Strategies to disseminate and implement Screening of Harmful use of Alcohol and Brief Intervention in PHC services in Juiz de Fora city (Brazil).

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INEBRIA
International Network on Brief Interventions for Alcohol Problems

BRASIL

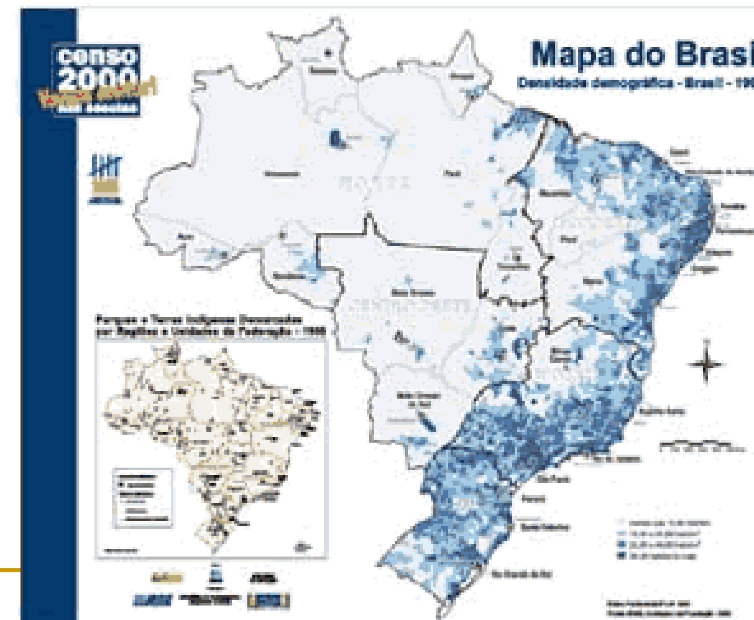
BRAZIL

Country with continental dimensions

- 8.5 million km^2
- 190 million inhabitants

78.4% live in urban areas

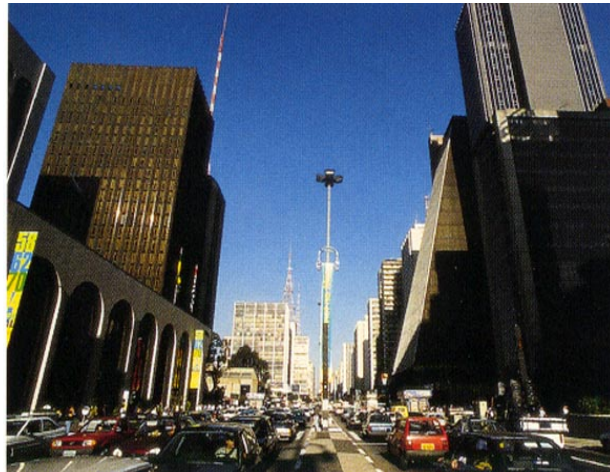
Most around the coast



(2001 data)

Enormous diversity among areas: the Southeast is richer and more developed and the North has the worst social indicators

In the big cities: very poor areas are close to very rich areas



- Race:
  - Caucasian 54.0 %
  - African American 5.4%
  - Mulatto 40%
  - Oriental 0.5%
  - Indian 0.2%

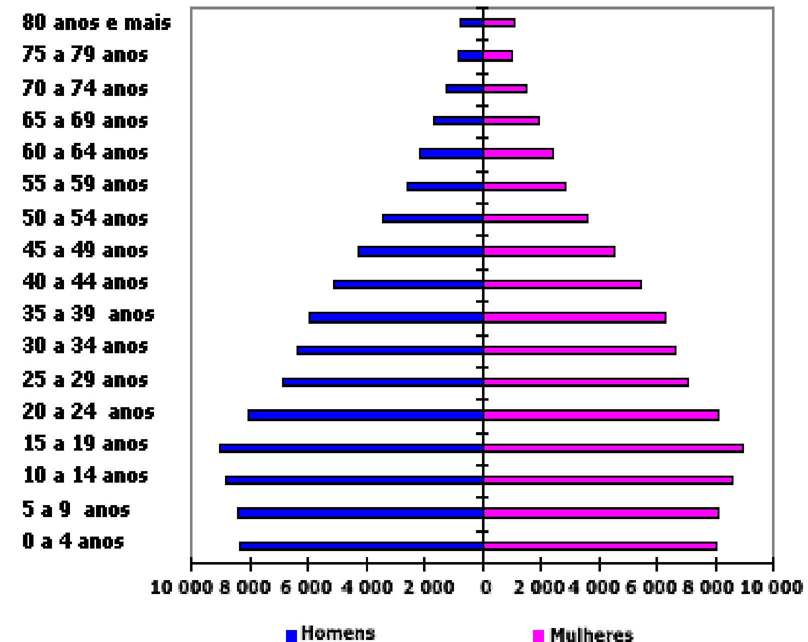
Demographic data:

49.2% men

50.8% women

- 36% younger than 18 years
- 9.1% older than 60 years

- Families size: 3.4 people/family



(2001 data)

Economy:

- 20% agriculture
- 20% industry
- 60% services

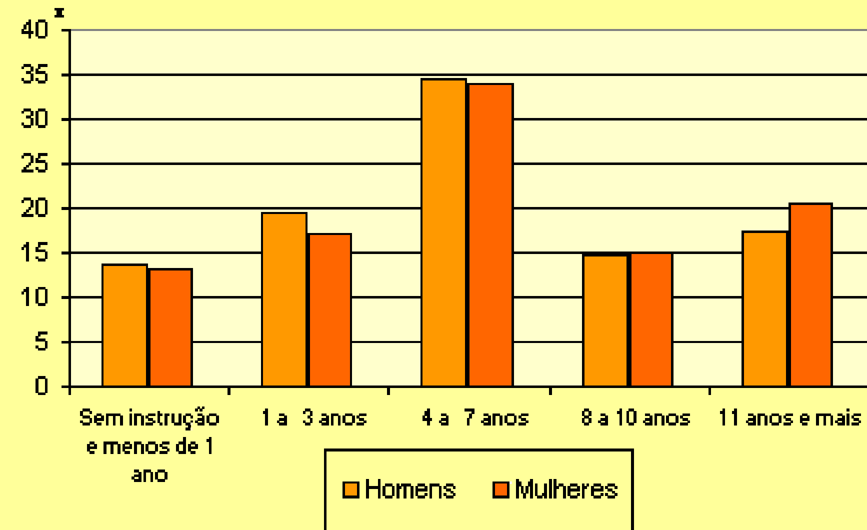
- Economically active population :70 million
- Per capita income: US$ 3.5 thousand/year
- 8th economy in the world (1st in Latin America)

