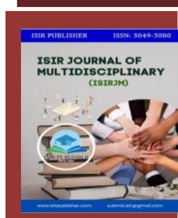

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Adolescent Sexuality and Barriers to Reproductive Health Services in Nigeria: Legal and Policy Implications for Children's Medical Tourism

By

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Abstract

Adolescents in Nigeria face several challenges in attempting to exercise their Sexual and Reproductive Health Rights. Although the Constitution and laws such as the Child Rights Act 2003 and the Violence Against Persons (Prohibition) Act 2015 provide protection to an extent, however the reality of the effective exercise of such Rights is different. Provisions of restrictive abortion laws, contradictions in the age of consent, lack of confidentiality in healthcare, and weak enforcement of existing laws limit adolescents' ability to access safe and appropriate services. These legal and institutional barriers are reinforced by socio-cultural and religious norms that discourage open engagement with adolescent sexuality and often stigmatise those seeking care. An emerging but underexplored consequence of these constraints is the recourse to cross-border reproductive healthcare. There is growing evidence that some adolescents and their families seek services outside Nigeria, within and beyond Africa to obtain care that is inaccessible or legally restricted domestically. This raises complex questions: how should conflicts of law be managed when Nigerian adolescents undergo procedures abroad that are unlawful domestically? How are issues of parental consent, adolescent decision-making capacity, and confidentiality reconfigured in transnational medical contexts? This paper interrogates these questions through a doctrinal and policy analysis of Nigerian law in light of comparative international practice. It argues that unless systemic legal and institutional reforms are undertaken particularly the clarification of adolescent consent, strengthening confidentiality protections, and harmonising domestic law with international obligations, Nigeria will continue to witness the externalisation of adolescent reproductive healthcare needs through medical tourism, with profound implications for health equity, child rights jurisprudence, and ineffective regulatory sovereignty in respect of adolescent sexual and health rights.

***Key Words**: Adolescent Sexuality, Reproductive Health, Medical Tourism, Health Rights, Childs Rights.*

INTRODUCTION

Adolescence, is defined by the World Health Organization as the period spanning between the ages ten and nineteen, which represents a critical stage in human development, marked by profound physical, emotional, and social transformation.[1] In Nigeria, this stage coincides with exposure to complex reproductive health challenges, including early sexual debut,

[1] *World Health Organization, Adolescent Health: Key Facts (2023) https://www.who.int/news-room/fact-sheets/detail/adolescent-health accessed 12 October 2024.*

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unintended pregnancy, unsafe abortion, and vulnerability to sexually transmitted infections[2] such as Human Immuno Deficiency Virus (HIV).[3] These challenges are compounded by limited access to accurate information, restrictive legal frameworks, weak health systems, and pervasive socio-cultural taboos that silence open discussions about sexuality.[4]

1.2. Overview of Adolescent Sexual Reproductive Rights in Nigeria

Empirical data show that a significant proportion of Nigerian adolescents engage in sexual activity before the age of eighteen, often without adequate knowledge or access to modern contraceptives.[5] According to the Nigeria Demographic and Health Survey,[6] approximately 19% of adolescent girls aged within the ages of 15 to 19 have begun childbearing, with higher prevalence in rural areas and the northern regions,[7] despite increasing awareness of contraceptive methods, utilisation remains remarkably low. For instance, only about 17% of sexually active unmarried adolescent girls reported using modern contraception.[8]

1.3. Challenges and Policy Contradictions

Studies reveal that adolescents who are sexually active often do not seek professional reproductive health services due to fear of stigma, confidentiality breaches, and judgmental attitudes of healthcare providers.[9] The lack of adolescent-friendly health facilities remains a persistent barrier across the country. Nigeria's legal and policy frameworks provide partial recognition of adolescent sexual and reproductive health rights. The 1999 *Constitution* of the Federal Republic of Nigeria guarantees the right to life, dignity, and health under *Chapter* II and related judicial interpretations, though these rights are not expressly justiciable.[10] The *Child Rights Act* 2003 affirms a child's right to survival, development, and participation,[11] while the *Violence Against Persons (Prohibition) Act* 2015 criminalizes sexual violence and harmful traditional practices.[12]

However, contradictions persist. The legal age of sexual consent is set at sixteen under Nigerian criminal law, yet the *Child Rights Act* defines a child as anyone under eighteen, creating interpretational conflicts in cases of adolescent consent to sexual or medical decisions.[13] Abortion remains criminalized under the *Criminal Code*[14] and *Penal Code*[15], except where necessary to save the life of the woman.[16] This restrictive framework has been linked to the prevalence of unsafe abortions among adolescents, contributing to maternal morbidity and mortality.[17]

In practice, adolescent confidentiality is poorly protected. Many healthcare providers require parental consent before offering contraception or related services to minors, a practice that discourages adolescents from seeking timely medical attention.[18] Beyond the legal sphere, socio-cultural and religious norms exert strong influence on adolescent Sexual and Reproductive Health behaviour. Nigerian society often perceives discussions of sexuality as immoral or taboo, particularly for unmarried adolescents.[19] This discourages comprehensive sexuality education both in homes and in schools.[20] Religious opposition, particularly from conservative Islamic and Christian communities, has hindered the implementation of the National Policy on the Health and Development of Adolescents and Young People.[21]

Institutionally, the health system lacks sufficient adolescent-friendly services. A 2022 study in Plateau State found that more than 75% of adolescents had never visited a health facility for SRH issues, citing lack of privacy, cost, and fear of judgment.[21] Economic factors also exacerbate disparities: rural adolescents are less likely to access Sexual and Reproductive Health services compared to their urban counterparts.[22] The consequences of inadequate adolescent Sexual and Reproductive Health services are far-reaching. Nigeria continues to record one of the highest rates of adolescent pregnancy in sub-Saharan Africa.[23] The World Bank in 2023 noted that teenage pregnancy and early marriage remain leading contributors to maternal mortality

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[2] *STI's*

[3] *National Population Commission (NPC) [Nigeria] and ICF, Nigeria Demographic and Health Survey 2018 (NPC and ICF 2019) 107.*

[4] *Ibid; see also UNFPA, Adolescent Sexual and Reproductive Health in Nigeria (UNFPA Country Office, 2020).*

[5] *Ibid. NPC & ICF*

[6] *Nigeria Demographic and Health Survey 2018*

[7] *Ibid.*

[8] *Federal Ministry of Health, National Policy on the Health and Development of Adolescents and Young People in Nigeria (2019–2023) (FMOH 2019). 74*

[9] *Tunde-Ayinmode M. F, "Barriers to Adolescent Utilization of Sexual and Reproductive Health Services in Nigeria" (2022).BMC Public Health 22(1) 1964.*

[10] *Constitution of the Federal Republic of Nigeria 1999 (as amended), Chapter II, s 17(3)(d).*

[11] *Child Rights Act 2003, s 11–14.*

[12] *Violence Against Persons (Prohibition) Act 2015, s 23–26.*

[13] *See Criminal Code Act, Cap C38 LFN 2004, s 30; Child Rights Act 2003, s 277.*

[14] *(Sections 228 to 230).*

[15] *(Sections 232 to 236).*

[16] *13. Criminal Code, ss 228–230; Penal Code, ss 232–236.*

[17] *Okonofua F, "Abortion Law and Policy Reform in Nigeria: Challenges and Prospects" African Journal of Reproductive Health 25(5) (2021). 7–17.*

[18] *Odo AN, "Perceptions and Barriers to Reproductive Health Services among Nigerian Adolescents" African Journal of Reproductive Health 25(2) (2021).93–104.*

[19] *Aderinto AA, "Culture, Morality and Adolescent Sexuality in Nigeria" 46(3) Journal of African Studies (2020) 51–65.*

[20] *UNESCO, International Technical Guidance on Sexuality Education: An Evidence-Informed Approach (2018).*

[21] *Yari IA et al, "Utilisation of Sexual and Reproductive Health Services among Adolescents in Plateau State, Nigeria" (2022) BMC Health Services Research 22(1) 154.*

[22] *National Population Commission & ICF (n 2) 135.*

[23] *World Bank, Adolescent Sexual and Reproductive Health in Nigeria: Country Brief (World Bank, 2023) 4.*

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and school dropout among Nigerian girls. Unintended pregnancies often lead to unsafe abortions, a major cause of preventable deaths among adolescents. Moreover, the lack of access to Sexual and Reproductive Health information and services perpetuates cycles of gender inequality, poverty, and health inequity.

