IIAR JOURNALS

Innovating Knowledge. Advancing Research.

IIAR Journal of Migration, Diaspora, and Population Mobility

Vol 1, No 1, 2026

Digital Health Data Governance for AI in Africa: Consent, Secondary Use, Cross-Border Transfer and the Nigeria Data Protection Act 2023 in Health Research

IGWE Emmanuel Sunday[1], NWOGBOJI Emmanuel Usulor[2]

[1] Veristzon Global Research Lab; [2] International Institute of AI and Research

ABSTRACT

Artificial intelligence (AI) in African health care depends on health data that are collected under research ethics regimes designed for single studies, reused for purposes those regimes did not anticipate, and often processed on systems outside the continent. The Nigeria Data Protection Act 2023 (NDPA) now governs this activity, yet no peer-reviewed study identified in the literature analyses how the Act applies to health research that uses AI. This theoretical and conceptual study sets out the lawful and ethical conditions under which health data may be used to train, evaluate, run and monitor AI systems in Nigerian health research. It combines an integrative review of 76 peer-reviewed journal articles published between 2023 and 2026, drawn from 80 records identified through ScienceDirect, MEDLINE and supplementary Crossref searches and verified against Crossref, with provision-by-provision doctrinal analysis of the NDPA and the Nigeria Data Protection Commission's General Application and Implementation Directive, and with normative framework development informed by Ubuntu, decolonial and trust-based theory. The analysis finds that the NDPA applies to foreign developers processing Nigerian data, contains no research exemption, and requires both a lawful basis and a sensitive-data ground for every use. Its consent standard sits uneasily with broad consent for future model training, while its research, public health and medical-care grounds lack AI-specific guidance; the status of pseudonymised research data is untested; and transfers abroad are prohibited unless adequacy or a narrow statutory condition applies. A four-use typology shows that training, evaluation, inference and monitoring each raise distinct consent and transfer questions that a single consent form or ethics approval cannot answer. The paper proposes a five-pillar governance framework covering use-specific legal mapping, layered and dynamic consent, a secondary-use gateway, transfer control and data sovereignty, and accountability, capacity and benefit-sharing. It recommends sector guidance from the Commission, adequacy assessments and approved transfer instruments, updated ethics guidance and committee training, institutional data access committees and data transfer agreements, and funding conditions that secure local data custodianship.

Keywords: health data governance; artificial intelligence; consent; secondary use; cross-border data transfer

Digital Health Data Governance for AI in Africa: Consent, Secondary Use, Cross-Border Transfer and the Nigeria Data Protection Act 2023 in Health Research

1. INTRODUCTION

Artificial intelligence (AI) is moving from pilot projects into African health systems, with applications in diagnosis, disease surveillance, resource allocation and epidemic preparedness (Alaran et al., 2025). Each of these applications depends on health data: clinical records, medical images, genomic sequences and surveillance streams collected from patients and research participants and reused to train, test and run algorithms. In Nigeria, the infrastructure for such reuse is expanding rapidly. Nigerian teams have proposed a national cancer imaging repository designed to support AI development (Adegoke-Elijah et al., 2026) and consolidated multi-source health data on a national analytics and triangulation platform (Atariata et al., 2026). Genomic research has also grown, although its clinical translation is still constrained by, among other things, weak data governance systems (Abdullateef et al., 2026).

These benefits are accompanied by significant risks. AI may widen health inequity in sub-Saharan Africa and other low- and middle-income countries (LMICs) unless infrastructure, capacity and regulation keep pace (Victor, 2025). A mapping of 12 African countries found no AI-specific health law, with relevant rules scattered across digital health, data protection, consumer and intellectual property law (Townsend et al., 2023), while survey data from 34 African countries showed widespread belief in a right to data privacy (Adeyeye, 2024). The legitimacy of health AI in Africa therefore depends on using health data in ways the law permits and the public accepts.

Nigeria is an instructive case. The Nigeria Data Protection Act 2023 (NDPA; 'the Act') established the Nigeria Data Protection Commission (NDPC; 'the Commission') and a comprehensive data protection regime under which health and genetic data are sensitive personal data (Nigeria Data Protection Act, 2023, s. 65). The Commission's General Application and Implementation Directive (GAID), in force since 19 September 2025, adds implementation detail (Nigeria Data Protection Commission [NDPC], 2025). Doctrinal studies find the Act substantially aligned with the European General Data Protection Regulation but raise concerns about its extraterritorial reach, the independence of the Commission and the strength of enforcement (Aloamaka, 2025). They also show that the Act works as a privacy law rather than an AI law, leaving gaps on algorithmic opacity, bias and the contestability of automated decisions (Joy Mgbeokwere & Ini-Obong Monday, 2026; Mohammed, 2026). The Act's requirements on consent, further processing and cross-border transfer weigh most heavily on health research, yet the national guidance on ethical oversight of health research predates the challenges posed by data science (Akintola et al., 2025).

Three gaps in the literature motivate this study. First, no peer-reviewed study identified in this review analyses how the NDPA applies to health research, including its lawful bases, sensitive-data rules, treatment of research and transfer regime. The Nigerian legal literature examines the Act in general (Aloamaka, 2025; Jaiyebo & Eruteya, 2026) or for automated decision-making (Mohammed, 2026). Second, Nigerian empirical work concentrates on research ethics committee (REC) oversight of AI and data science (Olawade et al., 2026), and two national studies of that oversight are still at protocol stage (Adebamowo et al., 2025; Akintola et al., 2025). Third, where African comparative analyses of data protection law address AI at all, they treat the use of data for AI as a single activity (Munung, Staunton, et al., 2024; Nienaber McKay et al., 2024; Staunton et al., 2025). In practice, training, evaluating, running and monitoring a model involve different data, parties, places and purposes, and therefore different legal questions.

This paper sets out the lawful and ethical conditions under which health data may be used to build, test and run AI systems in Nigerian health research (hereafter, AI health research), and draws lessons for other African jurisdictions. It addresses three

© IIARJournal. All rights reserved.

research questions: (1) How does the NDPA regulate consent, secondary use and cross-border transfer of health data used in AI research? (2) How do those requirements differ across four uses of health data in AI, namely training, evaluation, inference and monitoring? (3) What governance framework can researchers, institutions, RECs, funders and the regulator apply to close the gaps that emerge?

2. LITERATURE REVIEW

2.1 CONCEPTUAL REVIEW

2.1.1 Health data and the AI lifecycle

In this paper, health data means clinical, imaging, laboratory, genomic and surveillance data relating to an identifiable person; under the NDPA, health status and genetic data are sensitive personal data (Nigeria Data Protection Act, 2023, s. 65). This paper distinguishes four uses of health data in AI development. **Training** uses large historical datasets to fit a model. **Evaluation** uses held-out or external datasets to validate accuracy, test for bias and benchmark performance. **Inference** applies a deployed model to an individual's data to produce an output for care or research. **Monitoring** collects outputs and outcomes after deployment to detect drift, error and harm. The four uses differ in purpose, in the degree of identifiability they require, in the parties who handle the data and in where processing takes place.