Income distribution

One of the most lopsided income distribution in the world

43% total land is owned by 1% population

Education



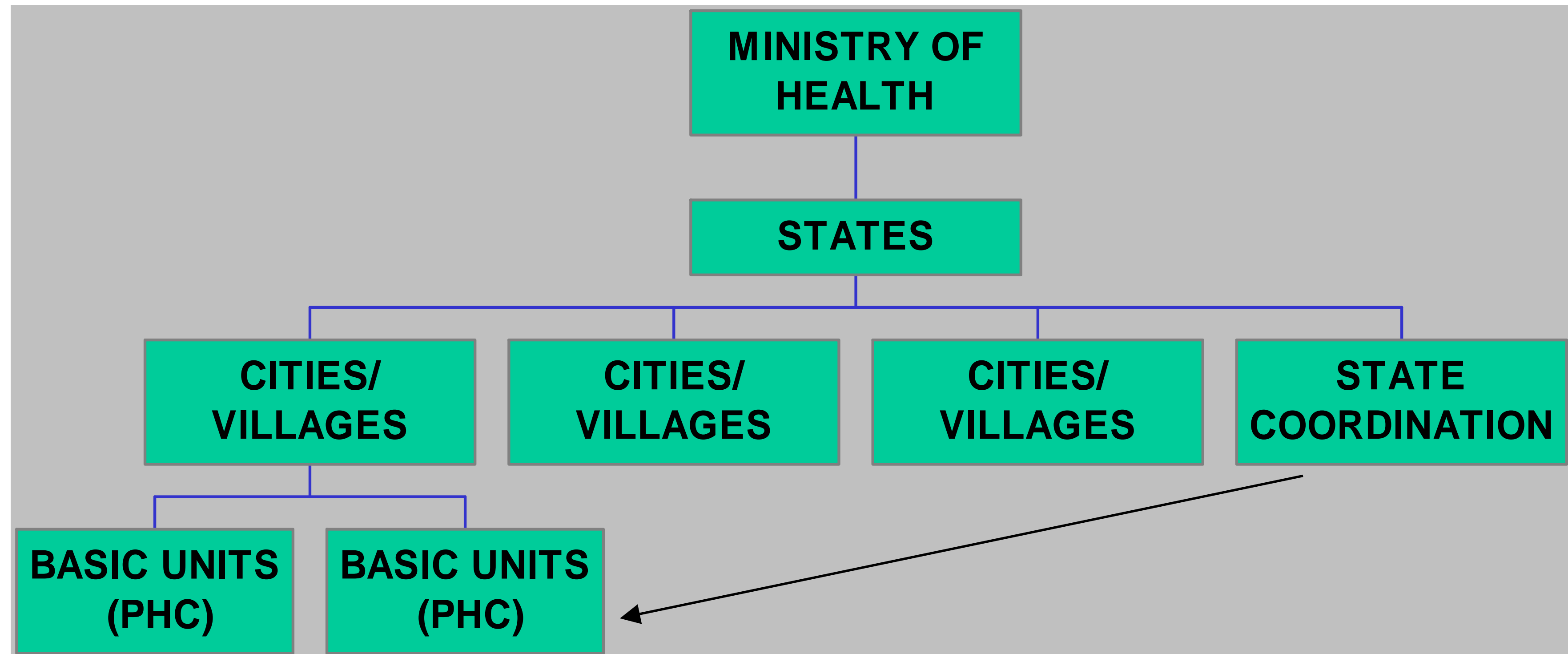
- **Illiterate children from 10 to 14 = 4.2%**
