

Primary healthcare in times of COVID-19: what to do?

Atenção primária à saúde em tempos de
COVID-19: o que fazer?

Atención primaria en salud en tiempos de la
COVID-19: ¿qué debemos hacer?

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The COVID-19 pandemic poses an unprecedented challenge for science and society, demanding rapid and diverse responses by health systems that need to be reorganized in all their components.

In Brazil and in various countries elsewhere in the world, the health response has centered on hospital services, expanding the number of beds, especially in intensive care units, and mechanical ventilators. Without denying the importance of adequate structuring of specialized care for more serious cases of COVID-19, much can and must be done in the sphere of primary healthcare (PHC).

In the absence of vaccines and specific drugs and due to the infection's high transmissibility, the only effective interventions to control the pandemic are public health measures such as isolation, social distancing, and case surveillance in order to reduce transmission, thereby avoiding suffering and death by slowing the pandemic's pace. It is also necessary to supply the system with resources to provide adequate and timely care¹.

Thus, the reorganization of PHC services to simultaneously fight the epidemic and maintain the regular supply of its activities is crucial. Documents and reports in Brazil have emphasized necessary leadership role and readjustment of PHC in this context^{2,3}. Even acknowledging various weaknesses in the action by Family Health Strategy (FHS) teams, PHC is the most adequate model, given its attributes of territorial responsibility and community orientation, to support populations in social isolation; more than ever, it is necessary to maintain the contacts and bonds with the professionals caring for the population's health.

This article analyzes the possibilities for action by PHC services in the Brazilian Unified National Health System's (SUS) network who contribute to controlling the epidemic and simultaneously play their essential role of guaranteeing daily and capillary care.

Lines for PHC intervention

Fighting the pandemic requires drafting risk management plans⁴ at various levels (national, state, municipal, and local), strengthening action in the territory, with the following: the population to be monitored (mild COVID-19 cases and other health problems); adequate protection of health professionals with safe conditions for performing their work, while preventing them from serving as a source of transmission; organizational changes consistent with the local reality; the needs for logistic

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and operational support (including transportation, material, and safety and protective equipment); health professionals' training and continuing education; mapping each territory's potentialities and difficulties; the necessary backing for coordinated action between PHC and other institutions and health services in the territory covered by the teams or outside it; and partnership with community organizations, bolstering local skills and encouraging solidarity.

The work by PHC can be systematized along four lines: (i) health surveillance in the territories; (ii) care for users with COVID-19; (iii) social support for vulnerable groups; and (iv) continuity of regular PHC activities.

Health surveillance in the territories

Aimed at blocking and reducing the risk of COVID-19 expansion, PHC should be involved in the epidemic's risk management, acting in cooperation with health surveillance in the municipalities, establishing two-way information flows to improve the quality of activities.

Case notification, detection, and follow-up with home isolation of cases and contact quarantine are central activities for mitigating the epidemic, to be developed by PHC teams.

Social isolation can be encouraged by all members of the team, especially the community health workers, mobilizing local leaders and resources with ample sharing of information and concrete measures. The literature has shown that community health workers are important allies in confronting epidemics⁵, especially in awareness-raising of the population and fighting the stigma related to the disease; this highlights their role in disseminating correct information on COVID-19 prevention, fighting fake news, and supporting educational activities in the territory, related to workers' and users' hygiene and protection in the various social installations to make them safe environments for the population.

Care for PHC users with COVID-19

Different flows have been implemented for the care of patients with mild forms of COVID-19, separating those with respiratory symptoms from users with other problems requiring face-to-face care, identifying and orienting individuals at increased risk of developing serious forms and guaranteeing timely referral of those needing care at other levels^{6,7}.

Modalities of online care have been prioritized and widely disseminated, creating the need to extend rapid access to cellphones and internet for health professionals and users. Remote consultations should be based on protocols with clear and objective messages, with preference for video, since it facilitates monitoring vital signs⁸.

Quality of care in PHC and continuity of care for COVID-19 patients can only be ensured with adequate resources that guarantee patient safety and problem-resolution capacity. In the evaluation of case severity and evolution, measurement of blood oxygen saturation is important, and it is necessary to provide oximeters to the teams for use in triage, face-to-face and home care, and follow-up of suspected and confirmed cases. As for continuity of patient care, PHC services need to be integrated with emergency hospital care and patient transport, associated with the regulation of beds with the definition of open and agile communication flows and channels to guarantee timely care according to case severity.