1.4. Rising Trend of Medical Tourism for Sexual Rights Healthcare

An underexplored but emerging phenomenon is the increasing recourse to medical tourism for adolescent reproductive health needs. Families with financial means often seek Sexual and Reproductive Health -related services such as surgical abortion, contraceptive implants, or confidentiality-assured counselling in jurisdictions where such services are lawful and socially accepted. This transnational dimension raises legal and ethical questions about parental consent, adolescent autonomy, and the extraterritorial reach of Nigeria's restrictive laws.

This raises complex legal and policy questions: How should Nigeria manage conflicts of law when adolescents undergo procedures abroad that are unlawful domestically? What are the implications for parental consent, adolescent decision-making capacity, and confidentiality in transnational contexts? Does the state's failure to provide safe and accessible Sexual and Reproductive Health (SRH) services domestically breach its obligations under international human rights treaties such as the *Convention on the Rights of the Child* (*CRC*) and the *Convention on the Elimination of All Forms of Discrimination against Women* (*CEDAW*), both ratified by Nigeria?[24]

The phenomenon of transnational healthcare mobility often termed medical tourism provides an illuminating lens through which to examine the consequences of limited adolescent Sexual and Reproductive Health access in Nigeria. Medical tourism has traditionally been studied in relation to adults seeking elective or specialized medical procedures abroad.[25] However, the rising incidence of Nigerian adolescents and their families travelling across borders to obtain reproductive or confidentiality-sensitive services such as abortion, contraception, and fertility treatment reveals a critical, understudied intersection between adolescent rights, domestic legal restrictions, and global healthcare networks.[26]

Persistent barriers to Sexual and Reproductive Health services legal restrictions, inadequate facilities, socio-cultural stigma, and inconsistent policy enforcement create a vacuum that adolescents and their caregivers attempt to fill through transnational options.[27] In effect, what begins as a domestic governance failure evolves into a cross-border legal problem. The inability of national health systems to guarantee accessible and confidential care pushes adolescents to countries with more liberal reproductive health frameworks, such as South Africa, Ghana, and Kenya.[28] These movements reflect the global reality that healthcare access is no longer confined within state borders but is mediated by mobility, information, and differential legal opportunity.

2.1. Adolescent Sexuality: Development and Identity Dimensions

The concept of adolescent sexuality refers to the process through which young people between the ages of 10 and 19 years' experience and express their sexual identity, emotions, relationships, and desires in the context of social, cultural, and biological change.[29] The World Health Organization (WHO) identifies this stage as a formative period during which individuals acquire the physical and psychosocial capacities to make reproductive and sexual decisions, while still being influenced by social norms and parental authority.[30]In the Nigerian context, however, adolescent sexuality remains a culturally sensitive and often silenced topic. Traditional and religious beliefs continue to frame adolescent sexual activity as immoral or premature, leading to widespread reluctance to discuss sexual health openly in homes, schools, or health facilities.[31] Such moral anxieties have influenced the country's legal and policy framework, resulting in restrictive reproductive health services for minors. The *Child Rights Act* 2003, for instance, guarantees the protection of children from sexual exploitation but is silent on adolescents' rights to reproductive autonomy or access to contraception.[32] Similarly, the *Criminal Code Act* criminalises "unlawful carnal knowledge" of a girl under thirteen, while the *Penal Code* in Northern Nigeria sets a lower threshold based on puberty,

[24] *13. Convention on the Rights of the Child, adopted 20 November 1989, 1577 U.N.T.S. 3; CEDAW, adopted 18 December 1979, 1249 U.N.T.S. 13*

[25] *Connell, J. Medical Tourism: Sea, Sun, Sand and Surgery. London: Routledge Publisher. (2015). 62.*

[26] *Lunt, N., Horsfall, D., &Hanefeld, J.. "Medical Tourism: Treatments, Markets and Health System Implications." OECD Health Working Papers No. 63, OECD Publishing, Paris. (2016). 129.*

[27] *Child Rights Act 2003; Convention on the Rights of the Child, adopted 20 November 1989, 1577 U.N.T.S. 3; African Charter on the Rights and Welfare of the Child, adopted 11 July 1990, OAU Doc. CAB/LEG/24.9/49 (1990).*

[28] *Okonofua, F. Abortion in Nigeria: Law, Policy and Practice. Ibadan: (2022).Women's Health and Action Research Centre.*

[29] *World Health Organization (WHO), Adolescent Health (Geneva: WHO, 2022), https://www.who.int/health-topics/adolescent-health. Accesses in Oct 2024.*

[30] *Blum, R. W. &Mmari, K., "Risk and Protective Factors Affecting Adolescent Reproductive Health in Developing Countries," Journal of Adolescent Health 45, no. 3 (2009): 241–250.*

[31] *Adegoke, T. G. &Oladeji, D., "Sexual Behaviour and Perception of HIV/AIDS Among Nigerian Adolescents," African Journal for the Psychological Study of Social Issues 10, no. 2 (2007): 242–257.*

[32] *Child Rights Act, Cap C50, Laws of the Federation of Nigeria (2003), ss. 11–34.*

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reflecting inconsistencies that obscure the recognition of adolescent consent.[33]

These contradictions leave adolescents in a precarious position legally classified as children yet physiologically and socially maturing into adulthood. Research indicates that this gap has contributed to high levels of teenage pregnancy, unsafe abortions, and sexually transmitted infections among Nigerian adolescents.[34]

2.2. Reproductive Health

Reproductive health, as defined by the International Conference on Population and Development Programme of Action (1994), implies "a state of complete physical, mental, and social well-being in all matters relating to the reproductive system."[35] It encompasses the right of all individuals—adolescents included—to access accurate information, family planning services, safe pregnancy care, and the ability to make decisions regarding reproduction free from coercion, discrimination, or violence.[36]

2.3. Medical Tourism and Cross-Border Healthcare

Medical tourism generally refers to the phenomenon of individuals travelling across national borders to seek medical care, whether for treatment, surgery, or preventive services, often due to cost differentials, legal restrictions, or the pursuit of higher-quality care.[37] The World Health Organization describes it as part of a broader trend in cross-border healthcare, where the mobility of patients, medical personnel, and technology transcends national boundaries to meet diverse health demands.[38] In its modern form, medical tourism is facilitated by globalisation, liberalised travel, and advances in information technology, which have made it easier for patients to access health information and arrange care abroad.[39]The Global Health Workforce Alliance identifies three primary motivations driving medical tourism:

a) affordability and availability of services;
b) avoidance of legal or cultural restrictions in the home country; and
c) Perception of superior medical expertise abroad.[40]

