into sports law frameworks.[25] Without legislative action, athletes remain without recourse to mental health protections within the sports governance system.

3.5 *Gender, Health, and Sports Law: Women Athletes and Reproductive Rights*

Women athletes face a constellation of health challenges inadequately addressed by either the health law or sports law frameworks operating in isolation. These include inadequate provision of gynaecological and reproductive healthcare at sports facilities, the health consequences of the Female Athlete Triad (low energy availability, low bone density, and menstrual disorder), the absence of maternity protection for professional sportswomen, and the discriminatory application of testosterone-based eligibility criteria.[26]

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[21] National Health Act 2014, s 1 (right of every person to access healthcare services).

[22] ibid, s 20 (emergency treatment obligation on health establishments).

[23] See: Inipami Prince Johnnie; Fidelis I. Emoh & Chinedu C. Nwachukwu, Assessment Of Safety Measures Adopted In The Management Of Selected Stadiums In South-South Nigeria. (2021) 9 International Journal of Innovative Scientific & Engineering Technologies Research 110-117;
<https://sportsvillagesquare.com/2019/08/13/its-40-years-since-nigerias-biggest-football-stadium-tragedy/> Accessed 16 April 2026.
Casualties averted as Lagos stadium floodlights collapse. Accessed 16 April 2026.

[24] Mental Health Act 2021, s 5 (rights of persons with mental health conditions); s 14 (prohibition of discrimination in the provision of mental health services).

[25] International Olympic Committee, *IOC Mental Health in Elite Athletes Toolkit* (IOC 2021) Available at IOC-Mental-Health-In-Elite-Athletes-Toolkit-2021.pdf Accessed 2 May 2026.

[26] See IOC Consensus Statement on Sexual Harassment and Abuse in Sport (2016). Available at The IOC Consensus Statement: harassment and abuse (non-accidental violence) in sport. Accessed 2 May 2026.

The Gender and Equal Opportunities Bill[27] and the Violence Against Persons (Prohibition) Act 2015[28] provide instruments for addressing some of these concerns. Nigeria's obligations under CEDAW (Convention on the Elimination of All Forms of Discrimination against Women) and the Maputo Protocol create a binding human rights mandate for the protection of women athletes' health rights.[29] A fully integrated health-sports law framework must address these gendered dimensions explicitly and systematically.

4. Intersectoral Collaboration and Population Health: Theoretical and Practical Dimensions

4.1 *The Health in All Policies Framework and Its Legal Implications*

The concept of intersectoral collaboration for health has its intellectual roots in the Declaration of Alma-Ata (1978), which recognised that health improvement requires action across multiple sectors beyond the traditional health sector.[30] This recognition gave rise to the Health in All Policies (HiAP) approach, formally articulated in the Adelaide Statement on Health in All Policies and subsequently embedded in the Sustainable Development Goals.[31,32] The Yoruba proverb *Àgbàdo kan kò lè dún ni ẹkọ* ("A single corn cannot make a pot of pap") captures the essential epistemological point: a single ingredient (or a legal instrument) cannot alone produce the nourishment that population health demands. Just as pap requires multiple corns ground together, so too does a healthy nation require the grinding together of multiple legal and policy instruments.

The legal expression of HiAP typically takes three forms: mandatory cross-sectoral impact assessments in legislation, statutory coordination mechanisms between health and other sectoral authorities, and the embedding of health-protective standards within non-health sector legislation. Enforceable obligations help to support effective and sustainable implementation of HiAP.[33] Nigeria has taken preliminary steps in this direction: the National Health Act 2014, Section 3, provides for a health impact assessment requirement for policies and programmes.[34] However, this provision has not been operationalised through enabling regulations, and it appears that a statutory health impact assessment has not featured in the country's sports policy, facility development projects, and sports legislation.

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[27] NigeriaGenderAndEqualOpportunitiesBill2016_English.pdf Accessed 2 May 2026. Not yet enacted at the time of writing.

