The contribution of Primary Health Care in the SUS network to face Covid-19

A contribuição da Atenção Primária à Saúde na rede SUS de enfrentamento à Covid-19

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ABSTRACT The focus on individual care for severe cases neglected the community-centered approach required to cope with the Covid-19 pandemic in the Unified Health System (SUS) in Brazil. This essay argues that the Family Health Strategy (ESF), by means of its multi-professional teams and community and territorial orientation, is able to successfully develop the community approach required to deal with the pandemic. Inspired by local and international experiences, this essay analyzes four dimensions regarding SUS' Primary Health Care (PHC) work in the fighting against Covid-19: community-based health surveillance, individual care for confirmed and suspected cases of Covid-19, community mobilization to support vulnerable local groups, and continuity of APS care routine. Limitations are acknowledged due to recent changes in the National Policy of Primary Health Care impacting health surveillance care model. The conclusion if for the need to: strengthen the community attributes of APS and Family Health Support multi-professional teams; collaborate with community organizations in initiatives of solidarity and articulate in an intersectoral way; guarantee the ongoing promotion, prevention and care actions by creating new working processes for health surveillance, social and health support for vulnerable groups, and for the continuity of the routine care for those in need.

KEYWORDS Primary Health Care. Health surveillance. Care continuity. Community participation.

RESUMO *A centralidade no cuidado individual a casos graves descurou a abordagem populacional comunitária necessária ao enfrentamento da pandemia de Covid-19 no Sistema Único de Saúde (SUS). Neste ensaio, argumenta-se que a Estratégia Saúde da Família (ESF), com suas equipes multiprofissionais e enfoque comunitário e territorial, tem potencial para atuar na abordagem comunitária necessária ao enfrentamento da epidemia. A partir de experiências locais e internacionais, analisa quatro campos de atuação da Atenção Primária à Saúde (APS) no SUS no enfrentamento da Covid-19: vigilância nos territórios; cuidado individual dos casos confirmados e suspeitos de Covid-19; ação comunitária de apoio aos grupos vulneráveis; e continuidade dos cuidados rotineiros da APS. Reconhecem-se limites dessa atuação decorrentes de mudanças recentes na Política Nacional de Atenção Básica que afetam o modelo assistencial da vigilância em saúde. Conclui-se ser necessário ativar os atributos comunitários das equipes multiprofissionais da ESF e do Núcleo de Apoio à Saúde da Família; associar-se às iniciativas solidárias das organizações comunitárias e articular-se intersetorialmente; e garantir a continuidade das ações de promoção, prevenção e cuidado, criando novos processos de trabalho na vigilância em saúde, no apoio social e sanitário aos grupos vulneráveis e na continuidade da atenção rotineira para quem dela precisa.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Vigilância em saúde. Continuidade. Ação comunitária.*

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Introduction

The Covid-19 pandemic has spread unrelentingly throughout Brazil since March 2020, giving rise to an unprecedented health and humanitarian crisis. The lack of a national health authority and of intergovernmental coordination and cooperation, together with the insufficient and slow allocation of resources, hinders the initiatives of state and municipal governments to address the pandemic. The centrality of coping initiatives based on individual care of severe covid cases by means of the creation of Intensive Care Unit (ICU) beds, field hospitals and sparse actions, in addition to the denial of science and federal government oversight, contributed to such situation.

Facing an epidemic requires that community-centered care be associated with individual care, demanding a population approach. This association is essential to face the current health and humanitarian crisis[1]. Health systems strongly based on Primary Health Care (PHC) can offer a comprehensive and integrated care, more effectively responding to emergencies[2-4].

PHC plays a crucial role in that necessary community approach and health surveillance. The Unified Health System (SUS)' PHC, especially the Family Health Strategy (ESF), by means of its multidisciplinary teams and community and territorial focus, which has proven positive impacts on the population health over time[5], can and should act in the community approach needed to face any epidemic, besides playing a decisive role in the care network, control of the epidemic and continuity of care.

PHC teams know their territories, their population, their vulnerabilities, and act mostly from the perspective of health surveillance, which is crucial for the control of contagion. However, there is need to recognize the weaknesses of SUS' PHC. Since the 2016 parliamentary coup, and especially since the 2017 National Policy of Primary Health Care (PNAB) launching, new difficulties have been added to the everlasting challenges[6].

Since than, the Brazilian PHC care model, by means of its territorial and community approach, has been mischaracterized and neared the individual care model, responding to acute problems, carrying no link, continuity, coordination or population responsibility[7]. The effects of the acute SUS de-financing since the 2016 coup, deepened by Bolsonaro-Guedes government, were revealed before the pandemic by the lack of supplies and essential medicines, absence or precariousness in the hiring of PHC human resources and huge work overload of municipalities, already in difficult financial situation and responsible for over 30% of SUS funding.

In addition, the Bolsonaro-Guedes government's economic policy had already impacted all social determinants of health, worsening indicators such as infant mortality, apart from the re-emergence of other diseases, such as measles, dengue and yellow fever[8]. Nevertheless, municipal initiatives underway reveal PHC capacities to cope with Covid-19 that can and should be strengthened.

Thus, this essay aims to discuss the need to strengthen SUS' PHC toward effective coping with the Covid-19 pandemic in Brazil. It is based on the still scarce literature on this recent event, until June 2020, on the institutional and organizational learning of Brazilian PHC and on these authors' PHC research experience. The article focuses the primary care organization without forgetting, however, that individual and collective care can only be delivered by PHC services well integrated into the care network, with agile and open communication channels to ensure comprehensive care, as the needs of each case and population.

