

CONSENT TO LIFE-SAVING MEDICAL TREATMENT FOR CHILDREN IN NIGERIA: AN EXAMINATION OF THE CHILD'S RIGHTS ACT AND THE NATIONAL HEALTH ACT

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ABSTRACT

The relationship between a medical practitioner and a patient is founded on the principles of contract in common law. These relationships require consent to be valid and to avoid trespass, assault, battery, or even criminal liability. The principle of consent is equally founded on competence or capability. Infants or minors are universally considered at law to be persons lacking competence to enter binding legal relations by reason of inability to comprehend the issues involved. In treatment, children of a certain age can understand the nature of medical treatment and the consequences of consenting to it. This article analysed the provisions of the Nigerian Health Act and the Child's Rights Act in relation to the topic of consent by children and parents or guardians to life-saving treatment. The research employed an analytical approach in which the legislation and relevant literature were analysed. It was concluded that Nigeria has neither specific legislation nor adequate provisions in existing legislation. Recommendations were made for the passing of legislation and also the granting of specific guidance to medical practitioners on the requirement of consent to life-saving treatment for children and limited right of consent to minors of competence or understanding to participate in decisions involving their medical treatment.

Keywords: *Minors, Medical Practitioners, Parent, Informed Consent.*

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1. INTRODUCTION

The principle of consent is a vital component in the relationship between a doctor and their patients. Rooted in common law contract principles, the relationship must be free from coercion or force; every valid contractual relationship is built on mutual agreement and the wilful acceptance of an offer by one party. The relationship between a doctor, surgeon, nurse, or other medical practitioner is no different, as the medical practitioner requires the voluntary and wilful acceptance of the patient of the treatment, medication, or examination they seek to offer. Consent has been defined as ‘*A voluntary yielding to what another proposes or desires; agreement, approval, or permission regarding some act or purpose, especially given voluntarily by a competent person; legally effective assent.*’¹

Undoubtedly, the relationship between a doctor and their patient requires consent, especially because a duty of care exists. A doctor, physician or surgeon is expected to exercise a standard of care or a degree of skill such as is reasonably expected of a careful and prudent physician under the same or similar circumstances.² In other words, a physician must use the same degree of dexterity and proficiency that would be engaged by a competent physician in the same field of medical practice. Nevertheless, the ‘same locality’ standard or duty of care succumbs to the fact that there exists in today’s world an accessibility of information and opportunities that greatly facilitates shared knowledge.³ It has been stated that the duty of care of a child’s medical professional is dual in nature; first is the duty to preserve life, restore health and prevent disease, making sure that every treatment confers maximum benefit and minimum harm, and secondly the duty to respect the parents’ right to make informed decisions, being careful not to coerce or manipulate parents into doing what the physician themselves believes is in the best interest of the child.⁴

A patient’s right to give or withhold consent is a primordial requirement in the relationship between the medical practitioner and the patient. This principle originates in the common law right to self-determination and applies universally.⁵ Both local and foreign courts have repeatedly held that a competent patient, under all reasonable circumstances, reserves the

¹ Bryan A. Garner (ed.) *Black’s Law Dictionary* (10th edition, Thomson Reuters, 2015) 368

² This concept was developed by the English courts in the case of *Bolam vs Friern Hospital Management Committee* (1957) 1 WLR 582 and came to be known over time as the ‘Bolam test’. The principle in summary is that the common practice accepted by a reasonable group of skilled practitioners is a relevant determiner of the standard of care required in any circumstance.

³ Simon Uchenna Ortuanya *Public Health Law and Policy in Nigeria* (Princeton & Associate Publishing Co Ltd, Ikeja, 2022) 322

⁴ Larcher, Vic, and others "Making Decisions to Limit Treatment in Life-Limiting and Life-Threatening Conditions in Children: A Framework for Practice." *Archives of disease in childhood* 100.Suppl 2 (2015): s1-s23. <<https://adc.bmj.com>> assessed on 21st July 2026

⁵ The principle also enjoys international acceptance and validation. For example, the United Nations’ International Covenant on Civil and Political Rights in force since 1976 includes as Article 7 the prohibition of experiments carried out without the ‘free consent to medical or scientific experimentation’ of the subject.

