

Civil society and community social support initiatives for vulnerable groups in primary care center catchment areas: the role of the FHS during the pandemic

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Abstract *The pandemic highlighted new and old health risks that require health actions and social support. This study analyzed the knowledge of health professionals working in primary health care centers (PHCCs) regarding civil society and health service separately or along with health promotion and social support initiatives targeting vulnerable groups. The article begins by discussing the concept of social support and then goes on to present an analysis of empirical data from the multidimensional cross-sectional study “Challenges facing primary health care in the response to COVID-19 in the SUS”, conducted using a nationally representative sample of PHCCs. Scores were calculated for selected and aggregated variables, and we calculated percentages for selected actions together with 95% confidence intervals at national and regional level. The percentage of PHCCs that supported actions and where the local community developed initiatives in the catchment area varied across regions, with rates being significantly higher in the Northeast and in non-urban municipalities with low MHDI, which was associated with actions developed in the catchment area by community health workers. The findings reveal several gaps and challenges, including the need to amplify the magnitude and scope of intra and intersectoral actions, strengthen ties between different actors, reverse the effects of the pandemic on health inequities and promote further research.*

Key words *Social support, Primary Health Care, Intersectorality, COVID-19, Pandemic*

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Introduction

The pandemic cast light on historically neglected societal demands. Vulnerability to infection was exacerbated by the exclusion of the homeless and peripheral communities, increased domestic violence, drug use and depression, requiring health care and specific forms of social support.

This type of situation requires government and community capacity to respond and the freeing up of resources for health and social protection systems. First, surveillance actions should be developed, provide continuity of health care and act in emergencies. Second, social actions are required to articulate principles such as comprehensiveness and solidarity and support social inclusion. Such actions include cash transfer programs to meet material needs created by disruption to employment and circulation, the distribution of hygiene supplies and food, communication of risks and social distancing and quarantine measures, as well as support for the mental health of the population and health workers.

The comprehensive study “*Desafios da Atenção Básica no enfrentamento à pandemia de COVID-19 no SUS*” (Challenges facing primary health care in the response to the COVID-19 pandemic in the SUS) sought to identify innovative local strategies addressing the organization of services, management of essential health services, surveillance and COVID-19 care, as well as measures that facilitate access using new technologies and procedures (electronic prescription, monitoring, remote consultations, etc.).

More specifically, the study design included the dimension “social support for vulnerable groups”, encompassing health promotion initiatives developed by health services, society and communities, community and intersectoral actions in response to the health, financial, psychological and social needs of the population aggravated by the COVID-19 pandemic, and prevention measures. The study did not consider ethnic and gender inequalities in Brazilian society that differentially affect the health-disease process in multiple minority groups.

Social support means offering the social and psychological assistance necessary to guarantee comprehensive, solidary social protection. It implies the identification of the most vulnerable groups or those at greatest risk of illness due to underlying health conditions, supported by the conceptualization of vulnerability and concept mapping, promoting community engagement and empowerment¹.

In the years leading up to the pandemic, the community-based approach, one of the premises underpinning the expansion of the Family Health Strategy (FHS), was partly neglected and fractured due to limitations of the work of community health workers (CHWs) and family health teams and a reduction of actions supporting vulnerable groups like children, older persons, people with disabilities and other minorities². In addition to these imposed identifiable weaknesses, backward steps were taken in the National Primary Care Policy (PNAB) and labor and social security reforms, deeply affecting social conditions and relations, the nature and management of employment contracts, and welfare benefits at a national, regional and local level^{3,4}.

This article looks at the theories that underpin the concept of social support and its application to social reality. It draws on literature reviews charting the trajectory of the concept and reframing the approach in the context of COVID-19, reinforcing its role in health systems, particularly in primary care, and performance expectations in order to cast light on differences and singularities across the territory. The aim of this study was to analyze the knowledge of health professionals working in primary care centers (PHCCs) about the existence and integration of civil society and health service health promotion and social support initiatives targeting vulnerable groups.

In the tradition of the human and social sciences there is an equivalence between the terms social “assistance” and “support”. This article departs from a more restricted view of social support as help provided by one person to another in the face of a problem or challenge. The focus is on resolving or, at least, alleviating the stress attributed to the problem, or factors capable of protecting or promoting health⁵.

According to Lacerda⁶, social support is one of the strategies used by individuals to cope with the complexity of health-related problems, especially in face of the limitations of public health services in terms of access, responsiveness and cure. It provides both physical and mental health benefits, because it comforts and cares for the person’s body and mind as a whole. The author articulates sociological theories of social support with the concept of the totality of subjects involved in health promotion in the field of public health, where health practices meet the demand and need for comprehensive health care.

Valla⁷ highlighted the relationship between the international crisis of the state as provider

caused by globalization in the 1980s and 1990s and the interaction between popular classes and health services in Brazil. High levels of income inequality and social exclusion have produced another world in which survival is related to solidarity, and where the social needs that give individuals access to services are mediated by social support.

This debate has given rise to the concept of family and community social support networks as “a group of systems and significant people who make up the relationship links received and perceived by an individual”⁸. Historically, the notion of social support also referred to the interaction between workers and their coworkers, and management in the workplace⁹, facilitating or not social integration.

Cited by Siqueira^{5,10,11}, the investigations of Cobb (1976) and Cohen and Wills (1985) emphasized the interface between the social environment and health, seeking to “identify types of relationships that are beneficial to health and analyze how experiences of social relationships impact physical health and how it would be possible to intervene in the social environment to promote and protect health”.