It begins by emphasizing the importance of PHC in coping with the pandemic, and identifies axes of PHC's action from local and international experiences, underlining the necessary articulation with the surveillance sectors of each municipality. Also, it lightens

some of the challenges to be faced for the full development of health surveillance actions originating on ESF teams, all adopting a reflection that aims to articulate the structural and conjunctural aspects of the announced crisis.

Why PHC?

Two important aspects should be regarded during a pandemic: to cope with the disease and to maintain the care of all the health problems that continue to occur.

Given the exponential capacity of the infection spreading, the early identification and isolation of cases by PHC services to reduce transmissibility becomes fundamental. Each case being identified and followed by active search for close contacts, isolation at home or in appropriately organized places, interrupts transmission and avoids numerous cases of Covid-19.

Parallel to that, to analyze previous experiences of coping with epidemics helps to define better intervention strategies of health systems. In epidemics, there is an excess of deaths from other causes that are no longer treated that can even overcome those generated by the pandemic itself.

In the case of the Ebola epidemic, it stayed demonstrated that the overall health response was dependent on the degree of PHC competence[9]. That same coping experience taught that the exclusive focus on the epidemic may have caused disastrous effects on morbidity and mortality in the short and medium run due to other health problems related to reduced access and continuity of care for users suffering from other conditions and injuries[2].

Regarding the current pandemic, and in addition to the specific impact related to Covid-19, over-mortality estimates are now being accounted from other causes in different scenarios of middle and low-income countries due to the reduction of access and coverage of actions usually offered in health services. It is estimated that the reduction of maternal care during the Covid-19 pandemic in middle and low-income countries may result in an increase of up to 40% in the mortality of children under five years, and up to 30% in maternal mortality[10].

The different ways of coping with the Covid-19 pandemic within PHC scope in countries throughout the world were influenced by models of organization within that level of care and by its integration in the national health systems, the local realities and policies. With few exceptions, it can be said that, due to the centrality of hospital care, opportunities for an effective PHC performance were lost. Nevertheless, several experiences and authors refer to the importance of strengthening PHC in coping with Covid-19.

In Portugal, specific PHC units – the so called 'Community Dedicated Areas Covid-19' – were created in each Conjoint of Health Centers to care for respiratory symptoms within the territory[11]. In Wuhan Province, China, most of the 203 PHC centers carried out actions to control Covid-19 that involved tracking and testing of suspected cases, monitoring of contacts and clinical care to quarantined people[12]. In places such as Cuba and the state of Kerala, India, the work of community agents and PHC teams in the communities contributed to the active search for cases and their contacts and to the identification of people in vulnerable condition[4,13]. In Spain, professionals of PHC centers were displaced to work in hospitals, causing PHC lack of assistance. The catastrophe of the Italian experience confirmed that the response to the pandemic cannot focus only on hospitals[9].

SUS' PHC fields of activity in coping with Covid-19

Therefore, PHC plays an essential role in coping with Covid-19, also now, at the time of the pandemic, as during the carrying on of

surveillance over other waves of the disease and over time. Thus, there is a risk that it becomes an endemic disease, at least until an effective vaccine is provided.

In coping with the pandemic, it is necessary to join individual and collective care, i.e., timely care of coordinated quality in the network and activation of PHC community attributes. Today, an integrated action is needed among health units, territories, community and their social equipment. The reorganization of the PHC working process in the context of the epidemic is relevant so to preserve its attributes of access, longitudinal character, care coordination, family and community approachs[14].

PHC operation means must be adapted to each context and in a way to avoid conflicts between actions. That will require both organizational changes according to each local reality[15] and mobilization of public resources, such as monetary, personnel and material. It will also require community resources by means of a partnership with institutions operating on the territory and with the community where health teams and units are located, ensuring the development of actions, enhancing skills and stimulating solidarity.

It urges to:

— activate ESF community attributes and those of the multidisciplinary Family Health Support Teams (Nasf).

— join the solidarity initiatives of community organizations and articulate in an intersectoral approach to support their population in their various vulnerabilities.

— ensure the carrying on of promotion, prevention and care actions, creating new working processes regarding health surveillance, social and health support to vulnerable groups, and the continuity of care routine for those who need it.

Protecting life implies finding the best ways to face the epidemic within SUS centered on PHC.

Even facing all the difficulties, SUS resists. Municipal and local initiatives have strengthened Primary Health Care also to try to control contagion on the territories and provide individual care for suspected and confirmed cases of Covid-19 as to ensure the continuity of PHC care routines by means of diversified processes in the national territory.

PHC teams can contribute to the care network and to the community approach needed to cope with the pandemic. Local experiences of PHC organization to cope Covid-19 in several municipalities suggest that the performance of PHC teams against Covid-19 is organized into four integrated fields of action involving the ESF teams, Oral Health, Nasf, Community Health Workers (CHW) and endemic workers on the territories, as summarized in *table 1*[15,16].