right to consent to treatment, surgical procedures, or medication. Any examination, procedure or treatment performed or given by a medical practitioner without the consent of the patient, whether express or implied, in person or by proxy, or in excess of that to which the patient has consented, gives rise to liability in tort for trespass to the person, assault, battery, or to criminal liability for indecent assault.⁶ Consequently, without a patient's consent, physicians can be liable in tort or culpable in crime. The law recognises the autonomy of the individual and the right to choose whether to undergo medical treatment or not, even if that decision could lead to death.⁷ As Black's Law Dictionary states in the definition of consent:

Consent is an affirmative defence to assault, battery and related torts as well as such torts as defamation, invasion of privacy, conversion, and trespass. Consent may be a defence to a crime if the victim has the capacity to consent and if the consent negates an element of the crime or thwarts the harm that the law seeks to prevent.⁸

The requirement of consent is so pivotal that courts will uphold it even when withholding consent is patently detrimental to the patient, provided the patient is well informed and competent to give consent. In the famous English case of *Sidaway v Board of Governors, Bethlehem Royal Hospital*,⁹ it was held that the patient is free to decide whether or not to submit to treatment recommended by the doctor, 'if the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject the advice for reasons which are rational or irrational'.¹⁰ The Canadian case of *Malette v Shulman*¹¹ is also instructive on this point. In this case, Dr Shulman was held liable in damages to the Claimant for failing to adhere to instructions in a note in her purse and still administering a blood transfusion, the note stating that under no condition would she consent to a blood transfusion. This position was upheld even though Ms Malette was unconscious from injuries sustained in a ghastly automobile accident when she was treated by the Defendant. The position in Nigeria has been no different, as the Supreme Court held in *Medical and Dental Practitioners Disciplinary Tribunal v Dr John Emewulu Nicholas Okonkwo* that a competent adult reserves the right to withhold consent to treatment or medication, even when such refusal is against medical advice

⁶ J. A. Dada *Legal Aspects of Medical Practice in Nigeria* (2nd Edition University of Calabar Press, Calabar, 2013) 214

⁷ Alison Diduck and Felicity Kaganas *Family Law, Gender and the State Text, Cases and Materials* (3rd edition, Hart Publishing Ltd., Oxford, 2012) 505

⁸ Garner (n. 2)

⁹ (1985) All ER 643, (1985) AC 871

¹⁰ Although the *Sidaway* case was overturned in 2015 by the UK Supreme Court in the case of *Montgomery vs Lanarkshire Health Board* (2015) UKSC 11, it was overturned in terms of the rules relating to the disclosure of risks that will qualify as meeting the threshold for informed consent, thereby affecting the liability of medical practitioners in negligence. The principle that a patient reserves the right to give or withhold consent remains unimpeached by *Montgomery's* case and is thus in force.

¹¹ (1990) 37 OAC 281 (CA)

and has life-threatening consequences. In this case, the Respondent was held to be not guilty of infamous conduct when he respected a patient's wish not to be given a blood transfusion, which eventually led to the death of the patient. The apex court held that the right to give and withhold consent is a constitutionally guaranteed right.¹²

The question then arises: who can give consent? Inherent in the very nature of the giving of consent is the concept of capacity. Consent can only be given or granted by a person who, in the eyes of the law, has the capacity to give such consent. As defined by Bryan Garner above,¹³ consent is only legally effective when given voluntarily by a competent person. Again, this principle is rooted in the common law principles that govern the law of contract. Every valid contract requires that the parties have capacity to contract.¹⁴

It is in this regard that children suffer a legal incapacitation. At common law, a child below the age of 21 lacks the capacity to enter into a valid contract. Major international and regional statutes regulating children's rights regard children as persons under the age of 18.¹⁵ The Child Rights Act 2003 of Nigeria, which is the primary legislation governing the rights of children and young people, states in no different manner that a child is anyone below the age of 18 years.¹⁶ This introduces, in the context of children needing medical care, the need for parental responsibility or the presence of a competent adult to give consent on behalf of the child.

