

XYZ TEST AND MEDICAL INFORMED CONSENT: RIGHT TO PRIVACY AT A DEAD END?

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Abstract

The doctrine of informed consent is a cornerstone of medical law and even more so modern medical law. Securing patient autonomy and bodily integrity by requiring that material information be disclosed after obtaining voluntary agreement is pertinent to the essence of medical processes.¹ In Nigeria, informed consent is supported by constitutional privacy enjoys statutory backing. Yet, contemporary testing practices, particularly in employment, education, insurance and public health screening, frequently convert consent into a procedural formality. This paper examines the ‘XYZ Test’, a coded nomenclature used in some Nigerian narratives to describe HIV testing without naming it, as a case study of how stigma, institutional incentives, and digitised health administration can distort consent and undermine privacy.² Through doctrinal and comparative analysis of Nigerian and common law jurisprudence, the paper argues that privacy is not at a dead end but at crossroads. To remain meaningful, privacy must be re-specified as a governance regime of legality, necessity, proportionality, minimisation, confidentiality safeguards and enforceable remedies.

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¹ Nigeria Data Protection Act 2023 (definitions: “consent” as freely given, specific, informed and unambiguous; and “sensitive personal data” including health status).

² National Agency for the Control of AIDS (NACA), ‘HOPE Magazine 2024’ (narrative describing an HIV test result “coded as XYZ test”) (pdf).

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1.0 INTRODUCTION

The last century witnessed a decisive shift in the structure of the doctor–patient relationship. Where clinical decision-making was once organised around professional paternalism, contemporary medical law insists that competent persons are entitled to decide what happens to their bodies. The doctrinal expression of this shift is informed consent: the principle that diagnostic testing and treatment are lawful only where the patient has been given adequate information about the nature and purpose of the intervention, the material risks and benefits, and reasonable alternatives, including the option of refusal and then freely agrees. Although expressed most clearly in tort and disciplinary frameworks, informed consent is ultimately a constitutional idea, grounded in dignity, autonomy and privacy.³

Against this normative background, the emergence of coded testing practices in Nigeria invites a re-examination of whether privacy and consent operate as meaningful limits on power. The expression ‘XYZ Test’ is not a standard clinical designation. Rather, it appears in Nigerian-facing narratives as a euphemism for HIV testing, used to avoid writing “HIV” in plain terms and to manage stigma within families and communities. The very need for such coding is revealing; where a diagnostic procedure is treated as socially explosive, consent, counselling, confidentiality and anti-discrimination duties should be at their strongest. Yet the institutional contexts in which HIV testing occurs, pre-employment medicals, school admissions, antenatal care,

³ *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (SC 213/1999) [2001] NGSC 14 (2 March 2001) (Supreme Court of Nigeria) (affirming autonomy and the right of a competent adult to refuse treatment).

insurance onboarding, migration screening and public health campaigns, often exert pressure that makes refusal costly or impossible.⁴

This article uses the XYZ Test as an analytical device to explore the intersection of three regimes: constitutional privacy under section 37 of the Nigerian Constitution; the doctrine and statutory codification of informed consent; and public health or institutional rationales that claim to justify mandatory or routine testing.

The argument proceeds in five major directions. First, it clarifies the conceptual content of privacy and informed consent. Second, it maps the legal foundations of both doctrines in Nigeria, including statutory and data protection developments. Third, it evaluates relevant Nigerian and comparative jurisprudence. Fourth, it assesses the claim that privacy is at a ‘dead end’ in an era of digitised diagnostics and risk management. Finally, it proposes reform measures that preserve public health objectives while maintaining autonomy and dignity.

2.0 INVESTIGATION INTO INFORMED CONSENT, RIGHT TO PRIVACY AND THE LEGAL BACKBONE IN NIGERIA

Informed consent constitutes a fundamental element of the relationship between patients and medical practitioners.⁵ Although the concept emerged and evolved within Western European legal and ethical traditions, its underlying principles correspond with universal aspects of human conduct, rendering it relevant and applicable across diverse cultural contexts.⁶ These principles embody fundamental human rights

⁴ *Georgina Ahamefule v Imperial Medical Centre & Anor* (2017) LPELR-41908 (CA).

⁵ J.W. Berg et al., eds. 2001. *Informed Consent: Legal Theory and Clinical Practice*. New York, NY: Oxford University Press.

⁶ National Commission for the Protection of Human Subjects of Bio-medical and Behavioral Research 1979. *The Belmont Report: Ethical Principles and Guidelines for*

that ought to be respected globally, notwithstanding contextual differences in their outward expression.⁷ The regulation of informed consent in Nigeria does not appear to be shaped by any unique attribute of the local culture or social context. This is unsurprising given the country's colonial legal heritage and its profoundly multicultural social structure. Medical practice in Nigeria is largely governed by formal professional and regulatory instruments rather than customary norms. In particular, the professional conduct of medical practitioners is regulated by the Code of Medical Ethics in Nigeria, in which Rule 19 of Part A expressly addresses the doctrine of informed consent, outlining the circumstances under which consent must be obtained and the standards required for its validity.⁸ Its provisions, together with the emphasis on personal autonomy and human rights, closely mirror the standards applicable in developed Western jurisdictions.

