RETHINKING WOMEN'S BODILY AUTONOMY IN NIGERIAN HEALTHCARE: A FEMINIST LEGAL THEORY ANALYSIS

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Abstract

Healthcare autonomy, the inherent right of adults with capacity to make informed choices about their own medical decisions represents a fundamental principle of contemporary medical law and bioethics. For women in Nigeria, this right is never exercised in isolation as it is often shaped by family dynamics, community expectations and economic constraints. This paper examines bodily healthcare autonomy for women in Nigeria via a feminist legal theory lens. It posits that existing liberal autonomy frameworks embedded in Nigerian healthcare law inadequately protect women's healthcare self-determination as this framework, while appearing universal and protective, embody distinctly masculine assumptions about personhood and decision-making. The paper proposes the relational autonomy theory to Nigerian healthcare contexts, arguing that protecting women's healthcare autonomy requires not only gender-neutral consent laws but gender-responsive frameworks implementing affirmative measures to address structural barriers and economic constraints for Nigerian women.

Keywords: Women's healthcare autonomy, informed consent, relational autonomy

1.0 INTRODUCTION

Healthcare autonomy describes the entitlement or competence of rational individuals to independently decide on matters concerning their medical treatment based on adequate knowledge and understanding.[611] Healthcare autonomy has always been a cornerstone of modern medical law and bioethics. In *Re T (Adult)*, Lord Donaldson articulated this principle with particular clarity: "An adult patient who... suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment... This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent."[612] This robust articulation establishes healthcare autonomy as encompassing more than the formal right to consent to or refuse treatment; it requires the substantive capacity for self-determination within healthcare relationships, including the ability to participate meaningfully in medical decision-making, to have one's values and preferences respected, and to make choices free from undue influence or structural coercion.

Autonomy in healthcare is never exercised in isolation. It is fundamentally relational, shaped by family dynamics, community expectations, economic constraints, and broader systems of power and privilege.[613] The achievement of genuine healthcare autonomy proves particularly complex for women, whose medical decision-making occurs within intersecting systems of gender, cultural, and economic subordination. Bodily autonomy becomes situated within contexts where women's agency is systematically constrained by patriarchal structures, cultural expectations, and economic dependencies, raising urgent questions about the gap between formal legal protections and substantive self-determination.[614]

The Nigerian healthcare context presents a particularly compelling case study for examining these tensions. While Nigeria has established formal legal protections for healthcare autonomy through constitutional provisions guaranteeing dignity and bodily integrity,[615] statutory frameworks

[611] General Medical Council, *Consent: Patients and Doctors Making Decisions Together* (2008) para 3.
[612] *Re T (Adult)* (1992) 4 All ER 649 at 652–653.
[613] C Mackenzie,"Relational Autonomy, Normative Authority and Perfectionism" (2008) 39(4) *Journal of Social Philosophy* 512.
[614] P E Osamor and C Grady, "Women's autonomy in health care decision-making in developing countries: A synthesis of the literature" (2016) 8 *International Journal of Women's Health* 191.
[615] Constitution of the Federal Republic of Nigeria 1999 (as amended), ss 34-38.

including the National Health Act 2014,[616] and international human rights obligations under instruments including the Convention on the Elimination of All Forms of Discrimination Against Women[617] and the African Charter on Human and Peoples' Rights,[618] reveals a profound implementation deficit. The 2024 Nigeria Demographic and Health Survey documented that only about 20 percent of currently married women reported making their own healthcare decisions independently, while about 56 percent indicated decisions were made mainly by their husbands, and 49 percent reported joint decision-making.[619] These statistics expose a significant disconnect between formal legal rights and lived reality, suggesting that existing legal frameworks fail to protect women's genuine self-determination in medical contexts.

This article examines how liberal autonomy frameworks embedded in Nigerian healthcare law inadequately protect women's healthcare self-determination. Traditional healthcare law conceptualises bodily autonomy through the lens of liberal political theory, emphasising individual rational choice free from external interference.[620] This framework, exemplified in landmark cases such as *Schloendorff v Society of New York Hospital*,[621] establishes that competent adults possess an absolute right to accept or refuse medical treatment based on personal preferences. The doctrine of informed consent operationalises this principle by requiring that patients possess decision-making capacity, adequate information about proposed treatment, and voluntariness understood as freedom from coercion or undue influence.[622]

However, feminist legal scholars argue that these principles, while appearing universal and protective, embody distinctly masculine assumptions about personhood and decision-making. Liberal theorists have developed their conceptions of autonomy at some distance from those attributes of human subjects, such as emotional or relational interdependence and strong gender-

[616] National Health Act 2014, s 11.
[617] Convention on the Elimination of All Forms of Discrimination Against Women, GA Res 34/180, UN GAOR, 34th Sess, Supp No 46, UN Doc A/34/46 (1979), art 12.
[618] African Charter on Human and Peoples' Rights, OAU Doc CAB/LEG/67/3 rev 5 (1981), art 16.
[619] National Population Commission (NPC) [Nigeria] and ICF *Nigeria Demographic and Health Survey 2024* (2024, NPC and ICF) at 357 <https://dhsprogram.com.pdf//FR395> accessed 27 April 2026

[620] J Feinberg, Autonomy' in J Christman (ed), *The Inner Citadel: Essays on Individual Autonomy* (Oxford University Press, 1989) 27 at 35.