2.1.2 Consent

Specific informed consent authorises a defined study. Broad consent authorises a class of future research under governance safeguards; the H3Africa access committee, for example, governs secondary use of samples and data collected on that basis (Rebai et al., 2025). Dynamic consent lets participants accept or refuse new uses over time (Prinsen, 2024). In South Africa, broad consent permitted by research ethics guidelines appears to conflict with the purpose-specification condition in section 13(1) of the Protection of Personal Information Act (POPIA) (Maseme et al., 2023), whereas dynamic consent can coexist with POPIA and improve trust (Prinsen, 2024). Meaningful consent is also difficult to achieve in practice: multilingual settings complicate comprehension (Omutoko et al., 2024), and reviews of African genomic research call for community engagement and culturally adapted processes (Li et al., 2025). Writing on India's Digital Personal Data Protection Act 2023, Sengupta and Mohandas (2026) argue that consent is a structurally weak basis for using health data to train AI, because patients face several layered consents that they cannot meaningfully give. The argument is directly relevant to the NDPA, whose consent provisions are similarly strict.

2.1.3 Secondary use, de-identification and pseudonymisation

Secondary use (termed 'further processing' in the NDPA) is the processing of data for a purpose other than the one for which they were collected, and most AI development depends on it. Its legality often turns on identifiability. African laws define de-identification, anonymisation and pseudonymisation differently, so researchers must use each jurisdiction's own terms to stay compliant (Edgcumbe et al., 2025). The NDPA defines pseudonymisation as processing after which data can no longer be attributed to a specific data subject without separately kept additional information (s. 65); in the text examined for this study it gives no separate definition of anonymisation. Under POPIA, Thaldar (2023a) argues that pseudonymised data transferred without the linking key are not personal information in the recipient's hands, although the provider remains bound. Synthetic data are a further option, but their legal status under African laws is unclear (Nyamawe & Shao, 2026).

2.1.4 Cross-border transfer and data sovereignty

Cross-border transfer covers the movement of personal data to recipients abroad, including foreign cloud service providers and AI developers. Across 37 African data protection laws, health and genetic data are classed as sensitive, and consent and adequacy dominate the grounds for transfer (Munung, Staunton, et al., 2024). Data sovereignty reframes the issue as one of control, which 'cognitive sovereignty' approaches pursue through federated learning and community-led surveillance that keep data within the country of origin (Kakraba et al., 2026).

2.2 THEORETICAL REVIEW

Three bodies of theory frame the analysis. The first is relational, communitarian ethics. Ochasi et al. (2025) reframe justice in health-care AI through Ubuntu, emphasising solidarity and sustainability, and

© IIARJournal. All rights reserved.

Munung, Royal, et al. (2024) propose an Afrocommunitarian social contract for genomics and data science that combines dynamic consent, benefit-sharing and participatory governance. On this view, individual consent is necessary but not sufficient, because one person's data also reveal information about families and communities. Community concerns about biobanking accordingly call for African-led collaboration and harmonised ethical frameworks (Amoakoh-Coleman et al., 2023).

The second is decolonial theory and epistemic justice. An assessment of 10 sub-Saharan countries found limited progress towards decolonised AI governance; only Rwanda was notably responsive to decolonisation indicators (Ayana et al., 2024). Equitable North–South data-driven research depends on aligned governance, capacity and shared leadership (Bekele et al., 2026). A scoping review of LMIC stakeholders' views warns that sharing under minimal-restriction mandates risks a neocolonial dynamic and concludes that equity requires structural change rather than better practice alone (Evertsz et al., 2023).

The third is trust. Researchers in 16 sub-Saharan countries described trust as the 'moral currency' of data sharing (Brown et al., 2024), and public trust in health-care AI in South Africa depended on governance, although human oversight of every AI output may not always be feasible in resource-constrained settings (Thaldar & Bottomley, 2025). Together, these lenses support the stance this paper terms relational data stewardship: data protection law sets the legal floor, but the legitimacy of health AI also requires accountability to communities, fair benefit-sharing and institutions that earn trust.

2.3 EMPIRICAL REVIEW

Empirical evidence from Nigeria remains limited. REC members recognised the benefits of AI but reported knowledge gaps, ethical concerns and regulatory deficiencies, and their trust was contingent on accuracy (Olawade et al., 2026). A qualitative study and a modified Delphi study of the ethical oversight of data science health research have been registered, but their results are not yet reported (Adebamowo et al., 2025; Akintola et al., 2025).

Evidence from the wider region is more extensive. In a survey of 160 researchers from 43 sub-Saharan countries, willingness to share rose when privacy was assured and governance and access controls existed. However, 40% of respondents' institutions had no process for storing data after projects ended, and respondents called for standard data transfer agreements (DTAs) and data access committees (Kabanda et al., 2023). Researchers' sharing practices were also shaped by geography, institutional constraints, and ethical, legal and funding issues (Obiora et al., 2024). REC members across sub-Saharan Africa showed variable perceptions and low awareness of data protection law and wanted training and guidance on DTAs (Cengiz et al., 2024).

In Uganda, stakeholders voiced concerns about privacy, equity and commercialisation in genomic data sharing and preferred contextualised consent and restricted third-party access (Ekusai-Sebatta et al., 2025), and both trust and perceived noncompliance costs predicted hospital staff compliance with data protection law (Kayondo & Kyobe, 2025). Sharing mandates alone do not deliver impact in LMICs without curation, metadata, recognition and equitable benefit-sharing (Waithira et al., 2026). Technical solutions exist: the federated INSPIRE platform lets data producers retain control through sharing agreements while enabling reuse (Kiwuwa-Muyingo et al., 2023). What is missing is any empirical or doctrinal account of how Nigerian health researchers can meet the NDPA when health data are used for AI.

3. MATERIALS AND METHODS

3.1 RESEARCH DESIGN

This is a theoretical and conceptual (non-empirical) study. It combines an integrative literature review, doctrinal analysis of primary legal instruments and normative framework development. No human participants were involved and no primary data were collected, so ethics approval was not required. In this design, Section 4.1 reports the analytical findings of the review and the doctrinal analysis rather than empirical results.

3.2 DATA SOURCES AND SEARCH STRATEGY

Searches were run on 20 October 2026 in ScienceDirect, accessed through an institutional library (eight strings), and in MEDLINE through the

© IIARJournal. All rights reserved.

PubMed interface (seven strings). Strings combined health, genomic and biobank data terms with governance, data protection, consent, secondary use, sharing, transfer, sovereignty and AI terms, and with Africa, Nigeria, named countries or LMICs. A representative MEDLINE string was: ("cross-border data"[tiab] OR "data transfer"[tiab] OR "data sovereignty"[tiab] OR "data localisation"[tiab] OR "international data sharing"[tiab]) AND (Africa*[tiab] OR Nigeria*[tiab]). Because Nigerian law journals are not indexed in either database, three supplementary Crossref searches were run for journal articles on the NDPA. Every string, its limits and its hit count are recorded in the literature matrix (Supplementary File S1).

