

Research on Primary Care during the pandemic in vulnerable territories of Campinas, São Paulo and Rio de Janeiro, Brazil

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Abstract *The COVID-19 pandemic found favourable conditions to spread in Brazil. A lack of coordinated action by the federal government, together with already weak Primary Health Care (PHC) had consequences for workers and users. This study examined PHC management and work process in response the COVID-19 pandemic in three municipalities, in view of the history of how PHC was set up, its relationship with the national public health system (SUS), and PHC and social activism in vulnerable territories, from the perceptions of users and workers. The study included a literature search, participant observation and 97 in-depth interviews of PHC workers and users. The results were organised into four areas: PHC implementation and management in the municipalities; the PHC work process; workers' and users' perceptions of PHC and the SUS; and territories, organised groups and social activism. Workers faced an environment of fear, overwork and changes in their work process, none of which prevented them from persisting and reinventing their practice. Users encountered barriers to access and difficulties in complying with public health measures, but the study found experiences of organised groups that emerged as means of coping with the pandemic.*

Key words COVID-19, Primary Health Care, Social vulnerability, Qualitative research

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Introduction

Despite its importance, Primary Health Care (PHC) has always been accompanied by funding and organisational difficulties. Brazil's national primary care policy (*Política Nacional de Atenção Básica*, PNAB 2017) and the 2019 *Previne Brasil* plan brought changes to PHC, including pegging funding to the number of registered users and performance targets. The changes posed difficulties for municipalities and distorted the model of care into selective, rather than comprehensive, PHC dialoguing with a community-action based, territorial approach and an inter-sector focus that contemplates and responds to social determinants. This situation was aggravated during the pandemic by the federal government's dual failure to propose protocols to guide municipalities and make a priority of expanding and reinforcing PHC¹⁻⁵.

This irresponsible political conduct by the federal government compromised health measures and the pandemic quickly reached socially vulnerable urban areas². This did not necessarily generate a commitment to expand supply to, and support for, these populations, given the fragility of social protection policies⁶.

This context can be associated with the term *syndemic* proposed in the 1990s by the medical anthropologist Merrill Singer to describe a combination of synergy and pandemic. With this concept, due importance can be given to the social conditions that render certain groups more vulnerable to disease⁷.

Contamination and death rates were extremely high in Brazil, as compared with the rest of the world: although representing less than 3% of the world's population, Brazil accounted for about 10% of total deaths and was among the 10 countries with most cases of COVID-19, ranking 6th in number of cases and 2nd in number of deaths⁸.

The historical process in which PHC was set up in Brazil, together with the absence of national coordination, had important repercussions on care for the population and on health workers, who were exposed to high risk of illness from COVID-19 and other effects on their physical and mental health⁹⁻¹¹.

This article examines how PHC was managed and the work process organised to combat the COVID-19 pandemic in three municipalities, in view of the history of how it was set up, its relationship with the SUS, and PHC and social activism in vulnerable territories, from the perception of users and workers.

Methodology

This article forms part of "Strategies for approaching the subjective and social aspects of PHC in the pandemic context", a research project conducted in the cities of Campinas, São Paulo and Rio de Janeiro. It reports on a qualitative study of data produced through a literature search on the history and construction of the PHC in the study municipalities, participant observation recorded by field diary and in-depth interviews¹².

Data were collected at four PHC facilities in each municipality. The facilities, selected jointly with the municipal administrations, are located in territories of high social vulnerability and their activities are framed by the Family Health Strategy (FHS). Data were collected between June 2021 and January 2022. The participant observation sought to understand the process by which these facilities' work was organised, as well as to identify key informants for a total of 97 in-depth interviews of health workers and users.

One to three meetings were held with each interviewee in order to discover what the pandemic was like for that participant in the following dimensions: the relationship with the SUS and PHC, social, subjective and family relationships, and the PHC (care and management) work process. The interviews were transcribed and formatted as narratives, validated by pairs of researchers and inserted into interpretative grids, organised by analytical core arguments¹³. Taking the triangulation of methods proposed by Minayo¹² as the frame of reference, it was found that, for the stage that she denominated "preparation of the final report", a stage that follows the organisation and performance of field work as described above, from analysis of the collected information, which prioritised the various different instruments and historical and institutional materials, from the interpretation by analytical categories, emphasising empirical categories, it was possible to establish an understanding of the study object¹².