Table 1. Fields of action of Primary Health Care in the SUS Covid-19 pandemic coping network

Fields of action	Actions required
Health surveillance on the territories	• Carry out primary and secondary prevention actions - Identification of cases and active search of contacts - Notification of cases according to updated definition - Support for home isolation of cases and their contacts - Daily distance monitoring of cases in home care - Support for surveillance in nursing homes and other long-term care facilities in its territory • Provide health information and education for the community and on essential services - Leverage existing collective communication resources in the community such as community radios, message groups, sound car etc. - Inform on epidemiological situation of the territory and protective measures, such as social distancing, use of masks, hands washing etc. • Test cases, their contacts and healthcare professionals
Individual care of confirmed and suspected cases of Covid-19	• Organize care flows - Separate care flows of respiratory symptoms and suspected cases from those of patients with other problems or needs - Reduce to a minimum the number of professionals who contact personally each suspected or respiratory symptomatic case - Adapt the infrastructure • Care for patients with mild conditions - Evaluation of history and clinic should be timely and fast - Classify severity according to clinical protocol - Make available the equipment to UBS, such as oximeter, infrared thermometer, oxygen - Caring as for most updated protocols and based on the best scientific knowledge - Telemonitoring by the team of cases and their contacts: daily contact is recommended, preferably each 12hours • Provide appropriate PPE for all professionals according to the activity performed and train on appropriate use • Ensure timely referral of those in need of care from other care levels - Ensure timely and specific transportation to Covid-19 - Provide clinical stabilization until transportation arrives reference service premises • Teleservice that makes phone contact available for users - Line of care begins by a specific telephone designated to the attention of respiratory symptomatic cases with communication to the case teams of the area for daily telephone monitoring - All teams and UBS need to be provided with telephones and internet access to ease a non-person-to-person care to users - PHC integration with the Covid Call Centers, as in Rio de Janeiro: 160, and with Municipal Centers, for the monitoring of suspected cases by PHC teams • Training of professionals on care
Support for vulnerable groups on the territory due to their health or social condition	• Articulate community initiatives and promote intersectoral action - Mobilize leaders and social organizations - Disseminate information and clarify doubts on prevention measures - Support the distribution of donated resources, hygiene kits, and food parcels etc. • Map users at higher risk for Covid-19 such as the elderly, chronic patients, people under extreme poverty or food insecurity - Strengthen prevention measures and ensure resources so to establish the conditions to stay at home - Trigger social support networks - Articulate with Cras professionals to include in social programs - Monitor problems of domestic violence *Any team professional can take charge of those actions, including CHWs, oral health teams, Nasf professionals.*

Table 1. (cont.)

Fields of action	Actions required
The carrying on of PHC care routine	• Carry on care routines - Prenatal care, attention to hypertensive and diabetic patients, vaccination etc. - Develop lists of chronic patients who need continuous care - Develop new forms of daily distance care: availability of internet access, individual WhatApp and for user groups, telephone, video teleconsultation, telemonitoring - CHW visits within a certain radius around the domicile for monitoring and information • Leave the door opened, but under restrictions • Ensure the carrying on of pharmaceutical attention - Organize the home distribution of medicines by the CHW - Develop forms of electronic prescriptions with digital certification
For an effective action, provide INTERNET FOR ALL: health professionals and population. The government should provide Wi-Fi services in each neighborhood and community, and articulate with telephone companies to broaden the internet of all citizens carrying a cell phone; at least articulate to provide broadened access also in minutes as through messages and internet, for all professionals, including all CHW.	

Source: Prepared by the authors as from Medina[16], Engstrom[15].

Health surveillance on the territories

The health surveillance care model on which ESF is grounded should guide the coping with the pandemic. Health surveillance adopts the articulated use of epidemiology and social sciences in the analysis of the health situation, planning and organization of practices on a specific territory. It integrates individual and collective activities, sectoral and intersectoral actions, of health promotion, risk and disease prevention, and care[17,18]. Several municipalities have strengthened health surveillance on the territories with PHC participation in facing Covid-19, although researches indicate that health surveillance is not yet the ESF dominant model[19,20]. There are important weaknesses in the integration between the epidemiological surveillance sectors and PHC teams related to lack of communication and joint planning between the two sectors, besides insufficient training on epidemiological surveillance, among other factors[21,22].

For the purpose of blocking and reducing the risk of epidemic expansion, health surveillance implies to coordinate, on the territory, actions of primary and secondary prevention to Covid-19, such as case identification, testing and active search for contacts, support for home isolation of cases and their contacts; notification of cases; and health education actions that enhance existing collective communication resources in the community, such as community radios, message groups, loudspeaker car.

Several municipalities have strengthened health surveillance on the territories by creating Working Groups involving PHC. The Municipal Health Department of Belo Horizonte, state of Minas Gerais (MG), created a Working Group with the purpose of discussing and defining joint actions between the areas of surveillance and health care, and production of technical notes, flows and protocols[23]. Similarly, the Zilda Arns Family Clinic, located in the community Complexo do Alemão, city of Rio de Janeiro (RJ), created four Working Groups to face the pandemic, including a Covid-19 Telemonitoring Working Group. The professionals pertaining to that Working Group developed, on their own initiative, a digital panel to support surveillance that is updated daily by the team and directly connected to the epidemiological surveillance e-SUS, which allows for notification[24].

For effective surveillance and control of the transmission, international experience has shown that a fundamental action is the timely molecular testing employing the RT-PCR method so to identify cases and active search for contacts. Contact tracking and quarantine were a central component of Vietnam's response strategy, which, until July 2020, accounted few cases and no deaths due to Covid-19. Contact tracking is a comprehensive initiative supported by a broad network of provincial and district disease control centers of 11,000 community health centers. Contacts of confirmed cases were tracked and tested, including contacts' contacts, being all positive cases isolated[25].

Support for home isolation of cases, contact tracking, incentive to contacts' quarantine, and daily remote monitoring of cases in home care are actions that can be performed effectively by PHC[26]. The successful support to the isolation and quarantine of contacts needs the public management to provide specific community spaces when the household conditions are not enabling.

Among health education activities, awareness of the need for mask use by all people is an urgent task. There is consensus that the use of masks by everyone in the community contributes to the effective reduction of contagion whenever the masks are used by the vast majority of people, due to the fact that the contagion also occurs from asymptomatic people[27].

