Humanising Healthcare in Nigeria: A Patient-Centred Care Approach

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Abstract

Background: Nigerian healthcare workers face numerous challenges that impact their ability to deliver patient-centred care. These include limited training spaces, high costs of education and licensure, scarce employment opportunities, low wages, interprofessional conflicts, and poor governance leading to inadequate resources. Despite these hurdles, there have been significant medical advancements and notable successes in public health initiatives, highlighting the resilience and commitment of these professionals.
Objectives: This study aims to critically review the current challenges in the Nigerian healthcare system that hinder the humanization of care and to explore strategies for implementing more patient-centred practices.
Methods: This review synthesizes existing research, policy documents, and case studies concerning patient-centred care in Nigeria. Articles published within the last 20 years focusing on Nigerian healthcare systems and patient-centred care practices were included. The review excluded non-peer-reviewed articles and studies not directly related to Nigeria.
Results: The study identified critical areas needing improvement, including healthcare delivery systems, patient journey mapping, available treatment options, and humanizing healthcare practices. Despite the progress in medical treatment and disease management, systemic issues such as inefficient healthcare processes, inadequate patient involvement in care decisions, and insufficient infrastructure persist, detracting from the quality of care.
Conclusion: Effective humanization of healthcare in Nigeria requires systemic changes to foster environments that prioritize patient safety, dignity, and respect. Recommendations include enhancing interprofessional collaboration, improving governance, increasing resource allocation, and adopting patient-centred care models to improve healthcare outcomes and patient satisfaction.
Keywords: Humanizing healthcare, Patient-centred care, Nigerian healthcare system, Healthcare challenges, Healthcare improvements.

Introduction

Nigerian health workers face a lot of challenges in their work environment[1,2]. From the beginning of your career, you have to deal with limited admission spaces, sometimes unfair admission process, uncertain duration of training, high training costs and high cost of renewing your practising licenses[3,4]. And when you finish your training, you struggle with scarce employment opportunities and low salaries

during your service. The work environment itself is also challenging, with harmful interprofessional conflicts and poor governance that led to lack of adequate equipment and supplies[5-7]. All these factors affect the quality of basic healthcare delivery, let alone "humanised" care.

Despite these difficulties, Nigerian health care providers have demonstrated remarkable resilience and success against all odds. For example, Nigerian health workers were instrumental in responding to the COVID-19 pandemic and the Ebola outbreak when most people were very scared[2]. You worked on the frontlines at great personal risk, with many paying with their lives, especially in the early stages of these pandemics. Sadly, we do not have memorials to honour these heroes.

Nigerian health workers also played a key role in eliminating polio in the country in 2020[8,9]. These achievements are very important to emphasise because most of this discussion will focus on areas where improvements are needed. Identifying the weaknesses is not intended to minimise the contributions our colleagues make daily but to acknowledge the gaps with the aim of improvement.

One can clearly see that most health workers have a strong passion for helping others, which motivates them to choose their careers. They have noble intentions to improve the lives of their patients and clients every day. Based on these observations, this review study examined how current work environment challenges affect patient-centred care among healthcare workers and humanizing healthcare practices in Nigeria.

Methodology

The study approaches employed synthesizing existing research, policies, and case studies related to the challenges and practices of humanizing healthcare in Nigeria. The review will draw upon the above to construct a comprehensive analysis. Inclusion criteria include studies published within the last 20

years, texts in English, studies focusing on Nigerian healthcare systems, and articles specifically discussing patient-centred care practices. The study excluded non-peer-reviewed articles, studies not specifically related to Nigeria, and outdated reports that do not reflect the current state of healthcare. The identified themes related to challenges and practices in humanizing healthcare in Nigeria were compared to global standards and practices to identify gaps and opportunities for improvement. This was followed by critically discussing the implications of the findings in relation to the overarching aim of promoting patient-centred care in challenging environments. It was ensured that all data, particularly personal accounts and case studies, are used ethically, respecting privacy and confidentiality.

Results and Discussion

A critical review of the evidence found some themes, as shown in Table 1. We then talked about how these themes connect to the human side of healthcare practices in Nigeria.

