

Interventions and Lessons Learned from  
Community-based Diabetes Experiences  
**Project: “Viva Bem no Sertão”**

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“Viva Bem no Sertão”

=

“Live well in the backlands”

# Objective



Create a care system that provides integral attention to 18 years or older patients with Diabetes Mellitus (DM) and Systemic Arterial Hypertension (AH), in the Taua Health Region, in the State of Ceara, Brazil.

# State of Ceara and Taua Region



Data SIO, NOAA, U.S. Navy, NGA, GEBCO  
© 2018 Google  
Image Landsat / Copernicus  
US Dept of State Geographer

Google Earth

# Tauá City



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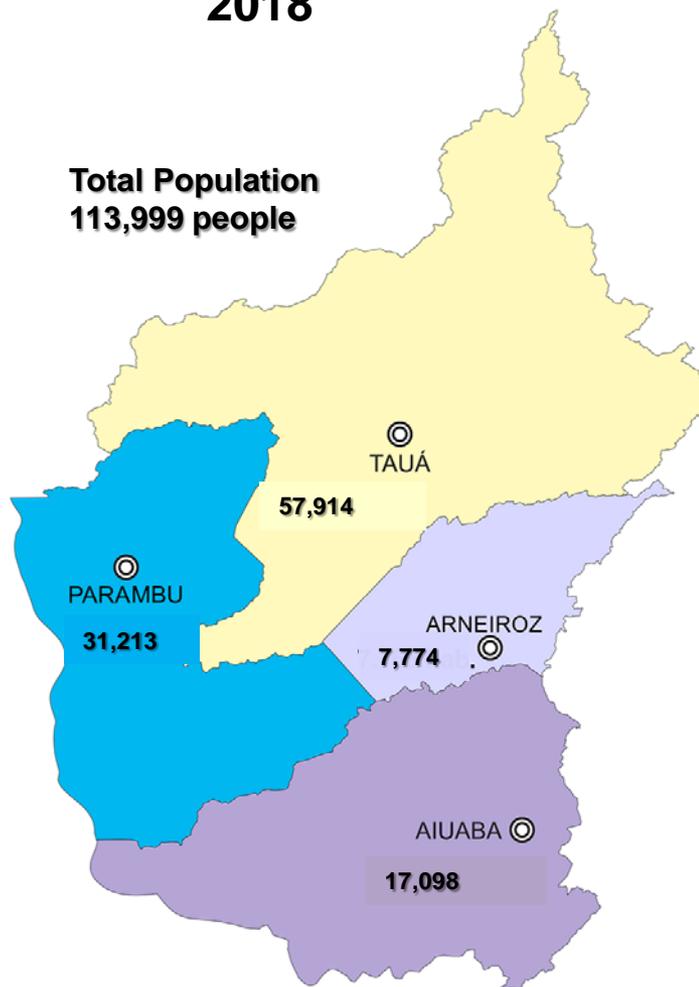