- **Illiterate children older than 10 = 12.3%**

(2001 data)

Health funding

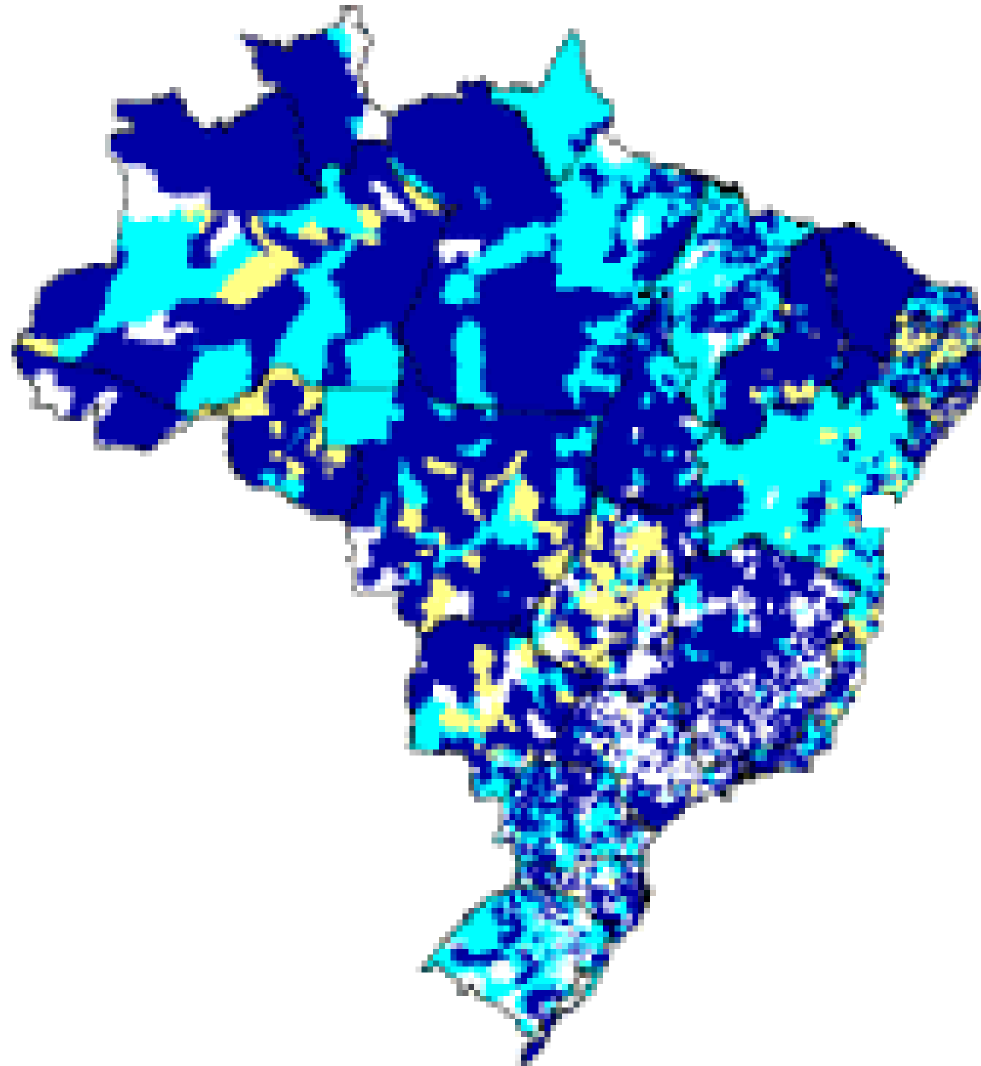
- **20% have a health insurance**
- **75% use public health services**

Brazilian Unified System of Health (SUS)



ALL BRAZILIAN CITIZENS ARE ENTITLED TO FREE PUBLIC HEALTH SYSTEM

Brazilian unified system of Health (SUS)



Family Health Program covers 100 million people

Teams: 30.000

- CHA
- CHA/FHP
- Dental Health/FHP
- Without CHA, FHP

Communitary Health agents (CHA)
Family Health Program (FHP)

Use of health services

- 71.2% regularly go to doctors
- 42% go to primary care centres

- Women often do it for routine or prevention, men often look for treatment

- Among 20 million people looking for treatment in the previous 15 days
  - 35.8% used health insurance
  - 49.3% used public health system

- Self evaluation of health
  - 79.1% good
  - only 3.6% as very bad

- 31.6% of the population reported at least one chronic disorder

Alcohol Use in Brazil

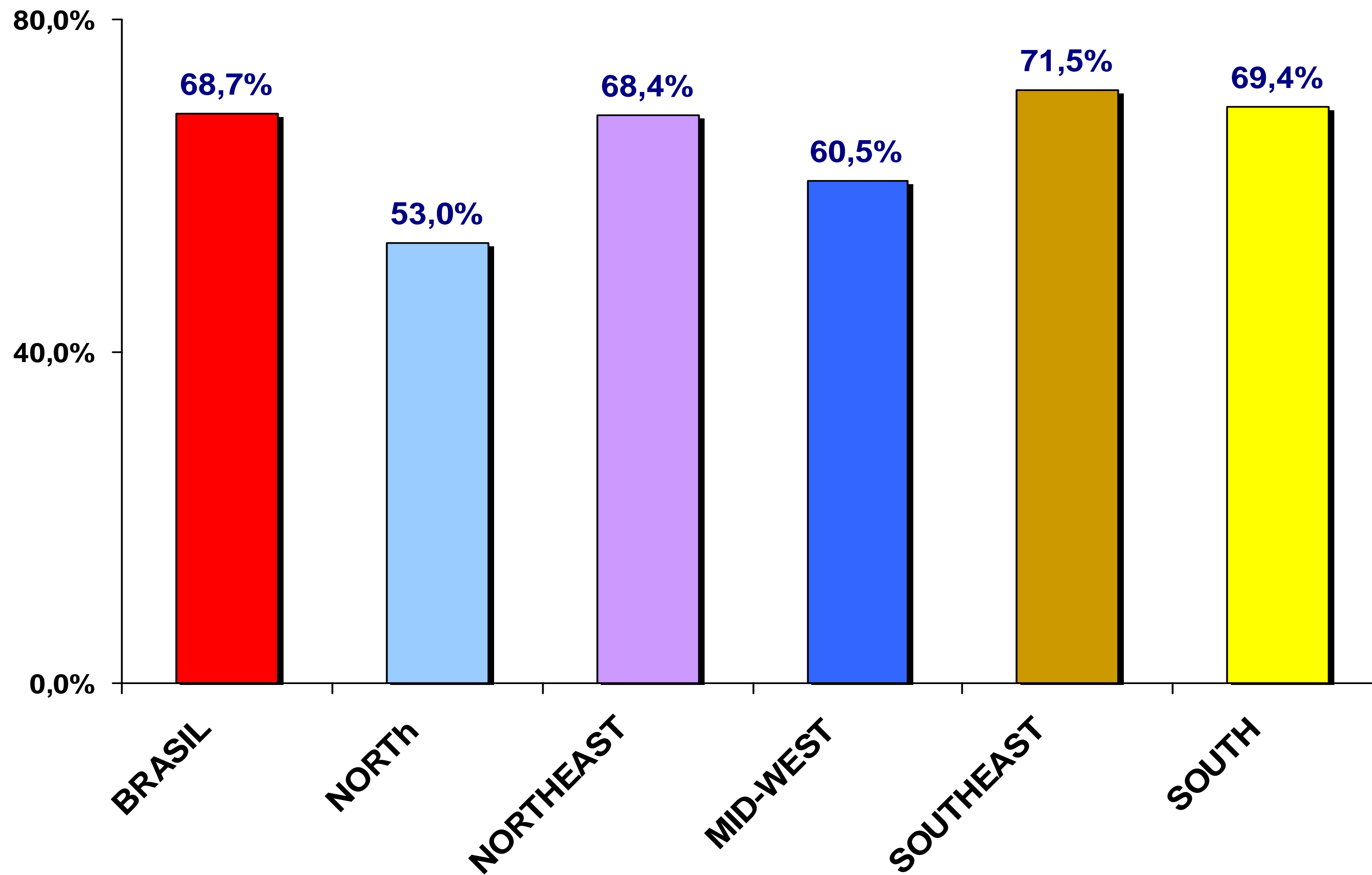
- Until recently - few “official” data available as well as few effective actions against alcohol abuse

- Brazilian society is very permissive
  about alcohol use

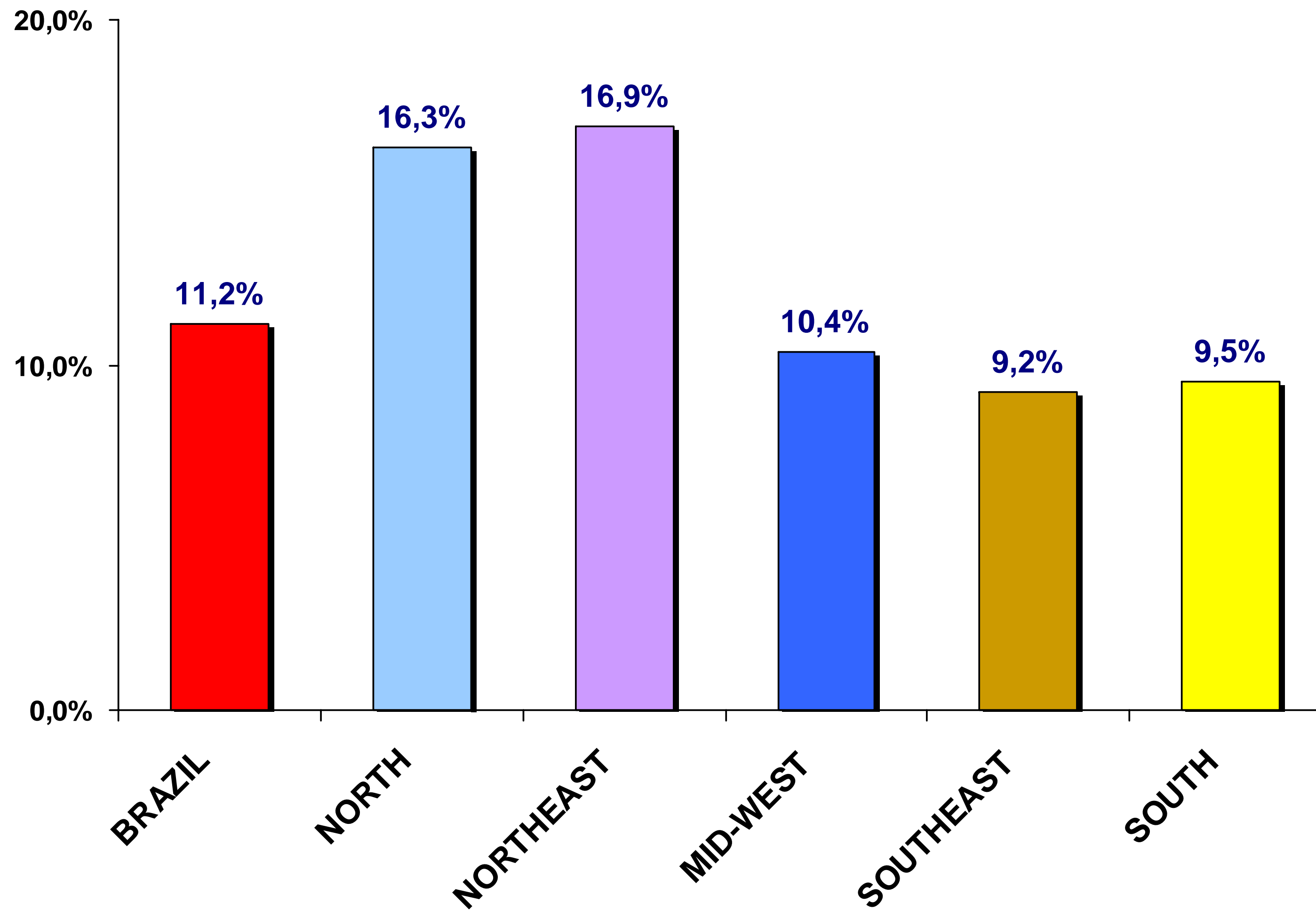
- According to industry there is a daily consumption of 70 million drinks of “cachaça” (spirit from sugar cane - 40%) that is considered the Brazilian national beverage

Lifetime alcohol use

National Brazilian Survey (2001)- main 109 cities



ALCOHOL DEPENDENCE

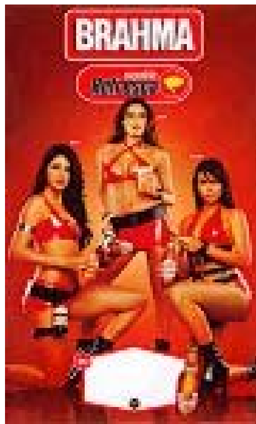


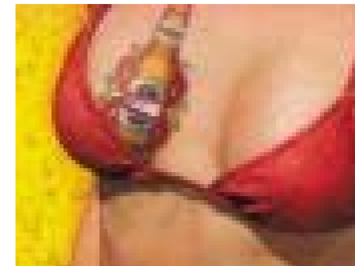
Alcohol Use in Brazil

- Restrictions to alcohol sales:
  - Places: must be at least 300m away from schools
  - There is a warning on the label of alcoholic beverages: "This can cause dependence. Drink with moderation."
  - Reasonable laws but with low efficacy because they are not enforced
    - Ex: teenagers under age buy alcoholic beverages
  - Some sectors (linked to non governmental organizations, universities, etc.) are trying to organize preventive actions as well as some governmental sectors linked to the Ministry of Health and SENAD (National Secretary of Policies about Drugs)

Advertisement on alcoholic beverages

Excessive use of sexual appeal, football, alcohol use to cope with unpleasant situations (stress, low self-esteem)





PREVENTION

SENAD, universities and some non governmental organizations developed some material and prevention programs.

TREATMENT

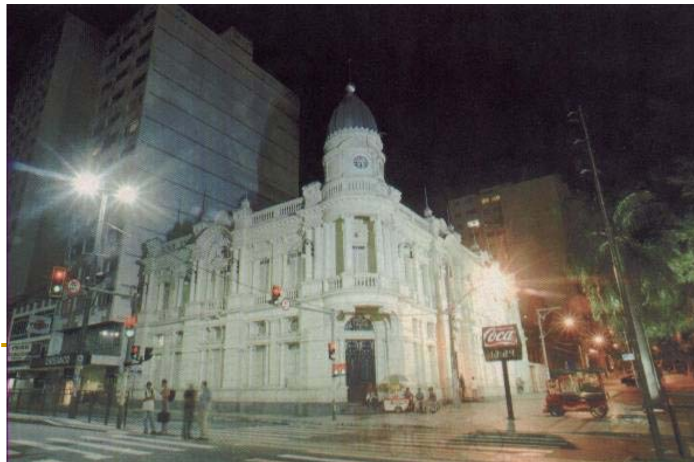
- Specialized outpatient services: public (linked to university) and private (very expensive)

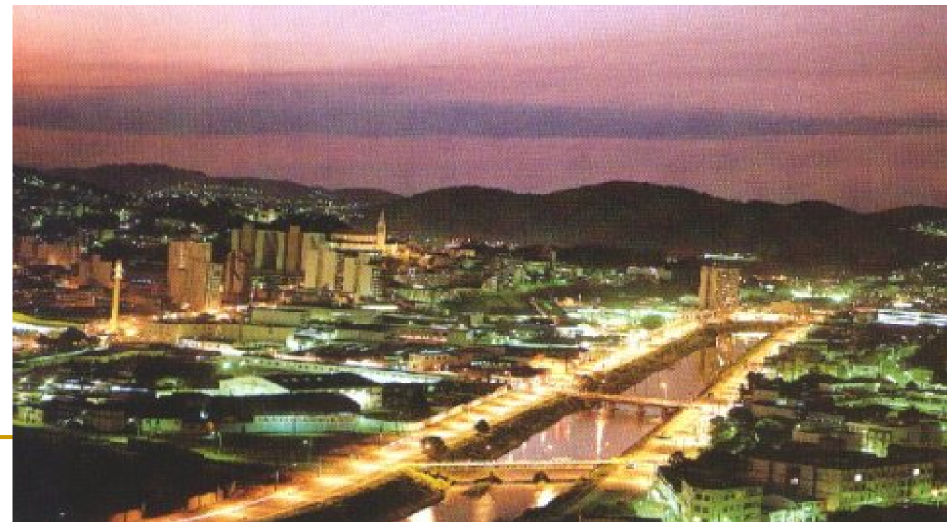
- **Few professionals have a formal training to screen, prevent or treat alcohol abuse and dependence - most of them are linked to universities and in the Southeast or South regions**

Juiz de Fora experience

This study is part of an international multicentric project (WHO Collaborative Project in Developing Countries)