3.3 INCLUSION AND EXCLUSION CRITERIA

Articles were included if they were peer-reviewed journal articles first published online between 1 January 2023 and the search date and addressed the law, ethics or governance of health data in Africa, in LMICs, or in a comparator jurisdiction relevant to the questions. Preprints, protocols of reviews already published in full (primary-study protocols were retained), conference papers, editorials, letters, items without an abstract and items whose authorship could not be verified were excluded.

3.4 SCREENING AND BIBLIOGRAPHIC VERIFICATION

In ScienceDirect, 417 unique records were screened and 10 retained, 4 of which were also retrieved from MEDLINE. In MEDLINE, 228 unique records were screened and 68 retained. The Crossref searches returned 22 unique Nigerian data protection titles, of which 6 were retained after 2 were excluded at verification. The final corpus is 80 unique articles. Each was checked against its Crossref record: the DOI had to resolve to a journal article, and the first author, author count, year, journal, volume, issue and pages or article number were compared with the database record. Crossref was also queried for any notice updating the DOI. No retraction or expression of concern was found; two articles carry published corrections and are cited together with them. Four verified articles were set aside at synthesis: one with unconfirmed journal indexing, one available only as version 1 on a post-publication review platform, one with conflicting volume and issue metadata, and one whose full author list could not be retrieved. The remaining 76 were synthesised and are mapped article by article in Supplementary File S1; the 58 on which the argument draws directly are cited in the text.

3.5 PRIMARY LEGAL SOURCES

The NDPA was read provision by provision, concentrating on sections 2 and 3 (scope and exemptions), 24 to 31 (principles, lawful bases, consent, information, impact assessment, sensitive personal data and children), 34 to 37 (data subject rights and automated decisions), 41 to 43 (cross-border transfer), 48 (sanctions) and 65 (definitions). The GAID (NDPC/NDP ACT-GAID/01/2025) was consulted for its cross-border provisions in Article 45 and Schedule 5.

3.6 ANALYTICAL APPROACH AND BASES OF JUDGEMENT

Analysis had four steps. First, each article was coded by country, design, focus strand, key findings and remaining gap, and the codes were synthesised thematically. Second, for each of the four AI uses, the NDPA was examined against five questions: which lawful basis applies, which sensitive-data ground applies, what consent requires, what governs transfer abroad, and which rights are engaged. Third, comparator laws, chiefly POPIA, were analysed through the peer-reviewed literature. Fourth, each gap was matched to a control and an accountable actor to build the framework. Where statute and commentary diverged, the statute governed; where scholars disagreed, both positions are reported. Extraction drew on abstracts and publisher records, and claims about each study are limited to what those sources report.

3.7 LIMITATIONS OF THE METHOD

EBSCOhost databases and HeinOnline could not be accessed during the search, so some legal scholarship may have been missed; Nigerian law journals were reached only through Crossref metadata. The doctrinal analysis reflects the NDPA and GAID as published, and no reported judicial decision on their application to health research was identified. The four-use typology and the framework are analytical constructs that still require empirical testing.

© IIARJournal. All rights reserved.

3.8 DATA AVAILABILITY

The literature matrix, including the search log, the bibliographic verification table, the analytical extraction table and the list of excluded records, is available as Supplementary File S1.

4. RESULTS AND DISCUSSION

4.1 RESULTS

4.1.1 Profile of the evidence base

The 80 verified articles were published in 2023 (13), 2024 (15), 2025 (30) and 2026 (22, to 20 October), indicating a rapidly expanding literature. By primary setting, 32 addressed several African countries or sub-Saharan Africa as a whole, 16 South Africa, 12 Nigeria, 7 a single other African country (Uganda, Kenya, Tanzania or Mauritius), and 13 LMICs in general or a non-African comparator. By design, 27 were legal, doctrinal or policy analyses, 21 empirical studies (2 of them protocols), 19 reviews and 13 conceptual or normative papers. Table 1 summarises the 76 synthesised articles by the strand they mainly inform. South African scholarship supplies most of the African legal analysis of secondary use, pseudonymisation, broad consent and DTAs, while the Nigerian legal articles in the corpus address the NDPA in general or for AI decision-making, not as applied to health research.

Table. 1. *Evidence map of the synthesised literature by manuscript strand (n = 76)*

Strand	*n*	Convergent findings
Context: AI in African health	7	AI promises gains in care and health security, but equity depends on regulation, infrastructure and privacy controls; AI regulation in Africa is fragmented.
Conceptual and theoretical framing	9	Ubuntu, Afrocommunitarian and decolonial lenses; trust and community legitimacy alongside individual consent.
NDPA and Nigerian governance	10	NDPA aligns with the GDPR but is a privacy law, not an AI law; enforcement and independence concerns; ethics oversight of data science is under-developed.
Consent and secondary use	21	Broad and dynamic consent sit uneasily with purpose specification; pseudonymisation terms vary; trust, access committees and incentives enable reuse.
Cross-border transfer and equity	15	Consent and adequacy dominate transfer grounds but fit research poorly; DTAs and reciprocity are needed to avoid extractive flows.
Comparative African law	10	POPIA debates on research application and codes of conduct; enforcement and fragmentation problems in Kenya, Uganda, Tanzania and Mauritius.
Governance models	4	Equity-oriented sharing culture, consortium access policies, REC readiness for AI and regulatory sandboxes.

Note. Each article is counted under the strand it mainly informs; the article-level mapping is given in Supplementary File S1. AI = artificial intelligence; DTA = data transfer agreement; GDPR = General Data Protection Regulation; NDPA = Nigeria Data Protection Act 2023; POPIA = Protection of Personal Information Act (South Africa); REC = research ethics committee.

4.1.2 How the NDPA regulates health data used in AI research

Table 2 sets out the governing provisions and their practical implications, from which seven findings follow.

Finding 1: the Act reaches foreign AI developers. The NDPA applies not only to controllers and processors in Nigeria but also to those outside Nigeria that process personal data of data subjects in Nigeria (s. 2(2)(c)). A foreign company that trains a model on Nigerian patient data is therefore subject to the Act regardless of where its servers are located.

Finding 2: there is no research exemption. Section 3(2) relieves listed activities, such as control of a national public health emergency, from some obligations, but research is not listed, and sections 24 and 25 apply even to listed activities. AI health research must therefore rest on a lawful basis under section 25 and a sensitive-data ground under section 30(1). Section 24(4)(b) provides that further processing for scientific or historical research is not incompatible with the original purpose. This eases purpose limitation for secondary use, but compatibility does not itself supply either requirement.

Finding 3: consent is demanding. Consent must be for the specific purpose (s. 25(1)(a)), affirmative rather than inferred from silence or pre-ticked boxes (ss. 26(3), 26(7)(a)), given after the person is told of the right to withdraw (s. 26(4)) and in clear and simple language (s. 26(6)), and the controller bears the burden of proving it (s. 26(1)). Consent may be withdrawn at any time (s. 35), but withdrawal does not make earlier processing unlawful (s. 26(5)). Read together, these provisions sit uneasily with broad consent for unspecified future AI uses, a tension that

© IIARJournal. All rights reserved.

parallels the South African debate on POPIA (Maseme et al., 2023).

