



ATHENA

# PERSPECTIVE

VOL. 3, ISSUE 19 • 12 - 18 MAY 2026

HEALTH



## Clinical Governance Gaps and Patient Safety Risks in Nigeria

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Athena Centre for Policy and Leadership operates as an independent, non-partisan think tank in compliance with Nigerian laws and regulations, committed to promoting good governance, transparency, and accountability.

Our mission is to conduct rigorous research and provide evidence-based recommendations that contribute to the development of a prosperous and forward-looking society in Nigeria.

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**Cover Image:** Medical professionals discussing treatment options during a collaborative hospital consultation. © magnific.com

Nigeria's patient safety crisis is routinely explained as a consequence of scarcity: too few clinicians, overstretched facilities, inadequate funding, and rising demand. These explanations are politically convenient and analytically incomplete. Scarcity alone does not account for why preventable clinical harm is persistent, predictable, and weakly sanctioned across the health system. Countries with comparable fiscal and workforce constraints have achieved meaningful patient safety improvements where governance systems convert standards into enforceable practice.

The more accurate diagnosis is institutional. Nigeria operates a health system in which licensure substitutes for accountability, data collection is decoupled from enforcement, and adverse clinical outcomes rarely trigger a structured regulatory response. Clinical governance exists formally but not functionally. Laws, councils, and agencies remain weakly integrated into a continuous accountability system linking adverse outcomes to regulatory consequences.

This edition of *Athena Perspective* advances a clear thesis: Nigeria's patient safety crisis is sustained by the absence of a mandatory, time-bound, post-licensure clinical governance loop that links adverse outcomes to regulatory and financial consequences. Licensing functions as an entry gate rather than a continuing accountability mechanism. Data is collected episodically without consequence. Enforcement is complaint-driven, slow, and largely invisible. The result is not episodic failure but structural risk.

Correcting this trajectory does not require new bureaucracies or exceptional spending. It requires disciplined execution within existing institutions: restoring feedback loops, aligning incentives, strengthening surveillance integrity, and re-establishing credibility. Above all, it requires deploying health-insurance purchasing power as the central enforcement lever rather than a peripheral reform tool.

The question is not whether Nigeria lacks authority. It is whether the state is willing to use it routinely rather than exceptionally.



A healthcare worker examining a young child as the mother looks on during a primary healthcare visit. **Photo:** Open Data Research Centre, School of Media and Communication, Pan-Atlantic University

## The Institutional Failure Behind Unsafe Care

Nigeria's patient safety challenge is often described through an expansive catalogue of weaknesses: workforce shortages, regulatory gaps, underfunding, antimicrobial resistance, medical tourism, and declining public trust. Each factor is relevant, but the breadth of diagnosis obscures the binding constraint.

The central institutional weakness appears to be the absence of a mandatory, enforced post-licensure clinical accountability system that connects adverse clinical outcomes to regulatory response across facilities and professions. Licensing, accreditation, and facility approval remain episodic administrative exercises rather than components of continuous oversight.

In practice, this means:

- a. Clinical errors are inconsistently reported
- b. Adverse events are weakly aggregated
- c. System-level analysis is rare
- d. Regulatory response is discretionary rather than automatically triggered

Clinical audits are optional rather than compulsory. Where adverse events are reviewed, they remain internal, informal, and insulated from regulatory consequence. Disciplinary processes rely heavily on individual complaints, transferring the burden of accountability from institutions to patients, often those least equipped to pursue it.

This architecture produces predictable effects. Medication errors recur without system learning. Healthcare-associated infections persist without consequence. Inappropriate antimicrobial prescribing continues despite rising resistance. Over time, unsafe practice becomes normalised, not because clinicians are indifferent, but because the system neither demands nor enforces improvement.

Nigeria's National Health Act establishes a statutory basis for quality assurance. Professional councils possess disciplinary authority. Ministries licence and inspect facilities. Yet these instruments operate in parallel rather than as a coherent loop. Authority exists without feedback. Standards exist without enforcement. Data exists without consequence.

