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

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“Viva Bem no Sertão”

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“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
Tauá City
Scenario

Total Population 113,999 people

2018

- Parâmbu: 31,213
- Tauá: 57,914
- Arneiroz: 7,774
- Aiuaba: 17,098
Mortality rate by major causes (ICD Chapter 10), cities of the Taua City Health Region, from 2015 to 2018

Source: Mortality Information System - MIS
Develop a care system
Implement clinical guidelines
Risk stratification for 100% of the target population
Provide equipment for 100% of the Basic Health Units and Taua Policlinic
Increase diabetics detection by 50%
Qualify 80% of PHC professionals (training)
Create the Diabetic Foot Ambulatory
Qualify 8 Family Teams for the first attention to gestational diabetes and gestational hypertensive disease
Provide retinography examination to all diabetic patients (Quixada Region)
Goals
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 1
Integral self-care
Assisted self-care

Workshop 6
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

Workshop 5
Clinical examination of diabetic or hypertensive gestational patients
Projeto VIVABEM NO SERTÃO
Cuidado Integral a Pessoas com Diabetes e Hipertensão

OFICINA 1
O cuidado integral e o autocuidado apoiado ao paciente diabético e hipertenso, e ao cuidador

OFICINA 2
Abordagem de pê diabético e com detecção precoce e tratamento das complicações macrovasculares

OFICINA 3
Abordagem clínica do paciente diabético e hipertenso, com anamnese qualificada e utilização das diretrizes e protocolos clínicos

OFICINA 4
A oftalmoscopia direta e tratamento das complicações microvasculares na prática do médico de família

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CONASS
Consultoria Nacional de Secretarias de Saúde

Organização Pan-Americana da Saúde

GOVERNO DO ESTADO DO CEARÁ
Governo do Estado do Ceará

WORLD DIABETES FOUNDATION
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Results

Increase diabetics detection by 50%
Qualify 80% of PHC professionals (training)
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

Centro Integrado de Diabetes e Hipertensão (CIDH)

Coordenadorias Regionais de Saúde de Canindé, Quixadá e Tauá.

Secretarias Municipais da Saúde de Arneiroz, Aiuaba, Parambu 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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