In Florianópolis, state of Santa Catarina (SC), protocols determine that people identified by telemonitoring with symptoms for less than seven days should be submitted to RT-PCR testing at home by trained PHC teams[28]. Equally critical is the testing of health professionals due to the high potential for contagion. The group was prioritized in municipalities such as Belo Horizonte[23] and Canaã dos Carajás, state of Pará (PA), cities in which exclusive clinical monitoring was set up for health professionals and users carrying comorbidities[29].

Testing will only be effective if accompanied by an active search for suspected cases and their contacts with the aim of early identifying and isolation, as PHC has done in Nova Lima (MG) and Sobral, state of Ceará (CE). In Nova Lima, the CHW follow the presence of signs and symptoms of influenza among families within their micro-areas through telephone contact or cellular messaging[30]. In Sobral, the CHW plan and conduct peridomicile visits to early identify signs of severity, provide guidance for home isolation, and adopt preventive measures to avoid dissemination[31]. In Nova Lima, CHW also contribute to the monitoring of commercial establishments that do not follow municipal regulations, prompting the Municipal Health Surveillance whenever necessary[30].

PHC teams have the potential to provide information and health education to the community and to essential services, such as pharmacies, markets etc., and to withhold fake news by taking advantage of existing collective communication resources – community radios, message groups, loudspeaker car etc. – with the aim of addressing the territory epidemiological situation and adopting protective measures such as social distancing, use of masks, hands washing. This is how a rural PHC Unit located in the arid interior of the state of Pernambuco (PE) established continuous communication with the community: by means of a radio program created by Primary Health Center (Unidade Básica de Saúde – UBS) professionals and weekly spread by WhatsApp for users, and of an open communication channel to clarify doubts related to the pandemic and to the UBS operating way[32].

In Londrina, state of Paraná (PR), ESF and Nasf professionals removed from the routine work for belonging to risk groups, collaborated remotely with teachers and students from the State University of Londrina in a project to provide guidance for those working in the region municipalities on measures to protect and prevent Covid-19 at work. The enterprise reached commercial and residential

condominiums, beauty parlors, schools, constructions and industries, when 109 multipliers replicated training to 2,500 workers[33]. In Recife, state of Pernambuco (PE), Nasf professionals guided efforts for the population health education in waiting and evaluation rooms, vaccination rooms and queues around the UBS[34].

In addition, PHC teams can provide surveillance in long-term institutions, such as nursing homes and institutional shelters in their territories. Those establishments need to implement special care and intensified surveillance, since they agglomerate vulnerable people and are hotspots of frequent contagion, which has been done by PHC teams in the municipalities of Nova Lima[30] and Belo Horizonte[23], for example. It is to bear in mind that, in Spain, half of the deaths occurred in nursing homes.

Individual care of confirmed and suspected cases of Covid-19

Another responsibility of PHC teams is the individual care of confirmed and suspected cases of Covid-19. The PHC teams separate care flows into suspected and respiratory symptomatic cases, take care of patients in mild conditions, and ensure timely referral of those who require assistance from other levels of care (in patient and specialized care). That is helped by the team adoption of telemonitoring of cases and their contacts, and by teleservice via contact phone availability for users.

The separation of care flows into respiratory symptomatic patients and those carrying other problems or needs has been performed in several ways. In larger PHC centers, flows were split inside the center, being the first care rendered outside; corridors, service rooms and professional teams were split for suspected cases. In other municipalities, tents were installed outside the PHC Unit or specific premises were defined to receive respiratory symptomatic patients who require a closer person-to-person care.

For example, the municipality of Teresina, state of Piauí (PI), separated 25 of its 90 UBS to aid Covid-19, while the municipality of Canaã dos Carajás defined a reference unit with an available ambulance to transfer serious cases to the field hospital[29]. In places where UBS infrastructure allowed the division of internal flows, evaluation tents were set up outside the units so to determine which entrance – Covid or Non-Covid – each user should use, such as in Florianópolis[28], Sobral[31] and Belo Horizonte[23].

The option to create Covid-19 care centers specifically addressed to suspected cases, to perform initial handling, and to ease access to hospitalization whenever necessary should be accompanied by effective communication with the UBS so that they are able to follow and monitor their territories[35].

Individual quality care by teams depends on their integration into the network and on the guarantee of timely and specific transportation for Covid-19, as provided in Belo Horizonte[23], where transportation was integrated to the assignment of beds, ensuring fast access to hospital care, granting well-established reference and counter-reference flows.

Another procedure to reduce contagion within the UBS is the teleservice provided by a specific contact telephone to care for respiratory symptoms, as adopted in Florianópolis[28]. That can be accomplished by integrating PHC call centers to the state or municipal population so to identify suspected cases in their homes and notify teams about cases occurring in their area in a way to enable daily monitoring by telephone, avoiding unnecessary trip to the UBS. In addition to PHC professionals, specialists from the SUS secondary network can contribute to the teleservice, as occurred in Belo Horizonte and Florianópolis, since care attendance was reduced due to social distancing measures[23,28]. In Florianópolis, ESB and Nasf professionals were also recruited for the function[28].

The feasibility of telemonitoring and teleservice requires the provision of telephones and

internet access to teams, easing a non-person-to-person service to users. In Florianópolis, even before the pandemic, the municipality had invested in a pre-clinical care service called 'Alô saúde Floripa' to provide ESF teams with smartphones, cell phones and access to the WhatsApp Business platform. The pandemic arrival called for the strengthening of the initiative, which included the broadening of care numbers to the population[28].