Finding 4: non-consent grounds exist but lack AI-specific guidance. Section 30(1) also permits processing of sensitive personal data for reasons of substantial public interest (s. 30(1)(f)), for medical care or community welfare by a professional bound by confidentiality (s. 30(1)(g)), for reasons of public health (s. 30(1)(h)), and where necessary for archiving in the public interest or for historical, statistical or scientific research (s. 30(1)(i)). The research ground offers a route for secondary use where re-consent is impracticable, but this review found no guidance from the Commission and no reported decision on how its necessity test applies to AI model training. Section 30(2) allows the Commission to prescribe further grounds.

Finding 5: the status of pseudonymised research data is untested. Because the definition of personal data turns on identifiability (s. 65), pseudonymised data remain personal data for any party that holds the key. Whether a recipient that receives pseudonymised data without the key holds personal data has not been settled under the NDPA. How personal data should be conceptualised under the Act remains debated (Jaiyebo & Eruteya, 2026), and Thaldar's (2023a) position under POPIA offers an argument that the Commission and Nigerian courts could consider.

Finding 6: transfer abroad is prohibited by default. Personal data may not be transferred from Nigeria unless the recipient is subject to adequate protection or a condition in section 43 applies (s. 41(1)). The absence of an adequacy determination by the Commission does not imply adequacy (s. 42(6)). The fallback conditions include consent from a data subject informed of the transfer's risks, performance of a contract, the sole benefit of the data subject, important public interest, legal claims and vital interests (s. 43(1)). The GAID provides criteria for evaluating the adequacy of recipient jurisdictions (NDPC, 2025, Art. 45 and Sch. 5). Since consent suits large research transfers poorly and adequacy is applied unevenly across Africa (Staunton et al., 2025), Nigerian researchers using foreign cloud or AI services have few transfer routes that are clearly lawful.

Finding 7: rights and accountability follow the data into deployment. A data privacy impact assessment (DPIA) is required before processing that is likely to result in high risk, with consultation of the Commission if high risk remains (s. 28). Data subjects may obtain erasure (s. 34(1)(d)) and have the right not to be subject to a decision based solely on automated processing, with safeguards including human intervention and the right to contest (s. 37). Penalties reach the greater of ₦10,000,000 or 2% of annual gross revenue for major-importance controllers and ₦2,000,000 or 2% for others (s. 48(4)–(5)).

Table. 2. *NDPA 2023 provisions governing health data used in AI research*

Provision	What it requires	Implication for AI health research
s. 2(2)(c)	Applies to controllers and processors outside Nigeria that process personal data of data subjects in Nigeria.	Foreign AI developers and cloud providers handling Nigerian patient data fall within the Act.
s. 3(2)	Exempts listed activities (e.g., criminal justice, national public health emergency, national security) from some obligations; ss. 24 and 25 still apply.	Scientific research is not a listed exemption; AI research must comply with the full regime.
ss. 24(1)(b), 24(1)(d), 24(4)(b)	Purpose limitation and storage limitation; further processing for scientific or historical research is not incompatible with the original purpose.	Eases purpose limitation for secondary use, but does not itself provide a lawful basis; retention of training data must be justified.
s. 25(1)	Lawful bases: consent for the specific purpose, contract, legal obligation, vital interests, public interest or official authority, legitimate interests.	Each AI use needs its own lawful basis; 'specific purpose' consent is hard to obtain for future model training.
ss. 26, 35	Controller proves consent; consent must be affirmative, informed of withdrawal and in plain language; withdrawal at any time, without affecting prior processing.	Broad consent is legally fragile; institutions must plan what withdrawal means for trained models.
s. 28	DPIA before high-risk processing; consult the Commission if high risk remains.	Large-scale training on health data should be treated as high risk and assessed before data collection or reuse.

© IIARJournal. All rights reserved.

Provision	What it requires	Implication for AI health research
s. 30(1)–(2)	Sensitive personal data may be processed only on listed grounds, including consent (a), substantial public interest (f), medical care (g), public health (h) and scientific research (i); the Commission may prescribe more.	Research and public health grounds offer routes for secondary use without re-consent, but no Commission guidance on their application to AI was identified.
s. 31	Parental or guardian consent for children and persons lacking capacity; age verification.	Paediatric datasets used for AI require guardian consent or another ground.
ss. 34(1)(d), 37	Right to erasure; right not to be subject to a decision based solely on automated processing, with human intervention and right to contest.	Clinical inference tools need human review and a contest route; erasure requests raise retraining questions.
ss. 41–43; GAID Art. 45, Sch. 5	Transfers abroad prohibited unless adequate protection or a s. 43 condition (e.g., informed consent to the transfer, contract, public interest); no inferred adequacy.	Use of foreign AI services needs an assessed transfer route; federated or in-country processing reduces exposure.
s. 48(4)–(5)	Penalties up to the greater of ₦10,000,000 or 2% of annual gross revenue (major importance) or ₦2,000,000 or 2% (others).	Non-compliance carries material financial risk for institutions and partners.

Note. DPIA = data privacy impact assessment; GAID = General Application and Implementation Directive; NDPA = Nigeria Data Protection Act 2023; NDPC = Nigeria Data Protection Commission. Source: Nigeria Data Protection Act, 2023; NDPC (2025).

4.1.3 A four-use typology of health data in AI

Table 3 applies these findings to each use. A single consent form or ethics approval cannot cover the AI lifecycle, because each use raises its own consent and transfer question. Training often relies on retrospective care data, so it depends most on the research ground and a robust DPIA. Evaluation can usually proceed on pseudonymised data within the custodian's environment. Inference serves the individual's own care and engages the rule on automated decisions. Monitoring, which links outputs to outcomes over time, is the use most likely to be overlooked in ethics approvals.

Table. 3. *Four uses of health data in AI mapped to NDPA consent and transfer questions*

Use	Data and parties	Likely lawful basis and s. 30 ground	Consent question	Transfer question
Training	Large retrospective datasets; developer, often a foreign partner.	Public interest or legitimate interest with research ground s. 30(1)(i); or specific consent s. 30(1)(a).	Was consent given for this purpose? If not, is re-consent impracticable and is the research ground necessary?	Does the developer receive data abroad? Adequacy or s. 43 route; federated training as alternative.
Evaluation	Held-out or external datasets; validators, journals, regulators.	Research ground s. 30(1)(i), pseudonymised where possible.	Usually covered by research ground plus REC approval; disclose evaluation in information notices.	Benchmark datasets shared abroad need a transfer route; prefer in-custodian evaluation.
Inference	Individual patient data in deployment; clinician, hospital, vendor.	Medical care s. 30(1)(g); contract or legal obligation for the provider.	Patient informed of AI use (s. 27); right to human review of solely automated decisions (s. 37).	Cloud-hosted inference sends patient data abroad in real time; contract and adequacy assessment needed.
Monitoring	Outputs linked to outcomes over time; deployer, vendor, regulator.	Public health s. 30(1)(h) or research ground; legitimate interest for quality assurance.	Often omitted from consent and ethics approval; must be planned and disclosed in advance.	Vendor dashboards and logs may be stored abroad; include in transfer assessment.