The framework acknowledges that consent may be obtained from the patient, a relative, or a public authority, depending on the circumstances. Although the patient retains the primary entitlement to information and decision-making concerning medical treatment, consent may be provided by a next of kin in cases involving minors or individuals lacking decision-making capacity. Where no relative is available, the most senior medical practitioner in the institution is empowered to issue an appropriate directive aimed at preserving life. In exceptional situations, judicial authorization may be required. The code further mandates that consent discussions and documentation be witnessed. It specifies that valid informed consent must encompass: (i) disclosure of

the Protection of Human Subjects of Research. Washington, DC: US Government Printing Office.

⁷ R.J. Levine. Informed Consent: Some Challenges to the Universal Validity of Western Model. *Law Med Health Care*. 1991; 19: 107–213.

⁸ Medical and Dental Council of Nigeria, *Code of Medical Ethics in Nigeria* (Revised edn, MDCN 2014) r 19(A).

the benefits and risks associated with the procedure; (ii) professional guidance on available treatment alternatives; (iii) the patient's selection of a preferred option; and (iv) formal authorization permitting the clinician to proceed with treatment through completion of the consent form. Fundamentally, the code affirms the patient's inherent right to bodily integrity and life.

In the *Medical and Dental Disciplinary Tribunal vs. Okonkwo*, the appellant, Dr Okonkwo, was found guilty of professional misconduct. He had honored the verbal and written wishes of a Jehovah's Witness patient who refused blood transfusion and consequently died during treatment.⁹ The Nigerian appellate court upheld Dr Okonkwo's appeal and the Supreme Court concurred. The apex court ruled that an adult Nigerian has a right to refuse life prolonging medical treatment, including blood transfusion. The court located that right in the constitutional right to privacy and freedom of thought, conscience and religion. This case epitomises the essence of informed consent and the efficacy of same in the legal parlance and the medical field.

Right to Privacy is established in Section 37 of the 1999 Constitution guarantees 'the privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications'. Although the text emphasises spatial and communicative privacy, its underlying rationale, protection of the intimate sphere from intrusion, extends to medical life. Medical information reveals deeply personal facts about identity, sexuality, reproduction, disability and mortality. In a society where stigma remains potent, disclosure can trigger exclusion from work, marriage, education and community. For these reasons, modern

⁹ Supreme Court of Nigeria. *Medical and Dental Disciplinary Tribunal V Okonkwo* (2001) 4 SCN 78. *Nigerian Weekly Law Report* 2001; Part 711: 205–255.

constitutional reasoning recognises informational privacy as part of the protected private sphere.¹⁰

Georgina Ahamefule v Imperial Medical Centre & Anor stands as a leading Nigerian authority on medical privacy and confidentiality. The Court of Appeal held that the unauthorised disclosure of the appellant's HIV status by a medical facility constituted a direct violation of her constitutional right to privacy under section 37 of the 1999 Constitution (as amended). The Court affirmed that a patient's medical information, particularly in relation to HIV, falls within the protected private sphere, and that healthcare institutions owe a strict duty of confidentiality to those who seek treatment. The stigma, discrimination, and social exclusion suffered by the appellant were recognised as foreseeable consequences of such disclosure, rendering the conduct both unlawful and professionally negligent.¹¹

The privacy right is not absolute. Section 45 permits laws that restrict sections 37–41 where such laws are 'reasonably justifiable in a democratic society' for purposes including public health. This limitation clause is critical: it is the constitutional route through which mandatory testing regimes seek legitimacy. But section 45 does not license unbounded intrusion. The key terms, reasonably justifiable and democratic society invite a proportionality analysis. In practical terms, an interference with medical privacy should be lawful only where (a) it is grounded in clear law; (b) it pursues a legitimate aim such as public health or workplace safety; (c) it is necessary and evidence-based; (d) it is the least restrictive means; and (e) it is accompanied by safeguards (confidentiality, minimisation, non-discrimination, access controls, and

¹⁰ Constitution of the Federal Republic of Nigeria 1999(as amended) s.37.

¹¹ (2017) LPELR-41908 (CA).

remedies).¹² Nigeria’s international human rights commitments support this reading. Article 17 of the International Covenant on Civil and Political Rights prohibits ‘arbitrary or unlawful interference’ with privacy. The African Charter on Human and Peoples’ Rights, though framed in dignity and integrity rather than an explicit privacy clause, protects human inviolability and dignity. In domestic constitutional interpretation, these instruments may not be self-executing unless domesticated; however, they serve as persuasive guides and can illuminate the content of constitutional rights, especially where domestic provisions are open-textured.¹³

Accordingly, Nigerian law does not present informed consent and privacy as competing values, but as mutually reinforcing principles. Consent operationalises privacy in clinical encounters, while privacy supplies the constitutional justification for insisting upon consent as the default rule. Where consent is bypassed, the burden rests squarely on the state or medical authority to demonstrate compelling justification within constitutional bounds. Properly understood and applied, this integrated framework affirms that respect for patient autonomy is not a foreign transplant but a legally entrenched norm within Nigeria’s constitutional order, consistent with international human rights standards and essential to ethical medical practice.¹⁴

3.0 DEFINING THE XYZ TEST: CASE, PROCEDURE, OR PLACEHOLDER?

A preliminary analytical question concerns the legal and conceptual status of the term “XYZ Test”. Specifically, does it denote a reported

¹² International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 art 17.