This is not an absence of rules. It is an institutional failure of regulatory closure.

## Fragmented Accountability and the Absence of System Learning

Globally, unsafe care is recognised as a leading source of preventable harm. The World Health Organization estimates that approximately 134 million adverse events occur annually in low- and middle-income countries, contributing to [2.6 million](#) deaths each year. These figures do not describe rare malpractice; they reflect systemic governance failure.

Nigeria lacks a national adverse-event reporting registry. This absence is not a data gap; it is institutional evidence. A system that does not mandate reporting cannot generate institutional learning.

In the absence of national surveillance, facility-level studies provide consistent signals of embedded risk:

- a. Medication error rates in Nigerian facilities range from [26% to 78%](#)
- b. Preventable post-operative complications remain a significant contributor to [avoidable mortality](#)
- c. Surgical site infection rates of [11-24%](#) far exceed accepted benchmarks
- d. Over [60%](#) of antibiotic prescriptions lack microbiological confirmation, accelerating resistance.

Individually, these studies vary in scope and cannot be uncritically generalised. Collectively, their consistency across time, geography, and facility type supports a governance conclusion: the evidence suggests that preventable harm is systematically tolerated rather than episodic. The problem is not a lack of evidence. It is a lack of consequence.



A healthcare worker in a hospital ward attending to a patient.  
**Photo:** magnificent.com

## Licensure Without Accountability

Nigeria's health regulatory framework is extensive on paper. Professional councils license practitioners. Ministries approve and inspect facilities. Product regulators oversee medicines and devices. Standards are articulated across multiple statutes and agencies.

What remains underdeveloped is an integrated feedback mechanism linking clinical outcomes to regulatory action. Professional licensure confirms that training standards were met at a point in time. It does not require a routine demonstration of ongoing competence tied to clinical outcomes. Continuing professional development requirements exist but are weakly verified and largely decoupled from audit participation or performance review.

Disciplinary processes are overwhelmingly complaint-driven. Patients bear the burden of escalation, often without access to records, legal support, or institutional transparency. Investigations are slow. Outcomes are rarely published. Deterrence effects are minimal.

Facility licensing follows the same pattern. Approval is often a one-time administrative event. Re-inspection is irregular and frequently announced. Checklist compliance substitutes for performance assessment. Infection control committees and audit systems vary widely and are rarely enforced as licensing conditions.

## The Political Incentives That Sustain Unsafe Care

Regulatory weakness persists partly because existing incentive structures do not sufficiently reward enforcement or compliance. For regulators, enforcement is costly. It attracts litigation, professional resistance, and political interference. In the absence of performance metrics tied to patient safety outcomes, delay often becomes institutionally rational within existing incentive structures. Administrative delay often becomes institutionally preferable to visible enforcement action.

For facility owners, investing in robust audit systems and infection control infrastructure increases operating costs without clear revenue returns. Patients lack reliable performance information. Demand remains relatively inelastic. Compliance becomes optional.

For practitioners, the expected cost of unsafe practice is low. Disciplinary timelines stretch over years. Outcomes are opaque. Reputational consequences are minimal. Behavioural change depends on individual ethics rather than system design.

Federal-state fragmentation further diffuses responsibility. Adverse outcomes are attributed to funding gaps or jurisdictional ambiguity. Accountability becomes diffused across jurisdictions and institutions.

Information without credible enforcement mechanisms rarely alters institutional behaviour.

### **Nigeria's Core Governance Failure**

Nigeria certifies entry into clinical practice but does not govern performance. Once licensed, clinicians and facilities operate within a system in which errors are neither systematically captured nor institutionally addressed. Adverse outcomes rarely trigger regulatory, financial, or reputational consequences. The result is not occasional failure but a health system with limited institutional capacity for continuous learning and corrective adaptation. Unsafe care persists partly because accountability mechanisms weaken substantially after licensure.

## What Functional Health Systems Do Better

International experience demonstrates that patient safety improvement does not require exceptional spending. It requires enforced governance loops.