Social support has beneficial effects on both physical and mental health and harbors a close relationship with well-being¹². It is a multidimensional concept that encompasses the material and psychological resources that people access through their social networks. From a social anthropology perspective, networks exert power over the social behavior of the people involved in them⁵. In the same vein, Valla⁷ underlines the role of social support networks in participatory and collaborative processes, unlike approaches mores focused on the individual/patient.

In the 1970s, the sociological approach sought to describe the absence of intervention by social services and the institutionalization of social measures via patient support services, the strengthening of community leaders and political engagement in public participation, and the collaborative construction of knowledge.

From a psychological perspective, recovered by Siqueira⁵, the information that enables individuals process what they understand by social support is underpinned by three forms of perception of reality in the realm of affectivity – being loved and having people who care; being appreciated and valued; and belonging to a social network. In other words, supportive social relationships are also associated with the extent to which a person satisfies their individual needs in

interactions with others in networks within permanent education processes.

In the 1980s, studies attempted to classify and measure social support initiatives and the quantity of interactions maintained by individuals in relation to the structural characteristics, nature and intensity of their networks – intimacy, reciprocity and public participation; and satisfaction with the support offered in relation to individual needs⁵.

In the 1990s, support networks were defined in terms of the specific features of the ties that unite a group of people with social contact or as interactive processes that provide sources of social support for their members¹¹. Cohen classifies support as follows: emotional support, through the expression of affection; instrumental support, in the form of help and objective and useful personal or institutional practices; and informational support for decision-making. There is no consensus among scholars regarding the latter, with some authors suggesting that instrumental support includes informational support, the latter not being a specific type of support.

While the focus of the first group of studies was the individual, more recent studies have investigated these relations (social ties and support) in the work environment in organizations. In Brazil, where organizations offer various types of support necessary for staff to perform their work activities, it is no different, with studies seeking to construct and validate the Scale of Perceived Social Support^{12,13}.

Fonseca and Moura¹⁴ studied the influence of social support in the work environment on workers' health and behavior. According to the authors, interpersonal relationships and attitudes and behaviors mutually influence each other due to willingness to trust, demonstrate concern for the other, value others, communicate, help and assist using available resources, minimizing illness and facilitating the performance of work tasks by the group that absorbs social support¹⁴.

In 2012, the journal *Ciência & Saúde Coletiva* returned to the theme of social support in a thematic edition and editorial written by Ana Maria Canesqui¹⁵, revisiting Valla's analysis⁷, where he highlights the complementarity of social support and social protection.

With regard to social inequalities and the debate surrounding new and old social and health needs during different stages of the lifecycle and various health risks without adequate intersectoral social policies and humanized care in social and health services, Canesqui¹⁵ draws attention

to the fact that life, especially in urban centers, has become almost impossible in terms of poverty and social interaction, highlighting as consequences a certain degree of isolation and social vulnerability determined by living conditions.

Canesqui and Barsaglini¹⁶ point out that the “national literature dialogues less with psychosocial theories and more with sociological and anthropological theories, highlighting the support approach with social networks, solidarity, sharing and cultural values, shifting from the individual and private sphere to civil society organizational capacity and collective actions”.

In Brazil, the lack of a comprehensive social protection policy led to the creation of statutes targeting specific social groups (children and adolescents, older persons and people with disabilities), a review of parental relationships and the expansion of primary health care service coverage. The latter took a humanized approach in partnership with families, vesting these groups with a new status, as subjects of rights and beneficiaries of welfare benefits.

Regarding social vulnerability and poverty, Canesqui¹⁵ views social support policies as a stimulus to relationships and social bonds with a view to strengthening society to counterbalance the weakening of the social fabric and individualization driven by structural changes in production, interpersonal relationships and power in modern society.

Her aim was to think of new consolidated social advances and overcome the fragmented view of support as a resource, instrument and neutral object detached from social protection and health policies, social and power relations, inequalities and the dynamics of social processes. Through this approach, it is possible to create another meaning for meeting the social needs of different social groups incorporated into comprehensive social assistance, cash transfer, education and health programs, even when these programs depend on the state without neglecting individual aspects.

Today, against a fragmented social and political backdrop, the new health emergency caused by the spread of the virus and the lukewarm response of the government and Brazilian society, is characterized by the poor quality of political debate, lack of consensus regarding emergency support measures^{17,18} and disinformation¹⁹ about the virus, its spread and prevention and treatment, the health situation of the population worsens. The impacts of contradictory communications about health and life need to be given greater at-

ention and minimized²⁰ through the implementation of community initiatives and other resilient social services targeting these issues.

In short, the identification of different approaches to social support that certainly cut across the intended analysis of this dimension in the response to the COVID-19 pandemic, as well as health system performance in times of crisis, indicate new challenges for the organization of strong, coordinated, responsive and comprehensive PHC²¹.

Methodology

We conducted a cross-sectional study with a nationally representative sample of PHCCs covering each of the country's five regions: North (N), Northeast (NE), Midwest (MW), South (S) and Southeast (SE)). The sample was randomly selected from the PHCCs registered in the National Registry of Health Facilities (CNES) up to December 2020. The sample was stratified by region, with sample size being calculated proportionately based on the number of registered PHCCs in each region. The national sample size was set at 750 centers and increased to 945, taking into account a potential loss rate of 20%. Sampling error was 3.92 and the design effect was 1.20 due to the weighting adopted²².