Note. Grounds shown are the most likely options; the appropriate basis depends on the facts of each project and should be recorded in the DPIA. DPIA = data privacy impact assessment; NDPA = Nigeria Data Protection Act 2023; REC = research ethics committee.

4.1.4 A governance framework for health data in AI research

Table 4 presents the resulting framework: five pillars, each linked to a gap identified above, an accountable actor and its supporting evidence. The pillars operate within the NDPA as it stands, so institutions can apply them while the Commission develops sector-specific guidance.

Table. 4. *Five-pillar governance framework for health data in AI research*

Pillar	Core controls	Accountable actors	Evidence base
1. Use-specific legal mapping	Record for each of the four uses its lawful basis, s. 30 ground, retention period and data subject rights; complete a DPIA before data collection or reuse.	Principal investigators; institutional data protection officers; NDPC (guidance)	NDPA ss. 25, 28, 30; Joy Mgbeokwere and Ini-Obong Monday (2026); Mohammed (2026)

© IIARJournal. All rights reserved.

Pillar	Core controls	Accountable actors	Evidence base
2. Layered and dynamic consent	Tiered options for AI uses; plain-language, multilingual and visual materials; community engagement; a stated withdrawal policy for trained models.	Researchers; RECs; community advisory boards	Li et al. (2025); Munung, Royal, et al. (2024); Omutoko et al. (2024); Prinsen (2024)
3. Secondary-use gateway	Data access committee; NDPA-consistent pseudonymisation standard; controlled access environments; register of approved reuses.	Institutions; consortia; data custodians	Edgcumbe et al. (2025); Kabanda et al. (2023); Nyachowe et al. (2025); Rebai et al. (2025)
4. Transfer control and data sovereignty	Transfer assessment under ss. 41–43; NDPA-aligned DTA template; preference for in-country or federated processing; contractual cover for model parameters and outputs.	Institutions; NDPC (adequacy and instruments); funders	Kakraba et al. (2026); Staunton et al. (2025); Swales et al. (2023); Thaldar et al. (2024)
5. Accountability, capacity and benefit-sharing	REC training in the NDPA and AI; human review of clinical outputs; post-deployment audit; benefit-sharing and recognition terms; regulatory sandboxes.	NHREC and RECs; NDPC; funders; health regulators	Cengiz et al. (2024); Munung et al. (2025); Olawade et al. (2026); Sekalala et al. (2026)

Note. DPIA = data privacy impact assessment; DTA = data transfer agreement; NDPA = Nigeria Data Protection Act 2023; NDPC = Nigeria Data Protection Commission; NHREC = National Health Research Ethics Committee; REC = research ethics committee.

4.2 DISCUSSION

The first research question asked how the NDPA regulates consent, secondary use and cross-border transfer of health data used in AI research. It regulates all three fully, without a research exemption. In South Africa, Bronstein and Nyachowe (2023) argue that sectoral health legislation prevails over POPIA's processing conditions in research, a view that Thaldar (2023b) rebuts. This review found no comparable debate in the Nigerian literature, and on its text the NDPA applies in full to health research. South Africa's proposed Code of Conduct for Research shows how a regulator-endorsed code can clarify application, despite unresolved issues such as a contested genetic-data exemption (Gooden & Thaldar, 2024). No Nigerian equivalent was identified, so researchers and RECs must interpret sections 24(4)(b) and 30(1)(i) alone. This supports the doctrinal finding that the Act is privacy legislation that has not yet been translated into rules for AI (Joy Mgbeokwere & Ini-Obong Monday, 2026; Mohammed, 2026). It also extends Aloamaka's (2023, 2025) critique of enforcement to the research setting.

The second research question concerned differences across the four uses. The analysis supports the argument that consent alone is a weak lawful basis for AI training (Sengupta & Mohandas, 2026): the NDPA's requirement of consent for a specific purpose is hard to meet for training data collected years earlier in routine care. Consent nevertheless remains ethically important. The relational lens suggests a division of labour in which a statutory ground, such as research or public health, provides the lawful basis, while layered and dynamic consent, community engagement and benefit-sharing provide the ethical legitimacy that Afrocommunitarian and Ubuntu-based scholarship demands (Munung, Royal, et al., 2024; Ochasi et al., 2025). Consent is then no longer asked to carry a legal weight it cannot bear in multilingual, low-literacy settings (Omutoko et al., 2024). Withdrawal raises a distinct problem for training: section 26(5) protects processing already done, but a trained model may continue to reflect withdrawn data, so institutions should state in advance what withdrawal will mean for future retraining.

For secondary use, the framework's secondary-use gateway draws on established African models. The H3Africa access committee governs secondary use under broad consent (Rebai et al., 2025), and the data sharing and access policy of the MADIVA research hub balances openness with participant protection in a resource-constrained consortium (Nyachowe et al., 2025). Survey respondents themselves called for data access committees and standard DTAs (Kabanda et al., 2023). Nigeria's proposed cancer imaging repository (Adegoke-Elijah et al., 2026) and national consolidation platform (Atariata et al., 2026) would benefit from such a gateway. Because the legality of reuse turns on identifiability, a clear pseudonymisation standard is central to any gateway, and Nigerian practice should use the NDPA's own terminology rather than borrow foreign categories (Edgcumbe et al., 2025; Thaldar, 2023a). South African law faces the same open questions of consent, ownership and intellectual property in secondary use (Edgcumbe et al., 2026). Synthetic data may reduce reliance on identifiable records, but

© IIARJournal. All rights reserved.

their legal and validation status first needs clarifying (Nyamawe & Shao, 2026).

Cross-border transfer is where law and practice diverge most, because the default prohibition and the refusal to infer adequacy leave many uses of foreign AI services on uncertain ground. South African experience shows the value of a voluntary national DTA template (Swales et al., 2023), since refined into SA DTA 1.1 (Thaldar et al., 2024). Analysis of common clauses in health-research DTAs offers further drafting guidance (Swales et al., 2024). It also shows the risk of forcing data into instruments designed for material transfer (Esselaar et al., 2024). Federated designs reduce the need for transfer (Kakraba et al., 2026; Kiwuwa-Muyingo et al., 2023), though model parameters and outputs can still carry information abroad and should be covered by agreements. Equity, however, cannot be left to the transfer clause alone. Avoiding the neocolonial dynamic described in the decolonial literature (Evertsz et al., 2023) requires reciprocity, enforceable benefit-sharing and an equity-oriented sharing culture built on custodianship and controlled access (Munung et al., 2025).

For the third research question, the principal constraint is institutional capacity. REC members across the region showed low awareness of data protection law (Cengiz et al., 2024), and Nigerian REC members reported knowledge gaps on AI (Olawade et al., 2026). South African RECs saw large language models as powerful but risky and insisted on human-centred, Ubuntu-informed governance (Obasa & Kabanda, 2026). The Ugandan finding that both trust and the costs of noncompliance drive compliance (Kayondo & Kyobe, 2025) suggests that the framework needs enforcement, which the NDPA's sanctions supply, and institutional trust, which only better practice can build. Regulatory sandboxes offer one route to testing AI tools under supervision (Sekalala et al., 2026). Comparative experience reinforces the point that legislation alone is insufficient. In Tanzania, health record governance has oversight gaps (Mwogosi & Simba, 2025), and South African work on mental health applications and radiology AI shows that general data protection law needs AI-specific guidance and liability rules (Botes, 2025; Sihlahla et al., 2023), a lesson that applies equally to Nigeria.

