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PRIMARY HEALTH CARE IN THE CONFRONTATION WITH OVID-19: ANALYSIS OF THE NORTHEASTERN STATE CONTINGENCY PLANS

ATENÇÃO PRIMÁRIA À SAÚDE NO ENFRENTAMENTO À COVID-19: ANÁLISE DOS PLANOS ESTADUAIS DE CONTINGÊNCIA DO NORDESTE

ATENCIÓN PRIMARIA DE SALUD EN FRENTE AL COVID-19: ANÁLISIS DE LOS PLANES ESTATALES DE CONTINGENCIA DEL NORESTE

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RESUMO

Objetivo: analisar de que forma a Atenção Primária à Saúde tem sido pensada pelas estruturas de gestão estadual, no Nordeste brasileiro, na proposição de medidas de contingenciamento para o enfrentamento a esta pandemia. **Método:** trata-se de um estudo documental onde se analisaram os Planos de Contingência elaborados pelas equipes gestoras em 2020 para o Nordeste brasileiro. **Resultados:** identificaram-se os seguintes componentes dos planos: (1) organização e estrutura formal; (2) objetivos definidos, gerais e específicos e (3) propostas definidas para o nível da Atenção Primária à Saúde. A análise dos planos de contingência para a COVID-19 dos Estados nordestinos deu-se à luz das características estruturantes da Atenção Primária à Saúde: atenção ao primeiro contato; integralidade e coordenação do cuidado; longitudinalidade; competência cultural e orientação familiar e comunitária. Mesmo com avanços, existe uma heterogeneidade na organização dos planos. Um dos planos estaduais analisados prevê todas as características estruturantes da Atenção Primária à Saúde, organizando, inclusive, a atuação da APS no sistema prisional em contraste a outro plano estadual analisado, que não prevê nenhuma ação sob responsabilidade da Atenção Primária à Saúde no contexto da COVID-19. Outro aspecto é que, em apenas três, dos nove planos estaduais do Nordeste, se contou com a participação de gestores responsáveis pela Atenção Primária à Saúde. **Conclusão:** a Atenção Primária à Saúde estando fortalecida, sendo ordenadora da rede assistencial e coordenadora do cuidado, combinada com a preparação de respostas rápidas pelos profissionais das urgências e emergências, com a ampliação de leitos para cuidados

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intensivos e medidas de distanciamento social, proporciona respostas mais efetivas à pandemia.

Palavras-chave: Atenção Primária à Saúde; Infecções por Coronavírus; Pandemias.

ABSTRACT

Objective: to analyze how Primary Health Care has been conceived by state management structures in northeastern Brazil, in proposing contingency measures to deal with this pandemic. Method: this is a documentary study where the Contingency Plans prepared by the management teams in 2020 for the Brazilian Northeast were analyzed. **Results:** the following components of the plans were identified: (1) organization and formal structure; (2) defined, general and specific objectives and (3) defined proposals for the level of Primary Health Care. The analysis of the contingency plans for COVID-19 in the northeastern states took place in light of the structuring characteristics of the Primary Health Care: attention to the first contact; integrality and coordination of care; longitudinality; cultural competence and family and community orientation. Even with advances, there is heterogeneity in the organization of plans. One of the analyzed state plans provides for all the structuring characteristics of Primary Health Care, including organizing Primary Health Care performance in the prison system in contrast to another analyzed state plan, which does not provide for any action under the responsibility of Primary Health Care in the context of COVID-19. Another aspect is that, in only three of the nine state plans in the Northeast, there was the participation of managers responsible for primary care. **Conclusion:** the Primary Health Care being strengthened, being the organizer of the assistance network and coordinator of care, combined with the preparation of rapid responses by professionals in urgent and emergency situations, with the expansion of beds for intensive care and measures of social distance, provides answers more effective to the pandemic.

Keywords: Primary Health Care; Coronavirus Infections; Pandemics.

