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HEALTH

# False Typhoid Diagnoses and The Erosion of Diagnostic Governance In Nigeria

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**Cover Image:** A laboratory scientist conducting blood test during Medical Outreach, Sanitation Exercise in Riyom, Plateau state on August 10, 2025. © The Dachung Musa Bagos Foundation

Nigeria's health system is increasingly shaped by a quiet but consequential distortion: the routine overdiagnosis of typhoid fever. What appears, at first glance, as a clinical convenience is, in fact, a governance failure embedded in diagnostics, regulation, and surveillance.

In many settings, febrile illness is swiftly labelled as typhoid, often based on poorly specific tests and weak clinical confirmation pathways. This practice is reinforced by patient expectations, cost pressures, uneven laboratory capacity, and inconsistent regulatory enforcement.

The result is not merely a diagnostic error. It is systemic distortion: inflated disease reporting, unnecessary antibiotic use, and accelerating antimicrobial resistance (AMR). Nigeria's surveillance architecture is consequently weakened, producing data that reflects clinical convention more than epidemiological reality.

This policy brief argues that the problem is not primarily technical but institutional. Diagnostic accuracy fails because governance systems do not consistently reward precision or penalise deviation.

It proposes four reform pathways:

1. Strengthening diagnostic standards and validation
2. Aligning incentives with accuracy through financing and regulation
3. Improving surveillance integrity through verification systems
4. Rebuilding public trust through communication and professional accountability

Without such reforms, diagnostic shortcuts will remain rational, and the system will continue to reproduce error at scale.

Widal is the standard test for Typhoid in the medical laboratory

## The Institutional Nature of Diagnostic Failure

Nigeria's health system cannot claim credibility while diagnostic shortcuts remain routine. Few issues expose this more starkly than the widespread overdiagnosis of typhoid fever. Across many facilities, any febrile presentation is routinely labelled as typhoid, a practice sustained by unvalidated tests and permissive regulatory oversight. What presents as a clinical challenge is, in fact, an institutional failure: a system that privileges speed over accuracy, volume over verification, and discretion over enforceable standards.

False typhoid diagnoses persist not because the science is uncertain, but because the governance framework does not enforce accuracy. Confirmatory diagnostics exist, yet their use remains constrained by cost, infrastructure deficits, and uneven implementation. More importantly, national standards, while formally established, are weakly enforced in practice. Federal guidelines depend on state structures and professional bodies for compliance, but supervision is inconsistent, particularly within private laboratories where inspections are infrequent, and sanctions are rarely applied.

These weaknesses generate predictable incentives. Providers face minimal consequence for poor diagnostic quality; patients, in turn, demand rapid treatment; and shortcuts reduce both time and cost pressures. The result is a persistent divergence between formal policy and everyday practice, one that distorts disease surveillance, accelerates unnecessary antibiotic use, and undermines antimicrobial stewardship.

Typhoid is widely diagnosed, yet much of the recorded burden reflects diagnostic uncertainty rather than confirmed infection. Continued reliance on the Widal test, alongside limited access to confirmatory diagnostics, produces ambiguous clinical signals that frequently translate into empirical antibiotic prescribing. Under pressure from time constraints, patient expectations, and weak oversight, discretion supplants diagnostic rigour. Typhoid fever

Within this environment, antibiotic misuse becomes entrenched. Regulatory bodies issue guidelines, but enforcement remains uneven. Over-the-counter antibiotic sales persist despite formal restrictions, while surveys indicate widespread self-medication. The consequence is a substantial antimicrobial resistance burden, including over 263,000 deaths linked to resistant infections, reflecting a systemic governance failure rather than isolated clinical misconduct.

This is an institutional chain with cumulative effects: diagnostic ambiguity enables discretionary prescribing; weak enforcement normalises substandard practice; and sustained antibiotic misuse accelerates resistance. The central constraint is not technical capacity, but governance discipline.

## What the Evidence Reveals

Evidence from across Nigeria is consistent and unambiguous: false typhoid diagnoses are widespread, and prevailing diagnostic practices significantly inflate the apparent burden of disease. Studies repeatedly demonstrate that the Widal test, still widely used in both public and private facilities, yields high false-positive rates, particularly in endemic settings where baseline antibody levels are elevated. By contrast, where blood culture is employed, confirmed typhoid incidence is substantially lower than routine clinical reporting indicates.