These motivations are particularly relevant in the context of adolescent sexual and reproductive health in Nigeria, where restrictive laws and social stigma often limit access to services such as abortion, contraception, and confidential counselling.
Cross-border healthcare, while overlapping with medical tourism, carries broader regulatory implications. It encompasses not only elective medical travel but also emergency and referred care, as well as regional health agreements between states.[41] In the European Union, for instance, Directive 2011/24/EU on patients' rights in cross-border healthcare establishes a legal framework guaranteeing EU citizens the right to seek treatment in other member states under certain conditions.[42] In contrast, African jurisdictions, including Nigeria, operate without a harmonised framework, leaving the cross-border movement of patients largely unregulated and dependent on informal networks or private arrangements.[43] The growth of medical tourism in Africa has been documented in several studies, with Nigeria emerging as both a source and recipient country.[44] Many Nigerians travel abroad, particularly to India, South Africa, the United Kingdom, and the United Arab Emirates, to access specialised medical services not readily available or legally accessible at home.[45] In recent years, adolescents have increasingly been part of this transnational flow, particularly for procedures

[33] *Criminal Code Act, Cap C38, Laws of the Federation of Nigeria (2004), ss. 218–221; Penal Code (Northern States) Federal Provisions Act, Cap P3, Laws of the Federation of Nigeria (2004), ss. 282–283.*

[34] *Fatusi, A. O., "Adolescent Sexual and Reproductive Health in Nigeria: Progress, Challenges and Opportunities," African Journal of Reproductive Health 19, No. 3 (2015): 7–16.*

[35] *United Nations, Report of the International Conference on Population and Development, Cairo, 5–13 September 1994 (New York: United Nations, 1995), para. 7.2.*

[36] *UNFPA, Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender (New York: UNFPA, 2018), 5–7.*

[37] *Carrera, P. M., & Bridges, J. F. P., "Globalization and Healthcare: Understanding Health and Medical Tourism," Expert Review of Pharmacoeconomics& Outcomes Research 6, no. 4 (2006): 447–454.*

[38] *World Health Organization (WHO), Public Health, Innovation and Intellectual Property Rights: Report of the Commission on Intellectual Property Rights, Innovation and Public Health (Geneva: WHO, 2006), 97–100.*

[39] *Johnston, R., Crooks, V. A., Snyder, J., & Kingsbury, P., "What Is Known About the Effects of Medical Tourism in Destination and Departure Countries? A Scoping Review," International Journal for Equity in Health 9, No. 1 (2010): 24–32.*

[40] *Global Health Workforce Alliance, Migration of Health Workers: WHO Code of Practice and the Global Economic Crisis (Geneva: WHO, 2014), 11–13.*

[41] *Lunt, N., Smith, R., Exworthy, M., et al., "Medical Tourism: Treatments, Markets and Health System Implications: A Scoping Review," OECD Directorate for Employment, Labour and Social Affairs Health Working Papers No. 54 (2011), 6–9.*

[42] *Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the Application of Patients' Rights in Cross-Border Healthcare OJ L [2011] 88/45.*

[43] *Mackey, T. K., & Liang, B. A., "The Global Reach of Medical Tourism: Balancing Access, Quality, and Cost," BMC Health Services Research 12, no. 1 (2012): 1–7.*

[44] *Crush, J., Chikanda, A., &Maswikwa, B., South–South Medical Tourism and the Quest for Health in Southern Africa (Kingston: Southern African Migration Programme, 2012), 7–10.*

[45] *Ijeoma, E., "Medical Tourism and the Nigerian Health System: Challenges and Opportunities," African Journal of Governance and Development 6, no. 1 (2017): 55–70.*

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related to reproductive health, cosmetic surgery, and treatment of complications arising from unsafe abortions.[46]From a legal standpoint, medical tourism raises complex issues concerning liability, consent, confidentiality, and regulatory sovereignty.[47] When minors travel abroad for procedures that are restricted or criminalised in their home country, questions arise about parental consent, the recognition of foreign medical practices under domestic law, and the enforceability of patient rights across borders.[48] Scholars have argued that such movements blur traditional notions of jurisdiction and highlight the tension between domestic health laws and the globalisation of care.[49]

2.4. Consent, Confidentiality and Capacity.

2.4.1. Consent

Consent in medical law refers to the voluntary agreement of a competent individual to undergo a medical procedure or intervention. In Nigeria, the legal framework for medical consent is largely informed by the Child's Rights Act 2003, which defines a child as a person under the age of 18 years.[50] Although the Act promotes respect for the child's views, it does not expressly confer independent decision-making authority on minors in medical contexts. Consequently, parental or guardian consent remains the prevailing norm for medical treatment of adolescents.In contrast, the United Kingdom's *Gillick* competence standard, established in *Gillick v. West Norfolk and Wisbech Area Health Authority*,[51] recognizes that a child under 16 may consent to medical treatment without parental approval if deemed sufficiently mature to understand the nature and consequences of the decision.[52] This principle has been affirmed in subsequent cases, such as *Axon v. Secretary of State for Health* (2006), which reinforced the adolescent's right to confidential sexual and reproductive health advice.[53] Nigeria, by comparison, has not explicitly adopted a similar doctrine, though calls have been made for a more nuanced approach that considers the adolescent's maturity and best interests.[54]

2.4.2. Confidentiality

Confidentiality refers to the ethical and legal duty of healthcare providers to protect patient information from unauthorized disclosure. For adolescents, this issue becomes complex when parents or guardians are involved in care decisions. In Nigeria, confidentiality obligations arise from both professional ethics such as the *Medical and Dental Practitioners' Code of Conduct* and broader rights under the *Constitution* of the Federal Republic of Nigeria 1999 (as amended), which guarantees privacy of citizens.[55] However, in practice, healthcare providers often struggle to maintain confidentiality in cases involving minors, particularly when Sexual and Reproductive Health services are involved.[56] In the United Kingdom, confidentiality for adolescents has a firmer legal footing. The Department of Health's "Fraser Guidelines" complement the *Gillick* principle, emphasizing that adolescents should be given confidential access to health services, including contraception, if they are judged competent.[57] This has been instrumental in encouraging young people to seek medical advice without fear of parental disclosure. Nigeria's lack of clear policy guidance on this issue has contributed to under-utilization of Sexual and Reproductive Health services among adolescents and, by extension, to the rise of medical tourism for discreet care.[58]

2.4.3. Capacity

Capacity refers to an individual's ability to understand, retain, and evaluate information relevant to a decision, and to communicate their choice.[59] Under Nigerian law, capacity is generally presumed to exist in adults aged 18 and above, while minors are presumed incapable unless otherwise demonstrated.[60] The rigid age-based approach contrasts with the functional test applied in the United Kingdom, where the *Mental Capacity Act* 2005 and the *Gillick* principle both

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[46] *Okoye, U. O., &Nwokolo, E. E., "Emerging Patterns in Adolescent Health-Seeking Behaviour: Implications for Policy in Nigeria," Nigerian Journal of Social Sciences 15, no. 2 (2019): 112–127.*

[47] *Cohen, I. G., "Medical Tourism: The View from Ten Thousand Feet," Hastings Centre Report 40, No. 2 (2010): 11–12.*

[48] *Snyder, J., Crooks, V. A., & Johnston, R., "Medical Tourism: A Review of the Ethics, Legalities, and Governance," Philosophy, Ethics, and Humanities in Medicine 8, No. 1 (2013): 1–7.*

[49] *Lunt, N., & Carrera, P. M., "Medical Tourism: Assessing the Evidence on Treatment Abroad," Maturitas 66, No. 1 (2010): 27–32*

[50] *Child's Rights Act, 2003 (Nigeria), ss. 7–11.*

[51] *Gillick v. West Norfolk and Wisbech Area Health Authority [1986] AC 112 (HL).*

[52] *Ibid.*

[53] *Axon v. Secretary of State for Health [2006] EWHC 37 (Admin).*

[54] *A.O. Enabulele, "The Legal and Ethical Dimensions of Consent to Medical Treatment in Nigeria," Nigerian Current Law Review 2016–2018, pp. 25–48.*