The split of flows refers not only to the physical spaces, but also to the human resources involved in the care. Therefore, the recommendation is to reduce to a minimum the number of professionals who make a person-to-person contact with each respiratory symptomatic case or suspected case of Covid-19. Besides, it is advisable that professionals dedicated to the care of Covid-19 patients be properly trained and that investment be made in the hiring of additional professionals to service the flows separately, as in Canaã dos Carajás[29]. Given the restrictions of social distancing, the Municipal Health Department (SMS) of Belo Horizonte organized online training through videos and web conferences for managers and health professionals[23].

The PHC services can take care of patients with mild conditions by performing a timely and rapid historic and clinical evaluation, classifying severity as for clinical protocols, and providing care by following updated protocols based on the best scientific knowledge. For such, the UBS need to have available the equipment and the necessary supplies for the care of suspected cases, such as oximeter, infrared thermometer, oxygen, in addition to ensuring appropriate Personal Protective Equipment (PPE) for all professionals, accompanied by training on appropriate use. Providing PPE for health professionals was a challenge for all health services at the beginning of the pandemic due to the explosion of consumption and to the difficulty in finding suppliers. In Belo Horizonte, the technical and purchasing areas joined forces to ease the acquisition of suppliers with greater agility and transparency[23]. In Sobral, local industries redirected processes to absorb PPE production[31].

Individual care includes systematic follow-up of cases with good communication and information about the disease and signs of worsening, allowing timely search for health services and early oxygen therapy. Mild cases and their contacts should be followed by PHC teams through telemonitoring. Daily contact is recommended, ensuring telemonitoring every 24 or 48 hours, according to the case severity[29,30]. Several professionals involved in PHC can contribute to the telemonitoring, including Nasf[34], Oral Health and CHW[30] teams.

Moderate and severe cases should be timely transferred to referring services by timely and specific Covid-19 transportation; conditions should be supplied so that PHC professionals can provide clinical stabilization until transportation arrives the reference service premises.

Community action to support vulnerable groups on the territory due to their health or social condition

Due to the close relationship with the territory, PHC teams can articulate community initiatives and promote intersectoral action to face the social aspects of the pandemic. By means of the mobilization of leaders and community organizations, community support and collaboration can be gathered also in coping actions as in broadening information and clarifying doubts about prevention measures, identifying homes with potential problems, such as domestic violence, and supporting the distribution of donated resources.

The interaction of social movements with health services, especially those mediated by CHW, eases mapping and support to users at higher risk for Covid-19, i.e., the elderlies, chronic sick persons, people under extreme poverty or food insecurity. That interaction strengthens prevention measures and ensures resources to provide the conditions to stay at home, mobilizing social support networks, registering in programs, and allocating food parcel.

In this sense, the Community Working Group created by the Zilda Arns Family Clinic (RJ) joined efforts with the Complexo do Alemão Crisis Office, composed of community leaders from the three main social devices of that area – the Papo Reto Collective, the newspaper 'Voz da Comunidade' and the Collective Women in Action for the Alemão. The partnership developed communication and health education actions, organized the distribution of donations, food parcels and hygiene kits, and connected with other community organizations and PHC units of Complexo do Alemão[36].

In Niterói (RJ), PHC collaborated with Reference Centers on Social Care (Cras) and public schools to map vulnerable populations so to define social protection measures and to broadcast inputs and information on contagion prevention[37]. In Florianópolis, the intersectoral articulation and with civil society was carried out together with the Secretariat of Social Assistance and with the project 'Somar Floripa', which consisted of a network of voluntary organizations[28]. Belo Horizonte' SMS mobilized to provide care for the homeless population, creating a temporary and emergency service in partnership with the public social assistance policy and with the Social Service of Commerce, which made available 260 individual accommodations with private bathroom, among other initiatives[23]. In Nova Lima, PHC teams were instructed to identify users with greater vulnerability on their territory and to develop support plans in collaboration with other social actors[30].

Any PHC team professional, especially the CHW, can lead such initiatives and take advantage of the availability of professionals whose workload has been reduced, as was the case of oral health teams and Nasf professionals.

The carrying on of PHC care routine

Contrary to what has been adopted in several international and national experiences, where PHC services were interrupted at the pandemic arrival[9,23], PHC care routine is essential to proceed. The needs remain and there is a risk that the conditions worsen, and suffering and mortality increase due to other causes.

After the pandemic arrival in Brazil, given the many uncertainties and the real fear of contagion, the UBS interruption of activities was observed, followed by an important fall in the number of PHC visits, whose permanence could lead to complications and problems due to lack of care for patients with chronic diseases[23]. Pregnant women, children under five years of age, hypertensive and diabetic persons still need care and follow-up, while lot of them make part of the groups at higher risk for Covid-19.

The care continuity requires the creation of new forms of daily distance care through telephones and mobile apps for following-up individuals and groups of users through teleservice. The key is to maintain the UBS opened, taking care of the necessary cases, although under restrictions, solving whatever possible at distance and reducing person-to-person care. The CHW can back up families and follow groups through peri-domicile visits. The possibility of home visits by nurses and physicians is an option that should be considered for patients at higher risk.

It is mandatory to ensure routine vaccination of children and pregnant women without exposing the population to Covid-19. The feasibility of vaccinating in a place outside the UBS premises may be analyzed whenever vaccination inside UBS may compromise the safety of the groups to be vaccinated.

In a teaching-care unit of the Bahiana School of Medicine and Public Health (EBMSP), Salvador (BA), the list of patients followed by the unit was revised so to determine priority criteria for teleconsultations, providing teleservice through a mobile app and possible scheduling of patients to the UBS, as required[38]. In Nova Lima, to maintain chronic people care, home visits were prioritized after the teleservice, leaving the visits to UBS for cases of greater need[30]. In

Vitória (ES), a similar initiative was led remotely by the CHW – previously restrained from conducting home visits by municipal decree –, backed up by Nasf teams[39].