A trained team of interviewers contacted the coordinator of each PHCC and/or a health professional with a degree-level qualification who had been working in the center for at least six months. The individual who could best answer the questionnaire was invited to complete an online survey, whose link was sent to respondents after they accepted to participate.

Conducted between July and November 2021, the survey addressed a range of topics, including a specific block of questions about social support during the COVID-19 response. The respondents were asked the following questions: 1) “Are the activities below developed within the PHCC catchment area?” (yes, with the support of the PHCC/yes, without the support of the PHCC/no). The activities were as follows: a) Distribution of food baskets; b) Distribution of personal hygiene items; c) Access to and completion of registration in the *Bolsa Família* (cash transfer program); d) Distribution of masks; and e) Support for women subjected to domestic violence; 2) “Would you say that following the COVID-19 pandemic, the population living in the catchment area developed initiatives to...” a) Improve access

to water; b) Improve cleaning of public spaces; c) Expand access to food through the distribution of meals; d) Tackle fake news about COVID-19; e) Ensure adequate conditions for social isolation (yes/no/do not know); 3) “Did your PHCC coordinate COVID-19 response actions with social movements?” (yes/no/do not know) and “Did the PHCC coordinate COVID-19 response actions with other sectors (city council departments, businesses, churches)?” (yes/no/do not know).

The Social support core component was assessed using a score based on a set of aggregated variables related to: 1) social support activities (considered comprehensive when the answer to question was yes to both items 1.1) distribution of food baskets with the support of the PHCC and distribution of food baskets to families experiencing food insecurity by CHWs and 1.2) Access to and completion of registration in the *Bolsa Família* with the support of the PHCC and identification of socially vulnerable people by CHWs); 2) popular initiatives in the catchment area: PHCCs that were aware of existing activities received the maximum score; and 3) coordination of actions with social movements and other sectors, with PHCCs answering yes for both items obtaining the maximum score.

The social support variables were analyzed at national and regional using percentages and respective confidence intervals (95%CI). The significance of differences between the percentages were assessed using the chi-squared test with Rao-Scott correction for complex samples, adopting a 5% significance level.

The Social support core component was dichotomized by the median (58 points) and compared to the other core component scores (COVID-19 patient care; Health surveillance and Continuity of care) and variables from other question blocks (vaccination; CHWs and PHCC management)²². The association between these variables and the results of the Social support core component was tested to assess the benefits of activities developed in the catchment areas, particularly health surveillance and PHCC management, while caring and valuing FHS professionals. The variables related to the predominant presence of CHWs in the catchment area, contact tracing, administration of vaccination in the PHCC and psychological support for health care workers were compared to the results of the core component categorized by the median using the chi-squared test.

The Mann-Whitney test was used to compare the mean scores of the core components that

make up the overall index²² and the aggregated variables from the Social support core component according to the Municipal Human Development Index (MHDI) and area (intermediate municipalities and rural adjacent or remote municipalities).

The Kruskal-Wallis and Dunn’s tests for multiple comparisons with Bonferroni adjustment were used to compare core components and aggregate variables across regions²².

The study was conducted in accordance with ethical norms and standards and the study protocol was approved by the ethics committee of the School of Public Health, São Paulo University (reference numbers CAAE 31414420.8.0000.5421 and 4.827.811).

Results

A total of 907 of the 945 PHCCs (95.8%) participated in the study, with a response rate of over 90% across all regions. Over half the respondents (64%) were center managers and 62.5% were professionals who had been working in the center for more than three years. The overwhelming majority of respondents (82.9%) were nurses, followed by doctors (7.8%).

Table 1 shows the social support activities developed during the response to the COVID-19 pandemic at national and regional level in 2021. Statistically significant differences were found in the distribution of food baskets and personal hygiene items and access to and completion of registration in the *Bolsa Família* program with the support of the PHCC across regions ($p < 0.05$). Almost half of the PHCCs in the N and NE did not distribute food baskets (48.8% and 47.8%, respectively) in the catchment area, compared to 41.8% at national level. However, CHWs complemented this activity, distributing food baskets to households experiencing food insecurity in 76% of PHCCs (Table 1).

Over half of the PHCCs at national level did not distribute personal hygiene items, with rates varying between 51.6% and 63.2%. The distribution of personal hygiene items was the activity with the lowest level of support from PHCCs: 18.9% (Brazil), varying between 16.1% and 27.1% (S and MW, respectively) (Table 1).

Most PHCCs supported access to and completion of registration in the *Bolsa Família* program, with the highest rates being found in the N, NE and MW (64.8%, 62.4% and 62.3%, respectively). The work of CHWs tends to enhance

this activity, with the former identifying socially vulnerable individuals in the catchment area in 93% of PHCCs (Table 1).

The distribution of masks was considerable across all regions, with 58.9% of respondents reporting that these items were distributed in the catchment area with or without the support of the PHCC, ranging from 50.8% to 61.5%. Most PHCCs (78.1%) supported this activity. Support for women subjected to domestic violence, with or without the support of the PHCC, was report-

ed in 67% of the PHCCs, with a non-significant variation of 8.1% across regions.

Table 2 shows some of the initiatives developed by the local community in PHCC catchment areas in response to the pandemic at national and regional level. The NE stands out in relation to improvements in access to water (41.6% x 26.9%), cleaning of public spaces (61.1% x 48.5%), access to healthy food though the distribution of meals (27% x 22.3%) and ensuring adequate conditions for social isolation

Table 1. Social support activities developed in PHCC catchment areas in response to the COVID-19 pandemic^a. Brazil and regions, 2021.

