

## Process of mischaracterization of Primary Health Care in the SUS in Campinas-SP, Brazil, during the pandemic

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**Abstract** *This article examines supply of Primary Health Care in the city of Campinas (São Paulo state) during the COVID-19 pandemic, taking changes in the work process as its guide. This descriptive, qualitative study included participant observation and in-depth interviews of workers and users at four PHC facilities, from June 2021 to January 2022. The analyses found significant differences between the first and second years of the pandemic. At first, care strategies were disorganised and care for COVID-19 cases, limited. In the second year, home visits and routine care were resumed. This, added to the worsening social and public health context and new demands, such as vaccination, caused overwork and strained relations between health personnel and users. Also, collective and co-management arrangements were found to weaken, both at the municipal management level and at staff meetings and for social participation. In the post-pandemic context, Primary Health Care is challenged to restore these arrangements and care for health workers exhausted by the pandemic.*

**Key words** *Primary Health Care, COVID-19, Health management, Community participation*

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## Introduction

The COVID-19 pandemic highlighted the importance of universal health systems in guaranteeing the right to health and an effective response to such a complex phenomenon. In the Brazilian scenario, combating the pandemic depended fundamentally on the participation of Primary Health Care (PHC) facilities, due to its presence in the territories and shared bonds with local residents. It was at these facilities that most people with respiratory symptoms sought care<sup>1</sup>.

The pandemic was a phenomenon experienced by Brazilians in a period of political crisis, involving counter-reforms and the dismantling of public policies<sup>2</sup>. Since 2016, there has been disinvestment in the national Unified Health System (*Sistema Único de Saúde*, SUS), aggravated by Constitutional Amendment No. 95/2016, which froze social policy spending for 20 years, and the 2017 National Primary Care Policy (*Política Nacional de Atenção Básica*, PNAB), which weakened the Family Health Strategy (*Estratégia de Saúde Familiar*, ESF) and social oversight. Added to this, in the territories where PHC facilities<sup>3</sup> are generally sited, the context was one of high socioeconomic vulnerability. In that scenario, the health emergency brought on by COVID-19 caused sudden changes in the healthcare work process, which had impacts on provision of care to SUS users and PHC workers' perceptions of health praxis.

PHC plays a fundamental role in guaranteeing the right to health and is an essential component in the organisation of universal health systems like the SUS. It is common knowledge that one of its main functions is to organise care, and it is also the point of first contact between users and the care system<sup>4</sup>. However, PHC's role during the COVID-19 pandemic was shrouded in contradictions, at least in Brazil, and the guidelines for its organisation and functions were unclear<sup>5</sup>. Precisely because its role was given less prominence in the media and in Brazilian national strategies, its importance needs to be better stated.

The Collective Health field rests on the belief that one of the purposes of health work is the co-construction of autonomy<sup>6</sup> and that a good management model must combine professional autonomy with health responsibility. Establishing that understanding hinges on a vision that regards autonomy as "a process of co-constitution of greater ability in subjects to understand and act on themselves and on their context, with a view to democratically established objectives"<sup>6</sup>(p.670). Such process is always relative and flexible.

This vision sees autonomy as being central to health practices<sup>7</sup>, both in management and in the clinic, and contrasts on many counts with a traditional view of medicine and public health that, in many ways, results in users and communities being objectified. In the absence of clear federal government guidelines<sup>8</sup>, states and municipalities extended their autonomy, giving rise to various local organisational arrangements and strategies, with varying degrees of participation by users and workers and of integration with other attributions of this level of care.

Accordingly, this article examines the supply of PHC in the city of Campinas (São Paulo state) during the COVID-19 pandemic, using changes in the work process as its guide. For that purpose, it was necessary to consider the extent to which the pandemic context encouraged vertical management practices and what impact they had on workers' and users' autonomy.

## The municipality of Campinas

PHC organisation in Campinas is bound up with the history of the public health care system's construction in the city: it was the flagship of that process, even before the SUS<sup>9</sup>. During the 1970s, "small health centers" were set up in the city's poorer neighbourhoods to work in the field of promotion, prevention and assistance, making the municipality one to pioneer the implementation of a model of community medicine, with the participation of PHC workers and the local community<sup>9</sup>. In the 1980s, PHC was modelled on Programmatic Health Actions in which traditional clinical care and isolated, vertical actions predominated<sup>10</sup>. In the 1990s, the "In Defence of Life" model was introduced, encouraging care that focused on collective health and expanding the range of actions offered, as well as the number of personnel and facilities.