Household and facility-level surveys show extensive empirical antibiotic use in response to fever. A majority of Nigerians access antibiotics without a prescription, frequently based on informal assessments of malaria or typhoid. This pattern is reinforced by weak enforcement of prescription-only regulations and by retail environments in which antibiotics remain readily accessible.

The antimicrobial resistance data further reinforce these findings. Nigeria records one of the highest burdens of AMR-related mortality globally. Surveillance evidence links rising resistance patterns to the extensive use of broad-spectrum antibiotics, commonly prescribed for presumed typhoid infections. Inflated typhoid figures, in turn, distort surveillance systems, weakening the ability to accurately characterise disease patterns or to design effective policy responses.

Where confirmatory diagnostics are consistently enforced, false-positive rates decline markedly. Comparative evidence from across Africa indicates that improved validation, strengthened supervision, and robust quality assurance—rather than new technological inputs alone—are associated with more accurate diagnosis.

Three conclusions emerge with clarity:

1. Widal-based diagnosis substantially inflates estimated typhoid incidence.
2. Empirical antibiotic treatment is widespread and weakly regulated.
3. Weak diagnostic governance undermines both surveillance integrity and antimicrobial stewardship.

Taken together, the evidence points decisively to an institutional failure of governance, rather than a gap in scientific knowledge or technical capacity.

## Why the System Sustains the Failure

False typhoid diagnoses persist because the system renders them rational. Providers operate under sustained pressure to deliver rapid consultations, minimise costs, and meet patient expectations. In high-volume clinical environments, unvalidated tests are inexpensive, quick to administer, and seldom subjected to scrutiny. By contrast, confirmatory diagnostics, while more accurate, are costlier, slower, and rarely mandated for reimbursement or regulatory compliance.

Patients further reinforce this dynamic. High levels of out-of-pocket expenditure, combined with limited trust in protracted diagnostic pathways, encourage demand for immediate treatment. Typhoid has become a default explanatory label for persistent fever, and antibiotics are frequently expected as first-line care rather than as a consequence of confirmed diagnosis.

Private laboratories and pharmacies operate within uneven supervisory regimes. The costs of compliance—upgrading equipment, enforcing prescription-only protocols, and meeting diagnostic standards—are borne by individual providers, while the benefits of improved public health accrue system-wide. In the absence of consistent inspection and credible sanctions, voluntary compliance remains structurally weak.

Regulatory authorities themselves operate under both operational and political constraints. Enforcement capacity varies across states, inspection systems are limited, and stringent sanctions risk public backlash, particularly in settings where access to alternatives is constrained. The result is an implicit tolerance of practices that erode diagnostic accuracy.

These interacting pressures produce a stable but damaging equilibrium. Diagnostic shortcuts are individually rational for providers, patients, and private actors alike, while regulators face structural difficulty in shifting behaviour. Any meaningful reform must therefore begin by altering the incentive structures that sustain this equilibrium.

Typhoid has become a default explanatory label for persistent fever

## Comparative Insight

Across Africa, several countries have addressed diagnostic inaccuracy not through technological expansion, but through deliberate redesign of the governance architecture that shapes diagnostic behaviour. Their experience demonstrates that Nigeria's challenge is not intractable; however, it is fundamentally institutional in nature and cannot be resolved through technical substitution alone.

Ghana strengthened diagnostic governance by linking laboratory operations to a national external quality assurance framework. Facilities that repeatedly failed verification lost accreditation, while reimbursement under insurance schemes was made conditional on validated testing. This enforcement mechanism aligned incentives across both public and private providers and significantly reduced reliance on non-standard rapid tests. The central lesson is straightforward: diagnostic accuracy improved when compliance became economically rational.

Kenya adopted a more explicitly regulatory approach. The Pharmacy and Poisons Board, in coordination with the National Public Health Laboratory, introduced routine supervisory audits backed by enforceable sanctions for non-compliance. Crucially, Kenya also distinguished between "clinical suspicion" and "confirmed cases" within its surveillance system, thereby removing incentives for facilities to report unverified diagnoses. The governance insight is clear: surveillance integrity improves when reporting systems reward verification rather than volume.

