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Patient-Centred Care in West Africa: A Narrative Review of Structural Barriers, Sociocultural Constraints, and Implications for Practice and Policy

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Abstract

Patient-centred care (PCC) is a key dimension of healthcare quality, but its implementation in West Africa remains inconsistent despite growing policy attention. This narrative review aimed to synthesise evidence on the structural, workforce-related, and sociocultural factors influencing PCC, distinguish country-specific evidence from contextual evidence, examine interactions among these factors, and identify implications for practice, policy, and research. The review focuses primarily on Nigeria and Ghana. PubMed, Google Scholar, and the WHO Institutional Repository for Information Sharing (IRIS) were searched between January and April 2026, with an updated search conducted on 18 October 2026, for publications published between 2010 and October 2026. Thirty-eight publications were potentially eligible after screening by a single reviewer. Following supplementary verification by a second reviewer, nine publications were initially excluded from the synthesis. Three were reinstated after re-review, leaving six excluded. The updated search identified two additional publications, and the final synthesis cites 34 sources. No formal quality appraisal was undertaken. Findings were synthesised thematically across four domains: structural and health-system factors, workforce and communication, sociocultural influences, and opportunities, including digital health.

Structural and organisational constraints, such as limited resources, long waiting times, and inefficient service organisation, were frequently reported as limiting respectful communication, patient participation, and responsiveness. These factors appeared to interact with workforce pressures and hierarchical provider-patient relationships, and the evidence did not permit their relative influence to be ranked. Digital health and service-integration initiatives were primarily reported in terms of acceptability or feasibility. Among the included sources, the only comparison of patient-reported participation came from an observational study of 12 health centres in Guinea, which found higher participation scores in centres where mental healthcare was integrated. No included source demonstrated effectiveness at scale. The evidence is concentrated in Nigeria and Ghana, so conclusions regarding other West African countries should be drawn cautiously. Advancing PCC will likely require coordinated attention to service organisation, workforce capacity and communication training, and context-sensitive approaches to patient engagement.

Categories: Health Policy, Public Health, Quality Improvement
Keywords: ghana, health systems, narrative review, nigeria, patient-centred care, shared decision-making, west africa

Introduction And Background

Patient-centred care (PCC) is widely recognised as a core dimension of healthcare quality. In this review, it is understood as care that respects and responds to individual patients' preferences, needs, and values, allowing these values to guide clinical decisions [1]. Drawing on a qualitative synthesis of hospital studies in sub-Saharan Africa, we adopt a grouping of PCC dimensions as an organising framework rather than a universally accepted classification. These dimensions comprise the patient as a person (communication, dignity and respect, privacy, shared decision-making, and empowerment), access to care, and integrated care, including continuity [1]. Access and infrastructure are included because the source literature considers them integral to how patients and providers experience PCC [1]. Global frameworks, particularly those of the WHO, place people-centred care at the centre of universal health coverage [2]. However, translating this commitment into routine practice has proved difficult in sub-Saharan Africa, where PCC has been described as poorly implemented [3].

West Africa is not a uniform setting. Health financing, service organisation, language, workforce capacity, and policy implementation vary across countries, and the available evidence comes mainly from Nigeria and Ghana. Government health spending illustrates this diversity: across the 15 member states of the Economic Community of West African States (ECOWAS), the average share of government expenditure allocated to health between 2010 and 2018 ranged from 3.05% in Guinea to 8.43% in Ghana, and no country reached the 15% benchmark [4]. Accordingly, country-specific findings are identified as such, while evidence from other settings is labelled contextual.

In Nigeria and Ghana, qualitative studies suggest that PCC is recognised but remains weakly institutionalised. Primary care nurses in Osun State, Nigeria, described poor approaches to patient care associated with heavy workloads and limited time and noted the absence of an enforcing body [5]. In three district hospitals in Ghana, managers identified leadership commitment and training as facilitators of PCC, whereas limited leadership understanding of PCC and the absence of defined goals were identified as barriers [6]. Structural features of health systems also shape patient experiences. A multicountry survey that included Nigeria found that health system responsiveness, which spans interpersonal as well as organisational domains, was the strongest predictor of patient-reported quality of care [7]. In Ghana, women who reported the highest levels of responsiveness were substantially more likely to rate their care as excellent. The authors argue that improving person-centredness requires attention to the full range of responsiveness, from waiting times to respectful treatment [8].

Shared decision-making, a central element of PCC, has been described as underdeveloped in West Africa, with more attention given to informed consent than to full shared decision-making [9]. A later overview found that documented efforts in Africa, most of them from West Africa, centred on partnership-driven programmes and patient-provider communication rather than comprehensive shared decision-making approaches [10]. In a tertiary hospital in north-western Nigeria, 52.9% of surgical patients did not believe that consent enabled shared decision-making, while 38.5% and 48.8% reported not being informed about the immediate and long-term complications of their procedures, respectively [11]. In a rural outpatient department in Sierra Leone, patients' preferences were patient-centred regarding friendliness and information-sharing but more doctor-centred regarding shared decision-making. Higher educational attainment was associated with higher patient-centred scores [12]. These findings suggest that models developed elsewhere may require adaptation to local expectations, although the evidence comes from a limited number of settings.

At the policy level, regional and global frameworks emphasise the need for more responsive, people-centred health systems [2,13]. Digital tools, such as patient-held records, and integrated models of chronic care have been explored in Nigeria [14,15], primarily in terms of acceptability or feasibility. Existing work includes a qualitative synthesis of PCC dimensions in sub-Saharan African hospitals [1], a conceptual analysis of barriers to PCC in sub-Saharan Africa [3], and a protocol for a scoping review in Ghana [16]. In Ghana, studies extending beyond maternal health have been reported to be limited [16], and the literature reviewed here is likewise concentrated in Nigeria and Ghana. Each of these publications addresses a different aspect of PCC. This review brings structural, workforce-related, sociocultural, and policy perspectives together to examine their interactions.