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

[56] *O. Ojo and O. Omololu, "Adolescent Sexual Health in Nigeria: Barriers and Policy Gaps," Vol. 23(2), African Journal of Reproductive Health, 2019. 62–73.*

[57] *UK Department of Health, Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People Under 16 on Contraception, Sexual and Reproductive Health (2004).*

[58] *S. Okonofua et al., "Social and Health System Barriers to Adolescent Sexual and Reproductive Health Services in Nigeria," African Journal of Reproductive Health 2020, Vol. 24(3), pp. 47–58.*

[59] *M. Brazier and E. Cave, Medicine, Patients and the Law 6th ed., Manchester University Press, (2016),.95–100.*

[60] *Child's Rights Act, 2003 (Nigeria), s. 277.*

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emphasize an individual's ability to comprehend and weigh information rather than their chronological age.[61]

2.5. Rights-Based Approach to Health

The rights-based approach to health situates healthcare, including sexual and reproductive health, within the broader framework of human rights obligations rather than as a matter of charity or policy discretion. It emphasizes the entitlements of individuals and the corresponding duties of the State to respect, protect, and fulfil these rights.[62] This paradigm draws from the *Universal Declaration of Human Rights*,[63] which recognizes health as part of the right to an adequate standard of living, and from the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) 1966, particularly *Article* 12, which guarantees "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[64] At its foundation, the rights-based approach to health is anchored on five interrelated principles: availability, accessibility, acceptability, quality, and[65] accountability.[66] Availability requires sufficient functioning health facilities and services; accessibility entails non-discriminatory access to healthcare; acceptability mandates that services be respectful of medical ethics and cultural values; quality emphasizes scientifically and medically appropriate care; and accountability requires mechanisms for redress and oversight.[67]

Applied to adolescent Sexual and Reproductive Health, these principles underscore that young persons are not passive recipients of care but active rights-holders. The Committee on the Rights of the Child has affirmed that adolescents' access to Sexual and Reproductive Health information and services is integral to their right to health and development.[68] Yet, in practice, adolescents in Nigeria encounter multiple barriers legal restrictions, parental consent requirements, and social stigma that undermine these rights.[69]

Nigeria's constitutional and statutory framework acknowledges the right to health but largely treats it as a non-justiciable objective rather than an enforceable entitlement. *Section* 17(3) (d) of the *Constitution* of the Federal Republic of Nigeria 1999 (as amended) provides that the State shall ensure adequate medical and health facilities for all persons, but this provision resides in the Directive Principles of State Policy, which are not legally binding,[70] but generally unenforceable.[71] This weakens the enforceability of health-related rights, particularly for vulnerable groups such as adolescents seeking confidential SRH services.

2.6. Child Rights Jurisprudence under International Law

Child rights jurisprudence under international law provides the normative foundation for protecting adolescents' sexual and reproductive health as an integral aspect of human dignity and development. The Convention on the Rights of the Child[72] is the cornerstone of this framework. It establishes the child as a rights-bearing individual, entitled to civil, political, economic, social, and cultural rights.[73] Under the Convention on the Rights of the Child, States Parties including Nigeria are obligated to ensure the survival, protection, and development of the child "to the maximum extent possible."[74] The jurisprudence of child rights is anchored on four cardinal principles: non-discrimination (*Article* 2), best interests of the child (*Article* 3), right to life, survival and development (*Article* 6), and respect for the views of the child (*Article* 12).[75] These principles operate in an interdependent manner to ensure that all policy, legal, and administrative measures concerning children including those related to health and medical decision-making are child-centred and participatory.

In the context of adolescent Sexual and Reproductive Health, the Committee on the Rights of the Child has clarified that adolescents' evolving capacities must be respected in determining their access to health services, including reproductive healthcare, without mandatory parental consent.[76] This interpretation situates autonomy, privacy, and informed consent as integral dimensions of the child's right to health under *Article* 24 of the Convention on the Rights of the Child. Nigeria ratified the Convention on the Rights of the Child in 1991 and domesticated it through the *Child's Rights*

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[61] Mental Capacity Act 2005 (UK), ss. 1–3.
[62] P. Hunt, "The Human Right to the Highest Attainable Standard of Health: New Opportunities and Challenges," Transactions of the Royal Society of Tropical Medicine and Hygiene 2006, Vol. 100(7). 603–607.
[63] (UDHR) 1948.
[64] International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966, Article 12.
[65]. (often summarized as the AAAQ framework)
[66] UN Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (2000), UN Doc. E/C.12/2000/4.
[67] . L. Forman, J. Tobin, and A. Friedman, "Framing Health and Human Rights: A Rights-Based Approach to Global Health," Health and Human Rights Journal 2016, Vol. 18 (2). 1–11.
[68] UN Committee on the Rights of the Child, General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child (2003), UN Doc. CRC/GC/2003/4.
[69] O. Fatusi and A. Hindin, "Adolescent Sexual and Reproductive Health in Nigeria: The Urgent Need for Policy Reform," Vol. 14(1) African Journal of Reproductive Health 2010. 9–15.
[70] 7. Constitution of the Federal Republic of Nigeria 1999 (as amended), s. 17 (3) (d).
[71] Sec 6 (6) (c).Ibid.
[72] Also referred to as CRC 1989.
[73] Convention on the Rights of the Child (CRC), adopted 20 November 1989, 1577 UNTS 3.
[74] Ibid, Article 6.
[75] UNICEF, Implementation Handbook for the Convention on the Rights of the Child, 3rd Ed. (Geneva: UNICEF, 2007).
[76] Committee on the Rights of the Child, General Comment No. 4: Adolescent Health and Development in theContext of the CRC, UN Doc. CRC/GC/2003/4 (2003).

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Act (*CRA*) 2003, which mirrors the CRC's key provisions.[77] The CRA recognizes the right of every child to the highest attainable standard of health and medical care (*Section* 13) and mandates that the best interests of the child must be a primary consideration in all actions concerning them (*Section* 1). However, despite this formal incorporation, practical implementation remains weak. Social norms, legal inconsistencies, and health system constraints limit adolescents' ability to access confidential SRH services.[78] For example, the CRA defines a child as a person under 18 years, while the *Criminal Code Act* and other statutes maintain varying age thresholds for sexual consent, creating ambiguity in Sexual and Reproductive Health service provision for older adolescents.[79] Such inconsistencies contradict the Convention on the Rights of the Child's call for clarity and uniform protection of minors' rights across all areas of law.

3. 0 Legal and Policy Framework Governing Adolescent Sexual and Reproductive Health Rights in Nigeria.[80]

3.1. Domestic Legal Instruments

3.1.1. The 1999 *Constitution* of the Federal Republic of Nigeria (as Amended)

The 1999 *Constitution* provides the overarching legal foundation for the protection of human rights in Nigeria, including those related to health and personal autonomy. Although the *Constitution* does not expressly guarantee the "right to health" as a fundamental right, several provisions indirectly support adolescent Sexual and Reproductive Health Rights through their broader protection of life, dignity, privacy, and equality.

Section 33 (1) guarantees the right to life, which has been interpreted to include the right to live with dignity and to access conditions necessary for survival, including healthcare.[81]*Section* 34 protects the right to dignity of the human person, prohibiting inhuman or degrading treatment a provision relevant to cases of sexual violence, coercion, and denial of reproductive care.[82]*Section* 35 safeguards personal liberty, which encompasses the freedom to make informed decisions about one's body, a principle that aligns with international norms on bodily autonomy.[83]

Further, *Section* 37 recognizes the right to privacy, which underpins the confidentiality of medical consultations, especially for adolescents seeking sexual and reproductive health services.[84] In practice, however, adolescents' privacy is often undermined by parental consent requirements and the reluctance of healthcare providers to treat unaccompanied minors.[85]*Section* 38 guarantees freedom of thought, conscience, and religion, relevant to adolescents' autonomy in choosing whether to access contraceptives or abortion-related counselling. *Section* 42 prohibits discrimination on the grounds of sex, age, or circumstance of birth, which implies that adolescent girls should not be denied reproductive healthcare because of their age or marital status.[86]

3.1. 2. The *Child's Rights Act* 2003.