[28] Violence Against Persons (Prohibition) Act 2015, ss 1–4 (defining and criminalising sexual violence, harmful practices, and harassment). Available at VIOLENCE AGAINST PERSONS (PROHIBITION) ACT, 2015 - Law Nigeria. Accessed 2 May 2026.

[29] Convention on the Elimination of All Forms of Discrimination Against Women (adopted 18 December 1979) 1249 UNTS 13, art 12 (right of women to healthcare on equal terms with men). Available at Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979 | OHCHR, Accessed 2 May 2026; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol, adopted 11 July 2003) OAU Doc CAB/LEG/66.6, art 14 (health and reproductive rights). 37077-treaty-charter_on_rights_of_women_in_africa.pdf; Accessed 2 May 2026.

[30] Declaration of Alma-Ata on Primary Health Care (adopted 12 September 1978) WHO/UNICEF, para VII (emphasising multi-sectoral action as essential to health).

[31] Adelaide Statement on Health in All Policies (WHO and Government of South Australia, 2010) 1–2. See also: WHO, (2019) Adelaide Statement II on Health in All Policies. Available at Adelaide Statement II on Health in All Policies Accessed 2 May 2026.

[32] UN General Assembly, Transforming Our World: The 2030 Agenda for Sustainable Development (adopted 25 September 2015) UN Doc A/RES/70/1, SDGs 3 (Good Health and Well-Being) and 17 (Partnerships for the Goals).

[33] Dawn Pepin, Benjamin D Winig, Derek Carr, Peter D Jacobson. Collaborating for Health: Health in All Policies and the Law. (2017) 45(1 Suppl) J Law Med Ethics 60. doi: 10.1177/1073110517703327

[34] National Health Act 2014, s 3 (health impact assessment requirement for policies and programmes).

4.2 *How the Health Law-Sports Law Intersection Exemplifies Intersectoral Collaboration*

The intersection of health law and sports law in Nigeria exemplifies intersectoral collaboration in four principal dimensions: institutional, normative, operational, and financial.

In the institutional dimension, effective health-sports law integration requires formal inter-agency coordination between the Federal Ministry of Health and Social Welfare, the National Sports Commission, the NADC, the National Primary Health Care Development Agency, and the National Health Insurance Authority. Existing statutory provisions create limited coordination mandates, but a comprehensive statutory framework is required.

In the normative dimension, health law norms (the right to health, occupational health standards, consent, non-discrimination, and patient confidentiality) should be imported into the sports law framework through cross-referencing statutory provisions, regulatory guidelines, and standard-form contractual clauses. This ensures that sports governance is health-rights-compliant by design rather than by accident.

In the operational dimension, joint operational programmes between sports and health agencies could translate intersectoral legal mandates into concrete health outcomes. Examples of such joint working include shared medical databases, co-located health services at national sports institutes, and collaborative public health campaigns leveraging sport. Experience with sport-for-health initiatives, including the use of football stadia for mass vaccination campaigns, demonstrates the untapped potential of this dimension.

In the financial dimension, the financing of sports health services requires coordinated investment from both sectors. The Basic Health Care Provision Fund, established under Section 11 of the NHA 2014[35] and the NHIA's benefit packages, should be explicitly extended to cover sports-related health interventions. The revenue provisions in sports legislation should include dedicated health and welfare levies on commercial sports activities.

4.3 *Sport as a Social Determinant of Health and Population Health Promoter*

Physical inactivity is responsible for an estimated 3.2 million deaths annually and is a major risk factor for non-communicable diseases, including cardiovascular disease, type 2 diabetes, certain cancers, and depression.[36,37] In Nigeria, the rising burden of non-communicable diseases alongside persistent communicable disease challenges makes the promotion of physical activity through sport a public health imperative of the first order.[38] The law that sustains the athlete's body is the same law that sustains the national capacity for sporting excellence.

Legal frameworks that support accessible, safe, and inclusive sporting participation, therefore, constitute instruments of population health promotion. Legislation mandating physical education in school curricula, zoning laws requiring recreational space in urban developments, and anti-discrimination laws ensuring access to sport for persons with disabilities, all of which are distributed across education law, planning law, and disability law, contribute to the social determinants of sporting participation and thereby to population health. The integration of a population health perspective into sport legislation, framing sport not merely as a social, cultural

[35] National Health Act 2014, s 11 (Basic Health Care Provision Fund); s 11(4) (disbursement for primary health care).

[36] WHO, Global Action Plan on Physical Activity 2018–2030: More Active People for a Healthier World (WHO Press, Geneva 2018) 12. Available at Global action plan on physical activity 2018–2030: more active people for a healthier world. Accessed 2 May 2026.

[37] I-M Lee and others, Effect of Physical Inactivity on Major Non-Communicable Diseases Worldwide. (2012) 380 *The Lancet* 219, 225.

[38] WHO, Country Disease Outlook. Nigeria . 2023. Nigeria.pdf Accessed 2 May 2026.

or commercial activity but as a public health infrastructure, would represent a paradigm shift in Nigerian sports governance.

5. Health Law in a Proposed Sports Governance Bill: Analysis and Recommendations

5.1 *Proposal for a Sports Governance Bill*

In 2022 the Federal Executive Council approved a National Sports Industry Policy (NSIP).[39] The following year, the then Minister of Sports Development, Senator John Owan Enoh, announced the new government's decision to implement the policy.[40] The publicly available draft version of the policy addresses a range of 'policy thrust areas'.[41] These include Federations and Athletes' Development; Sports and Education; Sport and Health; Sports Capacity Development and Training; Sports, Inclusivity and Social Development in the Community; Sports Facilities and Infrastructure; Sports for Economic Development; Sports, Legislative Environment and International Relations; Funding, Finance and Investment for Sports; Sports and the Digital Economy. The section on Sport and Health acknowledged that there was 'no coherent initiative, regulation, or legislation to encourage mass participation in sports through fitness and recreation as part of developing a healthy lifestyle among the citizenry', and lamented the 'gaps in regulatory mechanisms to support athletes development as well as the practice of Sports Science and Sports Medicine'.[42]

From a health law perspective, the NSIP presents a mixed and largely inadequate engagement with athlete health and population health concerns. Whilst it contains provisions addressing anti-doping, event safety, and welfare standards for professional athletes, these provisions are poorly integrated with the health law framework and subordinated to commercial and governance concerns.[43] The NSIP offers a promising foundation but has significant lacunae.

To build on the foundation and address the lacunae, this paper proposes the articulation of a Nigerian National Sports Governance Bill (NNSGB). The proposed Bill would represent the most ambitious legislative effort to restructure sports governance in Nigeria's sporting history. The Bill should seek to consolidate and modernise the regulatory framework for Nigerian sport, create licensing regimes for sports organisations and events, regulate sports agents and intermediaries, establish dispute resolution mechanisms, and create commercial and fiscal incentives for sports investment. The NNSGB would draw comparative inspiration from similar legislation elsewhere, such as South Africa's National Sport and Recreation Act 1998, Kenya's Sports Act 2013 and Namibia's Sports Act 2023.[44] The extant National Sports Commission Act could be repealed and its contents incorporated in the NNSGB. Alternatively, the NNSGB could cross-reference the National Sports Commission Act.

5.2 *Athlete Welfare Provisions: Strengths and Weaknesses*

The Bill's athlete welfare provisions would establish a minimum standard of care, including requirements for adequate medical examination prior to competition, minimum standards for

[39] The Sun, 3 November 2022. FEC approves National Sports Industry Policy Accessed 22 April 2026.

[40] Vanguard, 14 October 2023. FG set to implement National Sports Industry policy - Vanguard News Accessed 22 April 2026.