For the final report stage, the authors developed a synthesis of what Minayo terms "concrete thinking" based on the results and conclusions. Triangulation was achieved by analysis of the interpretative grids for users and workers, the historical context, plus analysis of the researchers' field diaries and the document research^{12,13}.

The study complied with the provisions of CNS/MS Resolution 466/2012 and its complements. All participants gave consent by signing a declaration of free and informed consent. The

study (CAAE 40699120.2.0000.5404) was approved by the research ethics committee of the Universidade Estadual de Campinas and those of the respective municipal health departments.

Results and discussion

Four areas were identified for discussion in relation to the proposed objectives in the fields of research. The first considered the implementation and management of PHC in the municipalities and highlighted the different historical processes with repercussions on models of care and management during the pandemic. The second addressed the PHC work process. The third covered workers' and users' perception of PHC and the SUS. The fourth comprised the relationship in each territory between PHC and organised groups and community activism.

Area 1: Implementation and management of PHC in the municipalities

In order to understand PHC management in the municipalities, it was necessary to review its history.

In Campinas, investments have been made since the 1970s in implementing PHC, mainly in the municipality's peripheral regions. The process of implementation of the SUS expanded population coverage of primary health care through Basic Health Units (BHUs). Since then, services have been organised under management by direct administration, with personnel engaged through competitive public selection processes. In 2001 Campinas introduced the *Paidéia* Family Health Programme, comprising referral teams of general practitioners, nurses, dentists and including community health workers. The teams were encouraged to practice expanded, shared clinical care and received matrix support from personnel present in each unit. Collegiate managing bodies were organised at all levels in the municipal health department and encouragement was given to participatory co-management. The proposals implemented in Campinas, including matrix support, institutional support and expanded, shared clinical care, influenced policies throughout Brazil and constituted a model of management^{14,15}.

This historic, innovative construction by Campinas was gradually dismantled, as observed in the process of investigation and expressed vehemently in the workers' narratives. Health personnel reported that, over the years, changes had been

taking place in the way PHC was managed, towards a vertical, manager-centred approach at odds with the tradition of the municipality and that, during the pandemic, the organisational guidelines prepared by the municipal health department were transmitted to service managers with no co-management or collective construction:

Changes in the work process sometimes come by notification from the district support function, from management or we learn about them from the media, before any official communication reaches us. WhatsApp is also used to notify us, but we press for meetings.

In São Paulo, PHC began to be organised in the 1980s. Between 1993 and 2000, however, municipal administrations broke with the SUS implementation process and opted to organise the "Health Care Plan" (*Plano de Atendimento à Saúde*, PAS). This plan consisted of providing emergency health care services on the view that private sector management would be more effective and efficient and, accordingly, embarking on management agreements and contracts with private institutions^{16,17}.

The municipality ceased to receive federal and state funding and financed its proposal by hiring private cooperatives of practitioners. Some BHUs were managed by the PAS cooperatives, others by the state government, thus constituting two different models in the municipality. In 1996, with Ministry of Health support, the state health department and Hospital Santa Marcelina implemented the Family Health Programme (FHP) in the district of Itaquera, which was expanded via the *Qualis* Project to two other local regions. From 2001 the new municipal management restored care through the SUS, replacing the PAS and municipalising the whole PHC network. The number of family health teams increased as semi-private "social health organisations" (*Organizações Sociais de Saúde*, OSSs) were brought in to manage PHC facilities¹⁸.

In 2005, an ambulatory medical care service (*Assistência Médica Ambulatorial*, AMA) was introduced, expanding the model of emergency care provided by duty doctors (clinicians and paediatricians), who were engaged as legal persons. The role of PHC was weakened, closing the door to spontaneous demand and leaving only the agenda of scheduled care. As the management contracts with OSS grew, so the work was gradually bureaucratised by a production-based model of management^{19,20}.

Conspicuous in the interviews of workers were reports confirming that organisation

of PHC was centred on production of procedures. That choice led to a shift away from the proposal for care from a community-based and health-surveillance approach, towards individual, emergency care.

During the pandemic, the secretariat required new spreadsheets, in addition to those we already had to fill out with data: people who had not been vaccinated, symptomatic and asymptomatic family groups, spreadsheets on deaths, spreadsheets on hospital admissions. We ended up prioritising those and not filling out those of the team... That way of managing a health service based on quantity and not quality is bad. It seems we are working just for numbers.

Historically, the model of care in Rio de Janeiro has been hospital-centred. Lately, from 2009 onwards, care was reoriented: FHS coverage was expanded through OSSs. FHS coverage in the municipality advanced from 3.7% in 2008 to 40% in 2012, and had reached around 70% in 2016. Another strategy used by the Municipal Health Department to commit to implementing medical residency programmes as a means of providing and retaining doctors in these units. Family Clinics (FCs) were set up in vulnerable territories²¹.

The interviewees reported that, in 2017, when a new political group came into office in the city government, PHC began to be dismantled in the municipality: the numbers of health teams and workers diminished, working conditions became precarious and there were other setbacks. The political scenario changed again in 2021 and investment in the FHS resumed, health care teams were gradually reconvened and coverage expanded. Challenges remained to be met in the quality of care and enrolling clientele, as well as meeting the health needs posed by the pandemic:

When I joined, there was a staff deficit, much fewer community health workers... Today they have been taken on again: almost all teams have five CHWs. Restoring the teams has really improved things.

We raised the hypothesis, which deserves specific investigation, as to the close relationship between the history of PHC implementation and performance observed during the pandemic. São Paulo city did not prioritise the FHS in the course of implementation of the SUS. Campinas made the FHS official policy only from 2001 onwards, although it did so ambiguously and always in conflict with traditional strategies. Despite late adoption in 2006, Rio de Janeiro managed to expand FHS coverage vigorously in subsequent years. In the perceptions of users and workers,

the municipal election in Rio de Janeiro brought a change in the political group and the city was the best evaluated, followed by Campinas, while the performance of PHC in São Paulo city during the pandemic the most criticised.

Area 2: PHC work process during the pandemic

Analysis of the narratives identified convergences and differences among the three municipalities. PHC was considered in terms of changes in care, new flows, appreciation for PHC practices, innovation, lack of care, staff overwork and the user-staff relationship²².

In the three municipalities, priority was found to have been given to care for respiratory symptoms, while the early months of the pandemic were marked by a lack of information about the disease and successive changes in protocols, as well as a lack of personal protective equipment and biosafety guidance.

Some teams maintained child, pregnancy and emergency care activities, as well as home visits by CHWs to preserve bonding and obtain information about the population. Street Clinic teams prioritised tuberculosis care with active detection. Referrals for examinations and to specialists were suspended.

Fearing possible contagion, the public avoided going to PHC facilities. As the pandemic spread, however, and the health situation worsened, users began to demand more care and health personnel came to live intensely with the fear of contamination:

I was very afraid of infecting my family members, particularly my son, who was very little. There was a lot of ignorance about everything. We didn't know for sure what we were dealing with [...] This created feelings of a fear that reached the point where the idea even crossed my mind of giving up my work.

Some job categories, such as CHWs, mental and oral health teams reported drastic changes in the work they did. Work hinging on close contact with users underwent changes that dictated a need for reinvention to discover new possible kinds of action. At times, they were assigned to administrative jobs, which caused discomfort, confusion about their professional identity and feeling less valued than the front-line team.

The workers interviewed pointed out that these changes resulted in repressed demand and discontinuity in longitudinal care and, thus, risk of worsening users' health situations:

...diabetics who were previously compensated and are now extremely decompensated, extremely decompensated hypertensives, those diagnoses increased by about 70%; mental health demands increased strongly. All of this was highly conspicuous.

As the pandemic spread, so the number and severity of cases increased and cases of long COVID emerged. Staff sick leave absences and the demand for vaccination and testing led to a scenario of diminishing clinical and preventive care by the teams, particularly with regard to chronic diseases.

In São Paulo, the pandemic affected the work of the extended family health centres (*Núcleos Ampliados à Saúde da Família*, NASFs), which was reorganised to an individual, outpatient model of care provided by psychologists and psychiatrists at mental health centres, breaking with the proposal for matrix support¹³:

...it seems that a multidisciplinary team is being structured on an outpatient model, completely the opposite of the NASF we tried to build. Matrixing is ending. They don't want us to organise to discuss cases, make visits, organise feedback. Unfortunately, it seems that shared care is being pushed into the background.

In Campinas, during the pandemic, new NASFs were set up using workers with different core professions, who had already worked at PHC facilities, which led to conflict and discontent.

