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PRIMARY HEALTH CARE AND COVID-19: CHALLENGES FOR UNIVERSITIES, HEALTH WORKERS AND MANAGERS

ATENÇÃO PRIMÁRIA À SAÚDE E COVID-19: DESAFIOS PARA UNIVERSIDADES, TRABALHADORES E GESTORES EM SAÚDE

ATENCIÓN PRIMARIA DE SALUD Y COVID-19: DESAFÍOS PARA LAS UNIVERSIDADES, LOS TRABAJADORES DE LA SALUD Y LOS GERENTES

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Objective: to describe the experience of the primary health care support group of the Nursing Committee to Combat COVID-19 in a capital of northeastern Brazil. Method: collection of information in health units about physical structure, action plans, care flows and workforce, between March and May 2020. Results: problems identified in 46 units, such as: weaknesses in health surveillance; physical structure to assist users with and without respiratory symptoms; inadequacy of personal protective equipment; removal of professionals infected with SARS-CoV-2; insufficient capacity building for the demands. The following were made available to the units: technical-scientific support materials, virtual spaces of debates, referral of labor demands, materials to adapt routines of services and recommendations for higher instance of municipal health management. Final considerations: precarious conditions of Primary Health Care imply the disorganization of adequate response in times of health emergencies.

Descriptors: COVID-19. Health Systems. Nursing. Primary Health Care. Universities. Health Management. Public Health Surveillance.

Objetivo: descrever experiência do grupo de apoio à Atenção Primária à Saúde, do Comitê de Enfermagem para Enfrentamento da COVID-19 em uma capital do Nordeste do Brasil. Método: coleta de informações nas unidades de saúde sobre estrutura física, planos de ação, fluxos de atendimentos e força de trabalho, entre março e maio de 2020. Resultados: problemas identificados em 46 unidades, tais como: fragilidades na vigilância em saúde; estrutura física

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para atender usuários com e sem sintomas respiratórios; inadequação de equipamentos de proteção individual; afastamento de profissionais infectados pelo SARS-CoV-2; capacitação insuficiente para as demandas. Foram disponibilizados às unidades: materiais de apoio técnico-científico, espaços virtuais de debates, encaminhamento de demandas trabalhistas, materiais para adequar rotinas dos serviços e recomendações para instância superior da gestão municipal de saúde. Considerações finais: condições precárias da Atenção Primária à Saúde implicam em desestruturação de resposta adequada em momentos de emergências sanitárias.

Descritores: COVID-19. Sistemas de Saúde. Enfermagem. Atenção Primária à Saúde. Universidades. Gestão em Saúde. Vigilância em Saúde Pública.

Objetivo: describir la experiencia del grupo de apoyo a la atención primaria de salud del Comité de Enfermería para combatir el COVID-19 en una capital del noreste de Brasil. Método: recopilación de información en las unidades de salud sobre estructura física, planes de acción, flujos de atención y fuerza laboral, entre marzo y mayo de 2020. Resultados: problemas identificados en 46 unidades, tales como: debilidades en la vigilancia de la salud; estructura física para ayudar a los usuarios con y sin síntomas respiratorios; insuficiencia de equipos de protección individual; eliminación de profesionales infectados con SARS-CoV-2; insuficiente creación de capacidad para las demandas. Se pusieron a disposición de las unidades: materiales de apoyo técnico-científico, espacios virtuales de debates, derivación de demandas laborales, materiales para adaptar rutinas de servicios y recomendaciones para la superior instancia de la gestión sanitaria municipal. Consideraciones finales: las condiciones precarias de atención primaria de salud implican la desorganización de la respuesta adecuada en tiempos de emergencias sanitarias.

Descriptores: COVID-19. Sistemas de Salud. Enfermería. Atención Primaria de Salud. Universidades. Gestión en Salud. Vigilancia en Salud Pública.

Introduction

The new coronavirus appeared in December 2019 in China and spread so rapidly that the World Health Organization (WHO) declared, on March 11, 2020, the global pandemic for Coronavirus Disease 2019 (COVID-19)[1-2]. Since then, the control and prevention of severe acute respiratory syndrome (SARS-CoV-2) infection has been challenging the health systems of countries given their high transmissibility, the potential for worsening of some groups[3] and the need for rigorous community surveillance of cases and their contacts[4]. In Brazil, the first case of COVID-19 was recorded in February 2020, and the rapid increase in cases motivated some Brazilian states to declare an emergency situation[5].

In European countries considered the epicenter of the pandemic initially, there was rapid collapse of health systems and excessive deaths, due to insufficient containment measures adopted[6]. These circumstances led the WHO to alert other countries regarding the urgency in organizing the care network, aiming to create conditions for coping with the disease, mitigating risks and reducing harm[7]. The initial concern in Brazil was focused on the prospect of high demand for intensive care beds and resulted in rapid purchases of mechanical ventilation equipment and opening of more hospital beds throughout the country[8-9].