This narrative review therefore aims to (1) synthesise evidence on structural, workforce-related, and sociocultural factors influencing PCC in West Africa, distinguishing country-specific evidence from contextual evidence; (2) examine how these factors interact with service delivery and policy implementation; and (3) identify context-sensitive implications for practice, policy, and future research. It focuses mainly on Nigeria and Ghana, draws on single-country studies from Mali, Sierra Leone, Guinea, and Senegal, and uses literature from wider sub-Saharan Africa, Central Africa (Equatorial Guinea), and low- and middle-income countries (LMICs) for comparison.

Review

Methods

Study Design

We conducted a narrative review, chosen because PCC is a conceptually complex topic and the available studies are heterogeneous in design and setting, which suits a narrative integration of qualitative, quantitative, and policy evidence. We used the Scale for the Assessment of Narrative Review Articles (SANRA) [17] as a guide to the aims, search description, referencing, reasoning, and presentation of this review. SANRA is a quality-assessment scale, not a reporting checklist. The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) 2020 flow-diagram format [18] was used only to report record numbers (see Study Selection). This review was not designed or conducted as a systematic review and does not follow PRISMA as a reporting guideline.

Search Strategy

PubMed, Google Scholar and the WHO Institutional Repository for Information Sharing (IRIS) were searched between January and April 2026, with the last searches run on 11 April 2026. The initial searches were limited to publications dated 2010 to 2025; an update search on 18 October 2026 extended coverage to 2026 (see Update search below). PubMed was used for peer-reviewed literature, IRIS for WHO policy and technical documents, and Google Scholar to identify further peer-reviewed and grey literature. Medical Subject Headings and free-text terms were combined with Boolean operators. Terms for the concept included "patient-centred care", "person-centred care", "patient experience", "healthcare quality", "shared decision-making" and "health system responsiveness". These were combined with geographic terms ("West Africa", "Nigeria", "Ghana", "Senegal", "Mali", "Sierra Leone" and "Guinea") and with "barriers", "implementation"

and “health systems”. The full search strings were not retained, so they cannot be reported, and this is acknowledged as a limitation.

Updated Search

An updated search was run on 18 October 2026 to cover more recent publications. The PubMed strategy was: (“Patient-Centered Care”[Title/Abstract] OR “Patient-Centred Care”[Title/Abstract] OR “Person-Centered Care”[Title/Abstract] OR “Person-Centred Care”[Title/Abstract] OR “shared decision making”[Title/Abstract] OR “health system responsiveness”[Title/Abstract]) AND (Nigeria OR Ghana OR “West Africa” OR Senegal OR Mali OR Guinea OR “Sierra Leone”) AND (“2026/01/01”[Date - Publication]: “2026/10/18”[Date - Publication]); 46 records were screened. WHO IRIS was searched for “patient-centred care”, “people-centred health systems”, and “Nigeria Ghana health systems” (70 records screened, none both relevant and new). Google Scholar was searched with four phrases (“patient-centred care” Ghana Nigeria 2026; “person-centred care” West Africa 2026; “shared decision-making” Nigeria Ghana 2026; “patient experience” Ghana Nigeria healthcare 2026), screening the first five result pages of each. All records in the updated search were screened by two reviewers, and two publications were included. The PubMed searches covered 2026 publications up to 18 October 2026.

Eligibility Criteria

Sources were included if they were published in English between 2010 and 18 October 2026, addressed PCC, patient experience, or healthcare quality, were conducted in West Africa or provided comparative insights from sub-Saharan Africa or other LMICs, and used qualitative, quantitative, mixed-methods, or policy-analysis designs, including reviews. Sources were excluded if they were editorials, opinion pieces, protocols, or other sources without relevant findings, except for the one protocol cited for contextual purposes, as described below; if they were non-peer-reviewed sources lacking sufficient methodological detail; or if they were duplicate or substantially overlapping reports of the same underlying study. Sources were also excluded if they did not address PCC or its core dimensions, discussed general healthcare quality without findings relevant to PCC, or fell outside the defined geographical and healthcare-setting scope, unless they provided relevant comparative evidence from sub-Saharan Africa or other LMIC settings, as explained below.

Studies conducted in West Africa were treated as direct evidence. Studies from other African regions and wider LMIC settings were treated as contextual or comparative evidence and identified accordingly. Sources addressing PCC but originating outside West Africa were labelled as comparative evidence. A small number of sources that did not directly address PCC, such as analyses of health financing, COVID-19-related disruption, or women’s autonomy in research participation, were used only to describe the health-system context or provide comparisons and were labelled as contextual. One protocol without findings was cited solely to indicate that research on person-centred care in Ghana is planned. Neither contextual sources nor the protocol was treated as evidence about PCC itself, and comparative sources from outside West Africa were not considered direct evidence of PCC in West Africa. Accordingly, sources used to describe the context were distinguished from those contributing findings to the PCC synthesis. Throughout this review, “sources” refers to all cited items, whereas “studies” refers exclusively to empirical research.

Study Selection

In the original search, one reviewer screened titles and abstracts and assessed full texts, which may have introduced selection bias. A second reviewer later checked the included sources and key exclusions. This was a supplementary verification, not independent dual screening. A total of 486 records were identified, and 112 duplicates were removed (374 records remained for title and abstract screening). After title and abstract screening, 93 full-text articles were assessed. Of these, 38 were judged potentially eligible, and 55 were not included. The original screening log is no longer available, so a reason-specific breakdown of the 55 full-text non-inclusions could not be reconstructed and is not reported.

