ORIGINAL ARTICLE

LESSONS LEARNED FROM THE REORGANIZATION OF PRIMARY CARE IN THE PANDEMIC CONTEXT IN TWO MUNICIPALITIES IN BAHIA

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Highlights: (1) Workflows were reorganized to ensure safe access in PHC. (2) Technologies such as WhatsApp strengthened remote care during the pandemic. (3) Intersectorality was essential for the local response to COVID-19. (4) Specific spaces and protocols were created for flu-like syndrome cases. (5) Training strengthened the PHC response to the health crisis

PRE-PROOF
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ABSTRACT

The objective was to analyze the reorganization of Primary Care health actions and services during the COVID-19 pandemic in two small municipalities in Bahia. This is qualitative and descriptive research that utilized 15 semi-structured interviews with managers and health workers from two Family Health Strategy (FHS) units in the municipalities of Souto Soares and Iraquara (BA), as well as documentary analysis. Data were analyzed with the support of MAXQDA software for Content Analysis and the categorization of health actions and services. Results evidenced changes in operational flows and the work process; monitoring of COVID-19 cases; strengthening of intersectorality; creation of specific spaces; protocol development; and general actions such as guidance to the population, sanitary barriers, and testing. Furthermore, the study highlighted the use of technologies, messaging apps, and permanent education. It is concluded that the reorganization of Primary Health Care (PHC) is an imperative necessity for the development of more qualified, humane, and resolute healthcare.

Keywords: Primary Health Care; COVID-19; Organization

INTRODUCTION

To face the new coronavirus pandemic, health systems worldwide had to reorganize flows, especially in primary health care (PHC), due to its capacity to link, manage, and monitor cases. In other words, this was due to its capacity for mobilization, capillarity, and resoluteness within the population[1].

.According to Medina et al.[1], the health response was centered on hospital services in several parts of the world. One cannot deny the importance of these specialized services in caring for a portion of COVID-19 cases, but it is necessary to adopt a more careful analysis

within the scope of PHC, given its strategic role in organizing care networks, health surveillance, and acting within territories and communities.

It is essential to highlight the capacity of countries with primary care to prevent and detect cases due to their greater capillarity for notification and, consequently, providing more reliable data regarding lethality and cure rates[2].

According to the World Health Organization (WHO)[3], about 80% of people who contracted COVID-19 recovered without the need for hospitalization, and one in six faced respiratory complications. It is in this context that strong primary care systems form the basis of any response to health emergencies; even in the face of outbreaks, epidemics, or pandemics, efforts must be directed toward this level of care, which is capable of mitigating harmful impacts on human health[4].

In Brazil, PHC is the main gateway to the Unified Health System (SUS) and the first level of care, guiding its actions by the principles of universality, integrality, and equity[5]. However, at the peak of the pandemic context, the system's underfunding and austerity policies adopted by the national government at that time may have impacted the capacity of PHC to respond to COVID-19, due to disjointed remarks from the federal manager regarding international recommendations. This context was aggravated by the concentration of resources in specific regions and large cities[4].

Furthermore, there was still low coordination between surveillance and health care actions in PHC; reduced use of the Family Health Strategy (FHS), given its capillarity and potential to increase community sense and engagement, in addition to the fragility of health information systems[6,7].

In Bahia, the COVID-19 pandemic evolved unevenly, seriously affecting small municipalities with precarious infrastructure. In these locations, the shortage of human resources, beds, and equipment highlighted the fragility of the local health system. This situation reinforced the importance of strengthening primary care, especially in vulnerable contexts and with less capacity to respond to health emergencies[30].

Given this reality, in February 2020, even without confirmed cases, the Ministry of Health activated the National Public Health Emergency Response Plan and established the Public Health Emergency Operations Center for the new Coronavirus[6].

According to the WHO, systems with a structured and innovative PHC expand care focused on more accessible, comprehensive, and longitudinal attention to the population[8]. In this sense, PHC translates into a potentially resolute space to break with the fragmentation of health systems and ensure continuity of care across all levels of care[1,9,10].

Thus, given the need to rethink PHC strategies and identify new paths for its reorganization during and after the health crisis, especially in small municipalities, this article aimed to analyze the lessons learned regarding the reorganization of health actions and services in Primary Care during the COVID-19 pandemic.