In Recife, Nasf professionals actively supported PHC routine actions, including the influenza vaccination campaign and the care for covid-19 cases[34]. In Sobral, the decision was to relocate professionals from medical and rehabilitation specialty centers that remained closed because of the pandemic to strengthen the provision of PHC routine services[31].

Mental health care during the pandemic requires special attention. It should be carried on and expanded, since measures of social distancing can cause mental suffering while overloaded health professionals need support. Nasf professionals can support distance consultations whereas PHC can back up mental health services.

In Itabuna (BA), an integration between UBS and mental health services allowed mental health users to continue renewing their prescriptions in the UBS, decreasing the need to travel to specialized centers. In this scenario, ESF teams become in charge of handling elective mental health care sought for mild anxiety or interpersonal relationship disorders, only referring to specialized services those most severe cases. That integration allowed for an important narrowing of mental health users to PHC services, to which those users rarely required care before the pandemic[40].

The maintenance of pharmaceutical care can be ensured by means of lists of chronic patients who require continuous treatment so to organize PHC home distribution of medicines, as provided in Canaã dos Carajás[29]. It is also possible to adopt electronic prescription forms with digital certification to avoid unnecessary visits to UBS, following the Florianópolis experiment, where regulations were determined for the pharmacy network to accept the prescriptions of common medicines and antibiotics made by video calling, in addition to agreements with laboratories for the acceptance of testing requests in electronic format[28].

CHW work maintenance is essential for the community approach to the pandemic in the four axes: surveillance, support for vulnerable groups, continuity of family monitoring by means of peri-domicile visit, and distance communication. Hence, it is necessary to provide CHW with continued education activities and to ensure adequate PPE for their safety, as for to the type of activity performed.

The effective and efficient development of that conjoint of actions requires training for all teams' professionals on coping with The Covid-19 and on the use of personal protective equipment appropriate to each type of activity performed.

Final remarks

PHC performance teams is crucial in all stages of the pandemic. If, at first, opportunities for PHC effective action were lost due to the absence of a national health authority and of clear national guidelines in Brazil, generating both interruption of activities and centrality on intensive hospital care during the pandemic, actions have been resumed in many municipalities, as shown by the experiences reported here.

The pandemic continues with different rhythms and stages in the vast and unequal national territory. To continue the deceleration of cases and resumption of activities, it is essential to intensify health surveillance with the participation of PHC teams so to prevent new infection waves. But there are challenges to overcome.

ESF articulated action and health surveillance for the control of Covid-19 require training actions of ESF professionals that go beyond the simple transfer of clinical technical information and that contribute to the reflection on the care model, social participation and community action by means of the use of

epidemiological and social data portraying the local reality. It is important that the various workers involved be able to conceptually operate the health surveillance model in its various dimensions.

Therefore, it is essential to further activate the community attributes of ESF and Nasf multidisciplinary teams; to join the solidarity initiatives of community organizations and articulate in an intersectoral way to support the population in its various vulnerabilities; and to ensure the continuity of promotion, prevention and care actions, creating new working processes for health surveillance and social and health support aimed at vulnerable groups, so to enable the continuity of routine care for those who need it.

Undoubtedly, PHC performance is only fully effective when belonging to an integrated network[41]. Without access to hospital services for intermediate and severe cases, the early diagnosis provided by PHC does not materialize in timely care.

More than ever, it is important to continue serving people, working as a team, even at distance, so to ensure the continuity of attention with a strong bond, because, due to uncertainties and social distancing, we are all more fragile.

The coping with the pandemic has revealed the unequal distribution of health services, requiring the construction of regionalized care networks and the strengthening of the state health authority, which can be a positive legacy for SUS. These are uncertain times that demand reinventing working processes oriented to each context, defining new flows, strengthening networks, exercising solidarity.

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References

1. Nacoti M, Ciocca A, Giupponi A, et al. At the Epicenter of the Covid-19 Pandemic and Humanitarian Crises in Italy: Changing Perspectives on Preparation and Mitigation. NEJM Catal. 2020 [acesso em 2020 abr 22]; 1(2):1-5. Disponível em: https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0080%0Ahttps://catalyst.nejm.org/doi/abs/10.1056/CAT.20.0080.

2. Dunlop C, Howe A, Li D, et al. The coronavirus outbreak: The central role of primary care in emergency preparedness and response. BJGP Open. 2020 [acesso em 2020 maio 28]; 4(1). Disponível em: https://bjgpopen.org/content/4/1/bjgpopen20X101041.

3. Redwood-Campbell L, Abrahams J. Primary health care and disasters - The current state of the literature: What we know, gaps and next steps. Prehosp Disaster Med. 2011; 26(3):184-91.

4. Sundararaman T. Health systems preparedness for COVID-19 pandemic. Indian J Public Health. 2020 [acesso em 2020 jul 10]; 64(6):91. Disponível em: http://www.ijph.in/text.asp?2020/64/6/91/285624.

5. Aquino R, Oliveira NF, Barreto ML. Impact of the Family Health Program on Infant Mortality in Brazilian Municipalities. Am J Public Health. 2009; 99(1):87-93.

6. Rede de Pesquisa em Atenção Primária à Saúde da Abrasco. Contribuição dos pesquisadores da Rede APS ao debate sobre as recentes mudanças na política de atenção primária propostas pelo MS. Abrasco. [2019]. [acesso em 2020 maio 28]. Disponível em: https://www.abrasco.org.br/site/wp-content/uploads/2019/10/Contribuicoesdospesquisaadores_REDEAPS.pdf.

