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Shared decision making in West Africa: The forgotten area

Partizipative Entscheidungsfindung in Westafrika: eine vergessene Region

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ABSTRACT

Up to now, little attention has been paid to West Africa when it comes to shared decision making (SDM). West African countries seem to lag behind with regard to SDM initiatives compared to many other countries in the world. There is some interest in informed decision making or informed consent, but little in a full SDM process. Few decision-making tools are available for healthcare professionals and the majority are not designed to support decision-making with patients. Furthermore, to the best of our knowledge, there are no training programs for implementing SDM in healthcare teams. Many barriers exist to implementing SDM in West Africa, including lack of options, few or poor health resources and low levels of education. However, African countries present many opportunities for SDM as well. Existing SDM innovations developed for other populations with low literacy could be explored and adapted to the West African context, and research on implementation and outcomes in West Africa could contribute to SDM worldwide. West African countries are in an excellent position to both learn from other countries and contribute to SDM development in other parts of the world. In this paper we reflect on SDM challenges and opportunities, and propose a research agenda for West Africa. We hope to awaken interest in SDM in West Africa and encourage future collaborations on SDM with various West African stakeholders, including patients, healthcare professionals, policymakers, non-government organisations (NGOs) and academic institutions.

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ZUSAMMENFASSUNG

Bislang hat man Westafrika, wenn es um partizipative Entscheidungsfindung (PEF) geht, nur wenig Aufmerksamkeit geschenkt. Westafrikanische Länder scheinen im Hinblick auf PEF-Initiativen hinter der Entwicklung in vielen anderen Ländern auf der Welt zurückgeblieben zu sein. Themen wie informierte Entscheidungsfindung oder informierte Einwilligung stoßen auf ein gewisses Interesse, an einem vollständigen PEF-Prozess ist das Interesse aber eher gering. Fachkräften im Gesundheitswesen stehen nur wenige Entscheidungshilfen zur Verfügung, von denen die meisten zudem nicht darauf ausgelegt sind, die Entscheidungsfindung von Patienten zu unterstützen. Darüber hinaus gibt es unseres Wissens keine Schulungsprogramme für die Implementierung von PEF in Gesundheitsteams. Der Umsetzung von PEF in Westafrika stehen viele Hindernisse entgegen, darunter fehlende Möglichkeiten, knappe oder unzureichende Gesundheitsressourcen und ein niedriges Bildungsniveau. Auf der anderen Seite eröffnen sich für PEF in afrikanischen Ländern aber auch viele Chancen. Bestehende PEF-Innovationen, die für andere Populationen mit geringer Alphabetisierung entwickelt wurden, könnten ausgewertet

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und an westafrikanische Verhältnisse angepasst werden, und die Forschung über die Implementierung von PEF und ihre Ergebnisse in Westafrika könnte zur Förderung von PEF auf der ganzen Welt beitragen. Westafrikanische Länder befinden sich in einer hervorragenden Ausgangslage, um einerseits von anderen Ländern zu lernen und andererseits zur PEF-Entwicklung in anderen Teilen der Welt beizutragen. In diesem Artikel reflektieren wir die mit PEF verbundenen Herausforderungen und Chancen und schlagen eine Forschungsagenda für Westafrika vor. Wir hoffen, damit das Interesse an PEF in Westafrika zu wecken und künftige Kooperationen mit verschiedenen westafrikanischen Interessengruppen, darunter Patienten, medizinischen Fachkräften, politischen Entscheidungsträgern, Nichtregierungsorganisationen (NGOs) und akademischen Institutionen, zu fördern.