Ordinarily, this ought not to attract a researcher, but as with areas of human endeavour, entrusting one person's rights to another quickly creates a need for regulation to prevent abuse. When the treatment or procedure is life-saving, consent becomes a decisive factor between life and death. Given the fact that the right to grant consent is synchronous with the right to withhold consent to medical treatment, what then becomes the plight of those dependent on others to exercise this right on their behalf? What statutory provision or guide is available in Nigeria to assist medical professionals on the granting or withholding of consent by children? Do children retain any autonomy to determine their own fate in Nigeria? What principles guide the exercise of consent on behalf of minors? What provisions do the National Health Act and the Child's Rights Act make to protect the right of children with regard to consent to life-saving

¹² Ibid at 588 C - E

¹³ Bryan A. Garner (n.2)

¹⁴ I. E. Sagay *Nigerian Law of Contract* (2nd Edition Spectrum Books Ltd, Ibadan, 2000) 457-458

¹⁵ Article 1 of the United Nations Convention on the Rights of the Child and Article 2 of the African Charter on the Rights and Welfare of the Child. Similar provisions apply with respect to the absolute minimum age for hazardous work in the International Labour Organisation's Minimum Age Convention and under International Humanitarian Law under the Rome Statute of the International Criminal Court.

¹⁶ Section 277

treatment? Are these provisions adequate in protecting the rights of children? By examining the National Health Act and the Child's Rights Act, this paper addresses these questions.

2. LEGAL FRAMEWORK FOR CONSENT TO LIFE-SAVING MEDICAL TREATMENT FOR CHILDREN IN NIGERIA.

2.1 The National Health Act 2014

From the outset, although the National Health Act is the principal and most comprehensive legislation regulating healthcare in Nigeria, it does not specifically address children. Unlike other jurisdictions with more advanced healthcare legislation, Nigeria has no legislation specifically targeting healthcare for children or other persons lacking legal capacity.¹⁷ Thus, no specific provision of the Act relates to the giving of consent to medical treatment by minors. Nevertheless, several provisions of the Act are germane to this discourse, and a community reading of the relevant provisions will reveal the framework for consent to life-saving treatment for children. The relevant sections are Sections 20 (1), 23 (1), 26 and 28 (1) (a) which are analysed below:

A. *Section 20 (1): 'A health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason.'*

The import of this section is that a legal duty or obligation is placed on all healthcare practitioners to provide emergency treatment to all persons; no child or other person lacking legal capacity is to be refused emergency medical treatment for any reason. By omitting consent, this section *prima facie* creates an exception to the general rule that prior consent is required for treatment. Where an emergency is involved, the practitioner or health worker has a legal duty to administer medical care, whether or not they have obtained the requisite consent. It would appear that a medical practitioner, who encounters an emergency involving a child and, acting under this legal duty, proceeds to administer medical treatment in order to save life, will not be held liable for any treatment which the parent, guardian, or other person exercising parental responsibility over the patient subsequently finds objectionable. However, this section applies only to emergencies, and a physician will therefore not find justification under this section if the treatment administered to the patient does not qualify as emergency treatment.

B. *Section 23 (1): 'Every health care provider shall give a user relevant information pertaining to his state of health and necessary treatment relating to—'*

¹⁷ For instance, the UK has such laws like the Children and Families Act 2014, Equality Act 2010, Mental Capacity Act 2005, Adults with Incapacity (Scotland) Act 2000 and other international Statutes and Conventions to which the UK is a party, all regulating the affairs of children's healthcare, in addition to The Children Act (England and Wales) 2004; Scotland 1995.

- (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;*
- (b) the range of diagnostic procedures and treatment options generally available to the user;*
- (c) the benefits, risks, costs and consequences generally associated with each option; and*
- (d) the user's right to refuse health services and explain the implications, risks or obligations of such refusal.'*

This section sets out the framework for informed consent in Nigerian medical law. It guarantees a patient's right to be informed of their health status, the options available to them, and the benefits, risks, cost, and consequences of each option, as well as their right to refuse treatment and the attendant implications of refusal. This section does not make a distinction between a 'user' and a minor. The implication of the foregoing *prima facie* is that a minor is also entitled to the benefit of informed consent and the right to refuse treatment. Nothing in this section or in the Act excludes any category of persons from the advantage of this right. However, in practical terms, medical practitioners do not expect to receive consent from children or other persons lacking legal capacity, such as psychiatric patients and thus do not consider themselves to be under a legal duty to give full knowledge to such patients.