Future research should test the framework through a Delphi study of Nigerian RECs, researchers and NDPC officials, building on the studies already registered (Adebamowo et al., 2025; Akintola et al., 2025). Empirical studies should measure NDPA compliance among health researchers, and doctrinal work should examine the research ground in section 30(1)(i), the status of pseudonymised data and the Commission's transfer instruments.

5. CONCLUSION AND RECOMMENDATION

This paper has shown that the NDPA applies in full to health research, including research by foreign developers who process Nigerian data. The Act offers no research exemption, but it does provide research, public health and medical-care grounds alongside a demanding consent standard. It prohibits transfers abroad by default, requires a DPIA for high-risk processing and gives data subjects erasure and automated-decision rights. Because training, evaluation, inference and monitoring each raise distinct consent and transfer questions, a single consent form or ethics approval cannot govern the AI lifecycle. A use-specific approach grounded in relational data stewardship is therefore required, and the paper recommends the following measures.

1. The NDPC should issue sector guidance on health research that explains how sections 24(4)(b) and 30(1)(i) apply to AI training and evaluation, sets standards for pseudonymisation, and states when a DPIA is mandatory for health AI.
2. The NDPC should prioritise adequacy assessments and approved transfer instruments for the jurisdictions that host the cloud and AI services Nigerian researchers use, so that research transfers do not depend on consent alone.
3. National and institutional research ethics bodies should update their guidance for data science and AI research, require protocols to specify each of the four uses separately, and train REC members in the NDPA.
4. Research institutions and consortia should establish data access committees, adopt an NDPA-aligned DTA template, prefer in-country or federated processing, and publish their governance arrangements.

© IIARJournal. All rights reserved.

5. Researchers should map each AI use to a lawful basis and a section 30 ground before data collection, use layered and dynamic consent with plain-language and multilingual materials, and agree in advance on benefit-sharing and on what withdrawal will mean for trained models.
6. Funders should make NDPA compliance, local data custodianship and equitable benefit-sharing conditions of funding for health AI projects in Nigeria.

6. CONTRIBUTION TO EXISTING KNOWLEDGE

The paper makes four contributions. First, it provides what appears, from the literature reviewed, to be the first provision-level analysis of the NDPA as it applies to AI health research, covering scope, lawful bases, sensitive-data grounds, consent, further processing, data subject rights and cross-border transfer. Second, it introduces a four-use typology of health data in AI (training, evaluation, inference and monitoring) and maps each use to its consent and transfer requirements. Third, it offers a five-pillar governance framework, grounded in relational data stewardship, that assigns each control to an accountable actor and can be applied under current law. Fourth, it supplies a verified evidence map of 2023–2026 African scholarship on health data governance.

7. REFERENCES

Abdullateef, R. O., Olawuyi, D. A., Usin, S. G., Olajire, G. A., Opatola, A. D., Agboola, R. A., & Ibrahim, G. (2026). Advancing genomic medicine in Nigeria: Research progress, clinical translation and policy priorities. *Journal of Community Genetics*, *17*(5), Article 117. https://doi.org/10.1007/s12687-026-00955-y

Adebamowo, C., Akintola, A., Maduka, O. C., Ikhane, P., Jegede, A., Callier, S., Akintola, S., Ogundiran, T., Adeyemo, O., Adebamowo, S. N., & BridgELSI Project as part of the DS-I Africa Consortium. (2025). Knowledge and recommendations of stakeholders regarding ethical oversight of data science health research: Protocol for a qualitative study. *JMIR Research Protocols*, *14*, Article e78557. https://doi.org/10.2196/78557

Adegoke-Elijah, A., Macauley, O., Jimoh, K. O., Zevallos-Aquije, A., Olopade, O. I., & Aribisala, B. (2026). A framework for a national cancer imaging repository in Nigeria. *Scientific Reports*, *16*(1), Article 15945. https://doi.org/10.1038/s41598-026-44098-z

Adeyeye, A. O. (2024). Public attitudes towards surveillance and privacy of personal communications in 34 African countries. *Telematics and Informatics*, *91*, Article 102147. https://doi.org/10.1016/j.tele.2024.102147

Akintola, A., Ikhane, P., Maduka, O. C., Akintola, S., Ogundiran, T., Jegede, A., Adeyemo, O., Callier, S., Adebamowo, S. N., & Adebamowo, C. A. (2025). Protocol for a modified Delphi study of ethical oversight of data science health research (DSHR). *BMJ Open*, *15*(12), Article e105799. https://doi.org/10.1136/bmjopen-2025-105799

Alaran, M. A., Lawal, S. K., Jiya, M. H., Egya, S. A., Ahmed, M. M., Abdulsalam, A., Haruna, U. A., Musa, M. K., & Lucero-Prisno, D. E. (2025). Challenges and opportunities of artificial intelligence in African health space. *Digital Health*, *11*, Article 20552076241305915. https://doi.org/10.1177/20552076241305915

Aloamaka, P. C. A. (2023). Data protection and privacy challenges in Nigeria: Lessons from other jurisdictions. *UCC Law Journal*, *3*(1), 281–321. https://doi.org/10.47963/ucclj.v3i1.1259

Aloamaka, P. C. A. (2025). A critical analysis of the Nigeria Data Protection Act 2023: Elevating standards to global norms. *UCC Law Journal*, *4*(2), 242–263. https://doi.org/10.47963/ucclj.v4i2.1724

Amoakoh-Coleman, M., Vieira, D., & Abugri, J. (2023). Ethical considerations for biobanking and use of genomics data in Africa: A narrative review. *BMC Medical Ethics*, *24*(1), Article 108. https://doi.org/10.1186/s12910-023-00985-y

Atariata, O., Asangansi, I., Adoghe, A., Alle, O., & Abdulsalam, U. (2026). Consolidation of health data to improve health data governance using the Multi-Source Data Analytics and Triangulation platform. *BMJ Health & Care Informatics*, *33*(1), Article e101837. https://doi.org/10.1136/bmjhci-2025-101837

Ayana, G., Dese, K., Daba Nemomssa, H., Habtamu, B., Mellado, B., Badu, K., Yamba, E. I., Faye, S. L., Ondua, M., Nsagha, D. S., Nkweteyim, D. L., & Kong, J. D. (2024). Decolonizing global AI governance: Assessment of the state of decolonized AI governance in sub-Saharan Africa. *Royal Society Open Science*, *11*(8), Article 231994. https://doi.org/10.1098/rsos.231994

Bekele, R., Moen, A., Belina, M., Saranto, K., & Berhane, K. (2026). Determinants of collaboration dynamics and challenges in North-South data-driven health research in the African context: An epistemic injustice perspective. *Frontiers in Research Metrics and Analytics*, *11*, Article 1885894. https://doi.org/10.3389/frma.2026.1885894

Botes, M. (2025). Regulatory challenges of digital health: The case of mental health applications and personal data in South Africa. *Frontiers in Pharmacology*, *16*, Article 1498600. https://doi.org/10.3389/fphar.2025.1498600

Bronstein, V., & Nyachowe, D. T. (2023). Streamlining regulatory processes for health researchers: To what extent does POPIA apply? *South African Medical Journal*, *113*(8), 30–33. https://doi.org/10.7196/SAMJ.2023.v113i8.781

Brown, Q., Chabilall, J., Cengiz, N., & Moodley, K. (2024). Trust as moral currency: Perspectives of health researchers in sub-Saharan Africa on strategies to promote equitable data sharing. *PLOS Digital Health*, *3*(9), Article e0000551. https://doi.org/10.1371/journal.pdig.0000551

© IIARJournal. All rights reserved.