7. Giovanella L, Franco CM, Almeida PF. Política Nacional de Atenção Básica: para onde vamos? Ciênc. e Saúde Colet. 2020 [acesso em 2020 abr 25]; 25(4):1475-82. Disponível em: http://orcid.org/0000-0003-1430-6951.

8. Rede de Pesquisa em Atenção Primária à Saúde da Abrasco. A APS no SUS no enfrentamento da pandemia COVID-19. 2020 mar 23. [acesso em 2020 maio 28]. Disponível em: https://redeaps.org.br/2020/03/23/a-aps-no-sus-no-enfrentamento-da-pandemia-covid-19/.

9. Lorenzo SM. La pandemia COVID-19: lo que hemos aprendido hasta ahora desde España. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(1):28-32. Disponível em: https://apsemrevista.org/aps/article/view/66.

10. Roberton T, Carter ED, Chou VB, et al. Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. Lancet Glob Heal. 2020 [acesso em 2020 maio 16]; (8):e901-8. Disponível em: https://doi.org/10.1016/S2214-109X(20)30229-1.

11. República Portuguesa. Serviço Nacional de Saúde. Diretoria Geral da Saúde. Áreas dedicadas Covid-19. [acesso em 2020 maio 16]. Disponível em: https://covid19.min-saude.pt/areas-dedicadas-covid-19/.

12. Li X, Krumholz HM, Yip W, et al. Quality of primary health care in China: challenges and recommendations. Lancet. 2020 [acesso em 2020 jul 9]; 395(10239):1802-12. Disponível em: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30122-7.pdf.

13. Vega R. Lecciones de Cuba en la contención de la pandemia por COVID-19 desde el papel de la Atención Primaria en Salud. Microsoft Sway. 2020. [acesso em 2020 jul 9]. Disponível em: https://sway.office.com/kMEWRcOaXcuhmJnn?ref=Link.

14. Vitória AM, Campos GWS. Só com APS forte o sistema pode ser capaz de achatar a curva de crescimento da pandemia e garantir suficiência de leitos UTI. [São Paulo]: Cosems SP; 2020. [acesso em 2020 abr 22]. Disponível em: http://www.cosemssp.org.br/wp-content/uploads/2020/04/So-APS-forte-para-ter-leitos-UTI-.pdf.

15. Engstrom E, Melo E, Giovanella L, et al. Nota Técnica. Recomendações para a organização da Atenção Primária à Saúde no SUS no enfrentamento da Covid-19. Série Linha de Cuidado Covid-19 na Rede de Atenção à Saúde. Rio de Janeiro: Observatório Covid-Fiocruz; 2020. [acesso em 2020 jul 2]. Disponível em: https://portal.fiocruz.br/sites/portal.fiocruz.br/files/documentos/

recomendacoes_aps_no_sus_para_enfrentamento_da_covid-19_versao_leitura_uma_coluna_1_.pdf.

16. Medina MG, Giovanella L, Bousquat AEM, et al. Atenção Primária à Saúde em tempos de Covid-19: O que fazer? Cad. Saúde Pública. 2020 [acesso em 2020 ago 30]; 36(8):e00149720. Disponível em: http://cadernos.ensp.fiocruz.br/csp/artigo/1140/atencao-primaria-a-saude-em-tempos-de-covid-19-o-que-fazer.

17. Teixeira CF, Paim JS, Vilasbôas AL. SUS, modelos assistenciais e vigilância da saúde. Inf. Epidemiol. Sus. 1998 [acesso em 2020 jul 10]; 7(2):7-28. Disponível em: http://scielo.iec.gov.br/scielo.php?script=sci_arttext&pid=S0104-16731998000200002&lng=pt. http://dx.doi.org/10.5123/S0104-16731998000200002.

18. Teixeira CF, Solla JP. Modelo de atenção à saúde: vigilância e saúde da família. Salvador: Editora EDUFBA; 2006. [acesso em 2020 jul 9]. Disponível em: https://static.scielo.org/scielobooks/f7/pdf/teixeira-8523204008.pdf.

19. Pedebos LA, Rocha DK, Tomasi Y. A vigilância do território na atenção primária: contribuição do agente comunitário na continuidade do cuidado. Saúde debate. 2018 [acesso em 2020 jul 10]; 42(119)940-951. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-11042018000400940&tlng=pt.

20. Nascimento MS, Nascimento MA. Prática da enfermeira no Programa de Saúde da Família: a interface da vigilância da saúde versus as ações programáticas em saúde. Ciênc. Saúde Colet. 2005; 10(2):333-345.

21. Santos S, Melo C, Dallaire C, et al. Contextual determinants of decentralization of epidemiological surveillance for the family health team. Interface. 2015; (54):443-454.

22. Santos S, Melo C, Costa H, et al. Avaliação da capacidade de gestão descentralizada da vigilância epidemiológica no estado da Bahia. Ciênc. Saúde Colet. 2012; 17(4):873-882.

23. Guimarães FG, Carvalho TML, Bernardes RM, et al. A organização da atenção Primária à Saúde de Belo Horizonte no enfrentamento da Pandemia Covid 19: relato de experiência. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):74-82. Disponível em: https://apsemrevista.org/aps/article/view/128.

24. Ruiz DC, Martufi V. Telemonitoramento durante a pandemia de COVID-19 na Clínica de Família Zilda Arns RJ. Rio de Janeiro: Rede de Pesquisa em Atenção Primária à Saúde da Abrasco; 2020. [acesso em 2020 jul 19]. Disponível em: https://redeaps.org.br/2020/07/18/telemonitoramento-durante-a-pandemia-de-covid-19-na-clinica-de-familia-zilda-arns-rj/.