METHODOLOGY

This is a qualitative and descriptive study, originating from the original research titled "Strategies and technologies to ensure access and resoluteness of Primary Health Care in the context of the COVID-19 pandemic in the east-central health macro-region," developed by faculty members from the State University of Feira de Santana (UEFS) – BA. The East-Central macro-region is composed of 10 municipalities joined into four health regions whose headquarters are: Serrinha, Seabra, Itaberaba, and Feira de Santana.

Municipalities in the east-central macro-region of Bahia with 100% coverage of the Family Health Strategy (FHS) and the highest number of reported COVID-19 cases were adopted as inclusion criteria. Although ten municipalities met these criteria, this study performed a territorial cut in the Seabra region, selecting Iraquara and Souto Soares. The choice considered methodological criteria and the feasibility of the research, allowing for a deeper analysis of the reorganization of Primary Care in the context of the health crisis.

Iraquara has an estimated population of 25,728 inhabitants and a Municipal Human Development Index (MHDI) of 0.599, while Souto Soares has 17,118 inhabitants and an MHDI of 0.592 (IBGE, 2021). Both have 100% coverage by the Family Health Strategy (FHS) and a service structure composed of health units, Psychosocial Care Centers (CAPS), and Health

Academies, in addition to a municipal hospital in the case of Souto Soares. They stand out in the region both for the high number of reported COVID-19 cases and for the organization of health services during the pandemic; Souto Soares, despite its smaller population size, presents a higher infant mortality rate, indicating additional challenges in facing social and health vulnerabilities (CNES, 2022).

The Consolidated Criteria for Reporting Qualitative Research (COREQ) guide, in its version translated and validated for the Portuguese language, was used for the writing of this research. Data collection was conducted by the researcher, who holds a Master's degree in Collective Health from the UEFS Graduate Program in Collective Health. Being male, he has experience in the public health field and training in qualitative research. Before the interviews, previous contact was made with the participants, who were informed about the research objectives, his institutional link, and guarantees of confidentiality and the use of data for scientific purposes.

Among the study participants are 15 interviewees: 6 managers and 9 health workers, based on the following inclusion criteria: all those who agreed to participate in the study and who worked or are currently working in primary care, either in management or direct care, for at least six months during the years 2020 to 2022. Exclusion criteria included those who were on leave and/or vacation. All invitations extended were accepted, resulting in full participation of the invited professionals.

For data collection, semi-structured interviews and documentary analysis were used. The instruments for data collection included interview scripts, a logbook, and technological resources (recorder and smartphone).

Data were collected at the Municipal Health Secretariats in the municipalities of Souto Soares and Iraquara, Bahia, including the primary care and epidemiological surveillance coordination offices, as well as the Family Health Strategy (FHS) units.

The interviews, with an average duration of 12 to 35 minutes, were guided by a script aimed at understanding the perceptions and experiences of managers and health workers regarding the (re)organization of Primary Care actions and services during the COVID-19 pandemic. The script addressed themes such as the participants' understanding of the pandemic,

the importance of Primary Care in the response, changes in work routine, innovative strategies and actions, interventions carried out, facilitators and difficulties encountered, evaluation of team activities, availability of human and material resources, interactions with other services, and suggestions for improvements in light of the challenges experienced during the pandemic period.

Secondary data exploration was conducted through the analysis of documents such as plans, ordinances, official government guidelines, and FHS activity reports. These sources allowed for an understanding of how services were reorganized, the strategies adopted, the innovations implemented, and the challenges faced in tackling the pandemic in the two studied municipalities.

The collected data were analyzed using Bardin's content analysis technique. This method involves organizing transcripts followed by an in-depth reading for the systematization and categorization of data. From an exhaustive reading, thematic categories are defined, which support the final stage of analysis based on a global understanding of the material and the studied context. This analysis was conducted with the assistance of MAXQDA, a Qualitative Data Analysis Software (QDAS).

The study adhered to all ethical aspects as it involved research with human subjects, following Resolution No. 466 of December 12, 2012. Data collection occurred only after the research project was approved by the Research Ethics Committee (CEP) of the State University of Feira de Santana (UEFS), under CAAE No. 65693716.7.0000.0053, and upon receiving authorization for fieldwork from the health secretaries. The interviewer sought to comply with the criteria and procedures that ensured the interviewee's confidentiality and anonymity, aiming to respect their integrity, privacy, and the security of the data obtained.

RESULTS AND DISCUSSION

The pandemic context showed the importance of the role of PHC in small municipalities for the reorganization of actions aimed at the early identification of suspected cases, immediate notification, active contact tracing, strengthening home isolation, health education, and support for vulnerable groups. The analyses conducted essentially demonstrated facilitating and

restrictive aspects of facing the pandemic, given the technical and governmental capacities present in the studied locations.

The analysis of the word cloud generated by the software showed that the term "cell phone" (celular) was most prominent, followed by the word "flow" (fluxo), which directly reflects the reality pointed out in the interviews. The use of cell phones was a fundamental strategy adopted by health services during the COVID-19 pandemic, both to enable communication between teams and patients and to support the (re)organization of care flows, contributing significantly to the continuity and safety of care processes.

Figura 1 – Nuvem de palavras referente às estratégias e serviços inovadores para reorganização das ações e serviços de saúde da APS durante a pandemia da COVID- 19

Fonte: Maxqda[13]

From this word cloud, it is possible to perceive that among the main strategies implemented by health services are technologies, which were widely used in the context of the COVID-19 pandemic. These strategies are distributed in the following categories:

Organization and alteration of operational flows and the work process

According to the records found in contingency plans, activity reports developed during that period, and meeting minutes, the reorientation of care flows was one of the main strategies used to facilitate the organization of work dynamics. This allowed for the reorganization of actions through innovations that gave a new face to the services offered, as reported below:

> [...] an identified room for flu-like syndromes was created; many of them did not enter through the main entrance, there was a door that gave access to the outside door. (ENT 1)
>
> [...] it decreased a bit due to the pandemic, so we had to decrease the flow of patients in the unit. (ENT 4)
>
> We organized so as not to see pregnant women with risk groups on the same day there are many medical consultations; we try to separate these groups. (ENT 6)

These findings corroborate the results presented by Giovanella et al.[15], which demonstrate that the reorganization of care flows in the FHS for tackling COVID-19 was a determining factor for the greater effectiveness of services in the view of health professionals (89.5%) and managers (80%).

Accordingly, extra spaces were created in the Family Health Strategy health units to care for suspected or confirmed COVID-19 cases, which for Guimarães et al.[6] was an especially important measure, given that PHC is based on the proximity between professionals and patients, which can increase the risk of disease transmission.

These changes were implemented to ensure that primary care services could continue providing quality care during the pandemic while minimizing the risk of virus transmission. As can be observed in the following statements:

> We used the **meeting room**, so these patients waited in that environment; there was a **change in the flow**, as we separated the waiting room from the other patients. (ENT 2)
>
> We had **to suspend all actions** regarding the multidisciplinary teams, which was NASF; in the face of the returning COVID-19 wave, we suspended collective actions. (ENT 5)

In this context, the FHS was fundamental in tackling the COVID-19 pandemic in Brazil by using innovations and changes in the work process to ensure access to health services and reduce the risk of virus transmission. This was especially important in light of the social distancing context adopted by a large part of the population to control the COVID-19 pandemic, which triggered a series of developments due to the lack of continuity of care, particularly for those living with chronic conditions (hypertension and diabetes), necessitating the implementation of new strategies for developing work in the FHS[16].

Thus, during the COVID-19 pandemic, the reorganization of care flows became an even more important strategy, as it helped to avoid crowding in health units and control patient flow, reducing the risk of virus transmission[17,2].

It is essential that the reorganization of the PHC work process during the pandemic is conducted in a way that preserves its attributes of access, longitudinality, and care coordination. This enables new actions to be developed within a family and community approach, through an integral perspective and humanized care[5].

All the strategies used in the FHS, which redesigned the service flow throughout the COVID-19 pandemic, represented a challenge for the health system, requiring rapid adaptation from teams and their practices; however, they have proven viable for ensuring continuity of care and access to health services for the population.

Use of technologies, with emphasis on messaging apps via smartphones, as a way to improve user access to health services

In the studied municipalities, initiatives to expand and continue population access to PHC care were observed through their contingency plans, as also evidenced in the interviews:

> The technologies, we used **sound trucks and radio to inform the population about the services being offered. (ENT 5)**
> **It was basically via cell phone, through the WhatsApp app, calls, text messages... We tried to maintain contact with users, scheduling, forwarding, exams, responses, video calls, medical consultations, and nursing consultations. (ENT 8)**

In this context of innovations, we agree with Silva et al.[18] and Keesara et al.[19] that the use of technologies such as tele-assistance for consultations and remote guidance, especially during the pandemic, reduced exposure to the risk of contamination for both professionals and users, while expanding the accessibility and quality of health services.