RESUMEN

Objetivo: analizar cómo la Atención Primaria de Salud ha sido concebida por las estructuras de gestión del estado en el Noreste de Brasil, al proponer medidas de contingencia para enfrentar esta pandemia. **Método:** este es un estudio documental donde se analizaron los Planes de Contingencia preparados por los equipos de gestión en 2020 para el Noreste brasileño. **Resultados:** se identificaron los siguientes componentes de los planes: (1) organización y estructura formal; (2) objetivos definidos, generales y específicos y (3) propuestas definidas para el nivel de la Atención Primaria de Salud. El análisis de los planes de contingencia para COVID-19 en los estados del noreste tuvo lugar a la luz de las características de estructuración de la Atención Primaria de Salud: atención el primer contacto; integralidad y coordinación de la atención; longitudinalidad competencia cultural y orientación familiar y comunitaria. Incluso con los avances, hay heterogeneidad en la organización de los planes. Uno de los planes estatales analizados proporciona todas las características de estructuración de la Atención Primaria de Salud, incluida la organización del desempeño de la Atención Primaria de Salud en el sistema penitenciario en contraste con otro plan estatal analizado, que no prevé ninguna acción bajo la responsabilidad de la Atención Primaria de Salud en el contexto de COVID-19. Otro aspecto es que, en solo tres de los nueve planes estatales en el noreste, hubo la participación de gerentes responsables de la Atención Primaria de Salud. **Conclusión:** el fortalecimiento de la Atención Primaria de Salud, siendo el organizador de la red de asistencia y coordinador de la atención, combinado con la preparación de respuestas rápidas por profesionales en situaciones de urgencia y emergencia, con la expansión de

camas para cuidados intensivos y medidas de distancia social, proporciona respuestas más eficaces para la pandemia.

Palabras-clave: Atención Primaria de Salud; Infecciones por Coronavirus; Pandemias.

INTRODUCTION

Just over four months ago, that is, since January 2020, health systems around the world have faced one of the greatest health challenges in history. It is a pandemic of unprecedented proportions that has launched inexhaustible challenges for the modern States and their leaders in maintaining health and preserving the lives of its population.

COVID-19 is the name given to this new respiratory syndrome, which initially reached China, reported in December 2019, after the identification of a relevant number of cases of a type of acute pneumonia, with high transmissibility, in Hubei province.[1-2]

This respiratory syndrome is caused by the action of SARS-CoV-2, a new viral strain of the *Coronaviridae* family, reported in the literature as causing other respiratory infections, such as SARS-CoV (which causes Severe Acute Respiratory Syndrome) and MERS-CoV (causing Middle East Respiratory Syndrome).[3]

COVID-19 has created an overload on healthcare systems across the globe. In Brazil, it is important to highlight the difficult task of health managers, at its different levels; in fulfilling the task imposed on them since the Federal Constitution of 1988, namely, the guarantee of the universal, integral and equitable right to health at all the Brazilian population.

Universal public health systems are the most successful in maintaining the health of the population. Some of these have, as one of their main characteristics, the valorization of primary health care as a prerogative to guarantee people's quality of life.[4]

The existence of a consolidated and strengthened Primary Health Care (PHC) network prevents the worsening of diseases and, as a consequence, hospital admissions in local health systems.[5] It is necessary, considering the centrality of PHC in the Brazilian Unified Health System (UHS), to contemplate its fundamental and derived attributes to reflect its potential and limitations in the production of responses to this pandemic.

It is from this premise that this article is developed, which intends to analyze how PHC has been thought by the state management structures, in Northeast

Brazil, in proposing contingency measures to face this pandemic, through the analysis of Contingency Plans prepared by its management teams.

METHOD

For the writing of this article, it is based on the premises of Spink[6] when referring to the work of "picking up documents" as a methodological strategy that makes it possible to approach and analyze public domain documents, in line with the researches that choose everyday as an object of problematization.[7-8]

Public domain documents are "social products made public"[6] and, as such, are "ethically open for analysis because they belong to the public space, because they have been made public in a way that allows for accountability".[8] Thus, their analysis is propitious, since "they can reflect the slow transformations in institutional positions and positions assumed by the symbolic devices that permeate the day-to-day", and may reveal important findings for the reflection of the movements of society, in time and space in which they operate.