From the 2000s onwards, the municipal health department administration opted for the Paideia model of care, an adaptation of the Family Health Strategy (*Estratégia de Saúde da Família*, ESF) to the health situation in Campinas<sup>11</sup>. Retaining the principle of user registration, Paideia proposed extended health care teams including gynaecologists, paediatricians and clinicians, in addition to a mental health team operating on the basis of matrix support. With a view to investing in user autonomy and supporting institutional democracy, this reorientation of the model of care set up collegiate management bodies at all levels of the health department and encouraged expanded, shared clinical care.

Although implementation of the SUS in Campinas broke new ground, the municipal system has suffered from steady dismantlement, disinvestment and the recent political and ideological crisis, aggravated by the pandemic. With this background in mind, this study also examines collegiate and co-management arrangements in the pandemic context.

## Methodology

The data presented in this article are drawn from a multicentre study entitled “Strategies for approaching subjective and social aspects in primary care in the context of the pandemic”, conducted in the cities of Campinas, São Paulo and Rio de Janeiro by the Collective Health Department of the Faculty of Medical Sciences at Universidade Estadual de Campinas (Unicamp), the Fundação Oswaldo Cruz and the Associação Brasileira de Saúde Coletiva (Abrasco), with funding from the Open Society Foundations. This study was approved by the ethics committee for research with human subjects at Unicamp (CAAE: 40699120.2.0000.5404). This article gives data for the city of Campinas only.

This exploratory, qualitative, descriptive study was conducted at four PHC facilities, between June 2021 and January 2022. The theoretical framework aggregated Support-Research<sup>12</sup>, Institutional Support<sup>13</sup> and critical hermeneutics<sup>14</sup>.

The chosen field of research comprises territories of considerable vulnerability. Each PHC facility (PHCF) is a reference point for a population ranging from 10,000 and 20,000. The data and context for each territory were surveyed based on an analysis of regulations and documents issued by the municipal health department, and the managers of each unit were interviewed to learn the history of the service and territory and how the facility operated during the pandemic.

The PHC system in Campinas currently comprises 66 PHCFs<sup>15</sup> with 227 Family Health Teams, covering about 65% of the population, plus 120 Oral Health Teams and a team from the Street Clinic<sup>16</sup>. Also, during the pandemic, the organization of staff was expanded in the Expanded Family Health Centres (*Núcleos Ampliados de Saúde da Família*, NASFs).

Data were collected at each PHCF, being visited once a week by a field researcher to monitor the team’s work and engage in participant observation, which was recorded in a field diary. After

this first stage of approximation with the services, the researchers conducted in-depth interviews with professionals and users. In all, 31 in-depth interviews were carried out, of 17 staff and 14 users, as well as 4 interviews of PHCF managers.

Staff interviews comprised 13 women and four men. Their job categories were: six doctors, four nursing technicians or assistants, three nurses, one community health worker (CHW), one psychologist, one social worker and one administrative technician. Length of service in the SUS ranged from one year to more than twenty; ages ranged from 24 to 68 years. Ten women and four men users were interviewed. The level of education ranged from illiterate to complete higher education and there was a diversity of professions, including day maids, social workers, retired people and others. There was also variety in race/colour, marital status and family structure, and notably some of the territory’s community and religious leaders were interviewed. An alphanumeric code will be used here to identify the participants’ reports, “P0101” to “P0404” for professionals, and “U0101” to “U0404” for users.

Most interviews took two meetings averaging 60 minutes each, which were transcribed and converted into narratives. These were then presented to interviewees in the second meeting, to arrive at a shared interpretation by researcher and research subject<sup>17</sup>. Narratives were constructed using the hermeneutic framework focused on social research in the health field<sup>17,18</sup>.

At the analytical stage, these narratives were entered into interpretive grids to identify the core arguments, that is, the main arguments in the interviewees’ discourse. This material underwent a process of mirroring between users and professionals. The data were analysed and interpreted by triangulating methods among the interpretative grids, field diaries, service manager interviews and data collected on regulations issued by the municipal health department during the pandemic.