South Africa's [statutory inspection](#) regime introduced disclosure and consequence, altering facility behaviour over time. Ghana embedded mandatory, [non-punitive incident](#) reporting linked to policy revision rather than punishment. Kenya standardised professional oversight and published disciplinary outcomes, making [transparency](#) the primary deterrent.

These systems did not eliminate errors. They made learning unavoidable.

## Policy Priorities: Restoring Accountability to Clinical Governance

Reform must close governance loops rather than expand structures. Four institutional rules are decisive.

### 1. Make Post-Licensure Accountability Mandatory

Licence renewal for secondary and tertiary facilities must be contingent on verified submission of adverse-event reports, infection control audits, and quality improvement actions. Professional re-registration must require evidence of audit participation. This is a binding institutional requirement rather than advisory guidance.

### 2. Use Health Insurance Purchasing Power as an Enforcement Tool

Accreditation for reimbursement under national health insurance must incorporate patient safety indicators. Facilities that fail to meet minimum standards must face graduated payment sanctions. No compliance must mean no reimbursement. Purchasing power should function as an enforcement mechanism rather than solely a financing instrument.

### 3. Link Surveillance to Regulatory Response

Healthcare-associated infection and antimicrobial resistance reporting must be mandatory, standardised, and linked to escalation protocols. Sentinel surveillance without regulatory response is performative.

### 4. Make Transparency Routine

Aggregate compliance data, inspection outcomes, and disciplinary decisions must be published routinely. Accountability cannot remain internal.

## **Conclusion: Patient Safety Requires Consequence**

Patient safety ultimately reflects state capacity: the ability of institutions not merely to set standards but to enforce them consistently. Where accountability remains discretionary, unsafe care becomes normalised, and public trust deteriorates accordingly.

Patient safety is not a technical aspiration. It is a governance obligation.

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## FG Removes UTME Requirement for NCE Admission

Candidates seeking admission into Nigeria Certificate in Education (NCE) programmes in colleges of education will no longer be required to sit for the Unified Tertiary Matriculation Examination (UTME).

The Minister of Education, Tunji Alausa, announced this on May 11 during the Joint Admissions and Matriculation Board (JAMB) 2026 policy meeting in Abuja.

Under the new guidelines, prospective students will only be required to obtain a minimum of four O-level credit passes to qualify for admission.

According to the minister, the reform is aimed at reducing administrative pressure on JAMB and encouraging greater interest in the teaching profession.

He added that the exemption would also apply to candidates seeking admission into National Diploma programmes in non-technology agricultural and agriculture-related courses.

<https://www.channelstv.com/2026/05/11/just-in-fg-scrap-utme-requirement-for-nce-candidates/>

## UI Students Protest Campus Shutdown Over Strike

Students of the University of Ibadan staged a protest over the disruption of basic campus services, including electricity and water supply, following an ongoing staff strike.

They lamented the hardship caused by the strike, including disruptions to academic activities on campus.

The demonstration reflects rising tensions on campus as negotiations between university management and staff unions remain unresolved. Academic activities and welfare services have been significantly affected by the industrial action.

<https://www.channelstv.com/2026/05/06/ui-students-protest-shutdown-of-basic-amenities-over-nasu-strike/>

## NNPP Spokesperson Resigns Amid Realignment

The National Publicity Secretary of the New Nigeria Peoples Party (NNPP), Ladipo Johnson, has resigned from the party, citing ongoing political realignments ahead of the 2027 general elections.

Johnson said his decision was informed by the need to participate in broader opposition coalition efforts as political actors reposition themselves for the next electoral cycle. His resignation comes amid increasing movement within Nigeria's opposition parties.

<https://punchng.com/just-in-nnpp-spokesman-johnson-quits-party/>



## Oyo Adopts Daily Sanitation Enforcement

The Oyo State Government has introduced a daily environmental sanitation monitoring system in place of its previous monthly exercise.