The *Child's Rights Act* 2003 domesticated the *United Nations Convention on the Rights of the Child* and represents Nigeria's most comprehensive child-focused statute. It consolidates existing legal provisions relating to the welfare, protection, and development of children, including their access to healthcare.

Section 11 of the *Childs' Rights Act* guarantees the right to dignity, prohibiting abuse, neglect, and maltreatment, major concerns in adolescent Sexual and Reproductive Health Rights where stigma and coercion are prevalent.[87]*Section* 13 recognizes the right to health and health services, mandating the State to ensure that "every child enjoys the best attainable state of physical, mental, and spiritual health."[88]*Section* 14 requires government authorities to provide necessary medical assistance and develop primary health services for children. *Section* 15 addresses parental responsibilities but balances them against the child's best interests, while *Section* 17 emphasizes the right to privacy, reinforcing the confidentiality of medical information.[89]

Together, these provisions affirm adolescents as rights-holders within Nigeria's domestic legal order. However, the *Child Rights Act's* implementation is federal in nature, applying only in states that have enacted it into local law. As at 2024, twelve states; mostly in the northern region, were yet to domesticate the *Act*, leaving significant protection gaps.[90] This uneven adoption undermines national coherence in adolescent Sexual and Reproductive Health Rights and perpetuates legal uncertainty concerning issues such as consent, confidentiality, and access to reproductive services. Moreover, while the

[77] *Child's Rights Act, Cap C50, Laws of the Federation of Nigeria 2003.*
[78] *O. Fatusi, "Adolescent Sexual and Reproductive Health in Nigeria: Challenges and Opportunities," Vol. 14(3) African Journal of Reproductive Health 2010. 37–45.*
[79] *Criminal Code Act, Cap C38, Laws of the Federation of Nigeria 2004, ss. 30–31.*
[80] *Also referred to as SRHR.*
[81] *Constitution of the Federal Republic of Nigeria (1999, as amended), s. 33(1).*
[82] *Ibid, s. 34(1).*
[83] *Ibid, s. 35(1).*
[84] *Ibid, s. 37.*
[85] *O. Fatusi& A. Hindin, "Adolescent Sexual and Reproductive Health in Nigeria: The Urgent Need for Policy Reform," Vol. 14(1), African Journal of Reproductive Health 2010. 9–15.*
[86] *Constitution of the Federal Republic of Nigeria 1999 (as amended), s. 42(1).*
[87] *Child's Rights Act, Cap C50, Laws of the Federation of Nigeria 2003, s. 11.*
[88] *Ibid, s. 13.*
[89] *Ibid, ss. 14–17.*
[90] *UNICEF Nigeria, Situation Analysis of Children in Nigeria 2022 (Abuja: UNICEF, 2022), 43–45.*

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Child Rights Act articulates the best interests of the child as a guiding principle (*Section* 1), it does not provide explicit guidance on the age or conditions under which adolescents may independently consent to medical treatment, contraception, or abortion.[91] This silence often results in restrictive interpretations by health professionals who defer to parental authority or local moral norms.

3.1. 3. *Violence Against Persons (Prohibition) Act* 2015

The *Violence Against Persons (Prohibition) Act*[92] 2015 represents a significant milestone in Nigeria's legal efforts to protect the bodily integrity and dignity of all persons, including adolescents. Enacted to eliminate all forms of violence in both private and public life, the *Act* broadens the traditional understanding of sexual and gender-based offences beyond what is contained in the *Criminal Code* and *Penal Code*. *Section* 1 of the *Act* explicitly prohibits all forms of violence against persons, whether physical, psychological, sexual, or harmful traditional practices.[93] This is particularly relevant to adolescent sexual and reproductive health, as the *Act* criminalises practices such as female genital mutilation (FGM),[94] forced early marriage,[95] and harmful widowhood rites customs that disproportionately affect young girls and compromise their reproductive autonomy. Furthermore, the *Act's* provisions on sexual assault and consent help to clarify boundaries in adolescent sexual relations. *Section* 23 defines rape in broader, gender-neutral terms, recognising various forms of sexual penetration,[96] and thereby offering more comprehensive protection for both male and female adolescents. Importantly, *Section* 38 guarantees victims' rights to privacy during proceedings and prohibits the publication of identifying information,[97] a provision that could help mitigate the stigma often attached to adolescent sexual abuse cases.

3.1.4. *National Health Act* 2014 (Patient Rights and Confidentiality)

The *National Health Act*[98] establishes the framework for regulating health services and delineating patients' rights in Nigeria. Under *Section* 26, every healthcare provider, health worker, and healthcare establishment must maintain the confidentiality of patient information unless consent is obtained or disclosure is legally justified.[99] This provision is central to adolescent Sexual and Reproductive Health Rights, as confidentiality often determines whether young people seek reproductive or sexual health services. Studies indicate that adolescents frequently avoid healthcare facilities due to fear that healthcare workers will disclose sensitive information to parents or community members.[100] The *Act* also affirms the right of every Nigerian to access healthcare services without discrimination (*Section* 1(1)),[101] aligning with *Article* 12 of the *International Covenant on Economic, Social and Cultural Rights*,[102] which recognises the right to the highest attainable standard of health.[103] However, the lack of adolescent-specific protocols in the *National Health Act* and its subsidiary regulations undermines the practical realisation of these rights. For instance, there are no clear national guidelines on consent for contraceptive services by minors, resulting in varying interpretations across medical institutions.[104]

3.1.5. Criminal and Penal Codes: Provisions on Abortion and Sexual Offences

Nigeria's colonial-era substantive criminal laws principally the *Criminal Code Act* (applicable in the southern and central states) and the *Penal Code* (applicable in many northern states) remain the primary statutory instruments that criminalise abortion and prescribe offences relating to sexual conduct. These instruments, together with more recent statutes such as the *Violence Against Persons (Prohibition) Act* and state-level laws, create a complex and at times contradictory legal environment for adolescent sexual and reproductive health.

1. Criminalisation of Abortion: Under the *Criminal Code Act* (as consolidated in the Laws of the Federation), procurement of a miscarriage is criminalised and those who procure, administer, or assist in procuring abortion may be guilty of an offence punishable with imprisonment.[105] The *Penal Code* (which operates in many northern states) contains parallel provisions criminalising the procurement of miscarriage and related acts.[106] Both codes generally permit intervention only where the life of the pregnant woman is at stake an exception that is narrow in scope and subject to

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[91] E. Durojaye& A. Adeniran, *"Realising the Sexual and Reproductive Health Rights of Adolescents in Nigeria: The Role of International Law," Vol. 33(3), International Journal of Law, Policy and the Family 2019, 331–350.*

[92] *VAPP Act 2015*

[93] *Violence Against Persons (Prohibition) Act 2015, s.1.*

[94] *Ibid.,s.6.*

[95] *Ibid.,s.21.*

[96] *Ibid.,s.23.*

[97] *Ibid.,s.38.*

[98] *Also referred to as National Health Act (NHA) 2014.*

[99] *National Health Act 2014, s.26.*

[100] *M.E. Bankole et al., "Barriers to Accessing Sexual and Reproductive Health Services among Adolescents in Nigeria" 24(2) African Journal of Reproductive Health, (2020).45–56.*