# Scenario

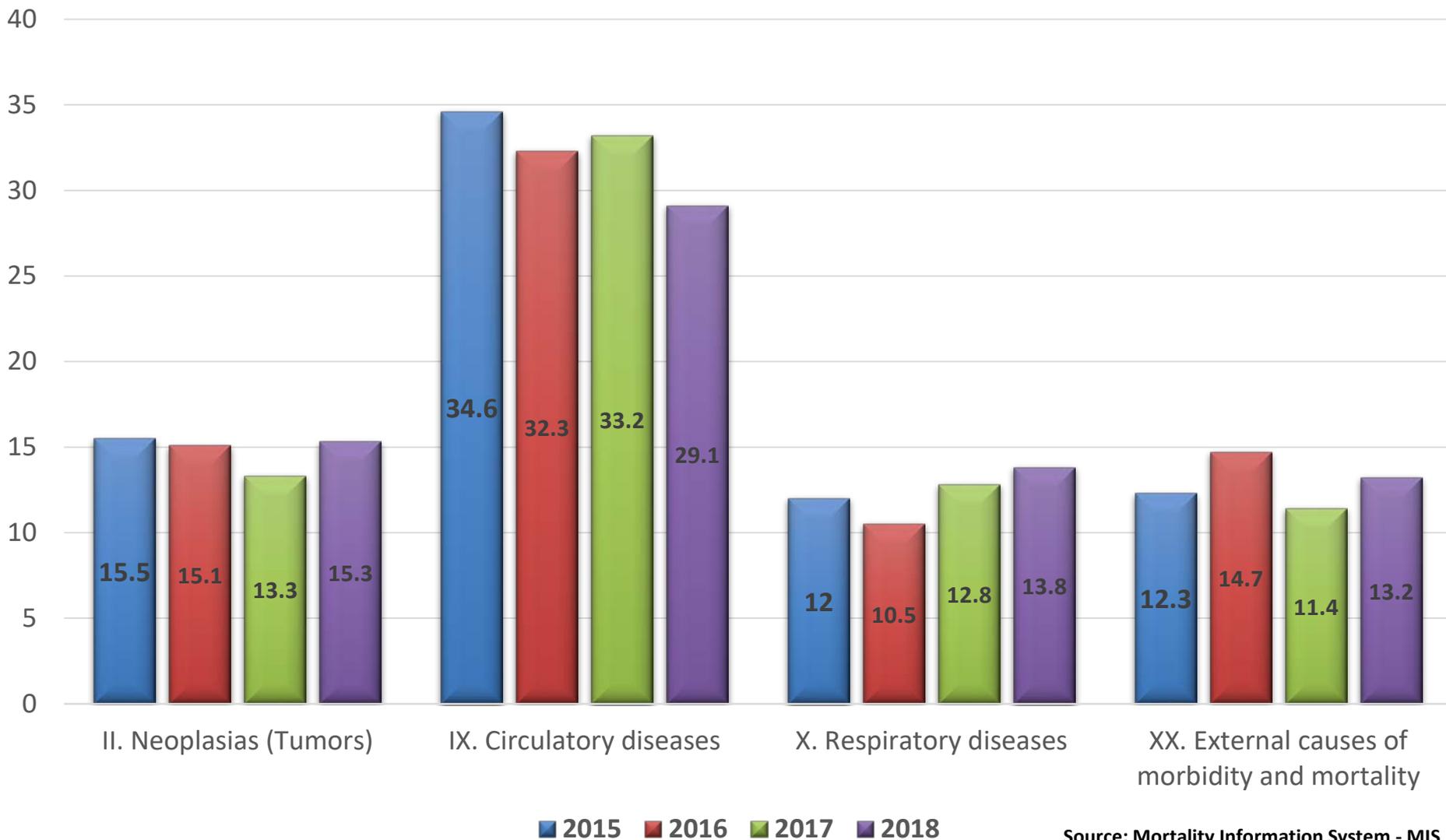


2018

Total Population  
113,999 people



## Mortality rate by major causes (ICD Chapter 10), cities of the Taua City Health Region, from 2015 to 2018



Source: Mortality Information System - MIS



# Methodology

## State Strategic Plan to Treat Chronic Non-Communicable Diseases



- Advocacy meetings
- Assistenship
- Health promotion
- Diabete & Hypertension prevention
- Tematic meetings
- Equipment acquisition

# Workshops



All health professionals

2 days meetings

Focus groups + whole group discussion

Always ended in an agreement and action plan.

# Workshops

## Workshop 6

Integral self-care

Assisted self-care

## Workshop 1

Population Screening – Findrisk, by Community Health Agents

Risk stratification (DM and/or AH )

## Workshop 3

# Workshops

## Workshop 8

Clinical examination of high/very high risk diabetic and hypertensive patients

Clinical examination of diabetic or hypertensive gestational patients

## Workshop 5

# Workshops



Workshop 2

Workshop 7

Oftamologic  
Evaluation

Diabetic Foot

Care System

Workshop 4

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**OFICINA 1**

O cuidado integral e o autocuidado apoiado ao paciente diabético e hipertenso, e ao cuidador



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**OFICINA 2**

Abordagem do pé diabético e com detecção precoce e tratamento das complicações macrovasculares



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**OFICINA 3**

Abordagem clínica do paciente diabético e hipertenso, com anamnese qualificada e utilização das diretrizes e protocolos clínicos