Social support activities		North % (95%CI)	Northeast % (95%CI)	Southeast % (95%CI)	South % (95%CI)	Midwest % (95%CI)	Brazil ^b % (95%CI)
Distribution of food baskets ^c p=0.0094*	Yes (with the support of the PHCC)	28.80 (21.51-37.38)	26.99 (21.59-33.17)	31.45 (25.96-37.52)	26.34 (20.49-33.17)	37.70 (29.52-46.66)	29.32 (26.27-32.57)
	Yes (without the support of the PHCC)	22.40 (15.91-30.58)	25.22 (19.97-31.31)	33.47 (27.85-39.59)	35.48 (28.92-42.65)	22.95 (16.31-31.29)	28.88 (25.85-32.11)
	No	48.80 (40.12-57.56)	47.79 (41.33-54.32)	35.08 (29.38-41.25)	38.17 (31.45-45.38)	39.34 (31.04-48.31)	41.80 (38.43-45.25)
Distribution of personal hygiene items p=0.0239*	Yes (with the support of the PHCC)	23.20 (16.60-31.44)	18.58 (14.02-24.22)	17.34 (13.11-22.58)	16.13 (11.50-22.16)	27.05 (19.88-35.65)	18.90 (16.34-21.75)
	Yes (without the support of the PHCC)	13.60 (8.603-20.84)	20.80 (15.98-26.60)	28.63 (23.33-34.59)	29.57 (23.43-36.55)	21.31 (14.91-29.51)	23.96 (21.14-27.03)
	No	63.20 (54.37-71.22)	60.62 (54.08-66.80)	54.03 (47.78-60.16)	54.30 (47.07-61.35)	51.64 (42.77-60.41)	57.14 (53.68-60.53)
Access to and completion of registration in the <i>Bolsa Família</i> program ^d p=0.0003*	Yes (with the support of the PHCC)	64.80 (56.00-72.70)	62.39 (55.87-68.49)	47.58 (41.41-53.82)	50.00 (42.84-57.16)	62.30 (53.34-70.48)	56.12 (52.68-59.50)
	Yes (without the support of the PHCC)	12.00 (7.35-19.00)	17.26 (12.86-22.77)	29.03 (23.70-35.01)	23.12 (17.60-29.75)	13.93 (8.82-21.32)	21.13 (18.45-24.09)
	No	23.20 (16.60-31.44)	20.35 (15.59-26.13)	23.39 (18.52-29.08)	26.88 (20.98-33.73)	23.77 (17.02-32.17)	22.75 (19.99-25.77)
Distribution of masks p=0.3824	Yes (with the support of the PHCC)	44.00 (35.52-52.84)	49.56 (43.06-56.07)	45.56 (39.45-51.82)	46.24 (39.17-53.46)	37.70 (29.52-46.66)	46.41 (42.96-49.89)
	Yes (without the support of the PHCC)	7.20 (3.78-13.30)	11.95 (8.31-16.88)	14.11 (10.30-19.04)	12.90 (8.79-18.56)	13.11 (8.17-20.39)	12.46 (10.33-14.95)
	No	48.80 (40.12-57.56)	38.50 (32.36-45.02)	40.32 (34.38-46.57)	40.86 (34.00-48.10)	49.18 (40.38-58.03)	41.13 (37.77-44.57)
Support for women subjected to domestic violence p=0.2991	Yes (with the support of the PHCC)	61.60 (52.75-69.74)	68.14 (61.76-73.91)	65.73 (59.58-71.39)	67.74 (60.67-74.09)	69.67 (60.91-77.20)	66.88 (63.53-70.06)
	Yes (without the support of the PHCC)	11.20 (6.73-18.07)	7.52 (4.72-11.78)	13.71 (9.95-18.59)	10.22 (6.60-15.48)	9.02 (5.05-15.59)	10.31 (8.40-12.58)
	No	27.20 (20.09-35.70)	24.34 (19.17-30.38)	20.56 (15.97-26.07)	22.04 (16.64-28.60)	21.31 (14.91-29.51)	22.82 (20.03-25.87)

Notes: PHCC: primary care center. ^aNumber of replies: Brazil = 907; North = 125; Northeast = 226; Southeast = 248; South = 186; Midwest = 122;

^bNational result calculated considering sampling weights; ^cDistribution of food baskets by CHWs to households experiencing food insecurity - total 76.36% (73.19-79.26); ^dIdentification of socially vulnerable people by CHWs - total: 92.88% (90.84-94.49).

Source: Data from a national survey conducted by the Brazilian Association of Collective Health's PHC Research Network "Challenges facing primary health care in the response to the COVID-19 pandemic in the SUS", 2021.

(61.1% x 52.6%). Differences across regions were statistically significant ($p < 0.05$). Differences in tackling fake news across regions (31%) were not statistically significant. The lack of knowledge of the PHCC about these initiatives is noteworthy: it ranged from 12.8% to 25.6%, with the greatest lack of knowledge about improving access to water and food.

PHCCs were more likely to coordinate actions with other sectors (42.2% of PHCCs), including businesses and churches, than social movements (29.9%) (Table 3). The lack of knowledge was less than 10%, much lower than that of the population's initiatives in the territory. No

significant difference was found between the regions. No statistically significant differences were found across regions.

In short, the Social Support axis showed significant differences between the regions, with those in the NE region being higher than those in the S and SE regions.