- C. *'Section 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 (1) 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.'*

In this context, this section addresses a minor's consent to disclose information regarded as confidential. The important observation to be made in relation to this section is the specific mention of minors and persons lacking capacity. These patients are particularly protected by law from disclosure of confidential information, except with the consent of their parents, guardians, or representatives. Natural curiosity would raise why minors and persons lacking legal capacity are specifically mentioned and protected from disclosure of confidential

information, but these words are visibly omitted in Section 23, which places a legal duty on medical practitioners to obtain informed consent. While Section 26 requires parental consent for a minor and the consent of a legal representative for a person lacking capacity, Section 23 does not require this oversight to secure informed consent to treatment. Section 23 uses the word ‘user’ without differentiating whether the user is a minor or lacks legal capacity. The implication of this, going by the *Ejusdem Generis* rule of statutory interpretation¹⁸ is that children and minors under Nigerian law are entitled to receive full disclosure of all information regarding their health status, the options available to them and the right to refuse treatment and the consequences of such refusal. It is not apparent whether this is the intention of the lawmakers, but it does appear that in some jurisdictions the law specifically intends that minors who have some capacity to understand the nature of the treatment should have this right in themselves. A similar provision appears in the law regarding the taking of samples for scientific testing to prove paternity.¹⁹ Suffice it to be stated that Section 27 creates an exception to the impedance to disclosure in Section 26. It is to the effect that medical and health care personnel may, within the ordinary course of their duties and for legitimate purposes, disclose a patient’s confidential information where it is in the interest of the patient to do so.

- D. ‘28. (1) A health care provider may examine a user’s health records for the purposes of—
(a) treatment with the authorisation of the user;’

Once more, there is no mention of minors in this section. As with Section 23, the generic word ‘user’ is employed to imply that minors are entitled or retain the right to give consent to medical practitioners for the use of their health record.

The problem of a community reading of the relevant sections of the National Health Act is immediately apparent. From the Act's wording, parental consent is required to disclose a minor's confidential information, yet these patients reserve the right to receive the information underlying informed consent and to consent to the use of their confidential records.

2.2 The Child’s Rights Act

The Child’s Rights Act is the primary and most comprehensive legislation regulating the rights of children and young people in Nigeria. Its scope is much wider than healthcare and treatment of children. However, it contains some provisions. The sections relevant to this discourse are Sections 1, 2, 13 (1), (2), (4) – (6), 14, 41 and 42, which are discussed below:

¹⁸J. Nnamdi Aduba and Samuel Oguiche *Key Issues in Nigerian Constitutional Law* (Nigerian Institute of Advanced Legal Studies, Jos, 2021) 146-148

¹⁹Section 64 of the Child’s Act

- A. *'Section 1. In every action concerning a child, whether undertaken by an individual, public or private body, institutions or service, court of law, or administrative or legislative authority, the best interest of the child shall be the primary consideration.'*

This general provision provides the underlying philosophy for all actions and endeavours relating to a child, whether taken by any person or institution. Irrespective of the situation or the circumstance which involves a minor, the best interest of the child is to always remain the primary consideration. The principle has been quoted, relied upon, and followed in numerous cases across various Nigerian courts.²⁰

- B. *Section 2 (1): A child shall be given such protection and care as is necessary for the well-being of the child, taking into account the rights and duties of the child's parents, legal guardians, or other individuals, institutions, services, agencies, organisations or bodies legally responsible for the child.*

(2) Every person, institution, service, agency, organisation or body responsible for the care or protection of children shall conform with the standards established by the appropriate authorities, particularly in the areas of safety, health, welfare, number and suitability of their staff and competent supervision.

This is another generic albeit important provision of the Act. The importance of this section lies not in the duty it places on institutions and agencies to give necessary protection and care for the well-being of children, but in the duty it places on such agencies and institutions to conform to the standards established by appropriate authorities in the area of health, safety, welfare, etc. By implication, therefore, the standards established by the National Health Act are expected to be followed as they concern children, based on their incorporation into the Child's Rights Act.