The Commissioner for Environment and Natural Resources, Ademola Aderinto, disclosed this during a press briefing held in the Ministry's Conference Room to mark his first 100 days in office.

The Ministry also launched the Oyo Soro Soke (Oyo SSS) Environmental Whistleblower platform accessible via mobile applications and WhatsApp, empowering residents to report environmental violations and promote community participation in environmental governance.

Officials say the new arrangement is aimed at improving environmental cleanliness and public health outcomes. The initiative includes increased deployment of sanitation officers, stricter compliance monitoring, and enhanced waste management measures.

<https://guardian.ng/news/oyo-introduces-daily-environmental-sanitation/>

## REGIONAL UPDATES



### Boko Haram Kills 23 Soldiers in Chad

Boko Haram militants have killed 23 soldiers in an attack on a military post in the Lake Chad region, Chad's armed forces said Tuesday.

The region has long been threatened by the Nigeria-based Boko Haram militant group, which is known for carrying out attacks in neighboring countries.

President Mahamat Idriss Deby in a separate statement called the attack "cowardly."

A number of armed groups compete in the resource-rich, four-country Lake Chad region to fund their operations by imposing what they call taxes on local communities.

Boko Haram in the past decade and a half has killed several thousand people and displaced millions, according to the United Nations, and continues to carry out operations across parts of Nigeria, Cameroon, Chad and Niger.

[https://apnews.com/article/chad-boko-haram-attack-militants-soldiers-4f091478e56b757957c7e16d303ae75c?utm\\_source=copy&utm\\_medium=share](https://apnews.com/article/chad-boko-haram-attack-militants-soldiers-4f091478e56b757957c7e16d303ae75c?utm_source=copy&utm_medium=share)

### Militant Activity Heightens Insecurity in Niger

Niger is facing increasing security pressure as militant activity expands across the Sahel region, with cross-border attacks and instability affecting multiple West African states.

The groups have expanded their presence in Niger and Burkina Faso and have linked up with Islamist militants in northern Nigeria. Their reach now stretches over 3,000 km (1,900 miles) from western Mali near Senegal, through Nigeria and into Chad.

Analysts warn that the widening scope of insurgent operations is straining national security capacities and complicating regional coordination efforts to contain violence.

<https://www.reuters.com/markets/commodities/mali-attacks-spotlight-growing-reach-militants-across-west-africa-2026-05-01/>

### Cameroon Joins Renewed Lake Chad Security Cooperation

Cameroon has joined Nigeria and Chad in renewed discussions aimed at strengthening joint military cooperation against terrorism and cross-border insecurity in the Lake Chad Basin.

The renewed coordination efforts are intended to improve intelligence sharing and operational collaboration in response to persistent militant threats across the sub-region.

<https://www.nta.ng/news/security/nigeria-chad-cameroon-strengthen-security-cooperation-against-terrorism>

### US boosts West Africa Lassa fever response in Benin

The U.S. Centres for Disease Control and Prevention (CDC), in collaboration with regional partners, has conducted a Lassa fever simulation exercise in Cotonou, Benin, aimed at strengthening surveillance coordination and response capacity in West Africa.

The exercise, held from May 4 to 8, was designed to test preparedness systems for epidemic outbreaks. It was organised in partnership with the African Field Epidemiology Network, the ECOWAS Regional Centre for Surveillance and Disease Control, the International Association of National Public Health Institutes, and Integrated Laboratory Services.

Surveillance officers and laboratory technicians from Benin, Mali, Togo, Ghana, Nigeria, Mauritania and Burkina Faso participated in sessions focused on laboratory systems, infection prevention, risk communication, community engagement, and cross-border health coordination.

According to local media, organizers indicated that this simulation exercise, coordinated by Dr. Kerton Victory, CDC Regional Workforce Development Advisor in West Africa, aimed to improve preparedness and strengthen coordination of responses to cross-border health threats.

<https://fr.apanews.net/news/afrique-de-louest-exercice-de-preparation-a-la-fievre-de-lassa/>

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