## Results and discussion

The interviewees’ descriptions point to a radical change in the work process at the PHCFs, most importantly, the suspension of much of the care previously offered to users with chronic conditions. This was justified by the need to meet the demands of the COVID-19 pandemic, distorting the nature of PHC. The pandemic also entailed new tasks and functions to be incorporated into

daily routines. In these new conditions, existing arrangements for co-management and meetings were being replaced by verticalized conduct and lack of communication, undermining a praxis that had been constructed in the municipality since implementation of the SUS.

### **The pandemic as driver of the tendency to distort PHC**

#### **The impact of the first year of the pandemic**

“Mischaracterization of PHC” is the name given here to the distancing of functions and attributes in health care provision by the PHCF, in that the clinical care being offered was based on emergency care for focused, immediate, occasional demands. In the staff accounts, this distortion was expressed as changes in the work process, which were being justified by the need to meet COVID-19-related demand, particularly influenza-like illness and later vaccination.

This distortion was also observed at the national level in other contexts<sup>5</sup>, as noted in the study by Santana *et al.*<sup>19</sup> of recommendations by the Recife municipal health department. These authors point to disease-focused changes in the work process, which now favours individual approaches, to the detriment of collective ones. This acted as a constraint, given the magnitude of the pandemic’s repercussions, such as isolation and social changes.

The biggest complaint of this period from the health personnel related to the reorganisation of work flow and process in the PHCFs. At the onset of the pandemic, the municipal health department and Ministry of Health (MoH) decided to cancel routine care, groups and home visits by the PHCF, following the guidance to maintain social distancing and focus care on emergency and COVID-19-related cases<sup>20</sup>. In the study PHCFs, a specific flow was set up for respiratory symptoms with screening outside the unit. Entry to the service was allowed only with the approval of this screening: “*Working here at the health centre is very difficult, because the facility has become a real emergency care unit*” (P0304).

At first, users seem to have agreed to avoid going to the PHCF, mainly for fear of contamination and recognising that the facilities were overworked: “*Generally speaking, the most common response from staff to users is that there is no service. For a while, people listened to the denials and this did not raise big issues*” (P0402). After a few months, however, the problems and health needs worsened.

Users criticised the restricted access and constant denial of care and reported having been advised several times to go to the emergency service for care. Overall, people’s contact with the service has decreased, which may have weakened the bond with, and recognition for, the PHCF as the main care resource: “*Now it’s more difficult. I go [to the PHCF] only when necessary, when I’m coughing a lot, or to get medicine because I’ve got high blood pressure*” (U0401).

On the one hand, a significant number of health personnel said that decisions about how the units should function during the pandemic started to come down vertically from the municipal health department, leaving little room for staff autonomy. Others, however, said they felt a void as regards work organisation strategies, which caused anguish in the teams. Another health department decision that caused discomfort and overwork was that staff with comorbidities were laid off, so as to reduce the risks to these workers, but that they were not replaced in the services:

*At the same time, the frontline team was very overworked, because many of the team were laid off for being part of a risk group. That left us feeling rather abandoned, having to cope with a lot on our own, having to work double time, taking on the frontline without anyone. [...] For me, in my mind, it may seem silly, but we were kind of punished for being healthy. [...] It’s like they said to us “You’re healthy, get on with it and manage however you can” (P0103).*

From the interviews and the researchers’ participant observation, it could also be seen that, on the basis of the SMS guidelines, each PHCF had organised differently. Some cancelled routine visits and appointments, maintaining only emergency, antenatal and childcare, while others maintained home visits by CHWs and surveyed for the most vulnerable cases, which were listed for visits or other kinds of care.

These changes in the unit’s flows and work culminated in a certain distortion of the roles of some job categories, as reported by some CHWs and NASF staff. Note that it was precisely these categories that were greatly affected by the national primary care policy of 2017<sup>21</sup> and by the *Previne Brasil* programme<sup>19</sup>:

*Before the pandemic, my job as a community health worker was based on actions in the territory, which at first were cancelled and I was left not knowing how my work would be done from then on (P0402).*

Meanwhile, the functions of doctors and nursing staff were more directed, even resulting

in overwork from the high demand for care. One part of the team, more used to collective and process-based actions, saw a need to resignify their activities. These situations contributed to discouragement and suffering among the staff, in a context already impaired by difficulties in communication and collective constructions.