Juiz de Fora-MG (480.000 habitants)
82 Family Health Teams





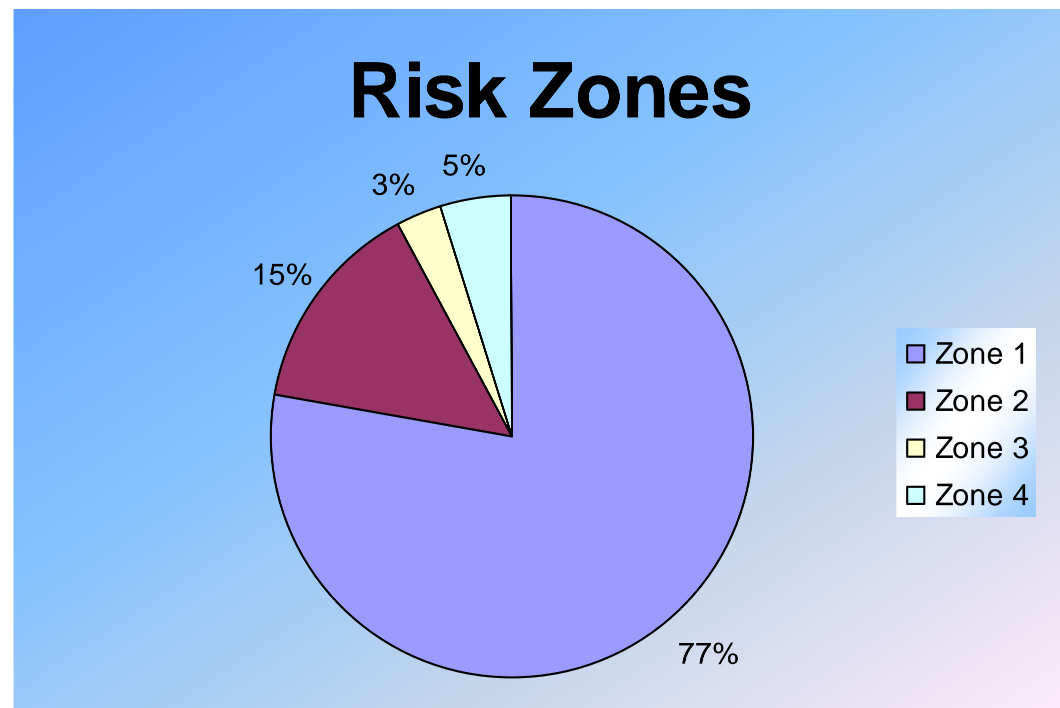
In a pilot program of Screening of Harmful use of Alcohol and Brief Intervention (SBI) developed in Juiz de Fora (Brazil) from 2003 to 2004, many difficulties to its implementation were detected, including the **lack of an "official" involvement** of the Municipal Health Secretary, as well as other sectors.

Other difficulties:

- Lack of time
- Lack of motivation to work with prevention = focus on dependence
- Many other official things to do
- Lack of an integrated network

First Phase (2004/2005)

- 120 trained PHC professionals
- 870 AUDITs applied (by professionals and students) in JF:
  - 52,1% to men and 47,9% to women



Objective:

To describe **strategies** used in the second phase of the project in order to increase the implementation rate.

Methods:

2006 - Researchers from Federal University of Juiz de Fora (UFJF) and from Federal University of São Paulo (UNIFESP) proposed, to managers and professionals from different sectors of the Municipal Health Secretary, AA members, community representatives in the municipal health council, the creation of a committee, called **COPPERA** (Permanent Commission about Alcohol Abuse Prevention Policies) in order to develop a unified strategy to implement SBI, based on the principles of permanent education.

Permanent Education in Health

The Policy of Permanent Education in Health

Regulation *(Portaria)* 198/GM/MS – 2004

Institutionalization of the Policy of Permanent Education in Health as a strategy to "SUS - Sistema Único de Saúde", to the health professionals' ongoing education and development.

- Redirect strategies and ways of care;
- Strengthen the movement towards changes in the ongoing education process.

*** The aim of education process should involve more than just the search for diagnostic evidence;**

*** Technical scientific updating is one aspect of practices qualification rather than its main focus.**

COPPERA (Permanent Commission about Alcohol Abuse Prevention Policies)

Six meetings were organized to collectively establish goals and make decisions based on the methodology of the project implementation, emphasizing the Policy of **Permanent Education in Health**.

Goals:

- Meeting (April, 2006)
- New Training (8-hours per group)
- Supervision (every other week)

Previous Results (second phase):

All invited sectors agreed to participate and organize COPPERA

- Number of trained professionals: 92
  - **PHC**
  - **Military Police**
  - **AIDS /Harm Reduction Program**

Discussion:

Main difference between first and second phases:

Three settings have different realities = different implementation

Military Police = institutional support; voluntary work

AIDS /Harm Reduction Program = personal motivation

PHC

The initial data suggest that some of the practical limitations observed in the first phase were reduced, probably due to the network movement (COPPERA) and to institutional support.

Agreements are being established to bring policies and practices closer.

BUT, previous interview analyses in PHC setting…

- Individual actions
- Lack of integrated network
- Need to make the program "official" = Regulation *(Portaria)*
  - Institutionalization **(?????)**
  - **Other reasons… (dependence focus, personal motivation, the local mental health system net, etc)**

Acknowledgements

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Thank you!!!!!!!

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