- C. *'Section 13 (1): Every child is entitled to enjoy the best attainable state of physical, mental and spiritual health.*

(2) Every Government, parent, guardian, institution, service, agency, organisation or body responsible for the care of a child shall endeavour to provide for the child the best attainable state of health.

(4) Every parent, guardian or person having the care and custody of a child under the age of two years shall ensure that the child is provided with full immunisation.

(5) Every parent, guardian or person having the care of a child who fails in the duty imposed on him under subsection (4) of this section commits an offence and is liable on conviction for-

²⁰See *Esabunor & Anor v. Faweya & Ors* (2019) LPELR-46961(SC) among others

- (a) a first offence, to a fine not exceeding five thousand naira; and
- (b) second or any subsequent offence, whether in respect of that child or any other child, to imprisonment for a term not exceeding one month.
- (6) The Court may make, in substitution for or addition to any penalty stipulated under subsection (5) of this section, an order compelling the parent of a child to get the child immunised.'

This is arguably the most comprehensive provision of the Child's Rights Act on the healthcare of a child. Unfortunately, it does not expressly provide for a child's consent to receive treatment. It does, however, deal squarely with the right of children under the age of two to receive immunisation. It clearly denies parents and guardians the right to refuse immunisation, making it a criminal offence to refuse immunisation on behalf of a child or to fail to receive it. This is a profound position and may be argued by many as being an infringement of the right of the parents or guardians to reject life-saving treatment on behalf of their children. At the very least, this provision creates tension between parental autonomy and a child's best interests. This is perhaps the only section of Nigerian legislation that expressly denies the right to refuse to consent to treatment. It is in direct contrast to Section 23 (1) (d) of the National Health Act, which unfortunately does not make a distinction between a 'user' and a minor, making it obligatory for medical practitioners to inform all patients of their right to refuse treatment and the implications of exercising such right.

- D. Section 14: *Every child has a right to parental care and protection, and accordingly, no child shall be separated from his parents against the wish of the child except-*
- (a) for the purpose of his education and welfare; or
 - (b) in the exercise of a judicial determination in accordance with the provisions of this Act, in the best interest of the child.

This section does not merely present an ideal in the objectives of child healthcare in Nigeria; it also gives the state or other appropriate authority the power to separate a child from their parents against their wish to exercise a judicial determination of the child's best interest. This immediately presents a scenario whereby the parents of a child who exercise their autonomy and right to refuse treatment by refusing to consent to life-saving treatment can have that child separated from them pursuant to an order of court by which the best interest of the child has been determined to be contrary to the autonomy of the parents. This was the position in *Esabunor & Anor v. Faweya & Ors*, where a one-month-old child received treatment by order of court against his mother's wishes.²¹

²¹(2019) LPELR-46961(SC)

- E. *'Section 41: (1) A State Government or an appropriate authority may apply to the Court for a child assessment order with respect to a child and the Court may make the order, if it is satisfied that-*
- (a) the applicant has reasonable cause to suspect that the child is suffering, or likely to suffer significant harm;*
 - (b) an assessment of the state of the health or development of the child or the way in which the child has been treated, is required to enable the applicant to determine whether or not the child is suffering, or is likely to suffer significant harm; and*
 - (c) it is unlikely that such assessment will be made, or be satisfactory in the absence of an order under this section.*
- (6) A child assessment order shall contain an authority to the person carrying out the assessment, or any part of the assessment, to do so in accordance with the terms of the order.*
- (7) Notwithstanding subsection (6) of this section, if the child has sufficient understanding to make an informed decision, he may refuse to submit to medical or psychiatric examination or any other assessment.'*

This section deals with the application for and grant of assessment orders by a court in favour of a child who is suspected to be suffering or is at risk of suffering significant harm. The most relevant consideration of this section is in subsection (7) in that it recognises that a child may be mature enough to withhold consent to medical or psychiatric exam pursuant to an assessment order. This vests an express right in a minor of sufficient understanding to refuse a medical exam. Although this right is not related to life-saving treatment, it recognises that a minor may be of sufficient understanding to withhold consent, and it also gives such a child the right to refuse medical examination in the circumstances of an assessment order.