Table 1: Topics associated with humanizing healthcare practices

Themes
Healthcare delivery journey
Patients' journey map
Available treatment options
Humanizing healthcare practices in Nigeria

Great strides in the world of medicine

Before anything else, I want to acknowledge the remarkable progress that medicine has made in the world and in Nigeria despite all obstacles. When I was a medical student in the 90s, HIV was a fatal diagnosis. But today, HIV is a controllable condition. Antibiotics have transformed public health, making diseases that used to be lethal curable and major surgeries, such as organ transplants, feasible and safer. Perhaps one of the most striking examples of the success of modern healthcare is the crucial role the smallpox vaccine had in eliminating one of history's

deadliest disease, as confirmed by the WHO in 1980[10].

Besides the obvious achievements of health systems, such as saving lives, preventing disease, and enhancing well-being, there are other less visible but equally vital functions of healthcare in our lives. I think we need to acknowledge and attend to these functions if we want to build health systems that are suitable and people-centred. Julio Frenk in his 1994 paper on Dimensions of Health Systems listed some of these functions[11]:

- Health systems have assumed responsibilities that used to be managed by people, families and customary/religious institutions in our communities, such as delivering babies; moreover, marriages nowadays require test results for HIV, Hepatitis, and Pregnancy to be valid.
- It is a major income and employment generator for various professionals, managers, and technicians. Healthcare is a crucial conduit for mobilising, exchanging, and redistributing large amounts of money, involving both public and private actors such as Government Agencies, HMOs, and NGOs. In 2020, the healthcare sector accounted for about 17.7% of the United States' Gross Domestic Product (GDP).
- It serves as a main platform where ordinary people encounter scientific matters, whether they are related to family conflicts or discussions about topics like reproduction, sources of health crises (e.g. COVID-19) - virus vs ethics.
- Healthcare is a key issue in political conflicts among parties, interest groups, and social movements, often affecting who wins elections. For instance, the impact of the affordable care act (aka Obamacare) or the NHS in elections in the US and the UK respectively.
- It embodies cultural meanings and interpretations of fundamental human

experiences such as birth, death, and crime. For example, rape or sexual violence investigation is incomplete without medical evidence.

- It raises key ethical questions of our time, such as the ethical dilemma of euthanasia (assisted suicide), execution of criminals on death row, cloning, artificial insemination, or as we encounter every day when we have patients with a condition that we can effectively treat but who cannot afford to pay. Something IMAN is well-known to help with.

The patients' journey map

Now, let's shift our attention to challenges from the patient's perspective. Our patients navigate a complex journey to reach us. Our hospitals, especially, are not designed with our patients in mind; they are primarily designed for our convenience[12]. Patients are not consulted or even considered in the design of our workflow, types of procedures, equipment, or in setting prices for services. For example, how do we arrive at the prices we set for each service? Are they reflecti ve of their value to the patient? Should we reuse a single-use device? Why should the burden of our failure to prevent corrupt practices by our colleagues be transferred to patients? For instance, queuing to get a number, queuing to pay for registration, queuing to register, then queuing for consultation, queuing to get a quote for a test, queuing to pay for a test, queuing to get the sample taken, queueing to get the result... It goes on and on. All because we want to prevent corruption in our revenue systems and our failure to deploy effective technology. Which steps of these processes truly add value to the patient?

Let's imagine ourselves in the shoes of a patient who needs our services. What steps do they have to take to reach us? How can we make those steps easier and more respectful for them? I will follow UNICEF's human-centred design handbook model[13], which is a

useful tool to map out the patient's journey, but not the only one available.

Step 1: Knowledge, Awareness, and Beliefs about Health Services. This stage of the journey is influenced by the practical knowledge, norms, values, trust in health services, and providers. For example, a parent who believes rumours that vaccines are harmful for children will refuse vaccination services despite their proven benefits. We have seen how this affected polio vaccination programmes in this country and, more recently, COVID-19 vaccination even among health professionals. It is important for all health workers and policymakers to research, understand and consider the knowledge, awareness, and beliefs of their target population when they design and deliver their services and not wait until they face a problem.

Step 2: Intent. The patient's ability or confidence to make decisions. For example, in our community, we understand that in most cases, the husband and father has the authority and makes all the significant choices about the health of the mother and child. We are aware of the serious outcomes of disregarding the husband's consent when providing some of our services. Health workers and policymakers need to be culturally sensitive and mindful of community norms in the design of services.