[101] *National Health Act 2014, s.1(1).*

[102] *Also referred to as ICESCR*

[103] *International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966, 993 UNTS 3, Art.12.*

[104] *11. O. Oji and L. Nwogugu, "Legal Barriers to Adolescent Reproductive Health in Nigeria: The Need for Reform" 12(3), Nigerian Journal of Family Practice (2021). 118–124.*

[105] *Criminal Code Act, Cap C38, Laws of the Federation of Nigeria (LFN) 2004 (consolidating colonial statutes); see generally ss. 228–230 (offences relating to procurement of miscarriage).*

[106] *Penal Code, Cap P3, Laws of the Federation of Nigeria (LFN) 2004; see generally ss. 232–236 (offences regarding causing miscarriage and related acts).*

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restrictive judicial and medical interpretation.[107] The practical consequence of these provisions is well documented: where abortion is largely criminalised, adolescents who experience unintended pregnancies face limited lawful options and may resort to unsafe providers, clandestine procedures, or travel abroad to jurisdictions where services are legally available and provided confidentially. Empirical and public-health research links restrictive legal regimes to a high incidence of unsafe abortion and related morbidity and mortality; the World Health Organization and leading reproductive health researchers emphasise that criminalisation does not eliminate abortion but increases the proportion that is unsafe.[108] The *Guttmacher* Institute's country analyses and Nigerian public-health studies corroborate that unsafe abortion is a significant contributor to maternal morbidity and mortality in Nigeria, with adolescents disproportionately affected.[109]

2. Sexual Offences and Age Thresholds: The *Criminal Code* and *Penal Code* also prescribe offences related to sexual assault, defilement and carnal knowledge. The statutory architecture differs across the two codes: the *Penal Code* (in some northern states) applies concepts of puberty and adopts different age thresholds than the *Criminal Code*, which provides separate offences for "carnal knowledge" and other sexual crimes.[110] These divergent formulations create legal uncertainty about the age of consent, defilement, and the circumstances in which sexual conduct attracts criminal liability. In practice, this legal patchwork complicates service provision: healthcare workers, fearful of criminal exposure or community sanction, may deny adolescents confidential care or insist on parental involvement even where clinical guidelines would support confidential treatment.[111]

Taken together, the foregoing domestic legal instruments reveal a fragmented and internally inconsistent framework governing adolescent sexual and reproductive health right in Nigeria. While the *Constitution* of the Federal Republic of Nigeria, the *Child Rights Act*, the *National Health Act*, and the *Violence Against Persons (Prohibition) Act* collectively articulate protections relating to dignity, health, privacy, and freedom from violence, these guarantees are significantly undermined by the restrictive and, at times, contradictory provisions of the *Criminal Code Act* and the *Penal Code*, as well as by the absence of clear statutory guidance on adolescent consent and confidentiality. The resulting legal architecture reflects a tension between protective paternalism and emerging notions of adolescent autonomy, producing uncertainty for both rights-holders and duty-bearers. In practice, this incoherence translates into inconsistent service provision, discretionary decision-making by healthcare providers, and the systemic exclusion of adolescents from confidential and timely reproductive healthcare. This doctrinal fragmentation does not operate in isolation; rather, it interacts with socio-cultural norms and institutional weaknesses to produce tangible barriers to access.

4.0. Comparative Perspective: South Africa Liberal SRHR Framework and Adolescent Consent Laws

South Africa presents one of the most progressive and rights-oriented legal frameworks for adolescent sexual and reproductive health in Africa. Its approach is grounded in the recognition of adolescents as autonomous rights-holders capable of making informed medical decisions, provided they possess sufficient maturity and understanding. The *Children's Act* 38 of 2005 is the principal legislation governing minors' consent to medical treatment. *Section* 129 (2) of the *Act* provides that a child aged 12 years or older may consent independently to medical treatment if he or she "is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment."[112] This provision shifts the paradigm from parental control to adolescent agency, recognising the evolving capacities of the child in line with international human rights standards.

Furthermore, South Africa's *Choice onTermination of Pregnancy Act*[113] liberalises access to abortion by allowing any pregnant female, irrespective of age, to consent to a termination of pregnancy, provided that she is capable of

[107] *See discussion in F. Okonofua, Abortion Law and Policy Reform in Nigeria: Challenges and Prospects (Women's Health and Action Research Centre; 2021. For legal commentary on the narrowness of the therapeutic exception, see O. Durojaye& A. Adeniran, "Realising the Sexual and Reproductive Health Rights of Adolescents in Nigeria," International Journal of Law, Policy and the Family 33(3) (2019): 331–350.*

[108] *World Health Organization, Preventing Unsafe Abortion (WHO, 2014) and World Health Organization, Global and Regional Estimates of Unintended Pregnancy and Abortions (WHO, Guttmacher Institute, 2018).*

[109] *Guttmacher Institute, Abortion in Nigeria: Factsheet (2018); see also A. Okonofuaet al., "Unsafe Abortion and Maternal Mortality in Nigeria," African Journal of Reproductive Health (2019). 74.*

[110] *See comparison of Criminal Code and Penal Code provisions in A. Ezehet al., "Legal Barriers to Reproductive Health Services in Nigeria," BMC Public Health (2020): discussion of divergent age thresholds and definitions.*

[111] *O. Fatusi& A. Hindin, "Adolescent Sexual and Reproductive Health in Nigeria: The Urgent Need for Policy Reform," African Journal of Reproductive Health 14(1) (2010): 9–15 (discussing healthcare workers' reluctance and stigma).*

[112] *Children's Act 38 of 2005 (South Africa), s. 129(2).*

[113] *Also referred to as CTOPAct No.92 of 1996.*

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giving informed consent.[114]*Section* 5 (3) of the *Act* expressly provides that "no consent other than that of the pregnant woman is required," while also encouraging but not mandating consultation with parents or guardians. This ensures that minors can safely access abortion services in a confidential and non-discriminatory manner, reducing recourse to unsafe abortion practices that contribute to maternal morbidity and mortality.[115] The South African Constitutional Court has further entrenched this rights-based approach in several landmark judgments. In *Christian Lawyers Association v. Minister of Health*,[116] the Court upheld the constitutionality of the *CTOPAct*, holding that the right to reproductive choice is implicit in the constitutional rights to dignity, privacy, and bodily integrity under *Sections* 10, 12, and 14 of the South African *Constitution*.[117] Similarly, in *S v. M*[118](Centre for Child Law as Amicus Curiae), the Court reaffirmed the principle of child participation in decisions affecting them, aligning with *Article* 12 of the United Nations Convention on the Rights of the Child.[119]

Policy instruments complement these legal provisions. The National Adolescent and Youth Health Policy (2017–2022) and the National Sexual and Reproductive Health and Rights Policy (2021) operationalise adolescent-friendly healthcare principles, emphasising confidentiality, accessibility, and comprehensive sexuality education.[120] This integration between law and health policy has been credited with improving adolescent access to contraception, Human Immuno Deficiency Virus testing, and counselling services.[121] However, implementation challenges remain. Studies indicate persistent disparities in access between urban and rural areas, as well as variability in how healthcare providers interpret adolescents' capacity for consent.[122]

4.1. Kenya: Adolescent-Friendly SRH Services and Legal Clarity on Confidentiality

Kenya has emerged as an instructive comparative model for how law, policy and health-system practice can be aligned to expand adolescents' access to sexual and reproductive health services while protecting confidentiality. Where Nigeria struggles with fragmented statutes and uncertain provider practices, Kenya demonstrates the value of clear statutory patient-rights language backed by operational guidelines and adolescent-friendly service standards.