25. Potter C. Zero Covid-19 deaths in Vietnam. Baltimore Estados Unidos: Outbreak Observatory. Johns Hopkins Bloomberg School of Public Health. Center for Health Security; 2020. [acesso em 2020 jul 14]. Disponível em: https://www.outbreakobservatory.org/outbreakthursday-1/7/9/2020/zero-covid-19-deaths-in-vietnam?utm_source=Nature+Briefing&utm_campaign=6d59e2cbe7-briefing-dy-20200714&utm_medium=email&utm_term=0_c9dfd39373-6d59e2cbe7-45390226.

26. Nedel FB. Enfrentando a COVID-19: APS forte agora mais que nunca! APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(1):11-6. Disponível em: https://apsemrevista.org/aps/article/view/68.

27. Cheng KK, Lam TH, Leung CC. Comment Wearing face masks in the community during the COVID-19 pandemic: altruism and solidarity. Lancet. 2020. [acesso em 2020 maio 28]. Disponível em: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30918-1/fulltext.

28. Silveira JPM, Zonta R. Experiência de reorganização da APS para o enfrentamento da COVID-19 em Florianópolis. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):91-6. Disponível em: https://apsemrevista.org/aps/article/view/122.

29. Vale EP, Rodrigues GM, Costa DP, et al. Reorganização da Rede de Atenção à Saúde para o enfrentamento da COVID-19 no município de Canaã dos Carajás, Pará. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):83-90. Disponível em: https://apsemrevista.org/aps/article/view/101.

30. Fernandez MV, Castro DM, Fernandes LDMM, et al. Reorganizar para avançar: a experiência da Atenção Primária à Saúde de Nova Lima/MG no enfrentamento da pandemia da Covid-19. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):114-21. Disponível em: https://apsemrevista.org/aps/article/view/84.

31. Ribeiro MA, Júnior DGA, Cavalcante ASP, et al. (RE) Organização da Atenção Primária à Saúde para o enfrentamento da COVID-19: Experiência de Sobral-CE. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):177-88. Disponível em: https://apsemrevista.org/aps/article/view/125.

32. Cardona Júnior AHS, Andrade CWQ, Caldas LNM. Educação em saúde: programa e canal de comunicação via WhatsApp da unidade básica de saúde do N6 para comunidade rural do sertão pernambucano. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):137-41. Disponível em: https://apsemrevista.org/aps/article/view/92.

33. Fillis MMA, Dellaroza MSG, Machado RA, et al. Saúde do trabalhador em tempos de COVID-19: a experiência do município de Londrina. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):106-13. Disponível em: https://apsemrevista.org/aps/article/view/97.

34. Oliveira MAB, Monteiro LDS, Oliveira RDC, et al. A prática do núcleo de apoio à saúde da família do Recife no enfrentamento à pandemia COVID-19. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):142-50. Disponível em: https://apsemrevista.org/aps/article/view/96.

35. Daumas RP, Silva GA, Tasca R, et al. O papel da atenção primária na rede de atenção à saúde no Brasil: limites e possibilidades no enfrentamento da COVID-19. Cad. Saúde Pública. 2020; 36(6):e00104120.

36. Ruiz DC, Martufi V. Enfrentando a pandemia no Complexo do Alemão: ações conjuntas do GT Comunitário da Clínica de Família Zilda Arns e do Gabinete de Crise do Alemão, município do Rio de Janeiro. Rio de Janeiro: Rede de Pesquisa em Atenção Primária à Saúde da Abrasco; 2020. [acesso em 2020 jul 10]. Disponível em: https://redeaps.org.br/2020/07/06/enfrentando-a-pandemia-no-complexo-do-alemao-acoes-conjuntas-do-gt-comunitario-da-clinica-de-familia-zilda-arns-e-do-gabinete-de-crise-do-alemao-municipio-do-rio-de-janeiro/.

37. Gomes Junior AS, Latge PK, Oliveira RAT, et al. A experiência de Niterói no enfrentamento da COVID 19: notas preliminares sobre a articulação de políticas sociais e de saúde. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):128-136. Disponível em: https://apsemrevista.org/aps/article/view/126.

38. Santos ABS, França MVS, Santos JLF. Atendimento remoto na APS no contexto da COVID-19: a experiência do Ambulatório da Comunidade da Escola Bahiana de Medicina e Saúde Pública em Salvador, Bahia. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):189-96. Disponível em: https://doi.org/10.14295/aps.v2i2.120.

39. Rodrigues AP, Felipe CR, Lima DB, et al. Telemonitoramento como estratégia de cuidado longitudinal a grupos prioritários em tempos da COVID-19: uma experiência na atenção primária à saúde do município de Vitória-ES. APS EM Rev. 2020 [acesso em 2020 jul 3]; 2(2):189-96. Disponível em: https://apsemrevista.org/aps/article/view/100.

40. Cruz NMLV, Souza EB, Sampaio CSF, et al. Apoio psicossocial em tempos de COVID-19: experiências de novas estratégias de gestão e ajuda mútua no sul da Bahia, Brasil. APS EM Rev. 2020 [acesso 2020 jul 3]; 2(2):97-105. Disponível em: https://apsemrevista.org/aps/article/view/94.

41. Fundação Oswaldo Cruz; Conselho Nacional de Saúde. Atenção primária e sistemas universais de saúde: compromisso indissociável e direito humano fundamental. Saúde debate. 2018; 42(esp1):434-451.

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