[41] Draft 2020 National Sports Industry Policy. Available at NEW NSIP LAYOUT INNER.cdr Accessed 22 April 2026.

[42] Ibid.

[43] The target is to establish a thriving Sports industry that contributes 5% to the nation's GDP, with annual net revenue of $3-4 billion by 2027. See The National Sports Commission | LinkedIn Accessed 30 April 2026.

[44] See National Sport and Recreation Act 1998 (South Africa), s 18 (transformation and equity). Available at National Sport and Recreation Act, 1998 – LawLibrary, Accessed 3 May 2026; Sports Act - Kenya Law, Accessed 3 May 2026; Namibia Sports Act 2023, Accessed 3 May 2026.

medical facilities at sports events, and a prohibition on the compulsion to compete while injured. These provisions should be extended to meet the occupational health standards applicable in comparable employment contexts under the Employees' Compensation Act.[45]

The NNSGB should establish mandatory health insurance coverage for athletes, compelling compliance with existing insurance obligations. It should create a right to independent medical advice, as this is essential for protecting athletes from pressure to conceal injuries. It should address the health consequences of overtraining and burnout, particularly in youth sport. It should create long-term health monitoring obligations, so that post-career health consequences such as chronic traumatic encephalopathy in contact sports are adequately addressed.

5.3 *Sports Facility Standards and Public Health Infrastructure*

Sports facilities are public spaces of considerable health significance: sites of mass gathering (raising communicable disease transmission risks), venues for physical activity (with inherent injury potential), and increasingly nodes in urban health infrastructure. The NNSGB should require that licence applications by sports facilities include a health impact assessment conducted in accordance with guidelines jointly issued by the National Sports Commission and the Federal Ministry of Health and Social Welfare.

Sports facilities also offer unique opportunities to serve as integrated public health hubs, providing health screening, vaccination points, and health promotion activities to surrounding communities. The Bill should contain enabling provisions for the National Sports Commission to enter memoranda of understanding with health authorities for the joint use of sports facilities as public health infrastructure, particularly in underserved communities, drawing on the NHS–Sport England partnership framework.[46]

5.4 *Anti-Doping, Medical Ethics, and Consent in the Bill*

The NNSGB's anti-doping provisions should cross-reference the NADC Act, to avoid legislative duplication. However, the Bill should further address the medical ethics dimensions of anti-doping governance that the NADC Act does not fully capture. In particular, the Bill should provide that anti-doping testing is conducted in conformity with the principles of medical ethics embodied in the Medical and Dental Practitioners Act, including the principles of consent, confidentiality, and the prohibition of harmful procedures conducted without therapeutic justification.

The confidentiality of medical information submitted in Therapeutic Use Exemption (TUE) applications must be protected by reference to health law confidentiality standards under both the National Health Act 2014 and the Data Protection Act 2023. The NNSGB should explicitly incorporate these protections, ensuring that sports regulators handling medical information are treated as "data controllers" with obligations equivalent to those of health establishments.[47]

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[45] Employees' Compensation Act 2010, s 56 (Employees' Compensation Fund);

[46] Sport England and NHS England, "Joint Strategy for Sport and Physical Activity as a Health Intervention" (Sport England 2020) Unlocking the power of movement in the NHS | Sport England. Accessed 3 May 2026.

[47] Data Protection Act 2023, s 24 (obligations of data controllers). Available at Resources – Nigeria Data Protection Commission, Accessed 3 May 2026; National Health Act 2014, s 26 (patient confidentiality in health records). Available at National Health Act 2014_Gazetted.pdf - Google Drive,. Accessed 3 May 2026..