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**OFICINA 4**

A oftalmoscopia direta e tratamento das complicações microvasculares na prática do médico de família



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# Timeline

Year: 2017



Project Initiation

Staff Hiring

Pan American Health Organization Visit

Health Surveillance (Findrisk)

Workshop 5

Mar/Apr

May

Jun

Jul

Aug

Oct

Nov

Dec

Planning Work Group

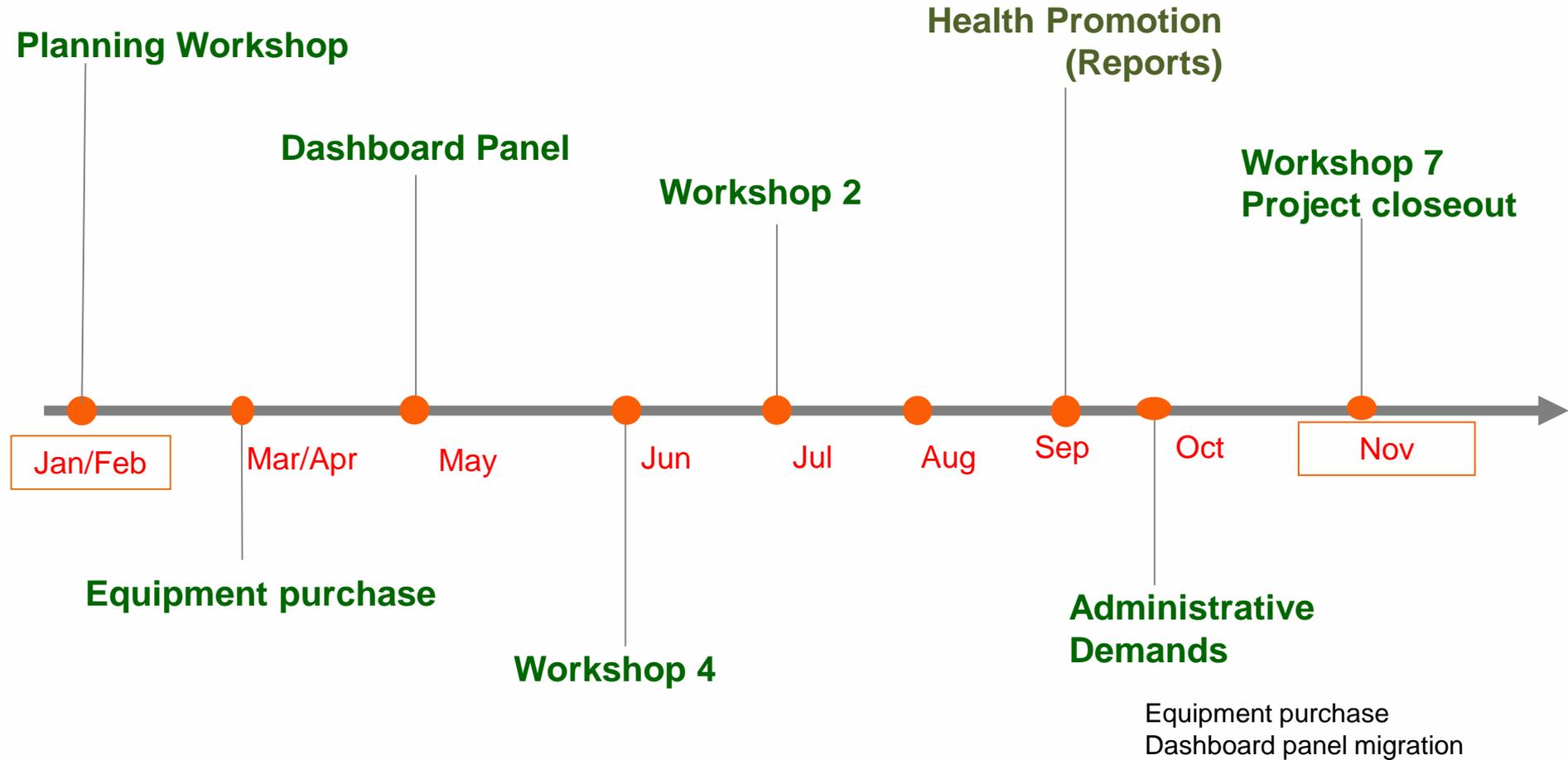
Workshops 1 and 6

Workshop 3

Workshop 8

# Timeline

Year: 2018



# Results

Develop a  
care system

Qualify 80% of  
PHC  
professionals  
(training)