In this period, the PHC model of clinical care was undermined by the centrality given to “combating” the virus. In the health workers’ and users’ accounts, there was a tension between subjects and contexts, which caused discomfort and insecurity, while the responsibilities of managers, staff and users became diffuse, leading to individuals being blamed or, in many cases, feelings of being powerless to organise care more effectively:

*The staff are overworked, because they have been on the front line for two years. That has affected their mental health. If we users are now going through that difficulty, imagine them on the front line (U0402).*

With the PHCF functioning in this new way, it was difficult to operate the expanded, shared clinic<sup>22</sup>, and led to mistrust among users, staff and management. Thus, needing to respond quickly to the crisis and cope with the COVID-19-related demands, the longitudinal practices became specific actions, and there was little opportunity for collective construction.

Added to this are the difficulties faced historically in countering the biomedical model of health care, which relates a degraded model, whose power is diminished in specific socio-economic and institutional contexts<sup>21</sup>. Giovanella *et al.*<sup>21</sup> explain that economic sanctions and reforms in the regulatory framework faced by PHC in recent years have contributed to distorting its model. This grew even worse with the pandemic.

This situation is at odds with certain studies<sup>21</sup>, which stressed the need for emergency responses to COVID-19, while preserving some of the attributes of PHC: “access, longitudinality, coordination of care and the family and community approaches”<sup>21</sup>(p.751). That orientation can be reasserted from the favourable evaluations of care provided to COVID-19 cases, which demonstrated that longitudinal care was maintained to some extent. In this respect, the health workers felt that they had “fulfilled their role” and the user interviewees diagnosed with SARS-CoV-2 praised the monitoring, particularly the remote monitoring, done by the PHC units:

*Here at the Health Centre, the health centre staff stayed very close when I caught COVID-19. They sent me messages every day to see how I was,*

*asking if I had a temperature, if I had lost my sense of smell or taste. They asked me about isolation, how I was doing it and how I managed at home. It was like that for those 14 days that I stayed at home, and the same with my sister and my niece (U0202).*

### **The second year of the pandemic: resumption of activities and advent of new demands**

The second year (2021) was notable for the first vaccinations in Brazil, the resumption of some PHCF activities, increased understanding of COVID-19 and health department guidelines. Although people were apprehensive and social distancing was still in place, it was possible to rethink the work and restore some kinds of care.

In early 2021, according to field diaries and interviews of coordinators, schedules were reopened for home visits and medical appointments, and team meetings recommenced and, after the first six months, some groups were reactivated.

During this period, there were new demands, including the excessive increase in cases treated, as stressed by both groups of interviewees. This resulted from COVID-19 cases, post-COVID-19 syndrome complications, mounting mental health cases and, given the precarious socio-economic situation of the most vulnerable populations, the growing SUS-dependent population.

Another new task, which emerged in the first year of the pandemic and continued during this period, was tele-care, an alternative modality of care compatible with the need for social isolation. This method was viewed positively by most users and professionals, because it enabled contact to be maintained with the population, permitted assessment and guidance, and lent agility to appointment scheduling. In this connection, tele-care was found to perform a longitudinal user follow-up function, preserving the relationship and preventing the decline of the clinic<sup>22</sup>. However, health personnel noted that the lack of investment in technology prevented this resource from being better equipped and that they often had to use their own electronic equipment for this purpose.

Vaccination was another new demand that brought changes to the work process. At the start of the vaccination campaign, the municipal health department organised five Immunisation Centres around the municipality, which users could access by scheduling via the Internet. Personnel from all sectors of the department,

including PHC, were seconded to this function. The option to centralise vaccines in Immunisation Centres may have responded to the scarcity of vaccines in the municipality at that time. In August 2021, these centres were closed and vaccination was decentralised to the PHCFs, further contributing to staff overwork.

In addition to these issues, professionals complained of inequity in access to vaccination: *“People from wealthier neighbourhoods went to the Health Centre to get vaccinated and you could see that the registered population of the territory has been denied access. The team needs to guarantee its population access”* (P0401). They explained that scheduling vaccination via the Internet limited the most vulnerable people’s access. They concluded that the overworked teams were unable to accomplish vaccination by other possible means, such as home visits, telephone scheduling or active detection.