¹³ African Charter on Human and Peoples’ Rights (Ratification and Enforcement) Act Cap A9 LFN 2004, arts 4–5.

¹⁴ R Clayton and H Tomlinson, *The Law of Human Rights* (5th edn, OUP 2018) 846–850 (on proportionality analysis and lawful interference with privacy).

judicial decision, a formally recognised medical diagnostic procedure, or a hypothetical construct employed for analytical convenience? A review of available legal, medical, and regulatory materials within the Nigerian jurisdiction reveals that “XYZ Test” is neither the name of a reported case nor a recognised clinical protocol.¹⁵ Rather, the term appears in narrative and institutional accounts as a form of coded nomenclature, deployed to reference HIV testing without explicitly naming it.

This paper therefore treats the “XYZ Test” not as a technical diagnostic category, but as a socio-legal phenomenon, a linguistic strategy operating within deeply stigmatised health contexts. Its analytical significance lies precisely in its informality and opacity. As a coded expression, the term obscures the nature of the medical intervention being undertaken, thereby diluting the informational threshold required for valid consent and muting the patient’s capacity to meaningfully object or inquire.¹⁶

In this sense, the “XYZ Test” becomes an entry point for examining how privacy and informed consent protections may be systematically weakened, not through overt illegality, but through routinised institutional practices, administrative formalism, and entrenched asymmetries of knowledge and power between patients and healthcare systems.¹⁷

¹⁵ Search of Nigerian Weekly Law Reports (NWLR), Nigerian Monthly Law Reports (NMLR), and medical regulatory instruments reveals no reported decision or formally recognised diagnostic procedure designated as “XYZ Test”.

¹⁶ See *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871 (HL) 889–890 (Lord Scarman) (emphasising disclosure of material risks as central to valid consent).

¹⁷ O Fasan, ‘Informed Consent and Medical Negligence in Nigeria’ (2013) 7 UNILAG Law Review 45, 58–60.

Seen in this light, the problem is not merely semantic. The deployment of euphemistic or coded language enables medical testing to be embedded within bureaucratic processes, such as employment screening, hospital admissions, or public health compliance where consent is treated as procedural compliance rather than as an expression of autonomous choice.¹⁸

The “XYZ Test” thus illuminates how consent may be transformed from a substantive legal safeguard into a symbolic ritual, while privacy is reduced to discretionary silence rather than enforceable control.¹⁹

4.0 THE CONFLICT; MANDATORY TESTING, COERCED CONSENT AND INSTITUTIONAL POWER

Conflicts between mandatory testing and privacy most frequently arise where institutions convert medical testing into a condition for access “*no test, no service*”. This dynamic is common in (i) pre-employment medical examinations; (ii) school admissions and hostel placement; (iii) antenatal screening; (iv) immigration, travel, or security clearances; and (v) insurance onboarding and periodic reviews.²⁰ In these settings, the decisive question is not whether a person appended a signature to a form, but whether the decision to submit to testing was free, informed, and practically reversible. Where refusal predictably triggers exclusion, delay, loss of opportunity, or stigma, “consent” risks becoming an administrative fiction rather than a legal safeguard.

Across these institutional contexts, consent is commonly compromised through four recurring mechanisms. First is Conditionality, where

¹⁸ D Durojaye, ‘HIV Testing and the Right to Privacy in Nigeria’ (2011) 55 *Journal of African Law* 1, 12–15.

¹⁹ R G Lee, ‘Privacy, Confidentiality and Health Information’ (2007) 66 *Cambridge Law Journal* 548, 553–556.

²⁰ See, generally, National Health Act 2014 (Nigeria) (patient rights and institutional obligations in healthcare settings).

refusal leads to exclusion or penalty (consent is obtained under structural pressure). Second is Opacity, where the nature or implications of the test are not properly disclosed, including the use of euphemisms or coded nomenclature that prevents meaningful understanding. Third is Administrative bundling, where a single signature is taken to authorise multiple unrelated acts, such as treatment, data sharing, and laboratory testing, without separating choices or explaining consequences. Fourth is coercive counselling, where information is framed in fear-inducing or moralising terms that undermine voluntariness and distort genuine choice.²¹ These mechanisms are especially troubling because Nigerian and comparative jurisprudence treats informed consent as a process of communication and choice, not a mere ritual of signing. The “XYZ Test”, understood here as coded HIV testing, intensifies the analysis because HIV engages two additional dynamics: stigma and discrimination.²²

Nigerian courts have confronted these issues directly in the employment context. In *Mr X v Jakobus Brink & 3 Ors*, the National Industrial Court of Nigeria held that an employer cannot lawfully compel an employee to undergo mandatory HIV testing as a condition for employment or continued work, recognising that such policies violate statutory privacy rights and constitute discriminatory conduct.²³ Similarly, in *Akinola v*

²¹ World Health Organization/UNAIDS rights-based approach to HIV testing emphasises voluntariness and non-coercion (see UNAIDS summary of Nigeria’s anti-discrimination protections and policy intent) Available at: https://www.unaids.org/en/resources/presscentre/featurestories/2015/february/20150211_nigeria_law?utm accessed 20 January 2026.

²² UNAIDS, ‘Nigeria passes law to stop discrimination related to HIV’ (11 February 2015). Available at: https://www.unaids.org/en/resources/presscentre/featurestories/2015/february/20150211_nigeria_law?utm

²³ *Mr X v Jakobus Brink & 3 Ors* (NICN/ABJ/464/2016) (National Industrial Court of Nigeria) (employee cannot be lawfully compelled to undergo HIV testing as a precondition for employment; rights to privacy and informed consent protected); see Lawyers Alert, ‘DISMISSAL OF AN EMPLOYEE BY AN EMPLOYER ON THE

Ocean Marine Solutions Ltd, the Court found that requiring an HIV test without meaningful disclosure and informed consent was unlawful, affirming that medical testing in the workplace cannot be used as a precondition to employment absent clear consent and lawful justification.²⁴ These decisions underscore that Nigerian courts treat institutionalised testing practices as potential rights violations, and not merely administrative housekeeping.

Nigeria’s HIV and AIDS (Anti-Discrimination) Act complements this case law by prohibiting discrimination on the basis of actual or perceived HIV status and restricting compulsory testing requirements in institutional settings.²⁵ That statutory choice is normatively significant: it recognises that “consent” procured under institutional leverage is frequently not consent at all, and that coerced testing practices generate predictable downstream harms, exclusion, reputational injury, and discrimination.

A distinctive feature of coerced medical testing is that the primary rights violation may crystallise before the needle is inserted. Where a subject is not informed of the test’s nature, the consent is defective at the point of collection; and where refusal is practically impossible due to conditionality, the voluntariness requirement is vitiated.²⁶ In Nigerian

BASIS OF HIV/AIDS STATUS – Mr X v Jakobus Brink & 3 Ors’ (Lawyers Alert, 24 July 2023) Available at: <https://www.lawyersalertng.org/post/dismissal-of-an-employee-by-an-employer-on-the-basis-of-hiv-aids-status> accessed 13 January 2026.

²⁴ *Akinola v Ocean Marine Solutions Ltd* (NICN Judgment) (National Industrial Court of Nigeria) (employer’s requirement for HIV test without proper informed consent unlawful); see National Industrial Court, ‘Akinola v Ocean Marine Solutions Ltd’ (NICN Judgement Portal) Available at: <https://nicnadr.gov.ng/judgement/details.php?id=6444> accessed 13 January 2026.

²⁵ HIV and AIDS (Anti-Discrimination) Act 2014 (Nigeria), ss 1–2, 9 (prohibiting discrimination on the basis of HIV status and restricting compulsory HIV testing as a condition of employment or service).

²⁶ Nigeria Data Protection Act 2023 (health data as sensitive personal data; heightened constraints on processing and disclosure, including explicit consent safeguards).

constitutional reasoning, bodily autonomy and decisional privacy protect the individual's right to be "left alone" to make fundamental choices about medical intervention, subject only to a clear and compelling justification grounded in law.¹⁵ Beyond collection, privacy violations are compounded when results are used or disclosed outside the bounds of permission, whether to employers, school authorities, insurers, or family members—because confidentiality breaches can be enduring and difficult to remedy, especially in stigmatised conditions. Modern data protection norms reinforce this point: health information is typically treated as sensitive data, requiring heightened justification, purpose limitation, and strict controls on disclosure and retention.²⁷

5.0 COMPARATIVE PERSPECTIVE I: SOUTH AFRICA

South Africa offers a particularly instructive comparator because its constitutional jurisprudence has confronted HIV-related stigma directly and because its labour and equality framework expressly regulates workplace HIV testing. Unlike Nigeria where regulation is still emerging primarily through statutes and employment litigation, South Africa has developed a rights-centred, constitutionally grounded model that integrates equality, dignity, and privacy into the governance of medical testing.

In *Hoffmann v South African Airways*, the Constitutional Court held that the refusal to employ a qualified applicant solely on the basis of his HIV status constituted unfair discrimination in violation of the Constitution.²⁸ Although the case was argued principally on equality grounds, the Court's reasoning carries significant implications for privacy and informed consent. It rejected institutional decisions premised on fear, stereotypes, or unsubstantiated assumptions about risk, emphasising that HIV status, in itself, bears no rational connection

²⁷ *ibid*

²⁸ *Hoffmann v South African Airways* 2001 (1) SA 1 (CC) para 28.

to an individual's capacity to perform work. The decision thus reinforces a privacy-respecting principle: where medical information is used to exclude or marginalise, it must be justified by compelling, evidence-based criteria rather than prejudice.