After the second reviewer’s check, nine of the 38 potentially eligible publications were initially not carried forward into the synthesis after supplementary review, because of limited direct relevance to PCC, thematic similarity to sources already retained, or both. Eligibility (meeting the stated criteria) and selection for the synthesis are treated here as separate steps: these publications were not judged ineligible, but they were not carried forward into the synthesis for the reasons given, and they were removed from the reference list. On re-review, three of the nine were judged to add evidence not covered by retained sources and were restored. Supplementary Table in the Appendices lists the six that remain not carried forward into the synthesis. The overlap with retained sources shown there was reconstructed afterwards from each publication’s published details, because the original record of the decision is unavailable. The 32 cited sources from the original search, together with the two publications added by the updated search, form the evidence base of 34 sources reported here. Record counts at each stage are shown in Table *1*.

Stage	Records
Identified across PubMed, Google Scholar, and IRIS	486
Duplicates removed	112
Screened by title and abstract	374
Not taken to full-text assessment at title and abstract stage	281
Full texts assessed	93
Full texts not included (reasons not recoverable)	55
Potentially eligible after full-text assessment	38
Initially not carried forward after the second reviewer's check	9
Restored after re-review	3
Not carried forward into the synthesis after supplementary review and re-review (limited relevance or thematic similarity)	6
Cited in the synthesis from the original search	32
Updated search, 18 October 2026 (publications dated 2026): records screened	PubMed 46; WHO IRIS 70; Google Scholar first five result pages for each of four phrases
Included from the updated search (screened by two reviewers)	2
Total cited in the synthesis	34

TABLE 1: Record selection and inclusion counts

WHO IRIS: World Health Organization Institutional Repository for Information Sharing

The counts for the title and abstract stage (374 and 281) and for full-text non-inclusion (55) are calculated from the reported totals, because the original screening log is no longer available.

Data Extraction and Synthesis

Study characteristics (design, setting, population, source type) and findings relevant to PCC were extracted using a structured form. Findings were synthesised thematically into four domains: structural and health-system factors; workforce and communication; sociocultural influences; and opportunities, including digital health and policy. The four domains were set in advance. In the synthesis, empirical studies, reviews, protocols and policy documents are distinguished, and country-specific evidence is separated from contextual evidence.

Quality Appraisal

No formal quality appraisal or risk-of-bias assessment was undertaken. Instead, the design and setting of each source are reported, and limitations that affect interpretation are noted in the text.

Ethical Considerations

Ethical approval was not required because the review analysed published literature and involved no human participants or identifiable data.

Results

Characteristics of the Evidence

The review cites 34 sources. Of the 38 potentially eligible publications from the original search, 32 are cited, and six were not carried forward into the synthesis after supplementary review because of limited direct relevance to PCC or thematic similarity to retained sources. Two further sources came from the update search. Table *2* describes the cited sources by geographical setting, design, and evidential role, and Table *3* lists each source individually. Nineteen are single-country sources from West Africa (Nigeria 10, Ghana 5, and one each from Mali, Sierra Leone, Guinea and Senegal), three are regional or multi-country West African

sources, and twelve come from other regions or have a global scope. Eleven are primary studies of PCC or one of its core dimensions in West Africa: four from Nigeria, four from Ghana, and one each from Sierra Leone, Mali and Guinea. The Malian study concerns medical students' patient-centred attitudes, not delivery of care. Six are studies or reviews of related constructs such as satisfaction, service models or quality improvement, five are overviews or syntheses, three are policy or guidance documents, and one is a protocol. Six are contextual sources that do not address PCC directly, such as analyses of health financing or of COVID-19 disruption; they describe the setting or provide comparison and are not treated as evidence about PCC itself. Two further sources, from Malawi and Eastern and Southern Africa, address person-centred care directly but lie outside West Africa and are treated as comparative evidence.

Dimension	Category	N	Refs
Geographical setting	Nigeria	10	[5,11,14,15,20,22,23,24,27,29]
	Ghana	5	[6,8,16,19,31]
	Mali	1	[25]
	Sierra Leone	1	[12]
	Guinea	1	[28]
	Senegal	1	[30]
	West African regional or multi-country	3	[4,9,36]
	Other regions, sub-Saharan Africa, multi-country LMIC or global	12	[1,2,3,7,10,13,21,26,32,33,34,35]
	Subtotal	34	
Design	Qualitative studies	7	[5,6,14,19,21,29,31]
	Mixed-methods study	1	[23]
	Quantitative surveys or observational studies	11	[7,8,11,12,15,24,25,27,28,30,33]
	Reviews, evidence syntheses and conceptual papers	7	[1,3,9,10,20,32,35]
	Other empirical (media content analysis, analysis of expenditure data, intervention development and acceptability study, single-hospital quality-improvement report)	4	[4,22,26,36]
	Policy and guidance documents	3	[2,13,34]
	Protocol	1	[16]
	Subtotal	34	
Evidential role	Primary studies of PCC or a core dimension (including PCC-related attitudes) in West Africa	11	[5,6,8,11,12,19,23,24,25,28,31]
	Studies or reviews of related constructs (satisfaction, service models, tools) in West Africa	6	[14,15,20,22,27,30]
	Overviews and syntheses on PCC or shared decision-making	5	[1,3,9,10,35]
	Contextual sources that do not address PCC directly	6	[4,7,21,29,33,36]
	Comparative evidence on PCC from outside West Africa	2	[26,32]
	Policy and guidance documents	3	[2,13,34]
	Protocol	1	16
	Subtotal	34	

TABLE 2: Cited sources (n = 34) by setting, design, and evidential role

Counts refer to the 34 sources cited in the synthesis. Each of the three dimensions (geographical setting, design, evidential role) sums to 34, so a source appears once under each dimension. Reference numbers in the Refs column correspond to the numbered reference list. Design categories are assigned by each source's principal purpose, not its data-collection method; for example, ref 26 (intervention development and acceptability testing using interviews and a focus group) is listed under other empirical

LMIC: low- and middle-income countries; PCC: patient-centred care

Ref	Country or scope	Setting and design	Role	Theme
[1]	Sub-Saharan Africa	Qualitative evidence synthesis of PCC dimensions in hospital settings	Overview or synthesis	Structural
			Policy or	Introduction,

[2]	Global	WHO framework on integrated, people-centred health services	guidance	policy
[3]	Sub-Saharan Africa	Conceptual paper on barriers to PCC	Overview or synthesis	Structural
[4]	15 ECOWAS countries	Analysis of WHO Global Health Expenditure Database figures, 2010 to 2018 (health financing, not patient experience)	Contextual	Introduction, comparison
[5]	Nigeria (Osun State)	Qualitative action research, nurses at 30 primary care centres	PCC	Workforce
[6]	Ghana (Central Region)	Qualitative study, 10 managers in 3 district hospitals (managers' views only)	PCC	Workforce, structural
[7]	Multi-country LMIC (included Nigeria)	Four-country survey of predictors of patient-reported quality of care	Contextual	Comparison
[8]	Ghana	Household survey of women of reproductive age on responsiveness and patient experience	PCC	Structural
[9]	West Africa (regional)	Narrative review and research agenda on shared decision-making	Overview or synthesis	Sociocultural
[10]	West, Central and North Africa	Overview of shared decision-making and PCC approaches in three African regions (includes non-West African content)	Overview or synthesis	Sociocultural
[11]	Nigeria (north-west)	Cross-sectional survey, 244 surgical patients, one hospital, on informed consent	PCC	Sociocultural
[12]	Sierra Leone	Survey of 144 outpatients, one rural department	PCC	Sociocultural
[13]	WHO African Region	Regional report on the state of health systems	Policy or guidance	Policy
[14]	Nigeria (Benue State)	Focus groups, 35 pregnant women, pilot smart card	Related construct	Opportunities
[15]	Nigeria	Survey of medical directors at 33 of 36 HIV treatment sites in one network	Related construct	Opportunities
[16]	Ghana	Scoping-review protocol on person-centred care research (no findings reported)	Protocol	Introduction, policy
[19]	Ghana (Greater Accra)	Qualitative exploratory study, 3 facilities: 33 provider interviews and 4 patient focus groups (28 patients)	PCC	Structural, sociocultural
[20]	Nigeria	Systematic review of 21 studies on national health insurance satisfaction	Related construct	Structural
[21]	Equatorial Guinea (Central Africa; the article's title describes it as West Africa)	Interviews with healthcare workers	Contextual	Structural
[22]	Nigeria (Lagos)	Single-hospital quality-improvement report over an initial 18 months using mystery shopping, a patient experience survey and SafeCare methodology, framed around responsiveness; describes the hospital's own programme	Related construct	Structural, opportunities
[23]	Nigeria (Enugu)	Mixed-methods study, 201 midwives	PCC	Workforce
[24]	Nigeria (Enugu)	Cross-sectional survey, 450 postpartum women	PCC	Structural, workforce
[25]	Mali	Cross-sectional survey, 430 medical students (attitudes, not delivery of care)	PCC	Workforce
[26]	Malawi	Development and acceptability testing of a communication training and mentorship intervention: 30 stakeholder interviews, 12 trained health workers, 8 in a focus group	Comparative (outside West Africa)	Workforce
[27]	Nigeria (north-west)	Study of women delivered at one general hospital, relating who makes health decisions to maternal complications; concerns household decisions, not provider–patient decisions	Related construct	Sociocultural

[28]	Guinea	Observational comparison, 12 not-for-profit health centres (4 with integrated mental health care), 450 consultations, patient exit interviews	PCC	Sociocultural, opportunities
[29]	Nigeria (Ibadan)	Qualitative study of women's autonomy in research participation (not clinical care)	Contextual	Sociocultural
[30]	Senegal	Survey of 300 dental patients	Related construct	Sociocultural
[31]	Ghana	Qualitative interviews, 39 participants, 2 HIV clinics	PCC	Opportunities
[32]	Eastern and Southern Africa (no West or Central African studies)	Scoping review of person-centred HIV prevention services in sub-Saharan Africa: 12 studies from six countries, published 2016 to 2024	Comparative (outside West Africa)	Opportunities, future research
[33]	Multi-country LMIC (12 countries, including Ghana, Nigeria and Senegal)	Internet survey of 17,996 respondents rating vignettes of poor-quality care; 53% rated the poor-quality care as good or better; internet users only	Contextual	Comparison
[34]	Global	Guidance paper on measuring patient experience and satisfaction	Policy or guidance	Implications
[35]	Sub-Saharan Africa (includes Nigerian and Ghanaian studies)	Scoping review of how PCC is measured in sub-Saharan African healthcare settings: 36 studies and 31 instruments, 1990 to 2024, most from South Africa, Nigeria or Ethiopia; two of its included studies are also cited here [24,31)	Overview or synthesis	Implications
[36]	Six West African countries (Ghana, Guinea, Liberia, Niger, Nigeria, Sierra Leone)	Qualitative media analysis of 4,388 news articles, January to June 2020; does not assess PCC directly	Contextual	Future research

TABLE 3: Sources cited in the synthesis

Reference numbers in the Ref column correspond to the numbered reference list

PCC: patient-centred care; ECOWAS: the Economic Community of West African States; WHO: the World Health Organization; LMIC: low- and middle-income countries

Structural and Health System Factors

Structural and organisational conditions were frequently reported as shaping the time, resources and setting in which PCC can take place. In Ghana, a survey of women found higher responsiveness strongly associated with ratings of care and of health, and its authors stress the whole range of responsiveness, from waiting time to respect [8]. A qualitative study across three facilities in Greater Accra likewise linked resource constraints and staff shortages to difficulty delivering PCC and described ability to pay and geographic distance as further barriers to access [19]. A qualitative study of managers in three Ghanaian district hospitals also named financial constraints, ownership type and centralised decision-making among organisational barriers, although it reflects managers' views only [6]. In Nigeria, a systematic review of satisfaction with the national health insurance scheme reported moderate satisfaction and recommended shorter waiting times [20]. Satisfaction is related to, but not the same as, patient-centredness, so this suggests only that expanded coverage does not by itself resolve service-delivery problems.

Contextual evidence points the same way: health workers in Equatorial Guinea described a lack of resources and trauma-care facilities [21], although this is Central African evidence from healthcare workers, not patients. Comparative reviews and a qualitative synthesis describe both relational and structural aspects of care as significant in sub-Saharan Africa, with providers mostly emphasising structural aspects such as infrastructure [1,3]. These sources are mainly descriptive and qualitative, and they do not allow structural factors to be ranked against interpersonal ones. They do suggest that structural conditions set limits on what individual providers can achieve. A single-hospital quality-improvement report from Lagos, framed around responsiveness (dignity, confidentiality, autonomy and prompt attention), describes a hospital's own programme using mystery shopping, a patient experience survey and SafeCare standards [22]; it concerns one setting and does not show that the approach works elsewhere.

Workforce and Communication Challenges

Evidence from Nigeria and Ghana suggests that providers' awareness of PCC does not reliably translate into practice. Primary care nurses in Osun State linked a poor approach to patients with workload, stress and limited time, and noted the lack of an enforcing body [5]. In three Ghanaian district hospitals, managers named leadership commitment and training as facilitators, but also leadership's limited conceptualisation of PCC and the lack of defined goals as barriers [6]. In Enugu, Nigeria, midwives themselves judged person-centred maternity care to be inadequate in public hospitals [23], and a survey of postpartum women found that only about a quarter reported high person-centred maternity care, with facility type among the associated factors [24].

Training is part of the picture but not all of it: medical students in Bamako, Mali, were moderately patient-centred and showed no decline in later years, although most favoured provider-dominant decision-making [25]. Attitudes during training do not necessarily predict practice after qualification. A study from Malawi, used here as comparative evidence from outside West Africa, tested a communication training and mentorship intervention for 12 primary health care workers at one hospital; in a focus group of eight of them, workload, space, medication availability and language barriers were reported as limits on person-centred communication [26]. Together these studies point to workload, organisational priorities and training as linked influences. They are qualitative or cross-sectional and drawn from few settings, and they do not show which of these matters most.

Sociocultural Influences on Patient Engagement

Hierarchical provider-patient relationships and limited patient participation in decisions are recurring findings. Shared decision-making has been described as little developed in West Africa [9], and an overview across three African regions found that efforts focus on communication and participation within specific programmes rather than comprehensive shared decision-making [10]. Both are overviews, not primary studies. In north-western Nigeria, many surgical patients did not see consent as enabling shared decision-making, and some had not received information on complications [11]. In a general hospital in north-western Nigeria, who made health decisions for women was associated with some maternal complications, with decisions by fathers-in-law notable; this is an association from one setting and concerns household, not provider-patient, decisions [27].

In Sierra Leone, patients preferred friendly, informative care yet scored doctor-centred on sharing decisions, and education was associated with more patient-centred preferences [12]. In Guinea, patients wanted to be more involved in treatment decisions, and providers rated their own involvement of patients more favourably than patients did [28]. Qualitative work in Accra identified patient agency and communication as influences on empowerment, with patients describing being shouted at or not given adequate information [19], and a study in Ibadan, Nigeria, found that patriarchy, religion and culture limited women's autonomy in research participation [29], which is contextual and not evidence about clinical care. Not all findings point one way: a survey of dental patients in Senegal reported 91.7% satisfaction with care, though in a single specialty and setting [30]. The evidence suggests that preferences vary by setting and by patients' education, and it does not support generalising a single sociocultural pattern across West Africa.

Opportunities for Advancing PCC

Opportunities are best read according to the strength of evidence behind them (Table *4*).

Level of evidence	Examples from the reviewed sources
Policy intention	WHO frameworks and the regional report on health systems[2,13]; a protocol for a scoping review in Ghana[16]
Acceptability or feasibility	Patient-held smart card for antenatal care, accepted by 35 women in focus groups, with cost a major barrier[14]; adaptation of a patient-centred medical home framework for Nigerian HIV clinics, with clinic performance self-reported by medical directors and no patient-experience measures [15]; exploratory interviews on what person-centred HIV care involves in Ghana [31]; a single-hospital quality-improvement programme in Lagos using mystery shopping, a patient experience survey and SafeCare standards, described by the hospital itself [22]
Observed differences in patient-reported experience	An observational comparison of patient-reported participation in 12 Guinean health centres with and without integrated mental health care, showing an association and not a trial result [28]
Demonstrated effectiveness at scale	None identified among the cited sources

TABLE 4: Opportunities for advancing PCC, by level of evidence

PCC: patient-centred care; WHO: the World Health Organization

In Guinea, patient-reported participation scores were higher in health centres that had integrated mental health care (mean 24.21 compared with 22.54; adjusted odds ratio 4.06, 95% CI 1.17 to 14.10, p = 0.03) [28]. The interval is wide; only four centres had integrated mental health care, scores also depended on individual providers, facilities and consultation length, and the authors note that integration alone does not explain the difference [28]. In the Nigerian HIV clinics, the authors identified access and continuity as the main areas for improvement against the adapted framework [15]. A scoping review of person-centred HIV prevention in sub-Saharan Africa reported improved uptake and engagement for several choice-based and community-based models, but all of its included studies were from Eastern and Southern Africa, so it does not show that these models work in West Africa [32]. Overall, the initiatives described show that several approaches are acceptable or feasible in the settings studied, but they do not yet show improved patient experience at scale.

Discussion

Principal Findings

This review suggests that PCC implementation in West Africa is constrained by interacting structural, workforce and sociocultural factors. Structural conditions shape the time, resources and organisational support available for respectful communication and patient participation, while communication and respectful treatment remain important in their own right. The included studies do not directly compare the influence of these factors, so no ranking is claimed. Policy attention is substantial, but the evidence for effective, scalable initiatives is limited.