Introduction

Shared decision making (SDM) has been shown to improve patient experiences and lead to better use of healthcare resources [1]. Interest among HealthCare Providers (HCPs) in adopting SDM is growing in developed countries [2], but up to now very little is known about the situation in African countries. Given that no African country was included in either of the SDM editions of this journal (2007, 2011), the seven African team members of the Tier 1 Canada Research Chair in SDM and Knowledge Translation in Quebec [3] sought to put Africa on the SDM radar by exploring and describing the status of SDM in West African healthcare contexts. To this end, we relied on our professional and academic knowledge and experience of our respective countries (Benin, Comoros, Senegal and Togo), a literature search based on one of our Cochrane reviews using terms related to "shared decision making" (OR "decision making" AND ("patient participation" OR "professional-patient relations")) AND "Africa" (any language) conducted in PubMed on 17th March 2017, and a grey literature search on papers related to SDM or to healthcare decision-making in African countries. The authors include medical doctors and researchers with Non Governmental Organisations (NGO) experience who have been involved in healthcare research and practice before coming to Canada. We discuss current SDM initiatives in selected African countries in light of their political and health systems, the challenges they face, and the possibilities and potential for SDM. Since Africa is a large continent with great variation in political climate and culture, our reflection will focus mainly on West African countries with somewhat comparable socio-economic and political features, and which are represented by the majority of our African team members.

Policy climate and health systems in West African countries

Africa is a continent consisting of 55 countries. In 2015 its population was 1,186 million, and its expected population in 2050 is 2,478 million, or 25% of the global population [4]. Because most African countries are poor[4,5], Africans face major challenges regarding access to healthcare services and thus have difficulty improving their health or social wellbeing [6]. West Africa includes 16 countries (Fig. 1) with a total land area of 6,140,000 km^2 and a population of around 370 million. Some of the poorest countries in the world (e.g. Burkina Faso, Liberia, Mali, Niger, Guinea, and Sierra Leone) are located in this subregion of Africa.

Since 1980, health care in West African countries has been heavily influenced by structural adjustment programs (SAPs). These were loan conditions established by lending financial institutions such as the World Bank and International Monetary Fund to increase the return on state revenues, and resulted in reduced operating expenses for healthcare. Instead of reducing poverty, SAPs undermined socio-economic improvement and reduced the amount participating countries injected in their healthcare systems [6,7]. Government expenditure on health as a percentage of gross domestic product in Senegal, for example, is 4.7% compared to 16.5% in North America and 9.9% as a world average [8]. The weak economic situation in West Africa that limits investment in their health systems has led NGOs and international institutions to fund their health systems [9]. West African countries have been offered non-governmental aid by organisations and institutions [9], such as Unicef, Child Fund, Save the Children, Red Cross, Médecins Sans Frontières, Intrahealth International and the United Nations Population Fund (UNFPA). However, their efforts are often adapted to their own changing policy visions rather than to their beneficiaries' needs and/or values [10].

In general, governmental health structures in West African countries can be visualized as a pyramid: hospitals, health centres, and peripheral health posts [11]. However, this structure does not always function optimally. Geographical accessibility, poverty [12], as well as cultural beliefs [13] prevent people from seeking out these health services. In addition, the official health care offered in most West African countries is not delivered in such a way that it meets the needs of patients [14]. As a result, most patients choose to consult alternative forms of healthcare, such as traditional medicine or illegally sold drugs on the street before they resort to official health centres. In addition, many West African HCPs still adopt a traditional paternalistic attitude to the patient-HCP relationship (the doctor always knows best) that puts the patient in a passive position with no autonomy in decision-making [14].

Primary health care alternatives and potential for SDM

Most West African countries are considered by the World Health Organization (WHO) to be prioritised for healthcare improvement [15] because they have not yet reached WHO standards in terms of health infrastructure coverage. In fact, the availability of human resources in healthcare is far from reaching the objectives of the WHO on health services delivery systems. WHO recommends 23 doctors, nurses and midwives for a population of 10,000 [15], but West African countries hardly reach this number. In West-African countries, the average number of doctors and the number of nurses and midwives are respectively 0.9 and 5.6 for 10,000 inhabitants [15]. In some developed countries, such as Canada, the numbers are respectively 19.1 and 100.5 for 10,000 [15]. Various initiatives have attempted to solve this problem, such as community participation in health management. The *Bamako primary health care initiative*, adopted by African ministers of health in 1987, proposed that local communities take charge of drug management and administration of health structures and that community health workers (CHWs) be trained to practice in villages and support community nurses in delivering healthcare [16,17]. These local actors are peripheral to the official health system pyramid, but their responsibility is to support the HCPs in their work. In fact, they are trained and are under the supervision of head nurses. Also, they are most often involved in organizing NGO activities and supporting head nurses at community levels. Some of these activities are behavioural change