One significant change in this period had to do with the relationship with users. In the first year, encouraged by the imaginary built up by media reporting of health personnel as “heroes”, the population began to relate to workers respectfully and cordially. In the second year, however, this relationship changed significantly, possibly under the influence of a context of staff overwork. Cases of violence against health professionals increased during this period, not only in Brazil, but elsewhere, such as in Italy<sup>23</sup> and the United Kingdom<sup>24</sup>. From one year to the next, health workers went from being heroes to villains:

*I felt abandoned. Nursing had never been so highly valued, the media built us right up and, at the same time, there was a side to our politics that set the population against us. That’s how I felt... it froze our salary, our paid absences froze everything. There was no evaluation like, are you OK? You’re going to do it and that’s that. You won’t be getting it; it won’t count for anything* (P0201).

Another factor that may have contributed to this conflict between staff and users was the reduction in social participation and co-management. With no formal, institutional means to voice opinions, complaints and dissatisfaction, people found other ways of expressing themselves (via social media, for instance), which raised obstacles to communication with the PHCF.

#### **Weakening of co-management arrangements**

The health personnel were unanimous in reporting difficulties in relations with management, which were expressed as feelings of aban-

donment, lack of support, lack of appreciation and vertical treatment of the PHC by the municipal health department and federal government, which jeopardised any mode of organisation close to ESF recommendations.

The first factor that contributed to this weakening was the difficulty in communicating with the municipal management, because information arrived via notices, WhatsApp or even the media, before any official announcement by the health department. This revealed the lack of clarity in directions, guidelines and strategies for combatting the pandemic. Decisions became unilateral, authoritarian, with no agreement and planning with the team, disregarded the needs of the PHCFs and offered little opportunity for autonomy with regard to work agenda and schedule. There were constant changes in flows and protocols, which undermined discussions and guidance for the public, making it very difficult for health workers and users to understand how the PHCF functioned: *“There’s a lot of disorganisation. You organise and disorganise. People don’t understand quite what is being offered... We suffer and the population does, too”* (P0401).

The second factor described was a sense of detachment and lack of support from Institutional Supporters. Since the 2000s, the city of Campinas had set up Institutional Supporters as one way to help implement co-management processes, so as to build capacity in subjects to think and act in the health production process<sup>25</sup>. Even before the pandemic, these supporters were already finding it difficult to act in line with the proposed model<sup>26</sup> and the present context seems to have distanced them still further from the services’ daily routine: *“They only go to the Health Centre when reception is done and they are not there long enough to understand what is going on”* (P0402).

The third factor was the cancellation of team meetings; when these did take place, they were described as bureaucratic and hollow. Although many personnel considered that, before the pandemic, meetings were important spaces for collective construction and group thinking, they reported a lack of interest in participating in this new configuration. There were criticisms of the cancellation of meetings, as well as declarations as to the relevance of constructive dialogue as a powerful tool for conflict resolution and for constructing health care. These factors show that health personnel and users recognised the importance of co-management arrangements.

The fourth factor that worked to weaken co-management was that working in PHC was

becoming increasingly precarious and depreciated. Staff reported suffering, illness and discouragement out of fear of being on the “front line”, which meant exposing themselves and risking their lives, partly for lack of proper protection, scarce resources, overwork, cancellation of holidays and a build-up of overtime. Those situations were expressed as feelings that the work they did was devalued: “*to see your work abandoned like that, the family health project being ignored, that’s really hard. It makes our work seem superfluous*” (P0203).

Despite this increasingly fragile context, staff reported resistance and repeated attempts to reorganise these collective arrangements and to seek support, such as by organising conversation groups at the end of the day for colleagues to discuss work and share care strategies. There were also attempts to restore shared management, which included resuming collegiate management meetings and requesting meetings with the facility’s management to discuss the work process, weaknesses, discontent and necessary reorganisation. This gives call to think about the porosity of the co-management model<sup>25</sup> in PHC in Campinas, in that workers and users recognised the potential of group sharing and, when these arrangements were challenged and dismantled, sought ways to salvage and (re)build collective decision making, knowledge sharing, and exchanges of affect and care.