Comparison With Existing Literature

The sub-Saharan African literature similarly describes interacting layers of provider, organisational and wider socioeconomic determinants [3], and finds that both relational and structural aspects matter to patients and providers, with providers placing more emphasis on structural ones [1]. A multi-country survey found responsiveness to be the strongest predictor of patient-reported quality, and responsiveness includes interpersonal as well as organisational domains [7]. A twelve-country internet survey that included Ghana, Nigeria and Senegal found that more than half of respondents rated vignettes describing poor-quality care as good or better, which supports caution in reading satisfaction ratings, although it covered internet users only [33].

This review adds attention to sociocultural dynamics, particularly the limited development of shared decision-making [9,10], while noting that the evidence base for this theme is small and drawn from few settings. Health financing is one structural context for these findings: no ECOWAS country reached the 15% benchmark for government spending on health between 2010 and 2018, and countries differed widely [4]. That analysis concerns expenditure, not patient experience, so it frames the setting and does not show how

funding affects PCC.

Implications for Practice and Policy

The literature reviewed suggests three areas for action, each tied to the findings above and none shown to be effective on its own. At system level, staffing, service organisation and waiting times shape the conditions in which PCC can take place [8,19,20]. At workforce level, communication training with institutional support and clear organisational goals for PCC may help [5,6]. A comparative study from Malawi found communication training with mentorship feasible at one hospital, but it does not show effectiveness in West Africa [26]. At the level of patient engagement, accessible communication and shared decision-making approaches that take account of local preferences and education may be needed [11,12,28].

Guidance on measuring person-centred care distinguishes patient experience from patient satisfaction, a distinction that matters when interpreting the satisfaction-based studies reviewed here [34]. A scoping review of PCC measurement in sub-Saharan Africa found that most instruments measure satisfaction or single subcomponents of PCC rather than PCC comprehensively, and that psychometric evaluation was incomplete or absent. Two of its included studies are also cited here, so it is not independent confirmation of them [24,31,35]. These are implications of the reviewed literature, and different countries and care settings may need different priorities.

Future Research Directions

More research is needed from countries beyond Nigeria and Ghana. Studies should also move beyond description to implement and evaluate PCC interventions in routine practice, with follow-up over time. Areas beyond maternal health, such as HIV care [15,31] and care for people with multimorbidity (for which only comparative evidence from outside West Africa was cited here [26]), need more attention. A scoping review of person-centred HIV prevention services in sub-Saharan Africa found no studies from West or Central Africa among its 12 included studies, although its authors note that their search may have under-captured them [32]. A media analysis from six West African countries reported reduced care-seeking and access to health care for mothers and children in the first half of 2020 [36], and the longer-term effects of such disruption on PCC warrant study.

Strengths and Limitations

This review integrates qualitative, quantitative, and policy evidence, distinguishes country-specific findings from contextual evidence, and acknowledges the limitations of what individual sources can demonstrate. However, several limitations should be noted. The evidence is concentrated in Nigeria and Ghana, limiting its generalisability to other West African countries. Only three sources were searched, and Google Scholar's ranking system and result limits mean that its searches cannot be reproduced exactly. Publications published after the updated search on 18 October 2026 are not covered. The full search strings used in the original search were not retained, limiting reproducibility; the updated search strategy is reported in the Methods. The updated PubMed search strategy used six PCC-related phrases and may have missed relevant papers indexed under alternative terms, such as respectful maternity care or patient participation. Screening only the first five pages of Google Scholar results for each phrase was not exhaustive, and the number of records screened through Google Scholar was not recorded. The original screening log is no longer available; therefore, the title and abstract counts have been calculated, and the reasons for excluding 55 full-text articles cannot be reported.

Six potentially eligible publications were not carried forward into the synthesis following supplementary review because of limited direct relevance or thematic similarity to retained sources. These decisions were not documented individually at the time. Supplementary Table S1 reconstructs the rationale based on published details. However, thematic similarity to a retained source does not necessarily indicate duplication, and three publications initially excluded were reinstated after re-review. Therefore, the possibility of selective citation cannot be entirely excluded. Excluding non-English publications may have resulted in the omission of relevant studies from Francophone countries. No formal quality appraisal was undertaken, limiting confidence in comparisons of the strength of findings across sources. The original search was screened by a single reviewer, with supplementary verification by a second reviewer, leaving the possibility of selection errors. The updated search, however, was screened by two reviewers. The included sources were heterogeneous in design, population, and setting. For these reasons, this review is best described as a broad narrative synthesis rather than a comprehensive review.

Conclusions

Patient-centred care is widely endorsed in West African health policy, yet the reviewed literature suggests that its implementation remains limited by the interplay of structural, workforce-related, and sociocultural factors. This review brings these perspectives together and highlights their interrelationships. It does not establish a uniform ranking of determinants, and the evidence base remains concentrated in Nigeria and Ghana. Progress will likely depend on coordinated efforts to improve service organisation, strengthen

workforce capacity and communication, and adopt context-sensitive approaches to patient engagement, supported by implementation and evaluation studies conducted across a wider range of countries. The recommendations presented here are derived from the implications of the reviewed literature and should not be interpreted as interventions demonstrated to be effective.

Appendices

Supplementary table

The original decision record is unavailable. The overlap and reason columns were reconstructed afterwards from each publication's abstract and publisher record, not from full-text reading, and do not record the reasoning applied at the time. The reasons varied: limited direct relevance to PCC, an opinion-piece type, thematic similarity to retained sources, or a combination. Thematic similarity is not duplicate reporting of the same study, and none of the six is known to be a duplicate report of a retained study. Sawhney et al. was checked against its abstract and main article text; its appendix tables listing the individual included studies were not reviewed.