However, in addition to requiring high complexity care for severe cases, COVID-19 also requires robust actions regarding the testing and production of information, essential for planning actions to prevent new infections, focusing on risk control[4]. In addition, actions among the sectors and articulation with civil society organizations are also necessary to enable the conditions of social distancing necessary to the expected impact on the reduction of virus transmission[6]. Given the characteristics of the Unified Health System (SUS), which is universal and has the preferred gateway to Primary Health Care (PHC), it is strategic to think about coping with the pandemic, having it as an order of the health care network[10] and a fundamental element in the structuring of chained actions, especially in a country with continental dimensions and great social inequality[11].

Faced with the challenges for strengthening PHC and reorienting health work, there is an urgent need for the contribution of several social actors to overcome weaknesses already existing in the Brazilian health system. It is understood that the conjunction of efforts, through strategies, such as the articulation between university and health services[12], can gain new contours with the participation of professional entities, promoting alternatives of organizational support, search for evidence and dissemination of knowledge.

It was in this context that, in a multi-institutional way, a Nursing Committee was constituted in a state of the Brazilian Northeast, seeking to think, discuss and propose actions to cope with the pandemic.

This manuscript aims to describe the experience of the Working Group (WG) to support PHC, of the Nursing Committee to Combat COVID-19 in a capital of northeastern Brazil. Elements of the construction and performance of the WG are presented, highlighting the relevance of this collaborative model, especially the involvement of workers' organizations and the University, to analyze challenges and possibilities of the first level of attention of the SUS.

Method

This is an experience report of a working group to support PHC created by the Nursing Committee for coping with Covid-19, in a capital of northeastern Brazil. The committee was formed in March 2020 by representatives of nursing entities (association, unions, professional council) and other workers, health service nurses and professors from a federal university. The focus of the committee's work was guidance, support and defense of nursing workers. To this end, a partnership was established with the Labor Public Ministry (MPT in Portuguese) and the State Reference Center for Workers' Health (CEREST in Portuguese). For the activities, working groups were organized by specific themes and actions.

The PHC support WG was formed by 14 members (teachers, union leaders and workers of the municipal health network, including one from management). The actions were initiated with the purpose of monitoring the preparation and review of the contingency plans of the PHC Units to cope with the pandemic. Thus, 78 (54.9%) PHC units of PHC in the municipality were randomly chosen and distributed among the members of the WG, for contact and follow-up through e-mails or telephone.

Given the lack of plans in most of the units in contact and the multiple situations reported, an instrument was elaborated for monitoring the Units by the members of the WG. We sought to identify elements of the work process and infrastructure in the face of the epidemic (existence of written protocol, distant professionals, actions of Community Health Agents (CHA), cases of COVID-19 in the area and problems faced).

In the follow-up of these teams for 45 days, starting on March 20, 2020, the WG elaborated diagnostics and implemented actions according to the identified demands. In addition to the units directly monitored, we sought to contribute to workers and managers throughout the PHC of the municipality. With regard to ethical aspects, for information of the type of complaint, the confidentiality of the whistleblower was ensured. For this situation, there was a flow of information between the committee's subcommittees. The complaint was received by the communications committee and only the reported situation was reported to the investigating committee, protecting the identity of the snitch.

Experience Results

Based on the conception of situational diagnosis[13], the instrument was applied and analyzed, considering the reality of the municipal system and the elements of the epidemic situation. In April 2020, the municipality had 50.27% PHC coverage, with 37.96% coverage by the Family Health Strategy (FHS)[14]. Of the 78 units selected, 46 responded to the contact, being 30 units with FHS and 16 units without FHS.

The implemented actions, recommendations or products elaborated were based on the

attributes of PHC, reaffirmed by the current National Primary Care Policy[15], in addition to technical standards related to the pandemic. As a theoretical subsidy, it was based on the perspective of the Health Surveillance Model[16].

Through situational diagnosis, in contact with the units, it was identified that, up to that moment, 41 (89.1%) of those who answered had not systematized in writing a care plan for COVID-19. However, some teams started the discussion and, both verbal reports and emails sent to the WG, indicated practical strategies supported by the municipal technical notes, based on recommendations from the National Health Surveillance Agency (ANVISA), the Ministry of Health and the State Department of Health.

After analyzing the information of the applied instrument, the most frequent problems were grouped into dimensions, as systematized in Chart 1 and subsequently detailed.