[621] *Schloendorff v Society of New York Hospital* (1914) 105 NE 92 (NY).
[622] T L Beauchamp and J F Childress, *Principles of Biomedical Ethics* (6th edn, Oxford University Press 2009) 99.

related socialisation, that bear heavily on the lives of women.[623] This theoretical distance becomes problematic when legal doctrine fails to recognise how women's choices are shaped by social relationships, economic dependencies, and internalised gender norms. Liberal autonomy's primary focus appears to be defining with conceptual clarity an ideal state for whatever subjects are able to attain it, rather than examining by whom, or how, said autonomy is to be achieved.[624]

Nigeria's multi-ethnic and multi-religious nature intensifies these complexities. Traditional African philosophical frameworks emphasise communal interdependence and collective decision-making, challenging western individualistic approaches to consent.[625] However, these communal structures intersect with patriarchal power relations that systematically subordinate women's agency to male authority and family interests[626]. In healthcare contexts, this manifests as patterns where women's medical decisions are mediated by husbands, fathers, or elders, particularly regarding reproductive health, childbirth, and surgical procedures. While such decision-making might appear consistent with African communal values, feminist analysis reveals how these practices often reflect and reinforce gender hierarchies rather than genuine community care.[627] The tension between communal values and women's individual rights creates what feminist theorists term "the paradox of oppressive choices", situations where respecting women's stated preferences may actually legitimise their subordination.[628] For instance, when a woman refuses life-saving medical care because her husband objects on religious grounds, liberal autonomy theory would typically respect her choice if she demonstrates capacity and understanding. However, feminist theory examines whether this choice reflects genuine self-determination or adaptive preference formation under conditions of gender oppression. Adaptive preferences refer to situations where individuals

[623] .K Abrams, “From autonomy to agency: Feminist perspectives on self-direction” (1999) 40 *William and Mary Law Review* 805 at 815
[624] P Benson, “Feminist intuitions and the normative substance of autonomy” in J S Taylor (ed), *Personal Autonomy: New Essays on Personal Autonomy and its Role in Contemporary Moral Philosophy* (Cambridge University Press 2005) 124 at 130
[625] G B Tangwa, “Informed consent: Communalism and the many senses of autonomy” (2007) 7(3) *Developing World Bioethics.*
[626] T R Ibitoye and F O Ajagunna, “Sexual autonomy and violence against women in Nigeria: assessing the impact of the COVID-19 pandemic on women in Nigeria” (2021) *De Jure Law Journal* 141–159.
[627] E Durojaye "Woman but not human: Widowhood practices and human rights violations in Nigeria" (2013) 27(2) *International Journal of Law, Policy and the Family* 176.
[628] S J Khader "Must theorising about adaptive preferences deny women's agency?" (2012) 29 *Journal of Applied Philosophy* 302.

develop desires and values that accommodate oppressive circumstances rather than challenging them.[629]

This article advances three central arguments. First, it demonstrates that Nigeria's current legal framework employs a liberal autonomy model that assesses cognitive capacity and direct coercion but systematically ignores subtler constraints including threats of family abandonment, social ostracism for violating gender norms, economic dependency, and internalised beliefs that lead women to devalue their own health and wellbeing. Second, it applies relational autonomy theory, developed by feminist scholars including Catriona Mackenzie and Natalie Stoljar,[630] to Nigerian healthcare contexts, arguing that autonomy should be reconceptualised as constituted through social relationships rather than independence from them. This reconceptualization distinguishes autonomy-supporting relationships characterised by mutual respect and recognition from autonomy-undermining relationships marked by domination and control.[631] Third, it proposes legal reforms that move beyond formal equality to substantive equality, recognising that protecting women's healthcare autonomy requires not gender-neutral consent laws but gender-responsive frameworks implementing affirmative measures to address structural barriers.[632]

The analysis proceeds from the premise that law plays both constitutive and transformative roles in social change. While legal reforms alone cannot dismantle deeply entrenched patriarchal structures, they can create conditions enabling women to exercise genuine self-determination, establish accountability mechanisms for autonomy violations, and contribute to gradual normative shifts wherein healthcare autonomy becomes social expectation rather than privilege. The moral imperative of healthcare autonomy as essential to human dignity, gender equality, and health justice demands nothing less than transformative legal change grounded in empirical evidence, theoretical sophistication, and commitment to substantive equality.[633]

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[629] B Colburn "Autonomy and adaptive preferences" (2011) 23 *Utilitas* 52 at 60.
[630] C Mackenzie and N Stoljar (eds) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency and the Social Self* (2000, Oxford University Press).
[631] C Mackenzie "Three dimensions of autonomy: A relational analysis" in A Veltman and M Piper (eds) *Autonomy, Oppression and Gender* (Oxford University Press 2014) 15 at 25.
[632] S Fredman "Substantive equality revisited" (2016) 14/3 *International Journal of Constitutional Law* 712.
[633] FO Ajagunna “Informed consent and ethical considerations in assisted reproductive technology in Nigeria” in O Adelakun and E Ndoni (eds) *Reproductive Health Rights, Tourism and Assisted Reproductive Technologies in Africa* (Palgrave Macmillan Publishing Ltd 2023).

2.0 DOMESTIC AND INTERNATIONAL LEGAL FRAMEWORK FOR HEALTHCARE AUTONOMY

2.1 Constitutional and statutory framework

The legal architecture that governs healthcare autonomy in Nigeria comprises of multiple layers of constitutional, statutory, and regulatory instruments that interact in complex and sometimes contradictory ways. This section examines the foundational legal framework that explains both the formal guarantees of healthcare rights and the systemic limitations that particularly affect women's autonomous decision-making in medical contexts, in Nigeria and Africa at large.

2.2 Constitutional provisions: Right to life, dignity, and healthcare

The 1999 Constitution of the Federal Republic of Nigeria (as amended) establishes fundamental rights that form the foundation of healthcare autonomy claims, even though these provisions remain notably silent on explicit healthcare entitlements. Section 33(1) guarantees that *"every person has a right to life, and no one shall be deprived intentionally of his life,"* while Section 34(1) protects "*the dignity of the human person"* and prohibits torture, inhuman, or degrading treatment[634]. In addition, S17(3)(d) of the Constitution provides that the Nigerian State shall direct its policy towards ensuring that there are adequate medical and health facilities for every Nigerian. All these provisions create an implicit constitutional foundation for healthcare rights, though Nigerian courts have historically adopted restrictive interpretations that limit their applicability to medical decision-making contexts.