Beyond constitutional adjudication, South African employment law expressly restricts HIV testing in the workplace. Section 7(2) of the Employment Equity Act 55 of 1998 prohibits HIV testing of employees or job applicants unless the testing is shown to be justifiable in light of medical facts, employment conditions, social policy, and the fair distribution of employee benefits, and is authorised by the Labour Court.²⁹ This statutory requirement transforms HIV testing from an employer prerogative into a legally regulated exception. It makes clear that even where an employer's interest is weighty such as in safety-sensitive roles, the law will permit testing only under strict procedural and substantive safeguards that preserve human dignity, confidentiality, and, so far as possible, voluntariness.³⁰

South Africa's model therefore demonstrates a crucial normative insight: public or organisational interests do not displace individual rights but must be reconciled through structured legal justification. HIV testing is not banned outright, but it is removed from informal institutional discretion and subjected to constitutional and judicial oversight. This approach offers a powerful contrast to the Nigerian experience, where testing is often embedded within administrative routines and employment processes without equivalent transparency or safeguards.³¹

²⁹ Employment Equity Act 55 of 1998 (South Africa), s 7(2).

³⁰ See *Joy Mining Machinery v NUMSA* (2002) 23 ILJ 391 (LC) (emphasising that HIV testing requires Labour Court authorisation and must satisfy dignity and fairness standards).

³¹ *ibid* (8)

6.0 COMPARATIVE PERSPECTIVE II: CANADA (WORKPLACE TESTING AND PROPORTIONALITY)

Canadian jurisprudence on workplace testing, particularly in relation to drug and alcohol screening, offers a sophisticated proportionality-based framework for assessing when employer-imposed medical testing can be justified. This approach is instructive for Nigeria because it does not treat workplace safety and employee privacy as mutually exclusive values, but instead requires that any intrusion into bodily integrity or personal information be demonstrably necessary, evidence-based, and narrowly tailored.

In *Communications, Energy and Paperworkers Union of Canada, Local 30 v Irving Pulp & Paper Ltd*, the Supreme Court of Canada invalidated a policy of random alcohol testing imposed on employees in a safety-sensitive industrial workplace.³² The Court held that, notwithstanding the employer's legitimate interest in safety, the absence of evidence of a "general problem" of alcohol misuse rendered the policy disproportionate and unjustified.³³ Central to the Court's reasoning was the recognition that bodily testing and the collection of biological data constitute a serious intrusion into privacy and dignity, which cannot be normalised by reference to abstract risk.³⁴

The Canadian approach therefore insists on context-specific justification rather than categorical assumptions. A dangerous workplace, the Court reasoned, is not, by itself, sufficient to justify blanket testing. Instead, employers must demonstrate a rational connection between the testing regime and a proven safety risk and must show that less intrusive alternatives are inadequate.⁴ This evidentiary

³² *Communications, Energy and Paperworkers Union of Canada, Local 30 v Irving Pulp & Paper Ltd* 2013 SCC 34, [2013] 2 SCR 458.

³³ *ibid* paras 44–45.

³⁴ *ibid* paras 19–20.

discipline reframes “medical fitness” not as an open-ended mandate to collect personal health data, but as a legally constrained exception to the general rule of privacy.⁵

For Nigeria, this proportionality model is especially valuable. In practice, employers frequently invoke “fitness” or “security” as broad justifications for pre-employment or periodic medical testing, without demonstrating necessity or limiting the scope of data collected. Adopting a Canadian-style evidentiary and proportionality analysis would align Nigerian law with a rights-respecting framework that balances institutional interests with the fundamental values of autonomy, dignity, and privacy.³⁵

7.0 COMPARATIVE PERSPECTIVE III: UNITED STATES (FOURTH AMENDMENT ‘SPECIAL NEEDS’ TESTING)

In the United States, compulsory bodily-sample testing is primarily analysed through the Fourth Amendment, which protects against unreasonable searches and seizures and treats the collection of blood, urine, or other biological samples as a form of “search.”³⁶ This constitutional framing requires courts to balance the gravity of the privacy intrusion against the governmental interest relied upon to justify it.

In *Skinner v Railway Labor Executives’ Association*, the United States Supreme Court upheld regulations mandating blood and urine testing of railway employees involved in certain accidents.³⁷ The Court accepted that the government’s compelling interest in transportation safety

³⁵ See also *Entrop v Imperial Oil Ltd* (2000) 50 OR (3d) 18 (CA) (random drug testing must be justified by demonstrable risk).

³⁶ *Skinner v Railway Labor Executives’ Association* 489 US 602, 616–617 (1989) (bodily-sample collection constitutes a “search” under the Fourth Amendment).