That said, the writing of this analytical-reflective article took as an empirical artifact the official publications of state health secretariats in the Northeastern states produced and made public from the elaboration of government responses to the COVID-19 pandemic. It originates, therefore, from a documentary descriptive study, which sought to recognize how these documents present directions for health decision-making, which make it possible to face the pandemic since the organization of PHC in their areas of coverage.

Thus, the Contingency Plans prepared by the state governments of the nine States that make up the Northeast Region of Brazil were analyzed, which currently concentrates 28,612 confirmed cases of COVID-19, being in the second position among the regions of the country, behind only the Southeast, with 46,728 reported cases. It is noteworthy that the States of Ceará, Pernambuco, Maranhão and Bahia, located in this region, are among the ten that most accumulate cases, with Ceará and Pernambuco standing out among the five with the highest number of deaths.[9]

The analyzed documents were obtained by accessing the Ministry of Health page dedicated to COVID-19, where the Contingency Plans and other normative documents prepared by the Federal Government, as well as by the governments of all Brazilian States, are stored for public consultation.[9] The search was carried out on May 2, 2020, from which the documents accessed and selected were stored for later analysis.

The analysis process considered the identification of the following component aspects of the plans: (1) organization and formal structure; (2) defined, general and specific objectives and (3) defined proposals for the level of PHC. For its operationalization, analysis tables were built filled out individually, contemplating such aspects in each of the analyzed plans. The findings were reflected taking as reference the operational model of PHC, highlighting its centrality in the organization and coordination of networked care, as inscribed in the current National Primary Care Policy (NPCP).[10]

RESULTS

All northeastern states have built Contingency Plans in the face of the COVID-19 pandemic. The states of Alagoas and Paraíba published their respective plans in January 2020. Bahia and Pernambuco, in February 2020. And Rio Grande do Norte, in April 2020. The other States do not mention the month of publication. There is heterogeneity in the organization of the documents, as well as in the programmatic and strategic actions to be developed in the context of the pandemic. Below, a brief description of the Contingency Plans of the respective states will be made.

The Alagoas plan was published on January 30, with updates made on February 8 and March 12, 2020. In the list of plan authors, there are no professionals responsible for PHC management. The defined objective and seven axes of action are presented. The plan provides for ten actions assigned to PHC, which can be grouped into two lines of work: surveillance and clinical-assistance actions and health communication actions for health professionals and the general population. There is no mention of agreements with municipalities for PHC-related actions.[11]

Bahia published its plan in February 2020, in which there are no updates. The publication file does not mention any manager directly responsible for PHC. In its structure, the defined objective is accompanied by five lines of action. Of these, two are related to PHC: guidance for municipal managers to assess their operational capacity, indicating professionals and reference units for cases of COVID-19, and clinical-care action, encouraging the implementation of a management protocol clinical approach for the entire health care network at different levels of complexity.[12]

The document produced by Ceará informs only the year of publication, 2020, with no updates. The list of authors does not mention professionals associated with PHC in the State. The Ceará plan has a general objective, four lines of action and 11 PHC actions. The PHC's duties include clinical-assistance, health surveillance and logistics actions, described in general guidelines for professionals in confirmed and suspected cases of COVID-19. The document does not refer to the negotiation with the municipalities for the execution of actions in the PHC.[13]

The Maranhão plan does not detail its publication date, only the year, 2020. Updates are also not mentioned and, among the list of authors of the document, no responsible for PHC in the State is identified. Its objective is divided into four axes of action. The document provides for seven actions of responsibility and / or with the participation of PHC grouped into three work fronts: clinical-care aspects; health education actions for the population and health professionals (providing permanent education actions for health workers) and communication and articulation actions with other sectors of the health sector. The plan provides for an agreement with municipalities to carry out the actions.[14]