- F. *'Section 42 (5): where the Court makes an emergency protection order, it may give such directions as it considers appropriate with respect to-*
- (b) medical or psychiatric examination or other assessment of the child.*
- (6) Where a direction is given under subsection (5) (b) of this section, the child may, if he has sufficient understanding to make an informed decision, refuse to submit to examination or any other assessment.'*

This section is on all fours with Section 41 above, except that it applies where a court grants an emergency protection order against an assessment order.

3. CHILDREN AND PROXY DECISION MAKING

Lack of capacity appears to be the underlying principle behind proxy decision-making for children. Many children, especially those of tender years, lack the capacity to comprehend the nature of life and the implications of decisions, even when they are properly informed or made aware of such consequences. Many countries have statutes that clearly provide the age at which a child of understanding may consent to treatment without requiring parental consent. For example, the Children's Act of South Africa provides²² that a child of 12 years who is sufficiently mature and has the mental capacity to understand the benefits, risks, social and other implications of medical treatment can give their consent to such treatment, except in the case of surgery, where parental consent is required. Children less than 12 years or who are over 12 years but fail to demonstrate an understanding of the treatment will require parental consent for both treatment and surgical procedures.²³ International best practices encourage involving children in decisions that affect their lives.²⁴ With the advancement of enlightenment in the 21st Century and the digital age into which most children are born, it is only reasonable that children of understanding are consulted or at least involved in the decision-making processes of their lives. Unfortunately, in Nigeria, there is no express legislation or provision that addresses the right of children to give or withhold consent or provides the age at which a minor may be involved in the decisions around their medical treatment.

3.1 Parental Consent and The Best Interests of The Child

It is generally accepted that the most suitable people to decide what is in the child's best interests are the child's parents, as they have the closest link to the child, know the child better than others, and have spent the most time nurturing the child and watching their development. However, modern family trends show that this ideal does not hold true in many cases. As Redding observed a long time ago:

Courts have typically advanced two reasons to justify denying children the right to consent to, or refuse, mental health treatment. First, the courts perceive that children are not competent to make such life decisions. Second, they assume that parents, in consultation with the clinician, will make treatment decisions based upon the child's best interests...however, (is that) these assumptions are invalid. The assumption that parents act in their child's best interest is intuitively sensible and inherently appealing. It undoubtedly holds true in most

²² Section 129, Children's Act of South Africa No 38 of 2005

²³ D. J. Mcquoid-Mason "Can Children Aged 12 Years or More Refuse Life-saving Treatment Without Consent or assistance From Anyone Else? *South African Medical Journal* (2014) (104) (7) 446-467 <<https://journals.co.za/doi/pdf/10.7196/SAMJ.8417>>assessed on 21st July 2026

²⁴ Article 12 of the United Nations' Convention on the Rights of the child states as follows: 'States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.'

families under normal circumstances. However, the legal system has extended this generally valid assumption to one area where it may not be tenable: the mental health context.²⁵

Although the focus of Redding's discourse is the area of treatment of mental health, the saying holds true in regard to general medical treatment. When there is dysfunction in the family characterised by conflict in the opinions of the parents or an inability to make logical decisions, or where the parents are themselves emotionally or psychologically unstable, a serious question is raised as to the parental responsibility of such a parent. Additionally, strict religious beliefs often create tension between the child's best interests and the child's autonomy. The parent's judgment may be so tainted by religious beliefs that they cannot agree with the medical practitioner's advice as the best option for the child.

3.2 Medical Emergencies and Treatment Without Consent; Doctrine of Necessity

Medical professionals in Nigeria have a duty to provide emergency medical services.²⁶ As has been highlighted above,²⁷ the wording of the National Health Act places a legal duty on all medical practitioners not to refuse to give emergency treatment 'for any reason'. Guided by the doctrine of necessity, medical practitioners in Nigeria can respond to emergencies without immediately satisfying the consent requirement. For example, if a minor is brought to a facility without their parents in an emergency requiring immediate life-saving treatment, medical practitioners may administer the necessary treatment to save the minor's life before addressing consent. The author is of the view that the provisions of Section 20 (1) of the National Health Act can be engaged to assist such a medical healthcare worker to escape liability, provided that the treatment administered was under circumstances that qualify as an emergency and did not exceed treatment such as was needed to immediately save life. Unfortunately, the section is, to the best knowledge of the author, yet to be tested in a court of law in relation to a minor under these circumstances to validate this opinion. It is, however, arguable that Section 20(1) does not impose a duty to administer treatment but a duty not to refuse, giving the subtle impression that consent is assumed in the circumstances, such that the medical practitioner is presented with a request to treat the emergency.