Step 3: Preparation, Cost, and Effort. When a decision is made to come to the health facility, patients have to consider logistics, transport, arrange childcare, juggle competing priorities, social and opportunity costs of attending a health facility. In some situations, these challenges can be prohibitive. For example, a total or partial ban on the use of motorcycles because of security challenges without taking into account that for most, it is the only means of transport to get to a health facility. The cost, not only of healthcare but transport and "informal" (under-the-table) payments, may

prove prohibitive for some. It is crucial for health workers to be sensitive to the hurdles that our patients have to cross to reach our clinics. It is even worse when they manage to cross all of these hurdles to get to a health facility and are not seen, harmed, or even subjected to violence, as is not uncommon. (I have had a patient undertake a journey from Gembu, Taraba State to Kano, Kano Stae and had to return without accessing the service they went for because of a failure to do some basic checks before the start of the journey of over 650km).

Step 4: Point of Service. For example, sometimes healthcare workers cannot provide the level of care the patient wants because the healthcare workers are stressed or overworked or lack a necessary equipment or supply. Patients may encounter lengthy waiting times and go through processes that do not add any value to them or address their needs. Sometimes they are disrespected, shouted at, or subjected to different forms of violence.

Step 5: The Experience of Care. When the patient gets seen, sometimes the procedures are not done properly, there is poor interpersonal communication, the environment may not be clean or convenient, especially women may not have access to toilets that are in good sanitary condition, etc. (men find it a lot easier to go behind the building.

Step 6: After Service. Often, the information provided is unclear. Many patients leave without knowing what condition they have, the implications of their diagnosis if they get one, what they need to do when they go home, what side effects to expect, when they should come for follow-up, how they can access help when problems arise. Whenever they return, it is like coming again for the first time because of poor record systems.

<u>Treatment paths available to patients in Nigeria</u>

We will now explore in greater detail the options available to our patients and the consequences of each option. For this purpose, I will employ the framework developed by Dahlgren and Whitehead for assessing health systems from the public's perspective, which is possibly the only one of its kind[14]. According to this framework, depending on factors such as age, gender, social class, type of disease, and type of treatment, patients or households have four options, each with different costs and consequences.

Option 1: No Care - A portion of people with a health problem will receive no care for their condition. Certain minor ailments may not require any special care, in which case 'no care' is the best option. However, when there is a need for care, 'no care' becomes a concern. It can even be life-threatening, depending on the type and severity of the condition. 'No care' may be the reality for a large proportion of poor people experiencing diseases that are costly to treat.

Option 2: Informal Care - A significant part of all healthcare is provided informally, either by the individual, the family, or friends without medical training. For example, this includes the use of over-the-counter drugs for self-treatment. In Nigeria, the vast majority of care is provided through informal means. Nigeria Demographic and Health Survey 2018 found that among children with a fever seeking advice or treatment, 58% sought care from chemists/patent medicine stores or pharmacies[15]. In contrast, only 18% sought care from PHCs and 10% from hospitals. Three categories of informal care need to be distinguished. First, normal informal care occurs when it is the appropriate level of informal care, such as for common colds and minor injuries. Second, forced informal care may be the only option when necessary professional care is not available or not affordable. In such cases, households have to

rely on whatever care is feasible, even though it may not be the appropriate level or type of care. Forced informal care due to limited or no access to formal professional care may have adverse social, economic, and health consequences for the household. Finally, when the informal care or treatment provided has adverse effects on the patient's health or population health, it may be termed unhealthy informal care. Examples of unhealthy informal care include the irrational use of drugs, such as overuse of antibiotics or failure to complete a prescribed course. Irrational drug use has led to the rapid development of drug resistance among microorganisms, particularly antibiotics and anti-malarials, resulting in limited prescribing options and the use of more expensive drugs.

Option 3: Professional Care - Geographic Access - In a poor country like Nigeria, the only way for poor people to reach a health facility may be on foot, while better-off groups may have access to a motorbike or a car. Geographical distribution, therefore, influences access to professional care.

Option 4: Economic Access - This includes the direct costs of care, such as formal and "informal" user fees, transport costs to the health facility, and drug costs. It also includes indirect costs, such as the opportunity costs of seeking care. Lost working time and income foregone for patients and accompanying individuals can be significant, especially if travel times are long and there are lengthy queues at the health facility[16]. For some groups, the opportunity costs can be overwhelming. For example, for small-scale cultivators, the costs can be high and long-term, as even a few days of lost labour can be catastrophic.