Social support and vulnerable groups

The FHS has expanded its action in response to the needs of socially vulnerable populations and risk groups, such as the elderly and individuals with comorbidities, living daily in situations of isolation or restrictions, now exacerbated during the pandemic.

In order to effectively follow the preventive guidelines for COVID-19, this population will need all kinds of support (health, financial, psychological, and social), including care in the health services network and social protection mechanisms.

Finding the best solutions to serious and diverse problems in the most vulnerable population groups requires coordinated action in the territory with local leaders, services, and institutions, link-

ing activities implemented by the teams to community initiatives, many of which were already underway, highlighting community engagement as an important global strategy for fighting the pandemic⁹. Key proposals include the supply of shelter in hotels, schools, or other installations for persons at risk (elderly, chronic patients living alone, women victims of violence, and homeless people) and home support for older people who have difficulties supporting and caring for themselves. Community engagement initiatives have been observed in experiences of solidarity, in which the communities themselves are organizing to distribute food baskets, mask-making by local artisans, and use of schools for isolating mild cases of COVID-19¹⁰.

Continuity of regular PHC activities

Routine PHC activities need to be maintained during the pandemic, among other reasons because the forecasts indicate that we will be living with the novel coronavirus for a long time, alternating between more and less social isolation, requiring adjustment of certain procedures and incorporation of others in order for PHC to fulfill its mission, including new forms of remote daily care, avoiding the risk of further aggravating exclusion from access and social inequalities.

The use of information and communication technologies such as WhatsApp and telephone for teleconsultations guarantee the safe supply of activities, in order to avoid discontinuity of care and aggravation of conditions in users under treatment. A suggestion is to respond to users' frequent demands – such as renewing prescriptions and distributing medications – in ways that avoid their need to visit the PHC service in person, by prolonging the time on the prescriptions and providing for home delivery of the medications by community health workers, while adopting the necessary precautions.

Telephone contacts with previously scheduled patients and teleconsultations with physicians and nurses from the team or medical residents and interns, plus the creation of an agenda for teleconsultations, are initiatives suggested by experiences underway¹¹, recalling that face-to-face appointments will be maintained for some, as well as other routine activities, such as vaccination, which should be administered without exposing the population to the risk of COVID-19 transmission.

Final remarks

The shortcomings of international experiences with attempts to confront the pandemic centered on individual hospital care have emphasized the need for a more territorialized, community-centered, and home-based approach, mobilizing strong and comprehensive PHC with all its potential. The Brazilian model, with its family health teams and territorial focus, had positive impacts on the population's health and plays an important role in the healthcare network, besides contributing vigorously to the community approach needed to fight any epidemic.

Despite this potential, the attempts since 2017 at dismantling the FHS, with the reduction in the number of community health workers, greater flexibility in health professionals' workweek, elimination of the priority for the fhs, extinction of the Family Health Support Centers in Basic Healthcare (NASF-AB), loss of professionals with the extinction of the More Doctors Program, disincentives to the territorial approach with the new model of financing basic care based on the number of enrolled users, and undermining the community focus, among others¹², represent important constraints on adequate action by PHC in fighting the pandemic.

These recent threats add to problems chronically faced by PHC in Brazil. Some of the obstacles to the action required by the FHS in the current pandemic include precarious labor relations in most teams, contracting-out to the so-called social organizations and other forms of management privatization in primary care units that commodify relations and undermine relations and bonds, organizational problems with low integration between PHC and other levels of care in the regionalized network, compromising coordination and continuity, with fragmentation of care and insufficient mediation of inter-sector activities to impact social determination, promote health, and reduce inequalities¹³.

The current health crisis amplified the existing debilities and has requires additional federal transfers to the states and municipalities, although insufficient to support the surveillance activities

and care for the population. Even with all these obstacles, more than 40,000 FHS teams throughout the country, 260,000 community health workers, 26,000 oral health teams, and 5,000 NASF represent the foundations of the SUS and should be strengthened in order for Brazil to successfully fight this pandemic.

Even with all the difficulties, the capillarity and strength of Brazil's FHS workforce and the numerous successful municipal and local experiences have demonstrated the family health teams' force and resilience in widely diverse contexts.

More than ever, we need PHC in a strong, vigilant, and capillary SUS, adapted to the context and faithful to its principles. The current planetary health, political, economic, and social crisis requires innovation in the operation and radicalization of the community intervention logic in exercising new forms of sociability and solidarity.

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