Create the  
Diabetic Foot  
Ambulatory

Implement  
clinical  
guidelines

Qualify 8 Family  
Teams for the first  
attention to  
gestational diabetes  
and gestational  
hypertensive disease

Risk  
stratification  
for 100% of the  
target  
population

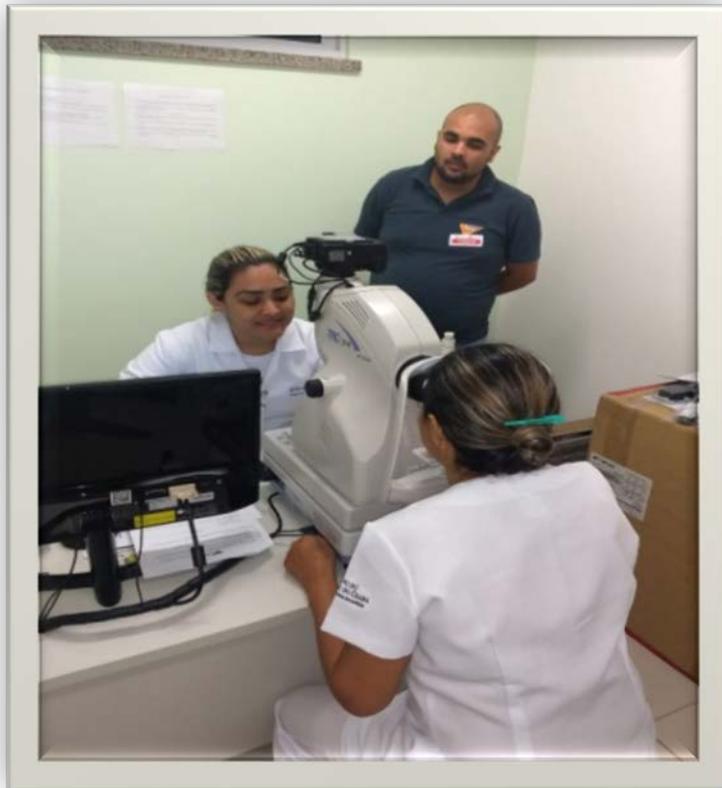
Provide  
retinography  
examination to all  
diabetic patients  
(Quixada Region)

Provide  
equipment for  
100% of the Basic  
Health Units and  
Taua Polyclinic

Increase  
diabetics  
detection by  
50%



# Provide Retinography Examination



# Findrisk - Community Health Agents in Action



# Project Challenges



- Processes completely dependent on local government
- Politics issues (Taua Mayor under investigation)
- Lack of culture of being monitored and evaluated
- Burocracy and delays on the bidding processes:
  - Dashboards
  - Purchase of equipments

# Challenges for project continuation

- Integration between Primary Care and Specialized Care
  - Unified system among care levels (regulation)
  - Traditional service model
- Prescription availability
- Validation of clinical guidelines for public release

# What would we do differently?



- Implement the monitoring tasks at the project start (the dashboard panel)
- Equipment delivery at project start
- Electronic record (not planned)

# Next Steps



- Focus on specialized care
  - Integration PHC x Specialized
  - Rethinking the model of Specialized Ambulatory Care
    - \*Operative groups
    - \*Shared service with multiprofessional team
    - \*Self-care workshops
- Emphasize importance self-management of care

# Partners



WORLD **DIABETES** FOUNDATION



Centro Integrado de  
Diabetes e Hipertensão  
(CIDH)

Secretarias Municipais da  
Saúde de Arneiroz, Aiuaba,  
Parambu e Tauá

Coordenadorias Regionais de  
Saúde de Canindé, Quixadá  
e Tauá.

Consórcio Público de Saúde da Microrregião de Tauá - CPSMT

“I’m applying the project “Viva Bem no Sertão” in my life”

*Parambu City Family Physician*



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