The Paraibano plan, published in January 2020, does not mention further updates to the document. The list of authors does not mention those responsible for PHC management in the State. There is a description of an objective and four axes of action. PHC assignments appear in two topics: the first named "patient care", listing five actions related to the handling of masks and other personal protective equipment for professionals and users, and the second, named "cleaning and disinfecting surfaces" , contains seven guidelines for disinfecting equipment and environments. Partnership with municipalities for PHC activities is not mentioned.[15]

The Pernambuco Contingency Plan was launched in February 2020. No updates are mentioned and, in the list of authors, managers responsible for PHC participate. Objectives and six axes of action are presented in their structure. Actions to be developed by PHC are not specified, nor are collaborative actions with municipalities within the scope of PHC.[16]

The document from the State of Piauí refers only to its year of publication, 2020, not mentioning any updates. The list of authors includes local primary care managers. It presents its objective and five lines of action. In the plan, three PHC responsibility actions are foreseen: the reception of suspected cases; PHC referrals

to other points in the health network and home care in mild cases. It does not mention the participation of municipalities in the development of PHC actions.[17]

The State of Rio Grande do Norte edited its plan on April 2, 2020, which is in its second edition. The list of authors contains PHC managers. It is structured with strategic objectives and five lines of action. There are 46 PHC responsibility actions that are foreseen, ranging from support to municipal management, structural organization of Basic Health Units (BHU), health education and communication actions, clinical assistance actions, home monitoring and health surveillance. Of the 46 actions, the plan provides for 16 actions exclusively for the Family Health Strategy (FHS) in the prison system. Municipalities are included in the planning and execution of actions.[18]

Sergipe published its plan in 2020 without specifying the date. In the list of authors, there are no persons responsible for PHC management. It has a defined objective and seven lines of action. Regarding PHC responsibility actions, there is only one guideline for monitoring mild cases. Articulations with municipalities are not mentioned in the scope of PHC.[19]

DISCUSSION

PHC is recognized as a basic component of health systems. This recognition is based on the evidence of its impact on the health conditions of the population, with improvements in health indicators, greater efficiency in the flow of users within the system and in the care processes, greater use of preventive practices and reduction of inequities in access to services.[20-21]

PHC is guided by structural axes that, in international literature, are called essential attributes: attention to first contact; integrality; coordination and longitudinality. And derived attributes: cultural competence and family and community orientation.[20] Thus, in order to discuss the Contingency Plans prepared for COVID-19 by the Northeastern States, it is important to resort to such structuring axes.

Care in first contact

The expression "first contact" is related to the accessibility and use of health services by people in the face of a new problem or a new episode of the same health problem.[20] Synthetically, the first contact can be understood as the gateway

to health services, that is, when users identify that service as the first resource sought in the face of a health need or problem.

This characteristic is present among the PHC attributions in the Contingency Plans of the States of Alagoas, Bahia, Paraíba, Piauí and Rio Grande do Norte. As an illustration, this component is expressed in one of the actions planned for primary care in the Piauí plan: "reception of suspected cases in basic health units".[17]

In UHS, PHC is the preferred gateway to the health system. It is expected that, at this level of care, services will be accessible and resolute to the needs of the population. The multidisciplinary approach, the planning of actions and the sharing of decision-making power in work processes can contribute significantly to offer attention to the first contact.[5,20-21] These are aspects that contribute to the system's resolution in the context of COVID-19.

Integrality and coordination of care

Integrality is one of the doctrinal principles of UHS that guides the need for integration between the various points of the health care network.[20-22] Coordination between care levels can be defined as the articulation between the various health services and actions, in a harmonious and synchronized way, with the establishment of a common goal, regardless of the location in the health network. It aims to offer the population a set of services and information that respond, in an integrated way, to their health needs through different points of care.[21-22]

This PHC characteristic stands out in the plans of Alagoas, Bahia, Ceará, Maranhão, Piauí and Rio Grande do Norte. The document from the State of Bahia, for example, expresses the "implantation or implementation of a clinical management protocol in the health care network",[12] with the inclusion of PHC in the context of COVID-19.