³⁷ *ibid* 633–634.

constituted a “special need” beyond ordinary law enforcement, permitting suspicionless testing in carefully defined circumstances.³⁸ Crucially, however, the Court did not endorse unrestrained testing. It emphasised that constitutionality depends on the narrow tailoring of the regime, the seriousness of the safety rationale, and the presence of procedural safeguards limiting discretion, scope, and disclosure.³⁹

The broader doctrinal lesson is therefore not that mandatory testing is inherently lawful, but that it must be justified by demonstrable, specific risks, supported by evidence, and constrained by safeguards that prevent function creep and misuse of sensitive data.⁴⁰ Where testing is justified, confidentiality and purpose limitation are non-negotiable; where it is not justified, refusal cannot lawfully be penalised through exclusion or adverse treatment.⁴¹ This proportional, evidence-based approach provides a useful template for Nigerian courts when confronted with institutional testing regimes that claim public safety or security as a blanket justification.

8.0 COMPARATIVE PERSPECTIVE IV: EUROPEAN HUMAN RIGHTS (ARTICLE 8 AND MEDICAL CONFIDENTIALITY)

European human rights jurisprudence places medical confidentiality at the core of the right to private life. Article 8 of the European Convention on Human Rights (ECHR) guarantees respect for private and family life, and the European Court of Human Rights (ECtHR) has consistently

³⁸ *ibid* 619–620 (recognising “special needs” beyond ordinary law enforcement).

³⁹ *ibid* 624–628, 634 (emphasising narrow scope, serious safety rationale, and procedural safeguards).

⁴⁰ See also *Chandler v Miller* 520 US 305, 318–319 (1997) (invalidating suspicionless drug testing where no concrete risk was shown).

⁴¹ Compare *Ferguson v City of Charleston* 532 US 67, 84–86 (2001) (use of medical test results for non-medical purposes without consent violates constitutional privacy expectations).

interpreted this protection to encompass both bodily integrity and informational privacy, particularly in relation to health data.⁴² The Court has repeatedly stressed that respect for the confidentiality of medical information is fundamental to maintaining trust in the medical profession and to ensuring that individuals are not deterred from seeking diagnosis and treatment.⁴³

In *Z v Finland*, the ECtHR held that the disclosure of the applicant's HIV-related medical information in the course of criminal proceedings constituted a serious interference with Article 8.⁴⁴ Although the Court accepted that the prosecution of serious crime was a legitimate aim, it emphasised that HIV-related data attract the highest level of protection and may only be disclosed where there is a pressing social need, supported by strict necessity and accompanied by robust safeguards.⁴⁵ The Court further insisted that states must limit both the scope and duration of access to such information, and must adopt measures to prevent unnecessary identification or wider dissemination.⁴⁶

The normative lesson for Nigeria is that even where public interests are legitimate, medical confidentiality cannot be treated as expendable. Disclosure and retention must be minimised, access must be strictly restricted, and anonymity or pseudonymisation should be employed wherever possible.⁴⁷ These principles align closely with modern data protection regimes governing sensitive health information and provide

⁴² *Pretty v United Kingdom* (2002) 35 EHRR 1 [61] (recognising bodily integrity and personal autonomy as part of private life under Article 8).

⁴³ *MS v Sweden* (1997) 28 EHRR 313 [41] (confidentiality of medical data is vital to trust in healthcare).

⁴⁴ *Z v Finland* (1997) 25 EHRR 371 [95]–[97].

⁴⁵ *Ibid* [96]–[100] (*HIV data require particularly serious reasons for disclosure*).

⁴⁶ *ibid* [112]–[114] (requiring time limits, restricted access, and safeguards against identification).

⁴⁷ See also *I v Finland* (2008) 48 EHRR 30 [38]–[42] (failure to secure medical data systems violated Article 8).

a valuable template for proportionality reasoning under section 45 of the Constitution, which permits rights-limiting measures only where they are reasonably justifiable in a democratic society.⁴⁸

9.0 IS PRIVACY AT A DEAD END? DIAGNOSING THE CLAIM

The “dead end” thesis asserts that privacy is no longer capable of meaningful protection in the face of contemporary realities such as mass diagnostics, digitisation, and risk-based governance. At first glance, the claim appears plausible. At least six structural drivers lend it surface credibility.

First, medical testing has become relatively cheap, rapid, and routinized, making “screen everyone” policies administratively attractive. Second, health systems increasingly depend on digitised records that can be easily copied, aggregated, and transmitted. Third, employers and insurers operate under actuarial and risk-management rationalities that incentivise broad data collection. Fourth, public health emergencies tend to expand the scope of justified intrusion. Fifth, identity infrastructures, biometrics, national identification numbers, insurance enrolment systems encourage interoperability and data linkage. Sixth, and most critically, consent fatigue has reduced consent to a ritualised signature, increasingly detached from genuine understanding or choice.⁴⁹

In Nigeria, these drivers operate within a particularly fragile socio-legal environment. HIV-related stigma, high unemployment, and unequal access to remedies magnify the coercive effects of institutional testing practices. Where individuals reasonably fear that refusing a test will

⁴⁸ Constitution of the Federal Republic of Nigeria 1999 (as amended), s 45(1).

⁴⁹ F Cate, ‘The Failure of Fair Information Practice Principles’ (2006) 6 **Consumer Protection Journal** 343; OECD, *Guidelines on the Protection of Privacy and Transborder Flows of Personal Data* (2013).

result in the loss of employment, admission, or access to services, the formal existence of consent rules may offer little practical protection.⁵⁰ Likewise, where confidentiality breaches are difficult to prove, regulatory enforcement is weak, and litigation is costly or slow, privacy rights risk appearing aspirational rather than operational.⁵¹ These realities explain the appeal of the “dead end” diagnosis but they do not justify it.