²⁵ Richard E. Redding 'Children's Competence to Provide Informed Consent for Mental Health Treatment' *Washington and Lee Law Review* (1993) (50) 695-753

<https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2387941#>assessed on 21st July 2026

²⁶ Nnaemeka Emmanuel Otagburuagu 'Ease of Medical Negligence and Abandonment of Liabilities in Nigeria' *Section on Legal Practice La Journal* (2025) (11) 104-130

²⁷Section 20 (1) of the National Health Act. See also the Compulsory Treatment and Care of Gunshots Act 2017

3.3 Judicial Interventions in Nigeria

The most prominent case in the area of parental consent to life-saving treatment on behalf of a minor is the case of *Esabunor & Anor v. Faweya & Ors*²⁸ In this case, the mother of a minor aged one month took him to a medical facility where he was diagnosed with an infection and was severely anaemic and in need of a blood transfusion. On religious grounds, being a member of the Jehovah's Witnesses sect, the mother refused to grant her consent for the transfusion. The hospital applied to a magistrate court under the Children's and Young People's Law of Lagos State, and the Magistrate issued an order allowing the hospital to administer the transfusion. The child thereafter recovered, and the mother brought this suit against the medical doctor, the hospital, the Magistrate and the Commissioner of Police of Lagos State. The Supreme Court held in that suit that a parent's right to religious freedom and to refuse treatment could not interfere with the best interests of a minor. The court affirmed the decisions of the High Court and the Court of Appeal that where parental autonomy conflicts with what is determined to be the child's best interest, the state may exercise its power to override the wishes of the parent or guardian in favour of the child's best interest.

This case is instrumental to understanding the courts' disposition in the absence of clear legislation giving minors of understanding and children with capacity the right to give informed consent for themselves. It is safe to draw an inference that where a child of understanding gives their consent to life-saving treatment, the courts will uphold that consent above the wishes of the parent. However, until a minor's refusal to consent is specifically tested, it is not possible to state what the outcome of such a challenge would be, as there is no legislation or clear indication of a possible outcome.

4. CONCLUSION

It is evident that there is no specific legislation in Nigeria that provides for the right of children to grant consent to medical treatment, much less to withhold consent to medical treatment. It does appear, however, from the National Health Act that children are entitled to give informed consent to treatment, especially seeing that nothing in the Act specifically empowers a parent, guardian, or other legal representative to make this decision on behalf of a minor. This inference, however, leaves room for many challenges because the Act does not specify how old a minor must be before the presumption of understanding can be made in their favour, as is the case in South Africa. Hence, the provisions of Nigerian law in this regard are grossly insufficient and in dire need of attention.

²⁸(2019) LPELR-46961(SC)

5. RECOMMENDATIONS

The following recommendations are made with regard to the consent to life-saving treatment for children in Nigeria:

1. The National Assembly, as a matter of utmost importance, needs to pass legislation regulating consent to medical treatment by minors, making a distinction between children of competence and understanding and those who lack the same.
2. The basic right to be involved in medical treatment and the restricted right to consent to treatment ought to be statutorily available to minors in Nigeria.
3. The National Health Act does not distinguish a minor from what it terms as a 'user'. Every provision in the Act relating to patients uses the term "user," without distinguishing minors. This makes it impossible, based on the Act's wording, to determine the peculiarities of minors.
4. Section 23 of the National Health Act should be amended to accommodate where the user is a minor or a person otherwise lacking capacity. Immunisation should also be excepted from this section to avoid conflict with section 13(4), (5) and (6), given that available scientific data indicate the overall benefits of infant immunisation outweigh the risks.