5.5 *The Sports Health and Welfare Fund: A Proposed Legislative Innovation*

Drawing inspiration from the Basic Health Care Provision Fund established under Section 11 of the National Health Act 2014,[48] this paper recommends that the proposed NNSGB establish a dedicated Sports Health and Welfare Fund (SHWF). The SHWF would be financed by a statutory levy on commercial sports broadcasting rights and media contracts; a percentage of proceeds from sports betting and gaming operators; direct appropriations from the National Sports Commission budget; and voluntary contributions from sports organisations and private sector entities.[49]

The SHWF would be applied to health insurance and medical care for athletes lacking NHIA coverage; construction and upgrading of sports medicine facilities at national and state institutes; funding of sports health research, including longitudinal studies of athlete health outcomes; mental health support services for athletes; and health promotion programmes leveraging sport as a vehicle for public education on prevention of non-communicable disease. The governance of the SHWF should include representation from the Federal Ministry of Health and Social Welfare, the Federal Ministry of Budget and Economic Planning, and the Federal Ministry of Finance, to ensure that expenditures align with national health priorities.

5.6 Safe Sport, Child Protection, and the Health Rights of Young Athletes

The safety and health of child athletes demand explicit legislative attention in the NNSGB. The Child Rights Act 2003 imposes a duty on the State and all persons dealing with children to act in the best interests of the child.[50] The National Health Act 2014 separately protects children's health rights. Yet neither statute contains sports-specific provisions adequate to address the unique vulnerabilities of child athletes. The law must express the community's protective obligation towards its youngest and most vulnerable sporting participants.

The NNSGB should incorporate a statutory Safe Sport Code as a mandatory compliance requirement for all sports organisations engaging with minors. This Code would draw on the United States Center for SafeSport model and Council of Europe standards.[51] It should address the minimum age and health requirements for competitive participation; pre-participation medical examinations by certified practitioners; limits on training loads and competition frequency for youth athletes; mandatory safeguarding training for coaches; and whistleblowing protections for those reporting abuse or welfare concerns.[52]

6. *Reform Recommendations: Towards an Integrated Health-Sports Law Architecture*

No single ministry, regulator, or statute can alone achieve the integration demanded by the evidence and the constitution. The following reform recommendations embody this principle, each requiring the coordinated exercise of authority across the health law and sports law domains.

1. **Health Impact Assessment Mandate:** The proposed NNSIB should mandate health impact assessments for all major sports policies, sports facility developments, and

[48] National Health Act 2014, s11. Available at National Health Act 2014_Gazetted.pdf - Google Drive. Accessed 3 May 2026.

[49] See Sport England and NHS England, Joint Strategy for Sport and Physical Activity as a Health Intervention. Unlocking the power of movement in the NHS | Sport England Accessed 30 April 2026.

[50] Child Rights Act 2003, s 1 (best interests of the child as primary consideration); s 11 (right to health and healthcare).

[51] United States Center for SafeSport, SafeSport Code for the U.S. Olympic and Paralympic Movement. 2024 SafeSport Code - Second Edition; Accessed 30 April 2026. Council of Europe Recommendation CM/Rec(2020)2 on Safeguarding Children in Sport. Resource centre - Child Safeguarding in Sport Accessed 30 April 2026.

[52] See IOC Safe Sport Initiatives - Official Olympic Documents Accessed 30 April 2026.

sports events, consistent with Section 3 of the National Health Act 2014.[53] The National Sports Commission should be required to consult the Federal Ministry of Health and Social Welfare in the conduct of these assessments.