Declaring privacy “dead” is analytically misleading. Privacy has not disappeared; rather, its legal form has changed. In contemporary constitutional, human rights, and data protection law, privacy is rarely absolute. Instead, it functions as a governance framework, structured by the principles of legality, necessity, proportionality, and accountability.⁵² This re-specification does not weaken privacy; it renders privacy workable within complex institutional systems. What it demands is justification and constraint: collection must be minimised, purposes clearly specified, disclosure strictly limited, and retention time bound. Crucially, the data subject must retain enforceable rights access, correction, objection, complaint mechanisms, and remedies.⁵³

When applied to medical testing, this governance model yields a concrete doctrinal framework. A testing regime should be lawful only if it satisfies five cumulative conditions:

- i. the testing is grounded in clear law or in valid, freely given, informed consent;

⁵⁰ *Mr X v Jakobus Brink & 3 Ors* (NICN/ABJ/464/2016) (National Industrial Court of Nigeria).

⁵¹ D Durojaye, ‘HIV Testing and the Right to Privacy in Nigeria’ (2011) 55 *Journal of African Law* 1, 14–17.

⁵² *Z v Finland* (1997) 25 EHRR 371; *I v Finland* (2008) 48 EHRR 30.

⁵³ Nigeria Data Protection Act 2023, ss 24–37 (rights of data subjects and obligations relating to sensitive personal data).

- ii. the purpose pursued is legitimate (such as public health or safety) and rationally connected to the testing;
- iii. the intrusion is necessary, supported by evidence, and represents the least restrictive means available;
- iv. adequate safeguards exist, including pre- and post-test counselling, confidentiality, data minimisation, anti-discrimination protections, and security controls; and
- v. effective remedies are available for unlawful testing or disclosure. And if any element fails, the testing regime should be unlawful.⁵⁴

This framework is especially important in Nigeria, where the constitutional basis for privacy protection is often treated as fragile. Even where legislation authorises testing or data processing, section 45 of the Constitution does not dispense with proportionality: the interference must still be reasonably justifiable in a democratic society and must employ the least restrictive means available.⁵⁵ In this sense, privacy is not at a dead end. It stands at a crossroads, between erosion through administrative convenience and renewal through principled legal governance.

10. REFORM PROPOSAL I: EMPLOYMENT AND EDUCATION CONTEXTS

Effective reform must focus on the institutional settings where coercion is most likely to occur and where the consequences of refusal are most severe. In Nigeria, three sites require urgent regulatory attention: employment screening, educational admissions, and insurance/financial

⁵⁴ *Communications, Energy and Paperworkers Union of Canada, Local 30 v Irving Pulp & Paper Ltd* 2013 SCC 34; *Skinner v Railway Labor Executives' Association* 489 US 602 (1989).

⁵⁵ Constitution of the Federal Republic of Nigeria 1999 (as amended), s 45(1); *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (2001) 7 NWLR (Pt 711) 206 (SC).

institution onboarding. These are contexts in which individuals face strong structural pressure to comply and where “consent” is therefore most vulnerable to distortion.

First, employment medical examinations should be limited to assessments of role-relevant fitness rather than open-ended health profiling. Employers should be prohibited from requiring HIV tests except where authorised by law and demonstrably justified by the nature of the role. Even where such testing is permitted, a “no-prejudice refusal rule” should apply: refusal to submit to testing must not, by itself, result in denial of employment or adverse treatment. This ensures that institutional leverage does not convert medical screening into a mechanism of indirect discrimination.

Second, schools and universities should be barred from making HIV tests a condition for admission, registration, or hostel allocation. Educational access is a core social good, and the use of health status as a gatekeeping tool risks entrenching stigma and exclusion without any demonstrable public health benefit. Where health information is genuinely required for student welfare, it must be obtained through voluntary disclosure and protected by strict confidentiality safeguards. A crucial institutional safeguard across all these two sectors is the separation of medical screening from decision-making authority. Where screening is legitimately required, results should be processed by qualified occupational or public health professionals who communicate only fitness conclusions, not diagnoses to employers, schools, or insurers, unless the individual gives explicit consent or disclosure is clearly required by law. This minimisation model, adopted in several jurisdictions, preserves organisational interests while significantly reducing stigma-based harm and misuse of sensitive health data.

Together, these reforms operationalise the core principles of necessity, proportionality, and non-discrimination. They shift medical testing away from institutional convenience and toward a rights-respecting governance framework, one in which access to work, and education is not conditioned on surrendering dignity, privacy, or autonomy.