2.3 National Health Act 2014: Informed Consent Provisions and Limitations

The National Health Act 2014[635] represents Nigeria's most comprehensive statutory intervention in healthcare regulation thus far. It marks a significant legislative milestone after several years of advocacy.[636] Section 11 of the Act explicitly addresses consent requirements, providing that "every person attending a health establishment or using health services has the right to participate in any

[634] Federal Republic of Nigeria (1999). *Constitution of the Federal Republic of Nigeria* 1999 (as amended). Lagos: Federal Government Press.
[635] National Health Act 2014 (Federal Republic of Nigeria Official Gazette Vol 101 No 122).
[636] O Enabulele and JE Enabulele "Nigeria's National Health Act: An assessment of health professionals' knowledge and perception" (2016) 57(5) *Nigerian Medical Journal* 260–265 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5036296/> accessed 24 September 2025
[636] O Okojie "Emergency care and consent requirements under the National Health Act: implementation challenges in Nigerian hospitals." *Nigerian Medical Journal*, 62(4), 201-210.

decision affecting his or her personal health and treatment". This provision ostensibly enforces patient autonomy as a statutory right that requires healthcare providers to obtain informed consent before treatment except in narrowly defined emergencies. However, the Act's informed consent framework contains limitations that compromise its protective potential. Section 11(3) for example, permits treatment without consent in emergency situations where the patient is unable to give consent and no legally authorised representative is available, but fails to establish clear criteria for assessing capacity or defining emergency circumstances. This ambiguity creates latitude for healthcare providers to invoke emergency exceptions expansively, particularly in situations where patriarchal medical cultures presume women's decisional incapacity. Furthermore, Section 11(4) allows healthcare providers to treat patients without consent when "failing to treat would endanger the life of the patient or the life of another person. This provision is susceptible to paternalistic application that subordinates patient autonomy to provider judgment[637] While this exception is grounded in the need to respond swiftly to emergencies and preserve life, its broad wording creates room for discretionary interpretation by medical practitioners. In practice, this may lead to situations where healthcare providers override a competent patient's expressed wishes on the basis of their own assessment of what is medically necessary or beneficial. As a result, this provision is vulnerable to paternalistic application, in which the professional judgment of the provider is elevated above the patient's right to make informed decisions about their own body and treatment. This suggests a situation wherein subjective clinical opinions are used to justify interventions without sufficient regard for the patient's preferences, values, or previously stated choices.

2.4 Medical and Dental Practitioners Act: Professional obligations and patient rights

The Medical and Dental Practitioners Act (Cap M8 LFN 2004) establishes the regulatory framework for medical practice in Nigeria. It empowers the Medical and Dental Council of Nigeria (MDCN) to regulate professional conduct and maintain professional standards. The Act's provisions on patient rights and professional obligations remain notably sparse, and only reflects its primary focus on practitioner registration and disciplinary processes rather than patient protection[638]

[637] P Osamor & C Grady "Women's autonomy in health care decision-making in developing countries: a synthesis of the literature" (2016) *International Journal of Women's Health*, 8, 191-202. https://www.dovepress.com/international-journal-of-womens-health-journal DOI: 10.2147/IJWH.S105483 [Accessed 19 September 2025]
[638] Medical and Dental Practitioners Act Cap M8 Laws of the Federation of Nigeria 2004.

Section 16 empowers the MDCN to determine what constitutes professional misconduct, and the Council has promulgated a Code of Medical Ethics that includes consent-related obligations. The Act's disciplinary provisions exemplify this practitioner-centric orientation. Section 16(2) enumerates grounds for disciplinary proceedings, including "infamous conduct in a professional respect" and conduct "which in the opinion of the Tribunal is infamous in a professional respect," but the consent violations are not explicitly identified as sanctionable offences. The Act's gender-blindness represents another critical limitation. No provisions address the particular vulnerabilities women face in healthcare settings or establish heightened protections for reproductive healthcare contexts where autonomy violations are most prevalent.[639] The regulatory framework treats all patients as juridically identical, failing to acknowledge how gendered power dynamics structure clinical encounters and compromise women's capacity for autonomous decision-making[640]. This formalistic equality approach perpetuates what feminist legal theorists identify as "autonomy deficits," which refers to structural conditions that systematically undermine particular groups' capacity for self-determination[641].

2.5 State health laws and their variations

Nigeria's federal structure permits states to enact health legislation addressing matters within their competence which has over the years, resulted in significant jurisdictional variation in healthcare regulation. Several states have enacted health services laws establishing consent requirements, patient rights charters, and healthcare governance frameworks that supplement federal statutory provisions. Although, this legislative diversity has produced a fragmented and inconsistent regulatory landscape that complicates healthcare autonomy protection[642]

Lagos State's Health Scheme Law (2015) exemplifies progressive state-level legislation, establishing a patients' charter that explicitly recognizes rights to informed consent, confidentiality,

[639] T R Ibitoye and FO Ajagunna "Sexual autonomy and violence against women in Nigeria: assessing the impact of the COVID-19 pandemic on women in Nigeria" (2021) *De Jure Law Journal* 141–159.
[640] T Okeke and P Agu "Gender blindness in Nigerian healthcare regulation: feminist critique of the Medical and Dental Practitioners Act" (2019) 19(4) *Developing World Bioethics* 234–245
[641] J Nedelsky 'Reconceiving autonomy: sources, thoughts and possibilities' (2019) 1(1) *Yale Journal of Law and Feminism* 7–36 <https://digitalcommons.law.yale.edu/yjlf/vol1/iss1/5/> accessed 23 September 2025
[642] Uneke et al 'Development of health policy and systems research in Nigeria: lessons for developing countries' evidence-based health policy making process and practice' (2010) 6(1) *Healthcare Policy* e109–e126 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2999804/> accessed 24 September 2025.

and participation in treatment decisions.[643] Conversely, several northern states' Sharia-based legal frameworks introduce religious considerations that may conflict with autonomy principles, particularly regarding women's healthcare decisions. The absence of harmonising federal legislation addressing these state-level variations perpetuates regulatory fragmentation. While the National Health Act establishes minimum standards, it does not pre-empt state laws or create uniform consent requirements applicable across all jurisdictions. Consequently, Nigerian women's healthcare autonomy rights vary significantly depending on their state of residence, undermining the constitutional promise of equal rights protection and creating an incoherent regulatory landscape that ill-serves patient protection objectives[644].