When compared to the aggregate variables, according to urban/non-urban situation and MHDl categorized by its median (0.70), the results were significantly higher in PHCC in rural and intermediate municipalities, with MHDl below the median (Graph 1). It is worth noting that the results were significant for the axis and two of

Table 2. Initiatives developed by the local community in PHCC catchment areas in response to the pandemic^a. Brazil and regions, 2021.

Initiatives		North % (95%CI)	Northeast % (95%CI)	Southeast % (95%CI)	South % (95%CI)	Midwest % (95%CI)	Brazil ^b % (95%CI)
Improvements in access to water $p < 0.0001^*$	Yes	28.80 (21.51-37.38)	41.59 (35.32-48.15)	15.73 (11.69-20.82)	14.59 (10.19-20.47)	22.13 (15.61-30.40)	26.93 (23.99-30.09)
	No	49.60 (40.89-58.33)	35.84 (29.84-42.33)	56.45 (50.19-62.51)	56.22 (48.96-63.22)	49.18 (40.38-58.03)	47.50 (44.11-50.91)
	Do not know	21.60 (15.22-29.72)	22.57 (17.57-28.50)	27.82 (22.58-33.75)	29.19 (23.07-36.17)	28.69 (21.33-37.38)	25.57 (22.68-28.7)
Improvements in cleaning of public spaces $p < 0.0001^*$	Yes	48.80 (40.12-57.56)	61.06 (54.53-67.22)	38.71 (32.83-44.94)	38.92 (32.14-46.16)	45.08 (36.45-54.02)	48.52 (45.13-51.93)
	No	38.40 (30.26-47.25)	29.20 (23.63-35.49)	42.74 (36.00-71.49)	45.95 (38.87-53.19)	41.80 (33.35-50.77)	37.65 (34.40-41.01)
	Do not know	12.80 (7.97-19.92)	9.74 (6.49-14.36)	18.55 (14.17-23.90)	15.14 (10.64-21.08)	13.11 (8.17-20.39)	13.83 (11.64-16.36)
Improving access to food through the distribution of meals $p = 0.0454^*$	Yes	19.20 (13.19-27.10)	26.99 (21.59-33.17)	20.16 (15.61-25.64)	15.14 (10.64-21.08)	24.59 (17.73-33.04)	22.30 (19.50-25.36)
	No	54.40 (45.58-62.96)	53.54 (46.99-59.97)	56.05 (49.79-62.12)	54.59 (47.35-61.65)	58.20 (49.23-66.65)	54.93 (51.44-58.37)
	Do not know	26.40 (19.39-34.85)	19.47 (14.80-25.17)	23.79 (18.89-29.51)	30.27 (24.06-37.30)	17.21 (11.47-25.01)	22.78 (20.03-25.78)
Combating fake news about COVID-19 $p = 0.0648$	Yes	30.40 (22.94-39.05)	35.84 (29.84-42.33)	29.03 (23.70-35.01)	21.62 (16.26-28.16)	32.79 (25.01-41.64)	30.97 (27.83-34.30)
	No	44.80 (36.28-53.64)	45.58 (39.17-52.13)	44.76 (38.66-51.02)	52.43 (45.21-59.56)	47.54 (38.80-56.43)	46.36 (42.92-49.84)
	Do not know	24.80 (17.98-33.15)	18.58 (14.02-24.22)	26.21 (21.10-32.06)	25.95 (20.12-32.77)	19.67 (13.52-27.73)	22.67 (19.92-25.67)
Ensuring adequate conditions for social isolation $p = 0.0104^*$	Yes	50.40 (41.67-59.11)	61.06 (54.53-67.22)	46.37 (40.23-52.62)	47.03 (39.92-54.26)	49.18 (40.38-58.03)	52.56 (49.12-55.98)
	No	38.40 (30.26-47.25)	27.43 (21.99-33.64)	40.32 (34.38-46.57)	36.76 (30.10-43.97)	37.70 (29.52-46.66)	34.60 (31.42-37.92)
	Do not know	11.20 (6.73-18.07)	11.50 (7.94-16.38)	13.31 (9.61-18.15)	16.22 (11.56-22.28)	13.11 (8.17-20.39)	12.84 (10.71-15.33)

Notes: PHCC: primary care center. ^aNumber of replies: Brazil = 907; North = 125; Northeast = 226; Southeast = 248; South = 186; Midwest = 122; ^bNational result calculated considering sampling weights.

Source: Data from a national survey conducted by the Brazilian Association of Collective Health's PHC Research Network "Challenges facing primary health care in the response to the COVID-19 pandemic in the SUS", 2021.

Table 3. Coordination of actions with social movements and other sectors in response to the COVID-19 pandemic^a. Brazil and regions, 2021.