#	Publication	What it is	Closest retained source(s)	Thematic similarity to retained sources	Main reason not carried forward
1	Byiringiro et al., Ann Glob Health 2024, 90:38	Five focus groups with 9 facility leaders and 24 clinicians at 15 primary facilities in Kumasi, Ghana, on health-system barriers to hypertension management	[6,19]	Ghanaian facility-level resource and organisational barriers are already covered; the study is condition-specific and does not address PCC	Limited direct relevance (partial overlap only)
2	Ezeamii et al., Cureus 2024, 16:e63881	Systematic review of telemedicine and patient outcomes, access and satisfaction, mainly chronic disease and diabetes; not West African	[14]	[14] is the only retained digital-health source; generic effectiveness evidence from outside the region adds nothing on West African acceptability	Limited relevance (generic, outside the region)
3	Tetteh et al., Radiography 2022, 28:919-925	Scoping narrative review of speaking up for patient safety, with lessons for radiography in Ghana	[5,6]	Concerns workforce voice and patient safety, not PCC; related to the workforce barriers in [5] and [6] only loosely	Limited direct relevance (not a duplicate)
4	Bhoo-Pathy et al., Cell Rep Med 2024, 5:101517	Commentary on operationalising patient-centred cancer care in LMICs; no West African data	[3,1]	General LMIC and sub-Saharan PCC syntheses already retained; as a commentary, it may also fall under the opinion-piece exclusion	Commentary (opinion-piece type); no West African data
5	Sawhney et al., J Pediatr Surg 2024, 59:900-907	Systematic scoping review (48 studies) of six PCC domains, including shared decision-making and informed consent, in paediatric surgery in low- and lower-middle-income countries	[1,3]	Thematically similar to the retained general syntheses; the article text indicates that Nigerian studies are included, but West African content is not reported separately (Nigeria is named only in passing)	Limited relevance: paediatric-surgery-specific, mostly non-African studies, no separable West African findings
6	Emmanuel-Ajayi and Gu, Value Health Reg Issues 2024, 40:45-52	Comparative review of the healthcare delivery systems of China and Nigeria	[4,13,20]	System-level context for Nigeria is already given by the retained policy and financing sources	Limited direct relevance (health-system context)

TABLE 5: Publications not carried forward into the synthesis (n = 6)

PCC: patient-centred care; LMIC: low- and middle-income countries

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Olisemeka Eboka

Acquisition, analysis, or interpretation of data: Olisemeka Eboka, Isabella Aghogu

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References

1. Okeny PK, Pittalis C, Monaghan CF, Brugha R, Gajewski J: Dimensions of patient-centred care from the perspective of patients and healthcare workers in hospital settings in sub-Saharan Africa: a qualitative evidence synthesis. PLoS One. 2024, 19:e0299627. 10.1371/journal.pone.0299627
2. World Health Organization. Framework on integrated, people-centred health services . (2016). Accessed: October 25, 2026: https://apps.who.int/gb/ebwha/pdf_files/wha69/a69_39-en.pdf.
3. De Man J, Mayega RW, Sarkar N, Waweru E, Leys M, Van Olmen J, Criel B: Patient-centered care and people-centered health systems in sub-Saharan Africa: why so little of something so badly needed?. Int J Pers Cent Med. 2016, 6:162-73. 10.5750/ijpcm.v6i3.591
4. Adebisi YA, Alaran A, Badmos A, et al.: How West African countries prioritize health . Trop Med Health. 2021, 49:87. 10.1186/s41182-021-00380-6
5. Lateef MA, Mhlongo EM: A qualitative study on patient-centered care and perceptions of nurses regarding primary healthcare facilities in Nigeria. Cost Eff Resour Alloc. 2022, 20:40. 10.1186/s12962-022-00375-y
6. Nkrumah J, Abekah-Nkrumah G: Facilitators and barriers of patient-centered care at the organizational-level: a study of three district hospitals in the central region of Ghana. BMC Health Serv Res. 2019, 19:900. 10.1186/s12913-019-4748-z
7. Kim JH, Bell GA, Ratcliffe HL, et al.: Predictors of patient-reported quality of care in low- and middle-income countries: a four-country survey of person-centered care. Int J Qual Health Care. 2021, 33:16-8. 10.1093/intqhc/mzab110
8. Ratcliffe HL, Bell G, Awoonor-Williams K, et al.: Towards patient-centred care in Ghana: health system responsiveness, self-rated health and experiential quality in a nationally representative survey. BMJ Open Qual. 2020, 9:32-4. 10.1136/bmjoq-2019-000886
9. Diouf NT, Ben Charif A, Adisso L, et al.: Shared decision making in West Africa: the forgotten area . Z Evid Fortbild Qual Gesundhwes. 2017, 8:7-11. 10.1016/j.zefq.2017.05.013
10. Gogovor A, Fakhfakh M, Asmaou Bouba D, Acakpo O, Ayivi-Vinz G, Musabyimana A, Garvelink MM: Shared decision-making and person-centred care approaches in three African regions. Z Evid Fortbild Qual Gesundhwes. 2022, 171:6-10. 10.1016/j.zefq.2022.04.023
11. Grema BA, Tanimu ST, Michael GC, Aliyu I, Aji SA, Takai IU, Sulaiman AI: Informed consent: the surgical patient's experience in a tertiary hospital in Northwest Nigeria. West Afr J Med. 2022, 471-8.
12. Lau SR, Christensen ST, Andreasen JT: Patients' preferences for patient-centered communication: a survey from an outpatient department in rural Sierra Leone. Patient Educ Couns. 2013, 93:312-8. 10.1016/j.pec.2013.06.025
13. World Health Organization Regional Office for Africa. The state of health systems in the African Region. Brazzaville: WHO Regional Office for Africa. (2020). Accessed: October 25, 2026: https://www.afro.who.int/publications/state-health-who-african-region.
14. Itanyi IU, Iwelunmor J, Olawepo JO, et al.: Acceptability and user experiences of a patient-held smart card for antenatal services in Nigeria: a qualitative study. BMC Pregnancy Childbirth. 2023, 23:198. 10.1186/s12884-023-05494-9
15. Ahonkhai AA, Onwuatuelo I, Regan S, et al.: The patient-centered medical home: a reality for HIV care in Nigeria. Int J Qual Health Care. 2017, 29:654-61. 10.1093/intqhc/mzx083
16. Amoh GK, Addo AK, Odiase O, et al.: Person-centred care (PCC) research in Ghana: a scoping review protocol. BMJ Open. 2024, 14:e079227. 10.1136/bmjopen-2023-079227
17. Baethge C, Goldbeck-Wood S, Mertens S: SANRA-a scale for the quality assessment of narrative review articles. Res Integr Peer Rev. 2019, 4:5. 10.1186/s41073-019-0064-8
18. Page MJ, McKenzie JE, Bossuyt PM, et al.: The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ. 2021, 372:n71. 10.1136/bmj.n71
19. Kodom RV, Netangaheni RT: Challenges in accessing patient-centered care and patient empowerment in selected Ghanaian hospitals. Health SA. 2024, 29:2623. 10.4102/hsag.v29i0.2623
20. Nwanaji-Enwerem O, Bain P, Marks Z, Nwanaji-Enwerem P, Staton CA, Olufadeji A, Nwanaji-Enwerem JC: Patient satisfaction with the Nigerian National Health Insurance Scheme two decades since establishment: a systematic review and recommendations for improvement. Afr J Prim Health Care Fam Med. 2022, 14:e1-e10. 10.4102/phcfm.v14i1.3003
21. Reuter KE, Geysimonyan A, Molina G, Reuter PR: Healthcare in Equatorial Guinea, West Africa: obstacles