Option 5: Quality Care - Accessing professional care doesn't always ensure that the quality of care provided meets the patient's needs. Imagine incurring all of these costs and achieving nothing after accessing

professional care. Even worse, some groups may be more likely to receive unsafe or dangerous care, such as irrational drug prescriptions, and therefore end up worse off than when they started the journey to access care. The rate of hospital-acquired infections (HAIs) is estimated to range from 25% to 40% in developing countries. A large study in low- and middle-income countries (LMICs) including Egypt, Jordan, Kenya, Morocco, Tunisia, Sudan, and South Africa, supported by the World Health Organisation, reviewed 15,548 patient records. This study revealed varying proportions of patient harm ranging from 2.5% to 18.4% per country, with the majority (83%) being preventable[17].

The need to shift the focus towards patient-centred care

These are some of the benefits of focusing on providing patient-centred care (or in other words, humanising healthcare):

- Prioritises patient safety means are addressing the first principle of medicine – "Do No Harm".
- Improves treatment plan adherence and reduces medical errors and therefore better health outcomes.
- Fosters trust in healthcare providers and institutions when patients feel heard and respected.
- Tailor treatments to each patient's unique values, preferences, and needs.
- Active patient participation reduces unnecessary tests and cuts healthcare costs.
- Promotes shared decision-making and encourages healthier lifestyles for disease prevention.
- Upholds patient autonomy, preferences, and values in line with medical ethics.
- Facilitates better understanding of medical conditions and treatment options.
- Helps healthcare institutions meet essential standards.

Where do we start?

Humanising healthcare is "not something you do; it's how you think". It requires a shift in mindset. To achieve this, you must prioritise the needs of the people who will use your services, placing them at the centre of the design process for your services and policies taking into account the obstacles on their journey to reach you. Thus, at its core, humanising healthcare involves a change in culture[18,19].

The bigger picture

Up to this point, the discussion has centred on what can be realistically applied within the confines of the local health institutions. These constraints stem from the fragile foundation upon which the Nigerian healthcare institutions are built and the inadequacies in our governance systems[1-7].

The review has sketched out some of the key problems that Nigeria's healthcare system faces. Here are 3 big ones: 1. Who's in charge of Healthcare? Nigeria is not sure who should take care of healthcare, and this makes things difficult. Different countries have different ideas about how much the government should get involved in healthcare, and this affects how well they can look after their people's health. For example, the UK's National Health Service (NHS) believes that everyone is responsible for healthcare, while the US healthcare system thinks that people should take care of themselves with less help from the government. 2. Following the Rules: The Nigerian healthcare system struggles to follow the rules and regulations that are supposed to make it work better. It's rare to see political leaders face consequences for not keeping their promises on health policies in Nigeria and other poor countries. Weak systems make it hard to hold leaders accountable for what they do. 3. Sharing the Knowledge: The Nigerian health system lacks enough knowledge, such as skilled health workers and medical technology, and

doesn't share it well. A top-down model, where medical education only happens in a few places, like teaching hospitals, with few chances to practice in different settings, adds to this problem by keeping knowledge in a few places. Also, a messy public sector and a chaotic private sector make it hard to get quality medicines and health products when needed.

Conclusion

In conclusion, despite the formidable challenges faced by Nigerian health workers, there have been significant strides in the medical field that have transformed patient outcomes both globally and within Nigeria. As we reflect on these advancements, such as the transition of HIV from a fatal disease to a manageable condition, and the global eradication of smallpox through vaccination, it becomes evident that progress is possible with concerted efforts and innovation. However, for healthcare to truly evolve into a patient-centered practice that prioritizes humanization and compassion, a systemic overhaul is needed. This requires acknowledging and addressing the multitude of operational challenges—from educational barriers to workplace conflicts, that currently hinder the provision of empathetic and effective care. By fostering environments that emphasize patient safety, dignity, and respect, and by redesigning health systems to better meet the needs of those they serve, we can ensure that the healthcare sector not only cures but also cares. This approach not only honors the sacrifices of healthcare workers but also maximizes the impact of their dedication to healing and helping others. In doing so, we pave the way for a healthcare system that is not only efficient but also equitable and humane. Policymakers and healthcare providers must consider both structural and cultural shifts to promote a more patient-centred approach in healthcare delivery. This involves not only upgrading physical infrastructure and processes but also

shifting the cultural attitudes of healthcare workers towards empathy and respect for patient autonomy.

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