Although the use of digital technologies has noticeably increased due to their role in communication between citizens and the State, the limitations of access by the most vulnerable population regarding both devices and internet access cannot be denied, as this limits services and impacts health actions[20].

Various paths were considered to implement health services during this pandemic, but access was facilitated by the use of technologies supporting the implementation of teleconsultations—primarily via cell phone—as recorded in patient charts and seen in the following statements.

> One way to facilitate contact was through teleconsultations, which we did via cell phone, and if necessary, we would conduct a home visit. (ENT 4)
> [...] when we started to have a cell phone in each PSF to maintain [contact], we had this ease of getting in touch with patients and for cases of continuous monitoring, [such as] a hypertensive person or a person who has some comorbidity. (ENT 6)

These findings corroborate the results of the study by Giovanella et al.[15], in which technology also allowed for the monitoring and management of cases that were mostly conducted through phone calls or messages via the WhatsApp application. However, despite the limitations of access by some population groups, telemedicine, during the COVID-19 pandemic, brought numerous facilities for the continuity of health care[18]. In addition to increasing and expanding listening, welcoming, and guidance to users, with an increase in the scale of care[21, 22].

Governance for tackling the pandemic.

Another implemented strategy concerns the adoption of intersectoral actions. In fact, valuing intersectorality as a central pillar makes it possible to fill gaps and rethink health strategies aimed at changing the current care model. These dialogues emerged during the interviews with great confidence from the professionals and managers interviewed, as follows:

> "[...] all the professionals in the network, social action, education, everyone contributed with us to strengthen the activities. (ENT 4)
>
> [...] with surveillance, with assistance, in 100% partnership with primary care, partnerships with other departments, providing staff, transportation, materials. (ENT 5)"

Undoubtedly, intersectorality was of utmost importance in fighting the COVID-19 pandemic, as the health crisis affected various sectors of society, not being restricted only to health, but also to the economy, the environment, security, education, and many other sectors[22].

Beyond Primary Health Care (APS) actions, the creation of other services was necessary to meet the demands imposed by the pandemic, such as the creation of influenza clinics (gripários), COVID-19 testing centers, as well as specific rooms for these consultations in health units:

> A COVID-19 sector was set up, an 'influenza clinic' (gripário), and in each unit, a room was also created, identified for flu-like syndromes; there were also sanitary barriers. (ENT 1)
>
> We created a specific COVID-19 sector in the municipality, which is in the polyclinic it is an additional service to attend to flu-like syndromes; we created a COVID-19 commission, we created a protocol. (ENT 4)

Thus, reserved spaces were created within the units for conducting COVID-19 diagnostic tests, as well as structured environments to care for infected users. [24].

Certainly, organizational innovations have the potential to improve access to primary care, restructuring health services to better serve the population. As a result, COVID-19 catalyzed a rapid and substantial reorganization of primary care, accelerating the dissemination of existing strategies and fostering the proliferation of innovations[25] .

The COVID-19 pandemic brought unprecedented challenges to society worldwide, demanding rapid and effective responses to deal with the crisis. As observed in the interviews below, various services were implemented in the municipalities under study as a way to address users who were circulating, especially at the entrances and exits of these cities, according to the following statements:

> Actions were carried out in the open-air market, [...] initially we used radio, sound trucks, health agents also provided guidance door-to-door, actions with banners in the city. (ENT 2)
>
> [...] we set up sanitary barriers. (ENT 4)
>
> [...] we developed a contingency plan, tested health professionals and discovered that 50% were positive, provided a cell phone for each team [...]. (ENT 5)
>
> There was a monitoring team, specifically for COVID-19 cases only, also via cell phone. (ENT 8)

According to Giovanella et al[26] Community actions emerged according to the needs experienced in each city, seeking to block and reduce the risk of the epidemic's expansion. In this way, health surveillance coordinated, within the territory, primary and secondary prevention actions for COVID-19, such as case identification, testing, and active contact tracing; support for home isolation of cases and contacts; case notification; and health education actions that leveraged existing collective communication resources in the community, in addition to community radios, sound trucks, among others.