Cengiz, N., Kabanda, S. M., & Moodley, K. (2024). Cross-border data sharing through the lens of research ethics committee members in sub-Saharan Africa. *PLOS ONE, 19*(5), Article e0303828. https://doi.org/10.1371/journal.pone.0303828

Edgcumbe, A., Botes, M., Donnelly, D. L., Townsend, B., Shachar, C., & Thaldar, D. (2025). 'Potato potahto'? Disentangling de-identification, anonymisation, and pseudonymisation for health research in Africa. *Journal of Law and the Biosciences, 12*(1), Article lsae029. https://doi.org/10.1093/jlb/lsae029

Edgcumbe, A., Strydom, A., Thaldar, D. W., & Pepper, M. S. (2026). Exploring the challenges and legal implications of secondary use of health data in South Africa. *Developing World Bioethics*. Advance online publication. https://doi.org/10.1111/dewb.70047

Ekusai-Sebatta, D., Kyaddondo, D., Kaawa-Mafigiri, D., Barugahare, J., Ssentongo, J. S., Singh, S., & Mwaka, E. (2025). "It just feels morally not right to sell the data": Ethical and social perspectives on human genomic data sharing in Uganda—A phenomenological qualitative study. *Research Ethics, 22*(2), 252–271. https://doi.org/10.1177/17470161251361575

Esselaar, P., Swales, L., Bellengère, D., Mhlongo, B., & Thaldar, D. (2024). Forcing a square into a circle: Why South Africa's draft revised material transfer agreement is not fit for purpose. *Frontiers in Pharmacology, 15*, Article 1333672. https://doi.org/10.3389/fphar.2024.1333672

Evertsz, N., Bull, S., & Pratt, B. (2023). What constitutes equitable data sharing in global health research? A scoping review of the literature on low-income and middle-income country stakeholders' perspectives. *BMJ Global Health, 8*(3), Article e010157. https://doi.org/10.1136/bmjgh-2022-010157

Gooden, A., & Thaldar, D. (2024). The proposed Code of Conduct for Research in South Africa: Despite good progress, unresolved issues remain. *Humanities and Social Sciences Communications, 11*(1), Article 251. https://doi.org/10.1057/s41599-024-02715-0

Jaiyebo, O., & Eruteya, U. (2026). An analysis of the scope and boundaries of personal data under the Nigeria Data Protection Act. *Abuja Journal of Public Law, 5*(1), 1–24. https://doi.org/10.70118/abjpl.202605010.26

Joy Mgbeokwere, C., & Ini-Obong Monday, M. (2026). Appraisal of the algorithmic governance gap under the Nigeria Data Protection Act, 2023 in the era of AI-driven decision-making. *Abuja Journal of Public Law, 5*(1). https://doi.org/10.70118/abjpl.202605010.08

Kabanda, S. M., Cengiz, N., Rajaratnam, K., Watson, B. W., Brown, Q., Esterhuizen, T. M., & Moodley, K. (2023). Data sharing and data governance in sub-Saharan Africa: Perspectives from researchers and scientists engaged in data-intensive research. *South African Journal of Science, 119*(5/6). https://doi.org/10.17159/sajs.2023/15129

Kakraba, S., Agyemang, E. F., & Srivastav, S. K. (2026). Cognitive sovereignty and decolonial public health: Reclaiming epistemic authority in the global AI era. *Frontiers in Public Health, 14*, Article 1785170. https://doi.org/10.3389/fpubh.2026.1785170

Kayondo, B. N., & Kyobe, M. (2025). Influence of trust on hospital staff compliance with the data protection act, moderated by noncompliance costs – a Ugandan case study. *Information & Computer Security, 33*(4), 649–669. https://doi.org/10.1108/ics-08-2024-0210

Kiwuwa-Muyingo, S., Todd, J., Bhattacharjee, T., Taylor, A., & Greenfield, J. (2023). Enabling data sharing and utilization for African population health data using OHDSI tools with an OMOP-common data model. *Frontiers in Public Health, 11*, Article 1116682. https://doi.org/10.3389/fpubh.2023.1116682

Li, Y., Bowen, D. J., & Yu, J. H. (2025). Informed consent in genetic and genomic studies in sub-Saharan Africa: A systematic review of bioethical issues. *BMC Medical Ethics, 26*(1), Article 99. https://doi.org/10.1186/s12910-025-01170-z

Maseme, M., Gardner, J., & Mahomed, S. (2023). Broad consent for biobank research in South Africa – Towards an enabling ethico-legal framework. *Global Bioethics, 35*(1), Article 2288331. https://doi.org/10.1080/11287462.2023.2288331

Mohammed, S. (2026). Human rights and algorithmic accountability under the Nigeria Data Protection Act 2023. *Scholarly Journal of Advanced Legal Research, 6*(1), 1–9. https://doi.org/10.46654/6102-1848

Munung, N. S., Ewuoso, C., Chimusa, E. R., & Ogundiran, T. (2025). Cultivating an equity-oriented data sharing culture for African health research initiatives. *Nature Communications, 16*(1), Article 8122. https://doi.org/10.1038/s41467-025-63289-2

Munung, N. S., Royal, C., de Kock, C., Awandare, G. A., Nembaware, V., Nguefack, S., Treadwell, M., & Wonkam, A. (2024). Genomics and health data governance in Africa: Democratize the use of big data and popularize public engagement. *Hastings Center Report, 54*(Suppl. 2), S84–S92. https://doi.org/10.1002/hast.4933

Munung, N. S., Staunton, C., Mazibuko, O., Wall, P. J., & Wonkam, A. (2024). Data protection legislation in Africa and pathways for enhancing compliance in big data health research. *Health Research Policy and Systems, 22*(1), Article 145. https://doi.org/10.1186/s12961-024-01230-7

Mwogosi, A., & Simba, R. (2025). Digital policy and governance frameworks for EHR systems in Tanzania: A scoping review. *Digital Policy, Regulation and Governance, 28*(1), 52–74. https://doi.org/10.1108/dprg-11-2024-0289

Nienaber McKay, A. G., Brand, D., Botes, M., Cengiz, N., & Swart, M. (2024). The regulation of health data sharing in Africa: A comparative study. *Journal of Law and the Biosciences, 11*(1), Article lsad035. https://doi.org/10.1093/jlb/lsad035

Nigeria Data Protection Act, 2023 (Federal Republic of Nigeria).