Coordination		North % (95%CI)	Northeast % (95%CI)	Southeast % (95%CI)	South % (95%CI)	Midwest % (95%CI)	Brazil ^b % (95%CI)
Social movements p=0.3824	Yes	27.20 (20.09-35.70)	32.74 (26.92-39.15)	29.84 (24.45-35.85)	23.78 (18.18-30.48)	31.15 (23.53-39.94)	29.96 (26.86-33.27)
	No	58.40 (49.54-66.75)	57.96 (51.41-64.25)	62.10 (55.88-67.94)	68.11 (61.02-74.44)	59.02 (50.05-67.42)	60.83 (57.37-64.17)
	Do not know	14.40 (9.24-21.75)	9.29 (6.13-13.85)	8.07 (5.25-12.19)	8.11 (4.94-13.04)	9.84 (5.65-16.57)	9.21 (7.40-11.41)
Other sectors (local government departments, businesses, churches) p=0.3537	Yes	47.20 (38.58-55.99)	40.71 (34.47-47.26)	40.73 (34.76-46.98)	49.19 (42.02-56.39)	36.89 (28.76-45.83)	42.15 (38.77-45.62)
	No	39.20 (31.00-48.05)	48.67 (42.19-55.20)	50.40 (44.19-56.61)	41.62 (34.71-48.88)	54.10 (45.17-62.77)	47.86 (44.40-51.34)
	Do not know	13.60 (8.60-20.84)	10.62 (7.21-15.37)	8.87 (5.90-13.12)	9.19 (5.78-14.31)	9.02 (5.05-15.59)	9.99 (8.09-12.28)

Notes: ^aNumber of replies: Brazil = 907; North = 125; Northeast = 226; Southeast = 248; South = 186; Midwest = 122; ^bNational result calculated considering sampling weights.

Source: Data from a national survey conducted by the Brazilian Association of Collective Health's PHC Research Network "Challenges facing primary health care in the response to the COVID-19 pandemic in the SUS", 2021.

its aggregate variables, relating to the joint action of the PHCC with the CHW, in the distribution of basic food baskets and enrollment in the *Bolsa Família*, as well as in social coordination actions, especially in coordination with other sectors. There was no significant difference when it came to the PHCC knowledge of population initiatives in their territory, although the values were slightly higher. However, when considering the implementation of these initiatives, all of them, except the distribution of meals, were significantly higher in the non-urban area.

The relative frequencies of the variables of the other axes that were linked to action in the territory and the axes themselves were compared, according to the performance of the Social Support axis (Graph 2). Thus, vaccination against COVID-19 at the UBS, the work of CHW in surveillance of COVID-19 cases and active contact tracing, and psychological support for health professionals showed significantly higher results, in line with the high performance of the Social Support axis (above 58.3). With regard to the predominance of the CHW work process in the territory, no significant association was found, although it was slightly higher in the same direction. Furthermore, when comparing the distributions of the mean scores and 95%CI of the PHCC, in the axes of Care for patients with COVID-19, Health Surveillance and Continuity of care, ac-

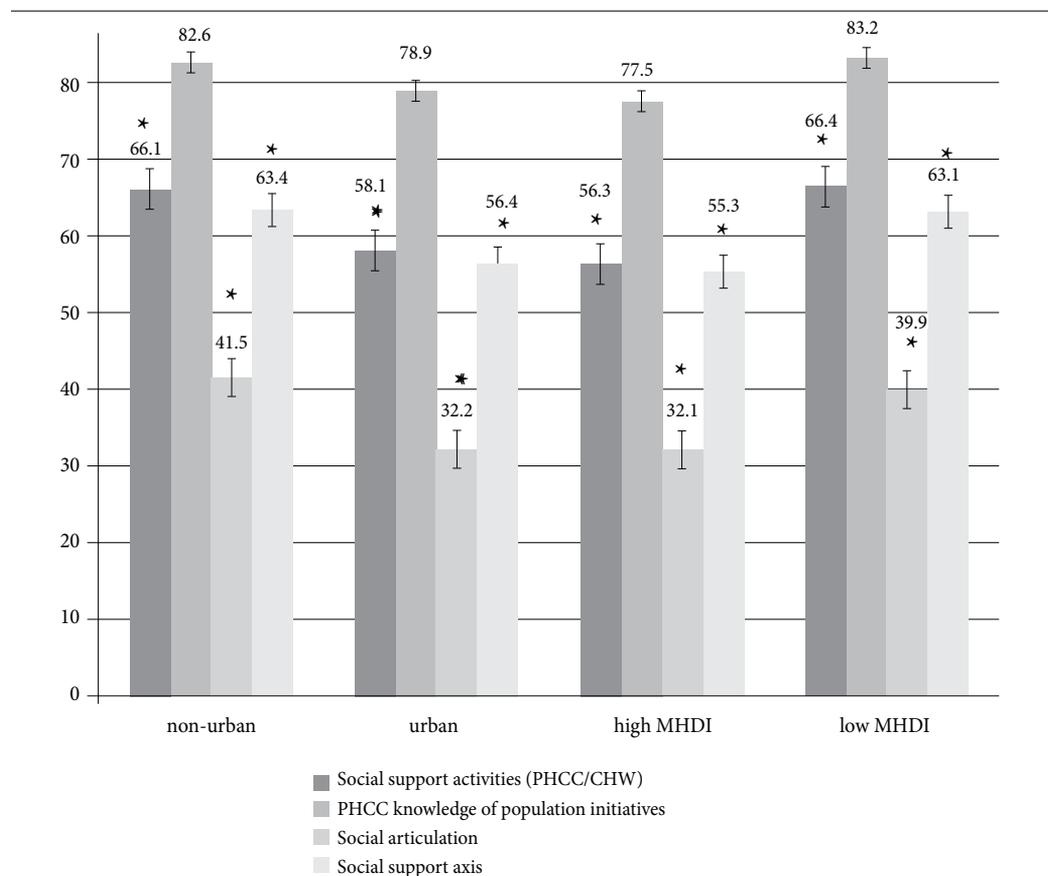
ording to the performance of the Social Support axis, their scores being significantly higher when there was a high performance of Social Support.