At the statutory level, the *Health Act*, 2017[123] enshrines patient rights and duties for health practitioners, including a statutory expectation of privacy and confidentiality in the delivery of health services.[124] Building on that foundation, Kenya's Ministry of Health has developed specific policy instruments addressing adolescents: most notably the National Adolescent Sexual and Reproductive Health Policy and successive national guidelines that operationalise youth-friendly service delivery and confidentiality for minors.[125] These instruments explicitly recognise adolescents as a priority population and require health facilities to provide confidential, non-judgemental services, including contraception, Sexually Transmitted Infections care and Human Immuno Deficiency Virus testing, without automatic parental consent where the adolescent is assessed as competent.[126]

Kenya has invested in a concrete package of Adolescent and Youth Friendly Services[127] standards and training for health workers. AYFS guidelines set out practical measures private consultation spaces, flexible hours, routine assurance of confidentiality, and provider training in adolescent communication that make confidentiality operational rather than merely aspirational.[128]Evaluations of AYFS pilots and scale-up efforts in Kenya report improved uptake of contraception, Human Immuno Deficiency Virus testing, and counselling among adolescents where these standards are applied.[129]

Crucially, Kenyan policy documents and programme guidance give clinicians clearer backing to offer Sexual and Reproductive Health services to adolescents without parental

[114]*Choice on Termination of Pregnancy Act 92 of 1996 (South Africa), s. 5(3).*

[115] *A. Strode, Z. Essack, and C. Slack, "Facilitating Access to Adolescent Sexual and Reproductive Health Services in South Africa," 6, No. 2.South African Journal of Bioethics and Law (2013): 44–47.*

[116]*1998 South African High Court Case. ID @ 106*

[117]*Christian Lawyers Association v. Minister of Health 1998 (4) SA 1113 (T).*

[118]*CCT3/94.1995 ZACC 3.*

[119]*S v. M (Centre for Child Law as Amicus Curiae) 2007 (2) SACR 539 (CC).*

[120]*Republic of South Africa, National Adolescent and Youth Health Policy 2017–2022 (Department of Health, Pretoria, 2017); see also National Sexual and Reproductive Health and Rights Policy 2021 (Department of Health, Pretoria, 2021).*

[121] *L. R. Richter and L. Mlambo, "Policy and Practice in Adolescent Health in South Africa: Lessons from the Last Decade," 25, no. 3 African Journal of Reproductive Health (2021): 63–74.*

[122] *D. Jewkes, R. Morrell, and K. Christofides, "Empowering Adolescent Girls in South Africa: Legal, Policy and Practice Challenges," BMC Public Health 23, no. 1 (2023): 141–152.*

[123]*No. 21 of 2017.*

[124]*Health Act, No. 21 of 2017 (Kenya); see generally Part II (patient rights and duties) and provisions on confidentiality.*

[125]*Ministry of Health (Kenya), National Adolescent Sexual and Reproductive Health Policy (various iterations; Ministry policy briefs and guidance documents).*

[126] *Ministry of Health (Kenya), Adolescent and Youth Friendly Services (AYFS) Standards and Guidelines; see also Ministry circulars implementing confidentiality provisions.*

[127] *Also referred to as AYFS*

[128] *World Health Organization, Global Standards for Quality Health-care Services for Adolescents (Geneva: WHO, 2015); Kenya Ministry of Health adaptation manuals for AYFS.*

[129] *Population Council & Kenya Ministry of Health evaluations of AYFS pilots (see Population Council Kenya reports on youth-friendly services uptake).*

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notification in many contexts, while simultaneously emphasising counselling and referral to guardians when appropriate and safe. This policy clarity reduces the "chilling effect" seen in settings where providers fear legal or social sanction, and it aligns practice with international guidance on evolving capacities.[130]

Kenya's approach to HIV testing and related services illustrates the pragmatic legal-policy interface. The Kenya HIV Testing Services (HTS) Guidelines and associated Ministry of Health circulars permit adolescent access to HTS and post-test services with appropriate pre- and post-test counselling, emphasising confidentiality and youth-friendly modalities (including community and school-linked services).[131] This clarity has been important for expanding adolescent uptake of testing and linkage to care while protecting privacy. Similarly, national family-planning guidance encourages provision of contraceptive information and services to adolescents again focusing on competence, counselling and confidentiality rather than automatic parental veto.[132]

Empirical research from Kenya suggests that where legal clarity is paired with distinct AYFS standards and provider training, adolescents are more likely to use SRH services and to trust health providers with sensitive information.[133] That trust is essential: confidentiality is not merely a legal promise but a practical determinant of service utilisation. Kenya's progress is not uniform. Access varies by region and socio-economic status, and implementation gaps persist in remote and highly conservative communities.

4.2. Ghana: Integration of Sexuality Education and Youth Clinics

Ghana provides a useful regional example of efforts to combine school-based sexuality education with facility-level youth-friendly services, aiming to give adolescents both accurate information and accessible clinical care. Its approach is notable for two complementary strands:

(1) The formal integration of age-appropriate sexual and reproductive health education into school and community platforms, and
(2) The roll-out of youth-friendly clinics and outreach services within the health system to deliver counselling, contraception and other SRH care in a confidential setting.

Ghana's legal framework recognises limited grounds for lawful termination of pregnancy through the *Criminal Code (Amendment) Act*,[134] which permits abortion in specified circumstances (for example, rape, incest, or risk to the life or health of the woman).[135] This statutory schema decriminalises certain medically indicated terminations and creates a statutory opening for health-centred SRH practice that contrasts with more punitive regimes elsewhere in the region.
Policy instruments from the Ministry of Health and the Ghana Health Service[136] explicitly prioritise adolescent reproductive health. The GHS and Ministry of Education have for years worked to strengthen the School Health Education Programme (SHEP) and to mainstream adolescent SRH messages into the curriculum and school health activities, linking education to referral pathways for clinical care.[137] UN agencies and civil-society partners—including UNFPA and IPPF/Mary Stopes (MSI Reproductive Choices)—have supported development of national guidelines and the training of providers in Adolescent and Youth Friendly Health Services (AYFHS).[138]

Ghana's approach to sexuality education emphasises age-appropriate, life-skills-based content delivered through the formal school system and community programmes. UNESCO technical guidance and global evidence on CSE have strongly influenced national curricula and teacher-training materials, and Ghana has participated in regional initiatives to institutionalise CSE in schools.[139] In practice, SHEP modules and complementary community outreach aim to increase adolescents' knowledge about contraception, STI prevention, and where to seek confidential services thus reducing misinformation and lowering the threshold for clinical help-seeking.[140]

On the service side, Ghana has implemented youth-friendly service models in public and private facilities. The Ghana

[130]*UN Committee on the Rights of the Child, General Comment No. 20 (2016) on the Implementation of the Rights of the Child during Adolescence, CRC/C/GC/20 (2016).*
[131] *Kenya Ministry of Health, Kenya HIV Testing Services Guidelines (2015/2019 editions) — guidance on adolescent access, counselling and confidentiality.*
[132] *Kenya Ministry of Health, National Family Planning Guidelines and Standards (relevant editions) and programme guidance on adolescent contraception.*
[133]*See programme evaluations and peer-reviewed studies reporting increased adolescent service uptake where AYFS standards were implemented (Population Council; peer-reviewed articles on Kenyan AYFS outcomes).*

[134]*PNDCL 102 of 1985.*
[135]*Criminal Code (Amendment) Act, P.N.D.C.L. 102 (Ghana) (1985) (permitting abortion under specified grounds such as rape, incest, or risk to the woman's life or health).*
[136]*Also referred to as GHS.*
[137] *Ghana Education Service & Ghana Health Service, School Health Education Programme (SHEP) Implementation Guides (various years); see Ministry of Education and GHS joint materials on school health.*
[138] *UNFPA Ghana, Country Programme Reports; Marie Stopes International / MSI Reproductive Choices, Annual Reports and Ghana Programme Briefs (Accra).*
[139]*UNESCO, International Technical Guidance on Sexuality Education: An Evidence-Informed Approach (Paris: UNESCO, 2018); see also regional West African CSE initiatives supported by UNICEF/UNFPA.*