11. REFORM PROPOSAL II: ENFORCEMENT, REMEDIES AND INSTITUTIONAL CAPACITY

Rights without remedies are structurally fragile. Any meaningful reform of medical testing and data governance in Nigeria must therefore move beyond declaratory norms and embed enforceable institutional and judicial safeguards. While the Nigeria Data Protection Act 2023 (NDPA) establishes a national supervisory authority with regulatory and enforcement functions, its effectiveness will depend on sustained capacity-building, operational independence, and inter-agency cooperation. Without these, statutory privacy guarantees risk remaining symbolic.

At the institutional level, healthcare providers, laboratories, insurers, and employers should be placed under a positive duty to implement privacy-by-design and privacy-by-default measures. These should include role-based access controls, encrypted record systems, audit trails to track data access, mandatory breach reporting, staff training on confidentiality obligations, and secure retention and deletion schedules for sensitive health data. Such technical and organisational measures are now recognised globally as essential components of lawful data governance, rather than optional best practices.

Judicial remedies must also evolve to reflect the gravity of privacy violations. Nigerian courts should expressly recognise compensable privacy harms, including emotional distress, loss of dignity, and reputational injury particularly in cases involving HIV-related

disclosures, where stigma and discrimination are foreseeable and enduring. Comparative human rights jurisprudence confirms that the absence of pecuniary loss does not negate the seriousness of privacy breaches, especially where health information is concerned. Awarding meaningful damages would not only vindicate individual rights but also generate deterrent incentives for institutional compliance.

As a matter of practice, Nigerian courts should inculcate the proportionality principle in their various rules, and practice directions within this context. Drawing inspiration from the Canadian Supreme Court’s approach in *Irving’s* case and the limitation analysis under South African constitutional law, courts should require institutions to demonstrate that testing is grounded in law or valid consent, pursues a legitimate aim, is necessary and evidence-based, and is accompanied by safeguards and remedies.⁵⁶ This would replace ad hoc balancing with predictable criteria, reduce arbitrariness, and encourage institutions to design rights-respecting policies from the outset.

In this way, enforcement, remedies, and institutional capacity would function not as afterthoughts, but as core pillars of a reimagined privacy structure, one capable of addressing modern testing practices without sacrificing dignity, autonomy, or trust.

12. CONCLUSION

This article has used the “XYZ Test” as a socio-legal lens through which the contemporary fragility of informed consent and medical privacy in Nigeria are interrogated. What initially appears as a linguistic curiosity, a coded reference to HIV testing ultimately reveals a deeper structural problem: the gradual transformation of consent from a substantive legal

⁵⁶ *Communications, Energy and Paperworkers Union of Canada, Local 30 v Irving Pulp & Paper Ltd* 2013 SCC 34; *Hoffmann v South African Airways* 2001 (1) SA 1 (CC).

safeguard into an administrative ritual, and the parallel erosion of privacy into discretionary silence rather than enforceable control. In institutional settings marked by stigma, economic vulnerability, and asymmetrical power, consent is too often secured through conditionality, opacity, and procedural bundling, rendering it formally present but substantively hollow.

The analysis has demonstrated that Nigerian law, properly interpreted, does not endorse this outcome. Section 37 of the Constitution, read together with the Code of Medical Ethics, the National Health Act, the HIV and AIDS (Anti-Discrimination) Act, the Nigeria Data Protection Act 2023, the *Okonkwo's* case and *Ahamefule's* case establishes a coherent normative framework in which privacy and informed consent are mutually reinforcing. Far from being abstract ideals, these principles are anchored in dignity, autonomy, and bodily integrity, and are subject only to limitations that must be reasonably justifiable in a democratic society. Nigerian jurisprudence, particularly in employment-related HIV testing, already reflects an emerging recognition that institutional convenience cannot override fundamental rights.

Comparative perspectives from South Africa, Canada, the United States, and Europe confirm that modern legal systems do not abandon privacy in the face of public health or workplace safety concerns. Instead, they reconceptualise it as a governance responsibility, structured in legality, necessity, proportionality, minimisation, confidentiality, and accountability. These jurisdictions illustrate that mandatory or routine testing is not inherently unlawful, but it is lawful only where justified by demonstrable risk, constrained by strict safeguards, and insulated from stigma, discrimination, and misuse.

The “dead end” thesis, though intuitively compelling in an era of digitised diagnostics and risk-based administration, is therefore

analytically misleading. Privacy in Nigeria is not extinguished; it stands at crossroads. One path leads towards normalised intrusion, symbolic consent, and unchecked data circulation. The other demands a re-specification of privacy as an enforceable architecture of justification and restraint, one that integrates constitutional reasoning, data protection norms, and institutional accountability.

The reform proposals advanced in this paper, limiting testing to role-relevant necessity, separating medical screening from decision-making authority, prohibiting discriminatory gatekeeping in employment and education, strengthening confidentiality infrastructures, and expanding judicial remedies, are not radical departures. They are the practical consequences of taking existing legal commitments seriously. If implemented, they would transform the XYZ Test from a symbol of hidden coercion into a catalyst for legal renewal.

Ultimately, the question is not whether Nigeria can reconcile public health, institutional efficiency, and individual dignity. The legal resources already exist to do so. What remains is the collective will to ensure that consent is real, privacy is operational, and medicine is governed not by fear or convenience, but by law, humanity, and respect for the person.