Discussion

Social support is characterized by understanding and getting close to the social reality of the PHCC catchment, which is done by creating material and financial social relations and promoting positive actions, that is, building a network of support to mobilize family, friends and the community around social goods and services.

Without detracting from the other dimensions addressed by the study, we seek to emphasize achievements and changes in the community and health system that can have an impact on determinants of health, promote health and reduce health inequalities supported by community-based planning and organization of health services, as envisaged by the pervading care model adopted by the FHS.

By focusing specifically on social support and assessing it together with health center managers and professionals as a dimension of PHC in the response to the pandemic, we sought to gain a broader understanding of the strengths and weaknesses of the community-based approach as the cornerstone of the country's pervading pri-



Graph 1. Mean scores and 95%CI for the Social support core component and aggregated variables by type of municipality (urban and non-urban, rural and intermediate) and MHDI (low, \leq median; high, above the median >70). Brazil, 2021.

Note: * $p < 0.01$ (Mann-Whitney test).

Source: Authors. UNDP, 2010; IBGE, 2017. Data from a national survey conducted by the Brazilian Association of Collective Health's PHC Research Network "Challenges facing primary health care in the response to the COVID-19 pandemic in the SUS", 2021.

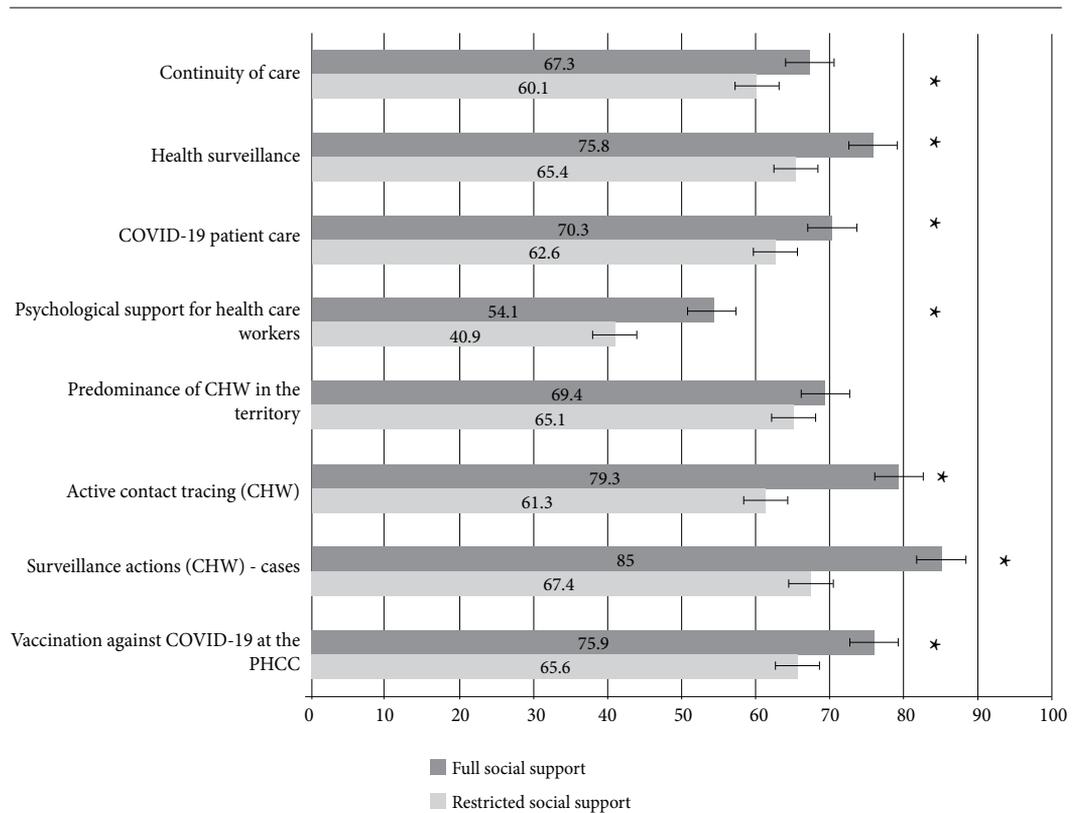
mary care model, the FHS: where it is adopted, how it manifests itself and is organized, and the participation of social groups.

The findings reveal that social support actions were strengthened in the NE, N and MW when compared to the SE and S. An example is intersectoral collaboration in the registration of families in the *Bolsa Família*, with the support from PHCCs and mobilization by CHWs in the catchment area²².

A central aspect of the response to the COVID-19 pandemic includes strengthening coordinated action in the catchment area by conceptualizing vulnerability to the effects of COVID-19¹, implementing community actions

with local leaders, groups and organizations, developing government action, and collaborating with other local government bodies and the private sector to fulfill the social function of primary health care²³.

Griep *et al.*²⁴ validated the Social Support Scale (MOS-SSS), originally developed in the US. The scale consists of five analytical dimensions: material, affective, social interaction, emotional and information. Comparisons can be drawn with this epidemiological study in two dimensions that are relevant to the pandemic: material support, through the provision of practical resources; and emotional-affective support, which refers to the network's capacity to support indi-



Graph 2. Relative frequencies and 95%CI of PHCCs for variables related to activities in the catchment from other blocks of questions and dimensions (D) compared to the results for the Social support core component (limited: \leq median; comprehensive: above the median >58.3). Brazil, 2021.

Note: * $p < 0.01$ (chi-squared test).