Chart 1 – Challenges identified in Primary Health Care Units in the face of the COVID-19 pandemic in a capital of the Northeast Region of Brazil,

Dimension	Challenges Encountered
Work process	Weakened performance in the territories, which compromises the fulfillment of PHC attributes and the care model centered on Health Surveillance.
Organization of services and network	Suspension of appointments for elective consultations and routine care, lack of information about the flow and the difficulty of access for diagnostic testing.
Physical structure	Units with reduced size, deficiencies in lighting, natural ventilation and the flow of people in circulation.
Work conditions	Problems with the supply of personal protective equipment, water supply, supply of hygiene materials.
Remoteness of professionals	Remoteness of professionals belonging to risk groups, due to isolation or suspected case.
Permanent education and matrix support	Updating difficulties and technical-scientific support for teams to develop their role.

Source: Created by the authors.

Work Process

The fragility of actions in agreement with the Health Surveillance Model was identified, based on the territory and in multiprofessional action, focusing on the individual and collective approach. Territorial actions aimed at identifying risks for specific protection actions was one of the elements most absent or restricted to the work of the CHA. In units without FHS, this aspect is even more compromised, because they cover a large population, without clientele registration and, often, without CHA.

In most units, the CHA were performing internal work, such as updating forms and registrations. In the territory, only specific demands were met by the team, such as dressings. One of the justifications presented was the insufficient supply of surgical masks in the units and the union orientation, so that the CHA would not expose themselves in the area without their use.

The fragile performance in the territory reflects issues prior to the pandemic, which reduce such actions, in most cases, to home visits and the work of the CHA. Circumstances, such as insufficient tablets for the registration of families, lack of knowledge of the possibilities of using the information system, deficiency in the analysis of health indicators and other elements of the socio-community network have repercussions in the absence of local health planning and programming. Such weaknesses, related to the insufficiency of health information

generated in the territory, reverberate in the current scenario of the pandemic and hinder its coping from PHC.

Organization of services and network

At first, there was suspension of appointments of elective consultations and routine visits. Prenatal, sexual and reproductive health and dental emergency consultations were maintained, as well as pharmacy, vaccination and dressings. This partial continuity was guaranteed, but with the attempt to separate space for symptomatic respiratory patients with flu-like symptoms.

The organization of the provision of services was one of the points most affected by the low coverage of PHC, especially the FHS, because the fragility of the registration of families and the recognition of the territory prevented an effective stratification of risks, essential at that time. Thus, with fragile ties with the community, it was verified the difficulty for the reorganization of regular follow-up, through alternative strategies such as telemonitoring or peridomiciliary activities.

Other deficiencies in the care network impaired the flow to perform diagnostic tests. There was misinformation about referrals and difficulty of access, even for health professionals. These problems were intensified in view of the low coverage of PHC and, sometimes, the existence of incomplete teams, which increased the usual overload of emergency services, besides derailing the reference and counter-reference system.

Physical structure

It was reported the repositioning of chairs from the reception of the units, floor signage and placement of "barriers" in some spaces, to try to maintain the distance between people. They also highlighted: rooms without natural ventilation and lighting; reduced space for user separation; lack of an alternative for exclusive entry of respiratory symptoms; absence of a place for hand washing when entering the unit.

Despite the attempts to adapt on the part of the teams, there were many difficulties to follow the recommendations of Anvisa. Such structural difficulties come from the operation in adapted units. At the time of the pandemic, the situations became more acute and made adjustments in the flow of care impossible, to ensure more safety for professionals and users.

Word Conditions

Some health units have previously faced irregularities in both water and provisions supply, and such conditions have become more evident with the increased use of hygiene products due to the need to intensify hand washing. However, the point most emphasized by managers was the quantity, quality and inadequacy of Personal Protective Equipment (PPE), identified as a actor that

These problems led some Basic Health Units (BHU) to suspend certain activities. Some have developed a spreadsheet to control the distribution of masks among workers, in addition to alternatives for obtaining insums, either through direct purchase by professionals or upon request to private educational institutions, contracted with the municipality for practical teaching activities.

Remoteness of professionals

There was a delay in adopting measures that allowed remote work for professionals who presented health conditions considered at risk. Even after the publication of municipal regulations recognizing this need, the analysis of merits was slow. On the other hand, the absence due to suspected infection was high in some units and, when added to the absences of professionals from the risk groups, impacted the functioning of the services, since there was no substitution of these professionals, and many units already worked with incomplete teams.

Permanent education, institutional support and matrix support

The professionals' doubts about the correct way of acting were recurrent, indicating weaknesses in the actions of continuing education and matrix support, which would have allowed specialized support. In this case, digital technologies could have been better used for this purpose, through virtual meetings and video classes with the teams, for pedagogical support and improvement of clinical-epidemiological reasoning, for updating and technical-scientific basis.

It was observed the disordered arrival of informative material, mainly via WhatsApp, with much overlap between the different spheres of government, without technical support of management or visits to the units for guidance. In this sense, weaknesses were revealed in the flow of information and in the support of the instances of the central and intermediate levels of management.