[140]*Ghana Health Service, Adolescent Health and Development Policy and AYFHS training materials (GHS training briefs and provider manuals).*

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Health Service and partner organisations have developed AYFHS standards and provider training packages that stress confidentiality, non-judgemental attitudes, flexible hours, and dedicated spaces for adolescents. Mobile outreach and NGO clinics (including MSI centres) extend access in peri-urban areas and facilitate discreet access to contraception and counselling. Evaluations of Ghanaian AYFHS pilots report increased adolescent uptake of family-planning services and counselling where standards are properly implemented.[141]

5.0. Conclusion and Recommendations

Adolescent sexual and reproductive health (SRH) in Nigeria remains constrained by a complex web of legal, cultural, and policy barriers that collectively hinders and limit access to safe, confidential, and youth-friendly health services. Despite the progressive tone of instruments such as the *Child Rights Act* 2003, *National Health Act* 2014, and *Violence Against Persons (Prohibition) Act* 2015, their implementation has been weak, under enforced, inconsistent, and frequently undermined by entrenched socio-cultural conservatism.[142]
The analysis reveals four interlocking dimensions of the problem. First, restrictive laws, particularly under the Criminal and Penal Codes, continue to criminalize abortion and limit contraceptive access, creating a legal environment hostile to adolescent SRHR.[143]

Secondly, conflicting age thresholds between sexual consent, medical decision-making, and criminal liability produce uncertainty for healthcare providers and discourage adolescents from seeking legitimate services.[144]Third, institutional and professional barriers, such as stigma among providers, lack of training, and inadequate youth-friendly facilities, further obstruct access.[145] And Finally, socio-cultural taboos and religious moralism silence public discourse on sexuality, reinforcing misinformation and fear.[146]
The cumulative effect of these factors has driven many adolescents and their families toward medical tourism as an alternative route to obtaining reproductive care, including contraception, abortion, and confidentiality-protected counselling.[147] This externalization of care toward destinations like Ghana, South Africa, Kenya, India, and the United Kingdom reflects not only a gap in service provision but also a failure of domestic legal and policy coherence.[148] Unless Nigeria undertakes urgent reform, this trend will continue to erode national health sovereignty, perpetuate inequities in access, and expose vulnerable adolescents to unregulated transnational care systems.

6.0. Recommendations

1. Comprehensive Legal Reform and Harmonization

Nigeria should harmonize the *Child Rights Act*, Criminal and Penal Codes, and *National Health Act* to establish a consistent, rights-based framework for adolescent consent, confidentiality, and access to SRH services. This should include a functional test for adolescent medical capacity similar to the *Gillick* competence standard in the United Kingdom.[149]

2. Decriminalization of Medically Indicated Abortion and Contraceptive Access

Align abortion law with international human rights instruments such as CEDAW and the African Charter on the Rights and Welfare of the Child to reduce unsafe abortions and adolescent mortality.[150]

3. Institutionalization of Adolescent-Friendly Health Services

Expand the Federal Ministry of Health's adolescent health policy by funding adolescent friendly clinics at the primary care level. These facilities should guarantee privacy, provide trained personnel, and ensure free or subsidized access to contraceptives and mental health support.

4. Strengthening Confidentiality and Provider Protection

Introduce explicit confidentiality clauses protecting adolescents who seek SRH care and clinicians who provide such services in good faith.[151]

5. Comprehensive Sexuality Education (CSE)

Integrate CSE into national curricula following UNESCO's 2018 Technical Guidance, ensuring adolescents receive age-

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[141] *Evaluations of AYFHS pilots in Ghana (GHS and partner reports; MSI programme evaluations) reporting improved adolescent uptake where youth-friendly standards are implemented — see MSI Reproductive Choices, Annual Impact Report (Ghana).*

[142] *Child Rights Act 2003 (Nigeria), ss. 11–17; Violence Against Persons (Prohibition) Act 2015.*

[143] *Criminal Code Act (Cap C38 LFN 2004), ss. 228–230; Penal Code (Northern States) Federal Provisions Act, ss. 232–236.*

[144] *.I Eze-Anaba. "Sexual and Reproductive Health Rights in Nigeria: Legal Framework and Challenges." 19(2) African Human Rights Law Journal, (2019).561–585.*

[145] *National Population Commission (NPC) & ICF. Nigeria Demographic and Health Survey 2018 (Abuja: NPC & ICF, 2019).*

[146] *L. A. Adeokun, "Cultural Taboos and Adolescent Reproductive Health in Nigeria." 35(1), Journal of Social Development in Africa, (2020) 23–42.*

[147] *I. G. Cohen,. (2013). Patients with Passports: Medical Tourism, Law and Ethics. Oxford: Oxford University Press.*

[148] *World Health Organization (2020).Adolescent Sexual and Reproductive Health Fact Sheet – Nigeria. Geneva: WHO.*

[149] *Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112 (HL).*

[150] *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979; African Charter on the Rights and Welfare of the Child (1990).*

[151] *National Health Act 2014, s. 26; WHO (2015).Global Standards for Quality Health-care Services for Adolescents. Geneva: WHO.*

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appropriate, scientifically accurate information to make informed decisions about their bodies and relationships.[152]

6. Regional and Bilateral Cooperation on Adolescent Healthcare

Establish bilateral health agreements with key medical tourism destinations and collaborate through ECOWAS and the African Union to develop cross-border regulatory mechanisms ensuring safe, ethical, and rights-based care.[153]

7. Data and Accountability Frameworks

Implement national data systems to track adolescent SRHR indicators, funding flows, and outcomes, aligning with global monitoring frameworks under the Sustainable Development Goals (SDG 3.7).[154]

Adolescent sexual and reproductive health is not merely a matter of morality or parental control it is a human rights and public health imperative. Nigeria's current framework leaves too many adolescents exposed to preventable risks, unsafe procedures, and cross-border exploitation. A coherent and compassionate reform agenda rooted in evidence, equity, and the principle of evolving capacity is essential to restore confidence in the domestic healthcare system and safeguard the dignity, health, and future of Nigerian adolescents.

Stakeholder Engagement in Adolescent Sexual and Reproductive Health in Africa

Stakeholder engagement that involves parents, religious leaders, and traditional leaders is essential for improving adolescent sexual and reproductive health (SRH) outcomes in Africa. These groups often act as gatekeepers to SRH information and services, and their views and attitudes shape the type and quality of services available to young people. In sub-Saharan Africa, sociocultural and religious beliefs frequently present adolescent sexuality as a sensitive or restricted topic. This can result in resistance to programs that aim to improve adolescent SRH outcomes[155]

Parents, particularly mothers, play an important role in providing SRH information. However, many delay these discussions until after adolescents become sexually active because they worry that early conversations may encourage sexual promiscuity. Religious leaders also influence adolescents' access to HIV prevention methods and contraceptive use, often guided by cultural and religious values.[156] Traditional leaders and counselors remain

[152] *UNESCO (2018). International Technical Guidance on Sexuality Education: An Evidence-Informed Approach. Paris: UNESCO.*

[153] *ECOWAS Commission (2018).Protocol on Cooperation in Health within the ECOWAS Region. Abuja: ECOWAS Secretariat.*

[154] *United Nations. Sustainable Development Goals Report 2023, Goal 3.7 Indicators on Universal Access to SRH. New York: UN.*

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