As regards social participation, some users mentioned the local health policy council as a driver of change and a prospect of defence for the SUS and oversight of health management, as well as being a vital tool for guaranteeing the quality of care provided by the PHCF. They saw the council as a setting for collective construction “*[that is] the responsibility of all parties: management, staff and users*” (P0401). Both groups of interviewees also recognised participation in social and social oversight movements as a guarantee of the right to health and qualified care.

Social oversight mechanisms, however, faced a series of difficulties during the pandemic, permeated nationwide by the weaker social participation induced by the federal government – particularly following Decree 9,759 of April 11, 2019<sup>27</sup>, which altered the rules governing collegiate bodies of the federal public administration – and by local issues, including difficulties in holding face-to-face meetings and using communication technologies<sup>28</sup>.

Lastly, political decisions by federal management, even prior to the pandemic, were also

described as authoritarian and remote from local health needs. Health personnel noted how Constitutional Amendment (EC) No. 95/2016 and the new PHC funding model of the *Previdência Brasil* programme made it difficult to comply with their guidelines<sup>19</sup>. The changes in MoH funding led the municipal management to pressure teams to “*maintain the volume of care at an unsustainable pace*” (P0203), so as not to lose even more funding. The longstanding lack of adequate investment in PHC already gives an idea of teams’ difficulty in operationalising the family health model: “*Sad to say, but Campinas is in a difficult situation. Many colleagues I talk to feel the city has abandoned the family health model and focused only on instances of care*” (P0204).

Meanwhile, specifically at the present moment in Brazil’s history, one staff member identified the relationship between the vast political divide in the thinking of Brazilian society and the realities of working at a PHCF, which led to divergences in health personnel’s thinking and actions:

*It is impossible to talk about public health and the disjointed work [being done] on Brazil’s political issues, and the ‘break’ that exists between different ways of thinking. So, since the beginning of the pandemic, with divergences in the protocols, there was a lot of confusion among health personnel themselves on how to act in cases of respiratory symptoms. This caused unspoken discomfort in the team, and users questioned these differences in conduct* (P0401).

In addition to reflecting the polarisation between political and ideological views in Brazilian society in recent years, that quote may relate to a series of fragmented actions by the federal government, including normative acts and publicity, connected with its intention to restore economic activities in spite of human rights abuses<sup>8</sup> and the more than 700,000 lives that were lost.

## Final remarks

Analysis of data collected, more than three years after the onset of the COVID-19 pandemic in Brazil, allowed certain events to be put into perspective. The pandemic challenged the health system – and especially PHC – in numerous ways. In a country that recorded among the highest COVID-19 case rates in the world, social policy restrictions and sharply increasing demands meant that PHC experienced a bottleneck in both funding and patient care. In this respect, the

post-pandemic challenge is twofold: to restore its normative framework and more robust funding, but also to improve the quality of care, expand clinical scope<sup>22</sup>, extend the presence in the territory and reinstate co-management arrangements<sup>25</sup>.

Reoccupying settings for democratic participation means overcoming not only the discouragement reigning among health workers, aggravated by burnout from overwork during the pandemic, but also combating alienation in a context of political polarisation and attacks on the democratic order<sup>8</sup>.

To identify the pandemic as a process that accelerated the dismantling of PHC is not to say that PHC was functioning to the full previously.

On the contrary, reports indicate that the pandemic potentiated a dynamics of denaturation that had already been at work in the municipality: insufficient staff were available to meet demand and quantitative criteria were prioritised to the detriment of the quality of care.

The study was limited particularly by fluctuation of the epidemiological scenario, which partly impaired data collection. The need to adapt PHCF routines also posed challenges to interviewers' accessing to some staff, as a result of alterations in the work process. Despite these factors, the chosen data collection and analysis methodology yielded a large volume of empirical material, which formed a substantial basis for future research.



## Collaborations

ACD Rosa-Cómitre and AR Campos: conception, data production and analysis, fundraising, field research, methodology, research management, drafting and final review of the article. Other authors: conception, data production and analysis, field research, methodology, research management, drafting and final review of the article. GWS Campos: fundraising, research management, drafting and final review of the article.

## Funding

Open Society Foundations.

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Article submitted 30/04/2023

Approved 09/08/2023

Final version submitted 11/08/2023

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Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva