

Perspective

Shared Decision Making (SDM) with Communities: A Peruvian Experience

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Shared decision making (SDM) has been defined as: “an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options in order to achieve informed preferences” [1].

Primary care clinicians in low or middle-income countries of Latin America, like Peru, are expected to include community interventions routinely in their practices. These approaches usually are developed following a unidirectional flow, with health authorities or primary care providers deciding which community interventions are going to be executed [2,3].

Community Oriented Primary Care (COPC) is a continuous process by which primary care is provided to a defined community on the basis of its assessed health needs through the planned integration of public health practice with the delivery of primary care services [4].

An approach in which decisions related to public health actions in primary care are discussed with communities could be a better way to make public health interventions

Indeed, bottom-up approaches such as empowerment strategies and community participation have become important paradigms in public health and development efforts to address local barriers to access health care services (social, cultural and economic barriers) and reduce inequalities in health [5] toward universal health coverage.

In this review we are going to explain the Community Oriented Primary Care cycle approach as a way to take shared decisions with communities, taking the Peruvian experience as an example.

PERUVIAN HEALTH SYSTEM

Peru is a South American country located in the Andean region, south of the equator line, on the coast of the Pacific Ocean. Its population reaches 31 million in habitants, with a 78% urban population. It has been a presidential republic of democratic representation since 1980. It is considered a lower/middle income country, with a life expectancy at birth of 77.7 years for women and 72.5 for men, and an infant mortality rate of 17 per

1,000 live births, which has fallen more than 60% in the last two decades [7].

In 2016, 20.7% (6 million 518 thousand) of the country's population was living in poverty; the incidence of poverty in rural areas reached 43.8% while in the urban area poverty affected 13.9% of the population. The highest levels of poverty were recorded in the rural highlands region (47.8%), the rural Jungle (39.3%) and the rural Coast (28.9%) [8].

Peru is a multiethnic, pluri cultural and multi lingual country. It has a substantial indigenous population. According to the Peruvian Ministry of Culture, 55 different indigenous populations live in Peru, and there are 47 different native languages been used [9].

Peru has a decentralized health care system administered by 5 entities: the Ministry of Health (MINSA), Es Salud, the Armed Forces (FFAA), National Police (PNP), and the private sector. As a consequence of both segmentation and fragmentation, there are huge inequalities in access to health care services, which deeply affect the poorest and most vulnerable. Therefore, there are many challenges to overcome in order to ensure that right to health is a reality for everybody. In fact, it is well known that a mean to improve efficiency in service delivery, is to institutionalize citizen participation in design, decision-making, and financial planning for social policy [10].

Peruvian government has design different strategies to involve people's views into social and health policy decision-making, under community approaches. For example, the Ministry of Health “Shared Administration Program” strategy (Asociación de Comunidades Locales de Administración de Salud, ACLAS), promotes co-management (citizens and government) of primary care facilities. In addition, the Ministry of Economy and Finance (MEF), has implemented the Participatory Budgeting (PB), which is a mechanism to assign public resources, according to priorities defined by community stake holders and authorities. Also, the Ministry of Development and Social Inclusion (MIDIS) has established Qali Warma, a program aim to guarantee food service for children in state infant schools from the age of 3 onwards, and in primary education from the first day of the 2013 school year. It promotes shared decision-making and joint responsibility by

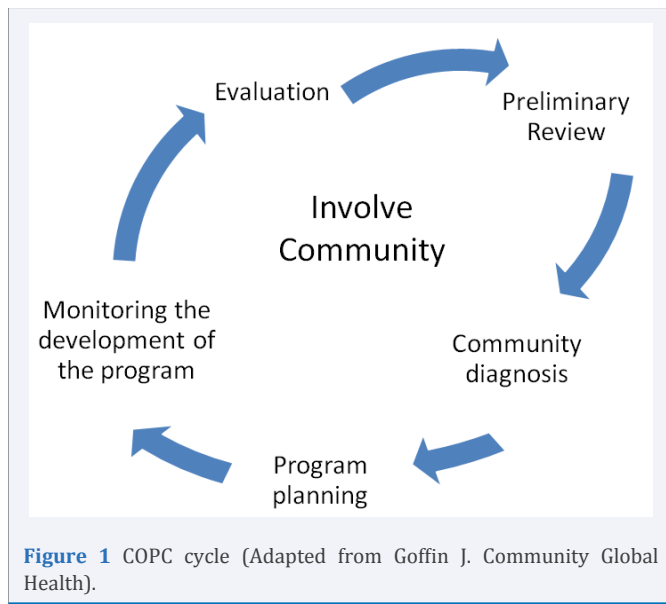


Figure 1 COPC cycle (Adapted from Goffin J. Community Global Health).

local communities because food purchasing, preparation and distribution are responsibility of school authorities and different community stakeholders.

DEFINITIONS

Community

The community refers to the entire population potentially served, whether its members are patients or not. Community can refer to a social group residing in a defined geopolitical boundary (a city, county, or state), or to neighbors who share values, religion, experiences, language, culture, or ethnic heritage [11].

Community engagement

The process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices [12].

Primary care

Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community [13].

Community oriented primary care

Defined as a “continuous process by which primary health care is provided to a defined community on the basis of its assessed health needs by the planned integration of public health with primary care” [14].

COPC model: Shared decision making with communities:

The COPC model emerged in 1940 as part of the work in family medicine (S. L. Kark and E. Kark, in a rural area of South Africa). The basic concepts and methodology were developed through the joint application of epidemiology and social and behavioral sciences [15].

A better scenario to practice COPC and to make shared decision making with communities should be:

1. A defined population, geographically based or with certain common characteristics - such as students in a school, workers in a factory or affiliated with a clinic or health center; in all cases it covers entirely population.
2. A primary care facility with a health care team that combines clinical, epidemiological and social sciences skills.
3. Capacity of assessing the physical and social determinants of health and micro environmental and community resources.
4. Community participation (individual and collective) in health care and improvement activities.

The process of development of COPC involves a series of stages, systematized by Abramson in a cycle [16]

A) Preliminary Review: Starting point of the process in which the essential purpose is the collection of the necessary information for the analysis of the health situation of the community and the identification of its main needs.

B) Community Diagnosis: It allows determining the needs and types of intervention to be carried out by means of the complete analysis of the community as a whole and the groups of prioritized problems.

C) Program Planning: It allows agreeing the priorities established with the possibilities of action, in order to guarantee the viability of the program.

D) Monitoring the development of the program: The need to adequately monitor the development of the activities proposed in the program is evident in order to know and correct possible deviations that may have been introduced in the objectives.

E) Evaluation: This stage, together with the review phase, will be the one that marks the decision on continuity and the changes to be introduced in the program, according to the degree of fulfillment of the preset objectives, the impact it has had on the health status of the community and the comparative analysis with the starting situation.

ACLAS AS AN EXAMPLE OF SDM WITH COMMUNITIES

In 1994, the Peruvian Ministry of Health started the “Shared Administration Program” strategy, which promotes co-management of primary care health facilities - ACLAS - aimed at improving the health status and quality of life of the most vulnerable population, through shared action and shared decision-making between citizens and government. In 2008, there were 763 ACLAS nationwide, which managed 2,152 primary care health facilities, 33% of the totality.

Towards 2007 and 2008, the Peruvian government enacted Law 29124, which establishes Co-management and Citizen Participation in the primary care health facilities. This law set out the guidelines for the development of citizen participation in health; and the administrative, legal, financial and accounting aspects of co-management, in order to contribute to improve equitable access to health services, expand coverage, improve the quality of interventions on health determinants, with the participation of civil society within the framework of the exercise of the right to health.

Health Co-management within the framework of this legislative support implies joint action in health between the different levels of government and citizens, under a formal agreement that establishes responsibilities for both sides. Moreover, citizen participation in the ACLAS is done through the involvement of citizens, in the development and implementation of the Local Health Plan (PSL), an annual plan, which is the basis of the Shared Administration Contract that should incorporate the community's opinion on priorities. The community should also participate in monitoring completion of previously agreed goals for health and development, which ensures a better fit of interventions with the real needs of the population. In addition, the PSL is an instrument of community development that should articulate intersectorial support to the community in a framework of the local district or provincial development plan.

A case study of ACLAS showed that the strategy improve equity of access, quality of service and social capital in several ways: nearly all ACLAS interviewed reported having a sliding scale of fees-for-services for the purpose of increasing access by the poor. All ACLAS interviewed made decisions on the need for providing health services to isolated and hard-to-reach communities. Furthermore, ACLAS reported a variety of ways in which they provide incentives or support to the work of Community Health agents (CHA), such as accreditation, recognizing CHA as partners of ACLAS, financing rotating employment of CHA in cleaning or laundry work of the health facility, ensuring that CHA obtain training. Moreover, ACLAS members promoted quality of care in these ways: improving personnel, equipment and infrastructure, improving patient-provider relationships, channeling community feedback. Finally ACLAS enhances social capital through leadership development for both men and women; ACLAS members consider membership to be an honor, their role is highly respected by community because they are seen as having power to change what needs to be changed in order to improve health services [5].

In spite of the attempts to evaluate the results of the implementation of co-management and shared decision-making with communities in primary care, there is a lack of impact evaluations that take into account key indicators of peruvian health system and its commitment toward universal health coverage. Such impact evaluations would be helpful to better understand the strengths and weaknesses of the strategy and promote more informed decision-making.

In fact, it is well known that the implementation of the co-management strategy proposed through the ACLAS has some hardships. For example, in some cases, elected community

members have used their participation in the ACLAS for political purposes, manipulating the population against local authorities and health workers if there was any disagreement. In other cases, internal conflicts arose among workers in primary care facilities, because workers who were hired under co-management had different employment regimes (different salary and benefits). Moreover, the coordination team of the ACLAS in the Ministry of Health is a very small team and consequently, the technical assistance and supervision carried out to the ACLAS nationwide are insufficient, with weak accountability mechanisms.

On balance, the strategy of ACLAS has strengths and weaknesses, and its sustainability requires a permanent commitment from the authorities of the Ministry of Health in order to deter threats, capitalize opportunities, address weaknesses and take advantage of strengths. Unfortunately, over the years, decision-makers have prioritized other strategies for strengthening primary care. Lack of political will and consequently insufficient allocation of resources have resulted in a progressive weakening of the strategy.

CONCLUSIONS

Public health and COPC have different roles and responsibilities. One acts at the population level and the other at individuals and families level within a community.

The focus of population as a whole could be a development model of public health; which can facilitate the meeting point between clinical practice and public health.

Taking into account what communities prioritize in relation to their health can generate a greater impact from public health systems and health services. The path initiated for the rights of patients should be extrapolated to what communities need and want to improve their health decisions.

The Peruvian strategy for Co-management of primary care facilities is a health program with legalized, regulated and institutionalized community participation.

Citizen participation, community empowerment and Shared decision making under a community approach are cornerstones for primary health care toward universal health coverage and socially sustainable health care systems.

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