Actions implemented and products developed

After the situational diagnosis and the identification of the challenges, the proposals of actions and products were discussed by the group, considering its limit of governability, but in order to contribute to the workers and managers of PHC.

Immediately after the first contacts with the units and due to the absence of contingency plans, the protocols and technical notes essential to the work were cast and the submission to the Units was guaranteed. The options of online courses and training and dissemination of the social networks of the Nursing Committee to Combat COVID-19 in Bahia were also disseminated, both as a means of information and for the reception of complaints. The demands related to the right of removal of workers from risk groups were handled by the committee, which managed, through lawsuits filed by professional entities, to guarantee the right of remoteness.

The preparation of technical-scientific material on disinfection, waste management, dressings, work of CHA and telemonitoring was initiated, to ensure the teams a qualified synthesis of the recommendations. The need for adequacy of the work process through teleservice was highlighted, in exchange for taking advantage of pre-pandemic experiences and liaising with the sectors of the state secretariat responsible for this type of action. Virtual debates were also promoted to address topics such as diagnostic tests, committee work and PHC work focused on the territory.

In the process, there were virtual meetings with municipal managers to formalize recommendations that addressed the following aspects:

a) protocol of activities for CHA, aimed at identifying risk groups; telemonitoring; reception and tracking of respiratory symptoms;

b) teleservice proposals in PHC;

c) expansion of remote work with rotation of teams in the units, meeting the needs of workers from risk groups;

d) update on attention to respiratory emergencies;

e) protection measures, rational use and adequate supply of PPE.

Discussion

The situation of the Units knowledge facilitated the articulation between university, management bodies and health workers. The experience allowed the deepening of discussions and collaboration in the search for feasible solutions that are appropriate to the local reality. The understanding of the process and working conditions of the teams was fundamental for the elaboration of proposals at a dynamic moment of guidance from national and international health authorities.

It is evident how the low coverage of PHC in large urban centers[17] becomes an obstacle at this time. These localities, with immense social inequalities, require the strengthening of longitudinal care, with regular monitoring and bonding to effect equity and, consequently, integrality. However, existing teams face both

the work overload related to the higher demand for care, and face an exacerbated volume of new information, amid the fragility in the scope of work management, continuing education and matrix support.

Reorganization of work in adverse conditions requires multiple efforts. In this respect, the WG considers that it had a relevant role, identifying demands and seeking to give quick and practical answers, giving meaning to the principle of decentralization of health actions, to better meet local demands. An innovative element, in relation to the experiences of articulation already experienced between universities and services[12], was the fact that the WG emerged from the initiative of professional entities and with continuous action.

Positive points stand out: the identification of a group of workers involved with PHC and committed to acting on evidence; the network of collaboration within the WG itself, in which people with scientific accumulation and institutional practices contributed to a space of debate, with exchange of knowledge, experiences and search for solutions.

As a support WG, the role of analytical and proposition was fulfilled, and good support of the teams was obtained. However, more impactal consequences for PHC, with regard to the structure of the units and the development of the work of professionals, depend on the conjunction of technical-scientific, political and administrative decisions on the part of managers.

The limits found were: the establishment of a link with the teams only by telephone or e-mail, the definition of the WGs own function and articulation with the Municipal Health Department, in addition to the risk of creating increased expectation by PHC teams and the impossibility of monitoring the total number of units in the municipality, due to the small number of people.

Final Considerations

The importance of Primary Health Care to cope with COVID-19 is faced with the numerous challenges in its implementation, especially in large cities. Given its strategic role, the work in the territories and the potential to order the use of the care network, it was necessary to mobilize actors to potentiate these actions. The precarious conditions of Primary Health Care imply adequate response disorganization in times of health emergencies.

Faced with weaknesses derived from the entire historical process of implementation of PHC, the moment requires technical actions, but also strategic and creative proposals, through new arrangements and multiple eyes capable of responding to the health emergency. This experience highlights the importance of the technical dimension and the need for political articulation, to influence the decision-making process and enable the implementation of actions. Every political construction is procedural and requires constant negotiation skills.

In this sense, the experienced WG pointed out new ways to strengthen participatory management and enhance institutional support in coping with complex situations. The knowledge produced and the search for solutions, through situational diagnosis in a collaborative way, increases the capacity for effective action for the reality worked, besides allowing the articulation of institutional actors that can achieve alternatives for strengthening PHC in the post-pandemic.

Collaborations:

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2 – writing of the article and relevant critical review of the intellectual content: Daniela Gomes dos Santos Biscarde, Ednir Assis Souza, Karina Araújo Pinto, Livia Angeli Silva, Melissa Almeida Silva and Maria Enoy Neves Gusmão;

3 – final approval of the version to be published: Daniela Gomes dos Santos Biscarde

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