Comprehensive and coordinated care is justified and necessary, in the context of the pandemic, because the number of people presenting symptoms of the disease and receiving health care by workers of different specialties is increasing.

Longitudinality

Longitudinality indicates a regular point of health care for people, with its use over time, regardless of the type of health-related problem.[20] This attribute appears more explicitly in the plans of the States of Ceará, Piauí, Rio Grande do Norte and Sergipe. As an illustration, the following guideline stands out in the Sergipe plan: "mild cases must be accompanied by PHC and home precautionary measures and social isolation must be instituted".[19]

Even in a pandemic context, the presence of the longitudinality attribute tends to produce more accurate diagnoses and treatments, ensuring case monitoring, the identification of possible comorbidities, reducing unnecessary referrals to specialists, in addition to actions that prevent the worsening and complications of conditions in mild cases.[21-22]

Cultural competence

Cultural competence refers to the capacity of the health system to take into account cultural and behavioral aspects and the needs presented by people and their territories in the organization of actions.[20] This structuring characteristic of PHC is contemplated in the plans of Maranhão and Rio Grande do Norte.

The Rio Grande do Sul document expresses as one of the actions of the PHC: "identifying, monitoring and articulating protection and care actions, in partnership with Social Assistance and other segments of society, aimed at specific and / or traditional populations such as: Street population, Gypsies, landless rural workers, quilombolas, Indians, people of African origin, rural population, others".[18]

It should be noted that cultural competence is not reduced to the knowledge of habits and customs, but to the ability to communicate, accessing and understanding the belief systems and practices of the communities, which are scenarios for the performance of institutionalized health actions.[23] In the context of the pandemic, these communication skills are fundamental for the adoption of protective measures by families and communities in different contexts, taking into account the different ways of life.

Family and community orientation

Family guidance is a guiding component of PHC that takes into account the need for comprehensive care focused on the family context.[21-22] In relation to

community orientation, an important aspect is the recognition that people's health needs are related to the social context where they live. This requires the health system to recognize social aspects and include them in the planning of health prevention and promotion actions.[24]

This characteristic appears more clearly in the plans of Alagoas, Maranhão and Rio Grande do Norte. As an example, in the Alagoas plan, the need for PHC to "guide the population regarding prevention and control measures for COVID-19" is described.[11] In this sense, this action can only be developed effectively due to the PHC's ability to plan and develop actions that take into account users' ways of life and family and community aspects.

CONCLUSION

The literature reiterated that approximately 80% of health problems could be monitored and resolved within PHC.[5,10] At the same time, in the case of COVID-19, it is estimated that 80% of the cases demonstrated are mild and, even the moderate ones, initially resort to basic health services,[2,25] with few of these evolving to more serious conditions, which would require intensive intervention, demonstrating the potential of PHC to act preventively in worsening the health situation of the population in the face of this condition.[25]

When considering the analyzed Contingency Plans, with a view to proposing PHC responses to COVID-19, it is noteworthy that only in three of the nine states in the Northeast did the PHC management teams from these. This can reorient the objectives designed for PHC from the perspective of its managers, with the prioritization of actions focused on medium and high complexity services, in view of the already reported acute worsening of symptoms of the disease. When the absence of mentions about the agreement of actions with the municipalities, which are responsible for the full management of PHC, is considered, this situation becomes even more delicate, in view of the overlapping of attitudes towards the management of the Health System, causing the fragmentation of the care network, with low integration of services and effects on the continuity of care, contributing to the non-fulfillment of PHC objectives expressed in its attributes.[5,22]

In this sense, it is worth emphasizing that a strengthened PHC, organizer of the assistance network and coordinator of care, combined with the preparation of rapid responses by professionals in urgencies and emergencies, the expansion of beds for intensive care and measures of social distance provide more effective

responses to the pandemic. The challenge is to integrate political-administrative decisions, technical-managerial skills and continuous practical-assistance support, with a permanent communicative flow, to overcome this pandemic context. The way out is complex, but the gateway is certainly PHC.

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