2.6 International Human Rights framework

Nigeria's obligations under international human rights law provide critical supplementary standards for healthcare autonomy protection, establishing normative benchmarks that exceed domestic statutory provisions in scope and specificity. These legal tools of international law acknowledge that healthcare autonomy is a part of human dignity and gender equality that establish binding obligations upon which domestic law should be interpreted. Nonetheless, there are still strong gaps in the implementation of the treaty commitments and the reality of healthcare practice in Nigeria, both in terms of structural issues and the lack of political determination to actualise international standards at national level.

2.6.1 CEDAW obligations and Nigeria's compliance record

Nigeria ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1985, assuming obligations to eliminate gender-based discrimination in healthcare access and decision-making[645]. Article 12 mandates that States Parties "eliminate discrimination against women in the field of health care" and ensure access to health services on a basis of equality

[643] Lagos State Health Scheme Law 2015 (Lagos State of Nigeria Official Gazette Vol 48) <https://www.scribd.com/document/815362433/Lagos-State-Health-Scheme-Law-2015> accessed 15 September 2025.
[644] B Nwankwo and C Onuoha "Federalism and healthcare regulation in Nigeria: challenges of legislative fragmentation" (2021) 28(3) *Journal of Law and Medicine* 567–582.
[645] Convention on the Elimination of All Forms of Discrimination Against Women 1979, GA Res 34/180, UN GAOR, 34th Sess, Supp No 46, UN Doc A/34/46 https://www.ohchr.org accessed 18 September 2025.

between men and women, including services related to family planning[646]. The CEDAW Committee's General Recommendation No. 24 elaborates that this obligation encompasses ensuring women's autonomous decision-making capacity in healthcare contexts, free from coercion by family members or healthcare providers[27]. Nigeria ratified the Convention as far back as 13 June 1985, and the optional Protocol on 22 November 2004, however, its compliance record/scorecard still reveals substantial deficiencies in its implementation. For instance, in 2024, an inquiry was set up to investigate Nigeria's compliance with Article 8 of the Optional Protocol when grave and substantial breaches were alleged to have been carried out by Boko Haram insurgents in North East Nigeria. Nigeria was said to have been unable to prevent the women and girls from abduction, trafficking, child marriage and sexual exploitation by Boko Haram and ensure their right to education.

2.6.2 African Charter on Human and Peoples' Rights

The African Charter on Human and Peoples' Rights was signed by Nigeria in 1983 and domesticated through the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act. The Act provides a regional human rights framework with direct domestic legal effect. Article 16 guarantees "the right to enjoy the best attainable state of physical and mental health" and obligates States Parties to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick"[647]. This provision establishes healthcare as a justiciable right under Nigerian law, one that offers potential avenues for enforcing healthcare autonomy claims that constitutional provisions alone cannot support[648].

2.6.3. Maputo Protocol: Reproductive health rights and implementation gaps

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), ratified by Nigeria in 2005, establishes comprehensive reproductive health rights that directly address healthcare autonomy concerns. Article 14 mandates that States Parties "ensure that the right to health of women, including sexual and reproductive health is

[646] CEDAW Committee, *General Recommendation No 24: Article 12 of the Convention (Women and Health)* (1999) UN Doc A/54/38/Rev.1 <https://www.ohchr.org> accessed 18 September 2025.
[647] African Charter on Human and Peoples' Rights 1981, OAU Doc CAB/LEG/67/3 rev 5 <https://au.int/en/treaties/african-charter-human-and-peoples-rights> accessed 19 September 2025.
[648] V Nmehielle *The African Human Rights System: Its Laws, Practice, and Institutions* (Martinus Nijhoff Publishers 2001.

respected and promoted," requiring measures to "establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding".[649] Article 14(1)(c) requires States to "protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus." However, implementation of the protocol is still very poor with the domestic laws working against the Protocol provisions. The Criminal Code and Penal Code criminalise abortion in nearly all circumstances, directly contradicting Article 14(2)(c)'s requirements for lawful abortion access[650,651]. This legislative misalignment persists despite Nigeria's binding treaty commitment, illustrating the disconnect between international obligations and domestic legal reality[652]

2.7 WHO Guidelines on healthcare autonomy and gender equity

The World Health Organization has developed extensive normative guidance on healthcare autonomy and gender equity that, while not legally binding, provides authoritative standards for ethical healthcare delivery. WHO guidelines emphasise that respect for autonomy constitutes a fundamental ethical principle in healthcare that requires patients receiving adequate information to make informed decisions and that their choices be respected without compelling justification[653]. The WHO's Quality of Care Framework specifically identifies respect for women's autonomy as essential to quality maternal healthcare, noting that care delivery must be respectful and preserve the dignity of service users and enable their informed choice and continuous support.[654]

The international human rights system therefore lays strong normative bases of healthcare autonomy protection which go beyond local legislative standards significantly. Nonetheless, the radical imbalances between international obligations and Nigerian healthcare reality show that there are inherent issues in adopting international standards into the local practice. Such gaps

[649] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa 2003, CAB/LEG/66.6.
[650] Criminal Code Act Cap C38 Laws of the Federation of Nigeria 2004.
[651] Penal Code Act Cap P3 Laws of the Federation of Nigeria 2004.
[652] C Ngwena “Inscribing abortion as a human right: significance of the Protocol on the Rights of Women in Africa” (2014) 36(4) *Human Rights Quarterly* 783–864 <https://muse.jhu.edu/journal/198> accessed 25 September 2025.
[653] World Health Organization *WHO Guidelines on Ethical Issues in Public Health Surveillance* (WHO Press 2017)
[654] World Health Organization *Gender Mainstreaming for Health Managers: A Practical Approach* (WHO Press 2018)

require immediate action to address the issues of domestication, judicial involvement, provider education, and accountability frameworks in Nigeria.

2.8 Judicial interpretation of healthcare rights

The Courts have played a limited but increasingly significant role in interpreting healthcare rights and autonomy principles, though jurisprudential development remains fragmented and inconsistent. Judicial engagement with informed consent, capacity assessment, and the intersection of cultural norms with medical decision-making reveals both progressive tendencies and conservative adherence to paternalistic frameworks. This section examines key cases and judicial approaches that shape the legal landscape of healthcare autonomy in Nigeria.

2.8.1 *Georgina Ahamefule v. Imperial Medical Centre & Anor*

The decision in *Georgina Ahamefule v. Imperial Medical Centre & Anor*[655] marks a significant milestone in Nigerian medical jurisprudence. The plaintiff, a nurse employed by the defendant hospital, was subjected to an HIV test without her knowledge or consent and, upon testing positive, was summarily dismissed and denied medical care. The Lagos High Court found that the hospital's conduct violated her constitutional rights to dignity, privacy, and freedom from discrimination as guaranteed under sections 34, 37, and 42 of the 1999 Constitution.

2.9 Feminist Legal Critique of Current Framework

The legal framework governing healthcare autonomy in Nigeria, as examined in preceding sections, operates predominantly within liberal individualistic paradigms that feminist scholars have extensively critiqued as inadequate for addressing the reality of women's healthcare experiences. This section applies feminist legal theory to expose fundamental flaws in Nigeria's autonomy framework and proposes alternative conceptualisations better suited to protecting women's healthcare decision-making rights within Nigeria's socio-cultural context.

2.9.1 Relational Autonomy Theory: Mackenzie and Stoljar's Framework

Relational autonomy theory offers a feminist alternative that reconceptualises autonomy as constituted through social relationships rather than independence from them. Catriona Mackenzie

[655] *Georgina Ahamefule v. Imperial Medical Centre & Anor (Unreported*, Suit No. ID/1627/2000, High Court of Lagos State, judgment delivered 27 April 2012).

and Natalie Stoljar's influential framework distinguishes three dimensions of relational autonomy: self-determination (governing one's life according to values one reflectively endorses), self-governance (capacity for rational deliberation and action), and self-authorisation (viewing oneself as entitled to make decisions about one's life). This tripartite conception acknowledges that autonomy requires not only decisional capacity but also social conditions enabling individuals to develop self-governing capacities and view themselves as legitimate decision-makers.[656]

The consideration of the relational autonomy theory concerning the situation in Nigeria healthcare offers insight into how women are gradually disempowered by the oppressive social circumstances. Notably, the theory draws the line between autonomy supporting and undermining relationships. Not every social determinant of decision-making undermines autonomy, inter-relationships, typified by respect, free communication and acknowledgment of decisional power may promote autonomy by offering emotional support, sharing information, and deliberative support. The legal frameworks should not then aim to alienate patients but rather to make sure that the healthcare decision-making process takes place in the social relationships that enhance self-determination but not hinder it. This involves consideration of power in relationships and institutional practices which support or hinder autonomy-supporting relationships.[657]

2.9.2 Substantive Versus Formal Equality in Healthcare Law

Nigerian healthcare law's embrace of formal equality rather than substantive equality represents another critical feminist concern. Formal equality principles, reflected in gender-neutral statutory language and judicial approaches treating all patients identically, assume that equal treatment produces equal outcomes. Substantive equality, in its turn, acknowledges that an actual equality cannot be achieved without mitigating structural unfairness and unequal treatment where it is warranted in an effort to address past and current subordination[658]. Substantive equality applied to healthcare autonomy would appreciate that women experience unique obstacles to self-determination that men do not experience, such as spousal domination of healthcare choices, provider presumptions toward female decisional incapacity and gendered violence that limit

[656] C Mackenzie and N Stoljar (eds) *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford University Press 2000)
[657] Ibid
[658] S Fredman 'Substantive equality revisited' (2016) 14(3) *International Journal of Constitutional Law* 712–738 <https://academic.oup.com/icon> accessed 24 September 2025

reproductive choice.[659] To fulfill the autonomy of healthcare among women, it is necessary not only to continue with the same treatment but initiate positive action to deal with these barriers unique to gender[660].

3.0 Patriarchal Structures and Healthcare Decision-Making

3.1 Traditional Gender Roles and Health-Seeking Behaviour

Nigerian societies, despite substantial ethnic and regional diversity, share patriarchal family structures that assign men authority over household decisions while positioning women in subordinate, dependent roles.[661] Traditional gender ideologies construct masculinity around authority and family headship, while femininity emphasises submission, obedience, and service to husbands and extended family. These gender constructions profoundly shape healthcare decision-making patterns, as healthcare choices become sites where gender hierarchies are enacted and reinforced.

The 2024 Nigeria Demographic and Health Survey found that only about 27% of married women aged 15-49 reported that they alone usually make decisions about their own healthcare, while 56% reported husbands alone make these decisions and 49% reported joint decision-making.[662] These aggregate figures obscure substantial regional variations. In northwestern states including Sokoto, Kebbi, and Zamfara, where Islamic Hausa-Fulani cultural systems dominate, about 25% of women report independent healthcare decision-making authority, compared to southeastern states including Anambra, Imo, and Abia, where over 50% of women report making independent healthcare decisions.[663]

Qualitative research reveals mechanisms through which patriarchal norms constrain women's health-seeking behaviour. Ethnographic studies in northern Nigeria document that women internalise expectations that husbands should authorise healthcare access, viewing autonomous

[659] OO Olomola and FO Ajagunna "Knowledge and access to reproductive health rights by adolescents in Ibadan, Nigeria" (2020) 28(3) *African Journal of International and Comparative Law* 401–417
[660]R Cook and S Cusack *Gender Stereotyping: Transnational Legal Perspectives* (University of Pennsylvania Press 2010)
[661] A Adelekan, P Omoregie and E Edoni "Male involvement in family planning: challenges and way forward" (2014*) International Journal of Population Research Article* 416457; FO Ajagunna "Women's rights to inheritance and changing conceptions of the primogeniture rule in Nigeria" (2023) 3 *Cavendish University Law Journal* 1–19.
[662] National Population Commission (NPC) [Nigeria] and ICF Nigeria Demographic and Health Survey 2024 (2024, NPC and ICF) at 479.
[663] Ibid at 480.