South Africa embedded diagnostic governance within its financing architecture. Through the National Health Laboratory Service, diagnostic standards are centrally regulated, and reimbursement under public insurance is strictly contingent on adherence to approved testing protocols. Laboratories are not remunerated for tests conducted outside established algorithms. This has fostered a system in which diagnostic accuracy is not discretionary, but structurally required.

Across these three cases, the lesson is consistent: reform succeeded not because clinical behaviour changed voluntarily, but because institutional design altered the cost structure of inaccuracy.

For Nigeria, the implication is direct. In the absence of credible enforcement mechanisms, financial penalties for non-standard testing, and surveillance systems that prioritise verified diagnosis, diagnostic shortcuts will remain both rational and widespread. Comparative experience indicates that progress depends less on exhortation than on governance discipline: reward accuracy, penalise deviation, and embed standards within the core systems of financing and reporting.

## Policy Pathways for Reform

Nigeria can reverse the entrenched cycle of diagnostic inaccuracy only by reshaping the governance environment that currently rewards diagnostic shortcuts. The following four pathways set out institution-anchored reforms designed to ensure that accuracy becomes the default rather than the exception.

### A. Restore Diagnostic Credibility

**1. Mandate Validated Testing Protocols Across All Facilities**

Nigeria must formally prohibit the routine use of unvalidated Widal tests and require strict adherence to nationally approved diagnostic algorithms. The Medical Laboratory Science Council of Nigeria (MLSCN) should publish a restricted and authoritative list of approved typhoid diagnostics and ensure uniform enforcement across both public and private facilities.

**2. Introduce Facility-level Diagnostic Dccountability**

Hospitals and laboratories should be required to record, audit, and publicly report diagnostic accuracy metrics. Facilities demonstrating persistent underperformance should face graduated administrative sanctions, including suspension of diagnostic privileges.

**Responsible institutions:** *MLSCN, Federal Ministry of Health (FMoH), NCDC*

### B. Align Incentives and Enforcement

**1. Link Compliance to Reimbursement and Licensing**

National Health Insurance Authority (NHIA) reimbursements, as well as private insurance payouts, should be explicitly contingent on the use of validated diagnostic protocols. Facilities deploying non-approved tests should be rendered ineligible for reimbursement and subject to regulatory penalties.

**2. Enforce Targeted Regulatory Consequences**

The MLSCN and state ministries of health should implement periodic, unannounced compliance inspections backed by enforceable sanctions. These should include fines, licence suspension, and withdrawal from eligibility for public procurement in cases of repeated non-compliance.

**Responsible institutions:** *NHIA, MLSCN, State Health Ministries*

### C. Strengthen Surveillance Integrity

**1. Distinguish Clinically Suspected from Laboratory-Confirmed Cases**

National surveillance systems must clearly separate suspected clinical diagnoses from laboratory-confirmed cases. This distinction is essential to reduce reporting inflation, improve data reliability, and align Nigeria with established international epidemiological standards.

**2. Embed Verification Checkpoints into Disease Reporting**

The Nigeria Centre for Disease Control (NCDC) should introduce automated validation mechanisms within reporting platforms, flagging facilities with significant discrepancies between suspected and confirmed cases. Facilities exceeding defined thresholds should be subject to structured supervisory review. Nigeria Centre for Disease Control

**Responsible institutions:** *NCDC, DHIS2/NHIS reporting units, State Epidemiology Units*

## D. Rebuild Public Trust

**1. Launch a National Communication Campaign on Febrile Illnesses**

Public understanding must be recalibrated: not all fevers are typhoid. A coordinated national communication strategy—leveraging radio, community health workers, and digital platforms—should directly confront entrenched misconceptions that drive demand for inaccurate testing.

**2. Strengthen professional accountability**

Professional regulatory bodies should establish clear disciplinary mechanisms for clinicians and laboratories that repeatedly issue false or unsupported diagnoses. Restoring confidence in the system requires visible consequences for systemic malpractice.

**Responsible institutions:** *FMoH, NCDC, MLSCN, MDCN, Health Promotion Units*

Across all four pathways, the underlying principle is consistent: diagnostic accuracy must be structurally enforced, not rhetorically encouraged. Only when governance mechanisms make deviation costly and compliance rational will Nigeria begin to dismantle the institutional conditions sustaining false typhoid diagnosis.