In fact, the COVID-19 pandemic required municipalities to adopt rapid and effective measures to contain the spread of the virus. The creation of monitoring teams was another important strategy in this regard, as it allowed local authorities to closely monitor the epidemiological situation and implement disease control and prevention measures[10].

Training and continuing education for healthcare Workers

APS teams have the potential to provide health information and education to the community, promoting actions in businesses and strategic spaces to reach the entire population with services and information to fight COVID-19. As a result, community radios, sound trucks, and open-air markets were essential for addressing the territorial epidemiological situation and adopting protection measures, such as social distancing, wearing masks, and hand washing[17, 1].

Given all the strategies mentioned so far, the worker qualification process was essential for the actions to be implemented in the studied municipalities:

> [...] technicians were trained to perform collections in the units and help the team here because two biomedics and a few technicians were not enough. (ENT 1)
>
> We had guidance, training, a lot of self-care, masks... We learned little by little; the pandemic taught us how to protect ourselves, how to take care. (ENT 7)

The Continuing Education in Health (EPS) policy historically presents itself as having the potential to drive change processes and the consolidation of the healthcare model as a precept for the inclusion of workers, users, and managers in the production and management of care and work processes, seeking to modify labor relations. This enables training and intervention through courses and workshops based on points experienced and discussed during the production of work, implying changes in the daily routine of health services[27].

Thus, we agree with Zingra *et al.*[28] (2020) that the educational process can be a facilitator in the reorganization of health actions and services, aiming to improve care strategies and harmoniously integrate the teams on the front line of the fight against COVID-19; thus, it is possible to invest in healthcare with more qualified professionals prepared to face this and other challenges.

However, in the studied municipalities, although the implementation of Continuing Education (CE) was verified through reports and team meeting minutes, there is a notorious lack of active CE that awakens in professionals the power to transform practices in the work environment, based on the engagement of various health system actors: workers, managers, and users. To dream of this reality is to believe in a transformative and humanized education in the construction of care[29].

The COVID-19 pandemic came as an imperative for health services regarding service innovation, given that actions and services needed to undergo a reorganization process based on the structuring and integration of health units, in their various complexities and technological densities. Furthermore, it is necessary to rethink humanization relationships, as well as the resoluteness of health teams toward the needs of families in the Family Health Strategy (ESF) coverage areas.

FINAL CONSIDERATIONS

The COVID-19 pandemic had a significant impact on the reorganization of primary health care worldwide, with the ESF (Family Health Strategy) being a structural and strategic pillar in the implementation of health actions to combat the pandemic in Brazil. In light of this, PHC managers and health workers had to adopt new strategies and innovations to face the challenges and maintain the continuity and quality of care provided to users.

This was a moment of great challenges for the health sector, providing a unique opportunity to learn and innovate. In this regard, it became evident that primary care is the first line of defense against any pandemic situation, specifically due to the rapid response provided by PHC in terms of mitigating the virus's spread and providing timely and appropriate health care to infected patients.

Given the main findings of this research, it is understood that its objective has been achieved and that the process of reorganizing health services, especially PHC, should be used as a tool to further improve primary care, identify gaps in response capacity during times of crisis, and better prepare for future health crisis situations. This requires continuous investment in motivation and appropriate tools for health professionals, as well as an innovative approach to the delivery of primary health services.

Considering the context presented, it is important to highlight that this research faced some limitations that may have influenced the discussion process. Among them, the absence of an updated management report according to the Ministry of Health's recommendations and insufficient records during the pandemic period by the studied municipalities stand out, which limited the documentary analysis in the process of analyzing the findings of this research.

This research revealed several gaps in the levels of care that will serve as a basis for other studies, such as the fragility of the integration between PHC services, epidemiological surveillance, and hospital services that were evidenced during the COVID-19 pandemic. As well as the deficiency of effective communication due to the absence of integrated information systems, which hinders integrated care in any emergency situation.

Given this discussion, we can elaborate on the lessons learned in this study regarding the needs for PHC reorganization in facing health emergencies; greater technical capacity of small-sized municipalities; fostering greater integration of care levels through health care networks; besides secure investments in PHC, above all, in continuing education for better professional qualification. And thus, being able to envision a restructured SUS based on its solid foundation centered on a PHC that organizes the network and coordinates care, capable of promoting comprehensive, human, and continuous care for all.

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