healthcare seeking as defying proper feminine behaviour and risking accusations of disobedience or infidelity.[664] Women describe delaying urgently needed healthcare while awaiting husbands' permission, sometimes resulting in preventable complications when husbands were unavailable or refused authorisation. Healthcare providers reinforce these patriarchal norms by routinely requesting husbands' presence or authorisation before treating married women, even for conditions unrelated to reproduction. A qualitative study of healthcare provider attitudes in southwestern Nigeria found that 68% of interviewed providers believed married women should obtain husbands' consent before receiving healthcare, with providers justifying this requirement as respecting cultural traditions and preventing family conflicts.[665]

3.1.2 Economic dependency and healthcare access

Economic dependency fundamentally constrains Nigerian women's healthcare autonomy which further creates practical barriers to accessing care even when formal decision-making authority exists. The 2024 NDHS found that only 38% of married women aged 15-49 reported earning cash income, and among those who earned income, 42% reported that husbands alone decided how their earnings would be used.[666] This economic dependence means that even women who theoretically possess decision-making authority cannot actualise healthcare choices without male cooperation in providing necessary funds.

Nigeria's healthcare financing system exacerbates economic barriers to autonomous healthcare access. The country lacks universal health coverage, with only approximately 3% of the population enrolled in any health insurance scheme.[667] Healthcare services overwhelmingly require out-of-pocket payment at point of use, creating immediate barriers when women lack financial resources or control over household funds. Qualitative evidence reveals how economic dependency translates into healthcare delays and foregone care. A study of maternal healthcare in rural southeastern Nigeria found that economic factors accounted for 41% of delays in accessing emergency obstetric care, with many delays resulting from negotiations with husbands or extended

[664] L L Wall "Obstetric vesicovaginal fistula as an international public-health problem" (2006) 33(2 *Latin American Perspectives* 123.
[665] G Woldemicael and EY Tenkorang "Women's autonomy and maternal health-seeking behavior in Ethiopia" (2010) 14(6) *Maternal and Child Health Journal* 988–998.
[666] NPC and ICF *Nigeria Demographic and Health Survey 2024*, at 449.
[667] C A Onoka et al "Promoting universal financial protection: Constraints and enabling factors in scaling-up coverage with social health insurance in Nigeria" (2015) 30(10) *Health Policy and Planning* 1285.

family members for funds.[668] Women participating in microfinance programs in southeastern Nigeria showed increased healthcare decision-making authority and higher rates of facility delivery and family planning use compared to matched controls. This suggests that addressing economic dependency constitutes a critical component of strategies to enhance women's healthcare autonomy.[669]

3.3. Religious and cultural influences on healthcare autonomy

3.3.1 Islamic perspectives and gender segregation

Islamic religious beliefs profoundly influence healthcare decision-making patterns in northern Nigeria, where Muslim populations predominate. Classical Islamic jurisprudence grants women rights to seek necessary medical treatment without requiring male permission, recognising healthcare access as essential for preserving life.[670] However, empirical research documents substantial restrictions. A study in Kano State found that 78% of married Muslim women reported requiring husbands' permission to visit healthcare facilities, with many citing religious obligations.[671] Religious scholars interviewed in the same study clarified that Islamic law does not mandate spousal permission for necessary healthcare, suggesting cultural practices are attributed to religion rather than deriving from religious texts.

Gender segregation and female modesty requirements create additional challenges. Most Muslim women in northern Nigeria express reluctance to seek healthcare from male providers due to religious concerns about physical contact with unrelated men, particularly for reproductive health conditions requiring intimate examinations.[672] The severe shortage of female healthcare providers in northern Nigeria exacerbates this problem, forcing women to choose between forgoing needed care or compromising religious values.

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[668] I I Okafor, E O Ugwu and S N Obi "Disrespect and abuse during facility-based childbirth in a low-income country" (2014) 128/2 *International Journal of Gynecology & Obstetrics* 110.
[669] W Hameed et al "Women's empowerment and contraceptive use: The role of independent versus couples' decision-making, from a lower middle income country perspective" (2014) 11 *Reproductive Health* 17.
[670] A I Padela and P del Pozo "Muslim patients and cross-gender interactions in medicine: An Islamic bioethical perspective" (2011) 37(1) *Journal of Medical Ethics* 40.
[671] S Babalola and A Fatusi "Determinants of use of maternal health services in Nigeria: Looking beyond individual and household factors" (2009) 13(3) *African Journal of Reproductive Health* 43.
[672] A I Adanikin, U Onwudiegwu and O M Loto "Influence of multiple antenatal care visits on maternal and fetal outcomes in southwestern Nigeria" (2017) 43(*4) Journal of Obstetrics and Gynaecology Research* 668.

3.3.2 Cultural taboos and extended family involvement

Cultural taboos surrounding sexuality and reproduction create substantial barriers to reproductive healthcare autonomy. Across many Nigerian ethnic groups, cultural norms prohibit open discussion of sexual and reproductive matters, particularly for unmarried women and adolescents.[673] Provider attitudes reflecting these cultural taboos compound the problem, with healthcare workers sometimes refusing services to unmarried women seeking contraception or treating them judgmentally, effectively denying autonomous access to reproductive healthcare.

Extended family involvement in healthcare decisions reflects Nigerian family systems that emphasise collective welfare and interdependence over western individualistic autonomy. Older female relatives, particularly mothers-in-law, exercise substantial authority over younger women's healthcare, especially regarding reproductive matters. When extended family members contribute financially to healthcare costs, they claim corresponding decision-making authority. A study in rural Benue State found that 43% of women's healthcare expenses were paid by extended family members rather than husbands or the women themselves, with financial contributors expecting consultation rights regarding treatment decisions.[674]

Nigeria's geographic regions demonstrate substantial cultural variations in healthcare autonomy patterns. . Northern cultural practices including purdah, early marriage, and patrilocal residence patterns create structural conditions limiting women's autonomous healthcare access. Southern Nigerian regions, particularly southeastern states dominated by Igbo ethnic groups, demonstrate greater female healthcare autonomy reflecting different cultural gender systems. Igbo traditional society historically accorded women substantial economic autonomy through trading activities. However, southern Nigeria's apparent female autonomy advantages require critical examination, as educated, urban women in southern cities experience autonomy patterns potentially unrepresentative of rural southern women's experiences.[675]

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[673] E A Envuladu et al "Factors determining the choice of a place of delivery among pregnant women in Russia village of Jos North, Nigeria" (2013) 2(1) *International Journal of Medicine and Biomedical Research* 23.; OO Olomola and FO Ajagunna "Knowledge and access to reproductive health rights by adolescents in Ibadan, Nigeria" (2020) 28(3) *African Journal of International and Comparative Law* 401–417.

[674] B S Aregbeshola and S M Khan "Out-of-pocket payments, catastrophic health expenditure and poverty among households in Nigeria" (2018) 7(*9)International Journal of Health Policy and Management* 798.

[675] N Nzegwu "Gender equality in a dual-sex system: The case of Onitsha" (2001) 7(1) *Canadian Journal of Law and Jurisprudence* 73.

4.0 HEALTHCARE AUTONOMY IN NIGERIAN CASE LAW

4.1 Judicial recognition of healthcare autonomy

The judicial interpretation and enforcement of healthcare autonomy rights constitute critical mechanisms through which abstract legal principles acquire practical meaning in patients' lives. Courts serve as gatekeepers determining whether autonomy claims receive legal recognition that establish precedents that guide healthcare providers and institutions and mediating tensions between individual self-determination and competing interests including medical paternalism, family authority and cultural expectations. In Nigeria, judicial attitudes toward healthcare autonomy reflect complex intersections of common law traditions inherited from British colonial rule, constitutional rights guarantee, customary practices and evolving international human rights standards.

4.1.1. Foundational Nigerian healthcare cases

Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo[676]

The Supreme Court's decision in *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo*[677] represents the most significant Nigerian judicial pronouncement on patient autonomy and the limits of medical paternalism. The case arose from disciplinary proceedings against Dr. Okonkwo, who was charged with professional misconduct after a Jehovah's Witness patient died following his refusal to administer blood transfusion contrary to the patient's religious beliefs. Dr. Okonkwo had initially respected the patient's refusal but was later disciplined by the Medical and Dental Practitioners Disciplinary Tribunal for failing to provide necessary medical treatment. The case presented the Supreme Court with fundamental questions about the scope of patient autonomy, whether religious beliefs can override medical recommendations, and the boundaries of physicians' professional obligations when patients refuse life-saving treatment. The Supreme Court’s decision in this case is an apparent affirmation that an adult patient of sound mind has the legal and constitutional right to accept or refuse medical treatment, even in instances where that refusal may result in serious harm or death. This places decision-making authority squarely with

[676] (2001) 7 NWLR (Pt. 711) 130

the patient and not the doctor. In addition, the Court made it clear in its decision that patients' beliefs are not to be dismissed merely because they conflict with medical opinion. Another profund inference from this decision is that paternalism has its limits as a medical practitioner cannot impose treatment simply because they believe it is medically necessary.

Ojo v. Gharoro

Ojo v. Gharoro[678] addressed medical negligence following surgical complications, and further providing insight into judicial attitudes toward professional standards, patient protection, and the evidentiary requirements for establishing medical malpractice. The plaintiff underwent surgery during which a needle broke and remained embedded in her body, causing chronic pain and requiring subsequent surgery for removal. She sued the surgeon for negligence, claiming breach of duty of care and failure to exercise reasonable skill. The case raised questions about what constitutes medical negligence, whether adverse outcomes alone prove negligence, and the standard by which courts evaluate physicians' conduct.[679] The Supreme Court, in a judgment delivered by Justice Oguntade, articulated the legal test for medical negligence in Nigeria where he adopted the *Bolam* test from English common law. The Court held that a medical professional is not negligent if they acted in accordance with a practice accepted as proper by a responsible body of medical practitioners skilled in that particular art, even if other practitioners would have adopted different approaches.[680] This professional standard of care defers substantially to medical judgment, requiring plaintiffs to prove that no reasonable body of medical opinion would have approved the defendant's conduct rather than merely showing that alternative approaches existed.

University of Nigeria Teaching Hospital Management Board v. Hope Nnoli

Hope Nnoli [681] addressed institutional liability for negligent care and medication errors resulting in patient death. The deceased had been admitted to UNTH for minor surgery but died following administration of wrong medication. The plaintiff (deceased's estate) sued the hospital for vicarious liability, arguing that institutional failures in medication management and supervision caused the death. The case raised questions about whether hospitals bear responsibility for

[678] *Ojo v. Gharoro* (2006) 10 NWLR (Pt. 987) 173 (Nigeria).
[679] *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582 (UK).
[680] *Ojo v. Gharoro* at 189-190.
[681] *University* of *Nigeria Teaching Hospital Management Board v. Hope Nnoli* [1994] 8 NWLR (Pt. 365) 367 (Nigeria).

individual practitioners' errors, the scope of institutional duties to patients, and standards for medication safety. The Supreme Court held that hospitals are vicariously liable for negligent acts committed by employed healthcare workers within the scope of their employment, and that hospitals owe patients independent institutional duties to maintain safe systems, provide competent staff, and supervise care delivery. Justice Ogundare's judgment distinguished between vicarious liability, where institutions answer for employees' torts, and direct institutional liability, where hospitals breach their own duties to patients. This dual liability framework recognises that healthcare delivery involves both individual practitioner conduct and organizational systems, both of which affect patient safety and autonomy.