2. **Statutory Multi-Sectoral Coordination Body:** Establish a Sports Health Advisory Council within the National Sports Commission, with statutory membership from the Federal Ministry of Health and Social Welfare, the Federal Ministry of Education, NHIA, NADC, NPHCDA, the Medical and Dental Council of Nigeria, athletes' associations, and civil society.
3. **Mandatory Athlete Health Insurance:** Require all commercially operating sports organisations to provide comprehensive health insurance for their athletes under NHIA-accredited schemes. Establish an Athletes' Health Insurance Guarantee Fund, modelled on the Employees' Compensation scheme,[54] to cover uninsured athletes.
4. **Sports Facility Health Standards:** Incorporate binding health and safety standards for sports facilities in the licencing framework, developed jointly by the National Sports Commission and relevant health regulatory bodies. Designate sports facilities as dual-use public health infrastructure eligible for health sector investment and programming.
5. **Mental Health Provisions:** Include explicit provisions in the NNSIB for athlete mental health support, requiring sports organisations to provide access to qualified mental health professionals and prohibiting stigmatisation of athletes seeking mental health treatment.[55] Cross-reference applicable provisions of the Mental Health Act 2021.
6. **Safe Sport Code and Child Protection:** Make compliance with a statutory Safe Sport Code a mandatory condition for recognition and licencing of all sports organisations engaging with minors. The Code should carry criminal sanctions for serious violations under the Child Rights Act 2003.
7. **Sports Health and Welfare Fund:** Establish the SHWF as proposed in section 5.5 above, with ring-fenced financing from commercial sports revenues, governed by a board with health sector representation, and subject to National Assembly oversight.
8. **National Sports and Health Research Agenda:** Mandate the National Sports Commission, in collaboration with the National Institute for Sports and the Nigerian Institute of Medical Research, to develop and fund a national research agenda on the health dimensions of sport, including epidemiological studies of injury patterns, mental health outcomes, and the population health benefits of sporting participation.

7. Conclusion

The intersection of health law and sports law in Nigeria is both intellectually rich and practically consequential. It reveals the inadequacy of siloed legal thinking in addressing the complex, multi-dimensional challenges of contemporary sports governance and public health. Athletes are workers, performers, and public health subjects simultaneously; sporting events are commercial spectacles, cultural celebrations, and epidemiological gatherings simultaneously; sports facilities

[53] Ibid

[54] The Employee Compensation Scheme in Nigeria, by virtue of the Employee Compensation Act of 2010, provides a comprehensive framework for compensating employees who suffer workplace injuries, disabilities, or occupational diseases.

[55] Mental Health Act 2021, ss 12–13 (prohibition of stigmatisation and discrimination against persons with mental health conditions).

are private investments, public infrastructure, and community health resources simultaneously. Law, to effectively regulate these realities, must be as multi-dimensional as the phenomena it governs.

The intersection of health and sports law in Nigeria exemplifies, in both its achievements and its failures, the promise and the challenges of intersectoral collaboration as a modality of governance for population health. Where institutional mechanisms, normative integration, operational collaboration, and financial alignment have been achieved (however imperfectly, as in anti-doping governance) the results demonstrate the potential of a coherent health-sports law framework. Where these elements are absent (in occupational health enforcement, mental health provision, and women's health protection) the consequences for athletes and for the broader population are tangible and unacceptable.

The proposed Nigerian National Sports Governance Bill would stand at a legislative inflection point. It could replicate the fragmented, health-indifferent approach of its predecessors, or it can pioneer an integrated, rights-based, health-oriented architecture that positions Nigerian sport as a genuine contributor to national health and wellbeing. The reform recommendations advanced in this paper provide a practical roadmap for the latter path.

Ultimately, the integration of health law within sports law is not a peripheral technical matter. It is a constitutional imperative, a human rights obligation, a public health necessity, and an investment in Nigeria's human capital. The Yoruba proverb *"Ọpẹ̀lẹ̀ tó bá fẹ́ gbéra gòkè, ó gbọ̀ dọ̀ fi igi ẹlòmíràn gbéra"* ("The climbing plant that wishes to grow tall must lean upon another's tree") distils the animating philosophy of this paper: the law of sport, if it is to reach its highest potential in service of athletes and communities, must lean upon the tree of health law, drawing from its roots, climbing along its branches, and flowering in the canopy of a governance architecture worthy of the nation's sporting tradition and constitutional commitments. Nigerian athletes, the nation's most visible ambassadors and among its most physically vulnerable workers, deserve no less.