Source: Authors. Data from a national survey conducted by the Brazilian Association of Collective Health's PHC Research Network "Challenges facing primary health care in the response to the COVID-19 pandemic in the SUS", 2021.

viduals experiencing problems resulting from violence, depression, abandonment (this support being a protective factor in promoting health)⁵ and its positive evaluation by social support network. In the same vein, Siqueira underlines the importance of values and dimensions of action, which intertwine approaches and enrich the debate by including clarification and guidance on risk and risk prevention⁵.

The findings reveal important structural and material initiatives (access to water and cleaning of public spaces) that complement initiatives specifically designed to combat the pandemic, ensuring adequate conditions for social isolation, mainly in the NE. However, lack of awareness of initiatives developed by the community illustrates lack of health team engagement in the

catchment area. While the percentage of respondents reporting community initiatives is considerably higher in the NE than in other regions, the high percentage of respondents who answered "do not know" to questions about the situation of households shows that in general health teams have little knowledge about the catchment area they work in, regardless of region.

Generally speaking, there are two core sources of actions: the community and those who represent it, and governmental and non-governmental organizations, the latter representing the social sector and private sector. It is worth highlighting social protection policies targeting vulnerable groups and food security policies in response to the return of hunger and malnutrition and poverty. Our findings show a general-

ly low level of engagement between PHCCs and social movements. In contrast, the percentage of PHCCs that coordinated actions with other sectors of society (churches, businesses and intersectoral actions) was higher. These findings reinforce the observation made by Valla⁷, who suggests that social support is growing in communities and the institutions that serve it, such as churches and organizations that provide shelter, food and educational support, filling the gap left by the absence or limited presence of the state. The author also highlights the need for improvements in health professional-community engagement in generating and sharing knowledge and practices⁷.

In the process of consolidating Brazil's public health system and institutionalizing an extensive PHC system, intersectorality and public participation walk hand in hand in the pursuit of comprehensive care, especially in view of social complexities that require a vision that goes beyond a single sector^{25,26}. With specific regard to PHC, an intersectoral approach is a key strategy in network-based care, both for the day-to-day functioning of services and during crises²⁴. The literature highlights major barriers to public participation in health care, including lack of public knowledge about the country's public health care system, potential participatory spaces, the functioning of local health councils and the operationalization of health agreements by health managers²⁵.

The weakening of the 2017 PNAB before the pandemic already posed a number of constraints on the community-based approach, with worsening working terms and conditions for the health workforce and restrictions on CHW activities in catchment areas²⁻⁴. While PHC work processes became more fragmented, our findings reveal a certain degree of resilience in non-urban areas with low MHD (<70), which showed a higher level of performance for Social support than other types of municipalities. Studies have shown an association between the presence of support networks and the development of individual, family and community resilience, promoting social protection and solidarity through interactivity and cultural identity⁸. In contrast, Canesqui¹⁵ shows that a new or different meaning for meeting the needs of unequal people through social assistance and cash transfer programs are provisional and discontinuous.

The process of social transformation entails changes in the community and health system that impact determinants of health, promote

improvements in population health status and reduce health inequalities through collaborative working and the community-based organization of health services. Performance in community-based organization, which is a cornerstone of social support, showed a strong association with other components of the pandemic response, particularly health surveillance, specific treatment for COVID-19 patients and continuity of care.

CHWs are the main line of contact between the PHCC and the community it serves, strengthening the community-based approach through activities such as contact tracing. Our findings showed that PHCCs that performed well in social support also took better care of their health professionals (psychological support) and made better use of the center's physical structure (vaccination). The huge burden placed on health professionals during the pandemic, including work overload, increased exposure to risk of infection and precarious working conditions in many health facilities (lack of personal protective equipment and psychosocial support) has had a number of adverse effects, including stress and burnout^{26,27}.

Teixeira *et al.*²⁷ showed almost all studies on the impact of the pandemic reported that hospital health workers failed to recognize the importance of primary care ("the front door" to the health system), outpatient services, home care and care for older persons in long term care facilities. Strong fear of infection and the need for physical distancing led to a certain level of paralysis of primary care services in the early stages of the pandemic²⁸.

Final considerations

Using empirical data, this article discussed the relationship between social support in the context of the COVID-19 pandemic and the response of primary care services from the perspective of health professionals involved in the latter.

One of the limitations of this study is that cross-sectional studies are limited to a specific point in time. However, this study is the first of its kind in the context of the pandemic and the findings can be amplified to other studies using different methodological approaches. One of the main challenges of the study was to define a dimension that is intersectoral and focused on multi and interprofessional care, given that the study looks into what is produced within the health system.

This study rekindles the debate about the concept of social support in the context of a social and health emergency. It was also possible to show how social vulnerability imposed by pre-existing underlying factors was addressed using existing health service resources, including for example the essential role of CHWs.

Certain gaps identified during data analysis may warrant further research to investigate the consequences of these processes during the pandemic for the functioning of social support in PHC, the organization of work in PHCCs in the face of social support measures, and the promotion of local planning and public participation, which amplify the decision-making process in response to new types of vulnerability that affect

the community-based approach in some regions and create new conditions for institutional governance.

Recommendations include amplifying the magnitude and scope of actions and strengthening ties between different actors to overcome the challenges and reverse the effects of the pandemic on health inequities. Strengthening strategies such as effective social communication and popular health education are other responses to the challenges imposed by the pandemic highlighted in this study.

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Collaboration

All authors reviewed the manuscript and replies sent to the editors.

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