4.2 Medical Paternalism and Professional Deference

Analysis of Nigerian healthcare cases reveals persistent judicial deference to medical authority and reluctance to question physicians' judgments about appropriate treatment or adequate consent. The Bolam test's adoption in *Ojo v. Gharoro,* requiring plaintiffs to prove that no responsible body of medical opinion would approve defendant's conduct, exemplifies this deference. While professional standards can appropriately guide liability determinations for technical medical judgments, extending similar deference to consent processes and patient communication perpetuates paternalism by treating physicians' assessments of adequate information disclosure as determinative.[682]

4.3 Fiduciary Healthcare Relationships

Fiduciary relationships arise when one party reposes trust and confidence in another who exercises discretionary power affecting the trusting party's interests, generating strict legal duties including loyalty, acting in the beneficiary's best interests, full disclosure, and avoiding conflicts of interest. Healthcare provider-patient relationships exhibit fiduciary characteristics as patients entrust providers with intimate information about their bodies and health, rely on providers' specialised knowledge to guide critical life decisions, and occupy positions of vulnerability due to illness, pain, and information asymmetries.[683]

[682] Herring, *Medical Law and Ethics*, 176-178.
[683] J C Shepherd, 'Towards a Unified Concept of Fiduciary Relationships,' *Law Quarterly Review* 97 (1981): 51-81; LI Rotman Fiduciary Law (Thomson Carswell 2005) 89–125.

Despite these fiduciary features, Nigerian courts have not explicitly recognised healthcare relationships as fiduciary. The Okonkwo judgment's language about trust and vulnerability suggests implicit recognition of fiduciary elements, but the Court did not employ fiduciary terminology or impose heightened fiduciary duties. This doctrinal gap limits legal protection against provider abuse of trust and power, as fiduciary duties exceed ordinary negligence standards by prohibiting self-interested conduct, conflicts of interest, and failures to disclose even when such conduct might satisfy professional standards.[684]

5.0 CONCLUSION

The fundamental inadequacy of the Nigerian legal framework lies in its adherence to a liberal individualistic paradigm of autonomy, which erroneously assumes that patients operate as atomised agents free from the structural constraints of patriarchal family systems and gendered power hierarchies. Current constitutional and statutory approaches adopt a "gender-blind" formal equality that ignores the systemic subordination of women, effectively allowing formal guarantees of dignity and informed consent to remain aspirational rather than justiciable. By neglecting the social reality of relational embeddedness where economic dependency, religious interpretations, and cultural norms of male guardianship dictate healthcare access, the law inadvertently perpetuates the very inequalities it purports to prohibit. To bridge this implementation gap, Nigeria must pivot toward a framework of relational autonomy and substantive equality, recognising that true self-determination is socially constituted and requires affirmative state intervention. This necessitates a multi-level reform strategy: legislative amendments to the National Health Act to explicitly criminalise spousal consent requirements, judicial training on gender-responsive jurisprudence, and institutional overhauls that prioritize patient privacy and provider accountability. Ultimately, as regional variations and the positive correlation between female education and decisional agency demonstrate, these barriers are not immutable cultural essences but socially constructed hurdles that can be dismantled through coordinated legal, economic, and

[683] Marc A. Rodwin, 'Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System,'*American Journal of Law & Medicine* 21, no. 2-3 (1995): 241-257, https://doi.org/10.1017/S0098858800006969.
[684] T Frankel *Fiduciary Law* (Oxford University Press 2011), 178-195; P B Miller and AS Gold (eds) *Philosophical Foundations of Fiduciary Law* (Oxford University Press 2014).

socio-cultural empowerment initiatives designed to foster an environment where women's healthcare preferences are both authentically formed and legally protected.

The pursuit of substantive healthcare autonomy for Nigerian women requires a comprehensive overhaul of the nation's legal, institutional, and socio-cultural architecture. The current landscape is often characterised by "spousal consent" requirements, whether formal or informal, that strip women of their agency. To dismantle these barriers, a multi-pronged strategy involving the judiciary, the legislature, and community stakeholders is essential, and as such the following recommendations are proferred.

a Judicial activism and enforcement

The Nigerian judiciary must transition from a traditionalist view of rights to a more progressive, interpretation of the Constitution. While Sections 33 and 34 protect the right to life and dignity, they are often interpreted as negative rights that merely protect citizens from state-sanctioned harm. A transformative approach requires courts to read these sections expansively to include positive obligations, meaning the state must create the conditions necessary for health and autonomy.

By utilising the domesticated African Charter on Human and Peoples' Rights, specifically Article 16, Nigerian courts can establish that healthcare is a justiciable right. Strategic litigation is a powerful tool here; by challenging non-consensual obstetric procedures or denials of reproductive care, lawyers can litigate and advocate the courts to adopt "relational autonomy" and "substantive equality" frameworks. This ensures that legal standards reflect the reality of gender power imbalances rather than a theoretical, gender-neutral ideal.

b Legislative amendment and enforcement

At the legislative level, the National Health Act 2014 requires amendment. While it provides a baseline for health administration, it lacks explicit protections against third-party consent requirements. New provisions must strictly prohibit healthcare providers from demanding a husband's or family member's signature for a competent adult woman's treatment.

Furthermore, Section 11 of the Act can be amended to include detailed disclosure standards thereby ensuring patients understand risks in a language they comprehend.Capacity assessment

protocols can also be included to standardise how competence is determined to prevent subjective bias.

The domestication of CEDAW and the Maputo Protocol is equally critical. These international instruments provide the specific language needed to decriminalise certain reproductive health services and establish a dedicated Gender Equality Commission with a mandate to monitor healthcare rights.

c. Socio-cultural interventions and stakeholder engagement

Perhaps the most difficult barrier to dismantle is the internalisation of patriarchal norms. Top-down legal reform must be met by bottom-up community engagement. This involves engaging Islamic scholars to clarify that Sharia does not mandate spousal permission for necessary healthcare, and Christian leaders to emphasise the sanctity of individual bodily integrity. Male engagement programmes must frame men as allies. By challenging the masculinity that links manhood to the control of women's bodies, these initiatives can promote a model of supportive partnership.