### Strategic Logic Behind These Pathways

These reforms are unified by a single governing principle: diagnostic accuracy improves only when institutions reshape the incentives that structure clinical behaviour.

The pathways, therefore, represent a shift in Nigeria's health governance architecture—from nominal rules to enforceable standards; from voluntary compliance to compliance anchored in incentives and sanctions; from inflated and unreliable surveillance data to verified national health intelligence; and from entrenched public scepticism to restored institutional trust.

Taken together, these shifts are not incremental adjustments but structural corrections to the incentive environment in which diagnosis currently occurs. They reconstitute the relationship between regulation, financing, and clinical practice in ways that make accuracy both economically rational and institutionally required.

This, ultimately, is the governance architecture required for a credible and functioning health system.

## Conclusion: The Institutional Stakes

Nigeria cannot build a credible health system while diagnostic inaccuracy remains tolerated. False typhoid diagnoses are not a marginal technical inconvenience; they reveal deeper weaknesses in how standards are defined, enforced, and sustained. When diagnostic accuracy becomes discretionary rather than obligatory, the integrity of the entire health intelligence system is compromised.

This challenge extends beyond a single disease. It is, at its core, a test of whether Nigeria can enforce national standards, align incentives with diagnostic accuracy, and shield its population from the escalating consequences of antimicrobial resistance. Comparative experience demonstrates that progress is achieved not through incremental improvements in tools, but through the strengthening of institutions and the consistent application of governance discipline.

Restoring diagnostic credibility is therefore central to rebuilding trust across the health system—among patients, clinicians, regulators, and development partners alike. In the absence of institutional reform, the system will continue to generate unreliable data, sustain misaligned incentives, and expose the population to avoidable risk. With reform, however, Nigeria can re-anchor its health system on accuracy, accountability, and enforceable standards that command public confidence.


### Author

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## Tinubu, German Chancellor Merz Pledge Closer Cooperation on Security, Power

President Bola Tinubu and German Chancellor Friedrich Merz have agreed to strengthen bilateral relations and deepen cooperation in the areas of security, power, and rail transport.
During a telephone conversation on February 18, the two leaders also expressed willingness to collaborate in the creative arts and skills development.
According to a statement issued by the presidential spokesperson, Bayo Onanuga, discussions covered the Presidential Power Initiative, with Tinubu indicating that Nigeria would require support in power transmission.
The German Chancellor said Siemens would be ready to provide technical assistance, while Deutsche Bank would be willing to support financing.
Both leaders also expressed concern over the security situation in the Sahel region. "The Sahel corridor is bad and needs our support. Intelligence support reconnaissance is needed," Tinubu said.

*https://www.thisdaylive.com/2026/02/19/tinubu-german-chancellor-merz-pledge-improved-collaboration-on-security-power/*

## Tinubu Signs Executive Order on Direct Remittance of Oil, Gas Revenues

President Bola Ahmed Tinubu has signed an executive order mandating the direct remittance of oil and gas revenues to the Federation Account, aimed at curbing leakages and boosting funds for the three tiers of government.

The gazetted order was issued pursuant to Section 5 of the 1999 Constitution (as amended) and anchored on Section 44(3), which vests control of mineral resources in the Federal Government.

According to a statement by his Special Adviser on Information and Strategy, Bayo Onanuga, the directive is intended to safeguard revenues, reduce waste, and eliminate overlapping structures.

It also seeks to restore the revenue entitlements of federal, state, and local governments, which the Presidency said were altered by the Petroleum Industry Act (PIA) in 2021.

*https://thenationonlineng.net/tinubu-signs-executive-order-for-direct-remittance-of-oil-gas-revenues-to-federation-account/*

## Tinubu Signs Electoral Act 2026 Into Law

President Bola Tinubu has signed the Electoral Act, 2022 (Repeal and Re-enactment) Bill 2026 into law, following the passage of the bill by the National Assembly on Tuesday after months of deliberations.

Tinubu signed the bill at the State House on Wednesday in the presence of top government officials, including the Senate President, Godswill Akpabio; the Speaker of the House of Representatives, Tajudeen Abbas; and the Chief of Staff to the President, Femi Gbajabiamila.