and barriers to care. Pan Afr Med J. 2014, 19:369. 10.11604/pamj.2014.19.369.5552
22. Dada A, Olaopa OI, Chukwuanukwu TO, Asumah A: Building a responsive healthcare system - a Nigerian experience. Niger J Clin Pract. 2022, 25:1615-23. 10.4103/njcp.njcp_649_22
23. Ogbuabor DC, Okoronkwo IL: Midwives' perspectives on person-centred maternity care in public hospitals in South-east Nigeria: a mixed-method study. PLoS One. 2021, 16:e0261147. 10.1371/journal.pone.0261147
24. Ogbuabor DC, Nwankwor C: Perception of person-centred maternity care and its associated factors among post-partum women in Enugu State, Nigeria. Int J Public Health. 2021, 66:612894. 10.3389/ijph.2021.612894
25. Hurley EA, Doumbia S, Kennedy CE, Winch PJ, Roter DL, Murray SM, Harvey SA: Patient-centred attitudes among medical students in Mali, West Africa: a cross-sectional study. BMJ Open. 2018, 8:e019224. 10.1136/bmjopen-2017-019224
26. Kwaitana D, Van Breevoort D, Mnenula M, Nkhoma K, Harding R, Bates MJ: Improving person-centred care for older persons with serious multimorbidity in LMICs. Afr J Prim Health Care Fam Med. 2024, 16:e1-9. 10.4102/phcfm.v16i1.4440
27. Abubakar R, Yohanna S, Zubairu H: Influence of health decision making on maternal complications among women delivered at a general hospital, North-Western Nigeria. Niger J Clin Pract. 2020, 23:675-9. 10.4103/njcp.njcp_659_18
28. Sow A, De Man J, De Spiegelaere M, Vanlerberghe V, Criel B: Integration of mental health care in private not-for-profit health centres in Guinea, West Africa: a systemic entry point towards the delivery of more patient-centred care?. BMC Health Serv Res. 2020, 20:61. 10.1186/s12913-020-4914-3
29. Princewill CW, Jegede AS, Nordström K, Lanre-Abass B, Elger BS: Factors affecting women's autonomous decision making in research participation among Yoruba women of Western Nigeria. Dev World Bioeth. 2017, 17:40-9. 10.1111/dewb.12112
30. Sankoung S, Marcellin NN, Lamine NM, Amy D, Toure B: Ethics and dental care: satisfaction survey among Senegalese patients. J Contemp Dent Pract. 2024, 25:1099-103. 10.5005/jp-journals-10024-3796
31. Abboah-Offei M, Bristowe K, Koffman J, et al.: How can we achieve person-centred care for people living with HIV/AIDS? A qualitative interview study with healthcare professionals and patients in Ghana. AIDS Care. 2020, 32:1479-88. 10.1080/09540121.2019.1698708
32. Asogun D, Larbi-Ampofo AK, Akhaine JO, et al.: Person-centred HIV prevention services in sub-Saharan Africa: a scoping review. AIDS Res Ther. 2026, 23:4-6. 10.1186/s12981-025-00839-0
33. Roder-DeWan S, Gage AD, Hirschhorn LR, et al.: Expectations of healthcare quality: a cross-sectional study of internet users in 12 low- and middle-income countries. PLoS Med. 2019, 16:e1002879. 10.1371/journal.pmed.1002879
34. Larson E, Sharma J, Bohren MA, Tunçalp Ö: When the patient is the expert: measuring patient experience and satisfaction with care. Bull World Health Organ. 2019, 97:563-9. 10.2471/BLT.18.225201
35. Okeny PK, Pittalis C, Brugha R, Gajewski J: Patient-centred care measurement in sub-Saharan Africa: a scoping review of the evidence (1990-2024). Int Health. 2026, 18:570-90. 10.1093/inthealth/ihaf139
36. Saalim K, Sakyi KS, Fatema-Tuz-Zohra, Morrison E, Owusu P, Dalglish SL, Kanyangarara M: Reported health and social consequences of the COVID-19 pandemic on vulnerable populations and implemented solutions in six West African countries: a media content analysis. PLoS One. 2021, 16:e0252890. 10.1371/journal.pone.0252890