Nigeria Data Protection Commission. (2025). *Nigeria Data Protection Act General Application and Implementation Directive* (NDPC/NDP ACT-GAID/01/2025).

Nyachowe, D. T., Bronstein, V., Robertson, H., Hazelhurst, S., Gardner, J., Ramsay, M., Owili, P. O., Klipin, M., Glover, K., Asiki, G., Odero, H. O., Mungai, P. C., Awuor, D., Iddi, S., Kisiangani, I., Nderitu, D. M., Masilela, N., Ohene-Kwofie, D., Kimongo, F., & MADIVA Research Hub and

© IIARJournal. All rights reserved.

the DS-I Africa Consortium. (2025). Balancing protection of participants and other stakeholders with openness: African lessons from the MADIVA data sharing and access policy. *Global Health Action*, *18*(1), Article 2590307. https://doi.org/10.1080/16549716.2025.2590307

Nyamawe, A., & Shao, D. (2026). On the use of synthetic data for healthcare AI in Africa: Technical performance, governance challenges, and policy readiness. *Digital Health*, *12*, Article 20552076261418897. https://doi.org/10.1177/20552076261418897

Obasa, A. E., & Kabanda, S. (2026). Research ethics committees (RECs) perspectives on large language models and AI ethics review: A South African case. *BMC Medical Ethics*, *27*(1), Article 206. https://doi.org/10.1186/s12910-026-01471-x

Obiora, O. L., Shead, D. A., & Olivier, B. (2024). Data sharing considerations and practice among health researchers in Africa: A scoping review. *Digital Health*, *10*, Article 20552076241290955. https://doi.org/10.1177/20552076241290955

Ochasi, A., Mahamadou, A. J. D., Altman, R. B., & Nkwocha, L. U. C. (2025). Reframing justice in healthcare AI: An Ubuntu-based approach for Africa. *Developing World Bioethics*, *26*(3), 146–155. https://doi.org/10.1111/dewb.70007

Olawade, D. B., Clement David-Olawade, A., Aderinto, N., & Wada, O. Z. (2026). Ethical oversight of artificial intelligence in Nigerian healthcare: A qualitative analysis of ethics committee members' perspectives on integration and regulation. *International Journal of Medical Informatics*, *206*, Article 106140. https://doi.org/10.1016/j.ijmedinf.2025.106140

Omutoko, L., Chingarande, G. R., Botes, M., Moyana, F., Singh, S., Jaoko, W., Sevene, E., Mtande, T., Edwin, A. K., Matandika, L., Burgess, T., & Moodley, K. (2024). Understanding and processing informed consent during data-intensive health research in sub-Saharan Africa: Challenges and opportunities from a multilingual perspective. *Research Ethics*, *21*(3), 503–518. https://doi.org/10.1177/17470161241274809

Prinsen, L. (2024). Introducing dynamic consent for improved trust and privacy in research involving human biological material and associated data in South Africa. *Frontiers in Genetics*, *15*, Article 1272924. https://doi.org/10.3389/fgene.2024.1272924

Rebai, A., Abayomi, A., Andanda, P., Kerr, R., Herbst, K., Mabuka, J., Wamuyu, R., Bukini, D., & Dandara, C. (2025). Responsible governance of genomics data and biospecimens in the context of broad consent: Experiences of a pioneering access committee in Africa. *BMJ Global Health*, *10*(2), Article e016026. https://doi.org/10.1136/bmjgh-2024-016026

Sekalala, S., Lake, S. J., Nsengimana, J. P., Weiss, M., & Mpiima, J. (2026). Health before hype: A V-Model blueprint for African digital health and AI regulatory sandboxes. *International Health*. Advance online publication. https://doi.org/10.1093/inthealth/ihag067

Sengupta, A., & Mohandas, S. (2026). The imaginary of informed consent: Rethinking approaches to data use for AI in healthcare. *Computer Law & Security Review*, *61*, Article 106309. https://doi.org/10.1016/j.clsr.2026.106309

Sihlahla, I., Donnelly, D. L., Townsend, B., & Thaldar, D. (2023). Legal and ethical principles governing the use of artificial intelligence in radiology services in South Africa. *Developing World Bioethics*, *25*(1), 35–45. https://doi.org/10.1111/dewb.12436

Staunton, C., Edgcumbe, A., Abdulrauf, L., Gooden, A., Ogendi, P., & Thaldar, D. (2025). Cross-border data sharing for research in Africa: An analysis of the data protection and research ethics requirements in 12 jurisdictions. *Journal of Law and the Biosciences*, *12*(1), Article lsaf002. https://doi.org/10.1093/jlb/lsaf002

Swales, L., Botes, M., Donnelly, D., & Thaldar, D. (2023). Towards a data transfer agreement for the South African research community: The empowerment approach. *South African Journal of Bioethics and Law*, *16*(1), 13–18. https://doi.org/10.7196/SAJBL.2023.v16i1.827

Swales, L., Gooden, A., & Thaldar, D. (2024). The anatomy of a data transfer agreement for health research. *Frontiers in Pharmacology*, *15*, Article 1332700. https://doi.org/10.3389/fphar.2024.1332700

Thaldar, D. (2023a). Does data protection law in South Africa apply to pseudonymised data? *Frontiers in Pharmacology*, *14*, Article 1238749. https://doi.org/10.3389/fphar.2023.1238749

Thaldar, D. W. (2023b). POPIA does indeed apply to health research: A response to Bronstein and Nyachowe. *South African Medical Journal*, *113*(11), 4–5. https://doi.org/10.7196/SAMJ.2023.v113i11.1345

Thaldar, D., Botes, M., Swales, L., & Esselaar, P. (2024). Enhancing data governance in collaborative research: Introducing SA DTA 1.1. *South African Journal of Bioethics and Law*, *17*(2), Article e2300. https://doi.org/10.7196/sajbl.2024.v17i2.2300

Thaldar, D., & Bottomley, D. (2025). Public trust of AI in healthcare in South Africa: Results of a survey. *BMC Medical Ethics*, *26*(1), Article 113. https://doi.org/10.1186/s12910-025-01272-8 (Correction published 2025, https://doi.org/10.1186/s12910-025-01293-3)

Townsend, B. A., Sihlahla, I., Naidoo, M., Naidoo, S., Donnelly, D. L., & Thaldar, D. W. (2023). Mapping the regulatory landscape of AI in healthcare in Africa. *Frontiers in Pharmacology*, *14*, Article 1214422. https://doi.org/10.3389/fphar.2023.1214422

Victor, A. (2025). Artificial intelligence in global health: An unfair future for health in sub-Saharan Africa? *Health Affairs Scholar*, *3*(2), Article qxaf023. https://doi.org/10.1093/haschl/qxaf023

Waithira, N., Kestelyn, E., Mukaka, M., Phuong, D. N. T., Chotthanawathit, K., Thanh, H. N., Odhiambo, R. A., Van Nuil, J., & Cheah, P. Y. (2026). Data reuse in global health: Perspectives from actors in policy, funding and research. *BMJ Global Health*, *11*(3), Article e021974. https://doi.org/10.1136/bmjgh-2025-021974

© IIARJournal. All rights reserved.