He said the essence of democracy is to have very solid discussions committed to national development and nation-building, essential for the stability of the nation.

*https://www.channelstv.com/2026/02/18/breaking-tinubu-signs-electoral-bill-into-law/*

## FCT Dispatch Riders Protest 'Multiple Taxation'

Thousands of dispatch riders in the Federal Capital Territory (FCT) on February 19 protested at the FCT Administration Secretariat in Abuja over what they described as "multiple taxation".

They called on the FCT Minister, Nyesom Wike, to intervene and halt what they alleged to be extortion.

Speaking to the News Agency of Nigeria (NAN), the riders' spokesperson, Mr Olawale Ilesanmi, said they had consistently met their tax obligations but that the burden of multiple levies had become overwhelming.

He added that motorcycles had been impounded, with owners forced to pay the new fee before release, while riders also pay N300 each time they enter a market.

The protest was suspended after officials of the FCT Transportation Secretariat met with the riders' leaders.

*https://dailypost.ng/2026/02/19/fct-dispatch-riders-protest-multiple-taxation/*

## Benin Establishes Anti-Malaria Agency

The Beninese government has announced, following the Council of Ministers meeting of 18 February 2026, the establishment of a National Agency for Combating Malaria and Mosquitoes, aimed at strengthening the response to a disease that remains endemic in the country.

Despite sustained efforts in recent years, malaria continues to rank among the leading causes of morbidity and mortality in Benin, particularly affecting children under five and pregnant women, with far-reaching health, social, and economic consequences.

In response, the government has elevated the eradication of the disease to a public health priority, creating a specialised, autonomous, and responsive body tasked with leading a coordinated and integrated campaign against malaria and mosquitoes.

The new agency will, among other responsibilities, design, implement, and evaluate nationwide mosquito control programmes in collaboration with relevant institutions.

*https://fr.apanews.net/news/benin-creation-dune--agence-anti-paludisme/*

## Chad, AFD Sign €15M Financing Agreement

The Chadian government and the French Development Agency (AFD) have signed a €15 million financing agreement under budget support for the 2023 fiscal year.

The agreement marks a further step in cooperation between Chad and its technical and financial partners, aimed at strengthening the national economy.

The grant supports the government's macroeconomic and fiscal consolidation efforts through financing eligible expenditures linked to structural projects, with two priority areas identified.

*https://fr.apanews.net/diplomacy/tchad-lafd-debloque-e15-millions-en-soutien-a-leconomie/*

## Cameroon Excluded from US–Africa Trade Programme

The United States has renewed the African Growth and Opportunity Act (AGOA), restoring duty-free access to its market for several African countries, while maintaining Cameroon's exclusion.
Cameroon was removed from the programme in 2019 over human rights concerns related to the conduct of security forces in the North-West and South-West regions.
Eligibility for AGOA requires countries to demonstrate progress towards a market-based economy, adherence to the rule of law, political pluralism, and respect for due process.
In 2022, the Cameroonian government indicated that discussions had begun with Washington regarding possible readmission to the programme, which grants tariff-free access to the US market.
US President Donald Trump signed the legislation reauthorising the pact until December 31, 2026, with retroactive effect from September 30, 2025, when it expired.

*https://theguardianpostcameroon.com/post/6617/en/hometrade-deals-with-african-countries-us--maintains-exclusion-of*

## Niger Neutralises 43 Terrorists in Security Operations

According to the weekly bulletin from the Defence and Security Forces (FDS), 43 terrorists were neutralised and 28 suspects apprehended during joint air and ground operations carried out between 9 and 15 February 2026.

The operations, coordinated by the Integrated Operations Coordination Centre (CICO) across Diffa, Dosso, Tahoua, and Tillabéri, also led to the seizure of weapons, ammunition, 5,452 sticks of dynamite, and over 68,000 litres of illicit fuel.

Ground forces, supported by air strikes, were key to the operations. Authorities also recovered sensitive materials and logistics, including detonating cords and illicit pharmaceutical products intended for criminal networks.

*https://lesechosduniger.com/2026/02/19/defense-et-securite--43-terroristes-neutralises--et-28-suspects-interpeles-par-les-fds-au-cours--de-la-derniere-semaine/*

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