Appointments and monitoring were introduced as online resources in the three municipalities for diagnosing cases of suspected COVID-19 with a view to maintaining social isolation and later as tools for monitoring priority cases. Official protocols were delayed, creating difficulties and uncertainties. At first, PHC facilities lacked technological infrastructure and staff used personal mobile phones to conduct remote monitoring. Generally speaking, the assessment was that online appointments were an improvement and should be incorporated into the teams' routine:

...at first we were rather lost, because our schedules had been cancelled... We started holding online appointments with no official guidance: we started by talking about it and decided what to do and what not to do. Then we started calling the parents of the children we see in groups to find out how isolation, school, health issues were going.

Reports from Campinas and São Paulo described ambivalent experiences and feelings in the relationship between users and services. Some users and health personnel spoke of feeling helpless and abandoned, and of weakening bonds.

Specifically in relation to COVID care, health personnel and users found that the service provided was of good quality, because monitoring was constant. In São Paulo, however, weakening of user bonds with PHC centres and their workers because of difficulties in accessing care for other health problems caused dissatisfaction and, in some situations, culminated in user violence against health personnel.

In the three municipalities, collective care spaces were closed. In São Paulo, the guidelines from management were to cancel team meetings. This decision resulted in anguish, distancing and conflict among health professionals, who regarded these spaces as essential for conversation were to reorganise care process and flow planning:

It made us anxious not being able to hold meetings, so we exchanged a lot of comments and information in the corridors to try to remedy or calm each other's anguish about care for our patients.

In Rio de Janeiro and Campinas, informal conversations were going on every day in the corridors, in other open spaces or via WhatsApp and interviewees considered them beneficial for discussing activity planning.

To begin with, health workers were praised as heroes by the media and the population, but that kind of recognition was not enough to eliminate the precariousness they were experiencing and sensation that they were undervalued. Their suffering was associated with overwork, poor autonomy, lack of day-to-day co-management in services and disinvestment in PHC, plus cancelled holidays and longer working hours.

In São Paulo and Campinas, some personnel classified as risk groups were taken off work, causing discomfort in the team. Also, at various times, staff had to be laid off for suspicion and diagnosis of COVID-19, and management's failure to replace them increased the tension and overwork among workers who continued active.

In the three municipalities, personnel felt the work they did was undervalued, in terms of both workers' rights and a social and political context of a lack of recognition for the value of PHC and of proper working conditions, making it seem "that this work was not essential". These issues led health personnel to question the importance of the work they were doing and undermined enthusiasm and motivation:

[...] it is very hard to see your work being abandoned like that, the family health project being ignored. It makes our work seem superfluous, doesn't it?

Vaccination arrangements different among the municipalities and this was another demand that increased workloads. In São Paulo and Rio de Janeiro, from the outset, vaccination took place at PHC facilities and decentralised stations at places people tended to frequent. Campinas opted not to vaccinate at PHC facilities, but to prioritise vaccination at five immunisation centres, accessed by registration and appointment over the Internet.

At first, there were no tests and, when testing did become available, protocols were set by local administrations. As access to rapid tests advanced, Rio de Janeiro organised large testing centres to complement PHC-based testing.

Area 3: relations between PHC and the SUS: workers' and users' perceptions

The survey results showed that workers and users in the three cities perceived the SUS and PHC differently.

In Campinas, workers complained that the FHS has been disfigured and users indicated a need for social movements to resist the changes²³:

Sad to say, Campinas is in a difficult situation. I talk to many colleagues who feel that the city has abandoned the family health model and focused only on care procedures. No thought is given to offering other kinds of care, other strategies.

We can't give up on the social struggle, because if you give up then that's when things won't get better at all, right. We work like little ant. I am in contact with several people from associations of former residents and everything that was achieved took a lot of hard work. It wasn't easy at all.

Workers also pointed out that the strong point of PHC is its offering longitudinal care, but that the model of care is still doctor-centred. Users corroborated this perception, complaining at the lack of preventive action, while predominantly seeking medical care:

What I see is that both health personnel and users focus first on medical care and unfortunately Primary Care in Campinas follows this doctor-centred logic: almost all care ends up involving referral to medical care and this belief that the doctor has the ability to solve everything, as if other personnel had no ability to intervene.

The workers interviewed in São Paulo regarded the SUS as a public policy capable of guaranteeing access and expanding the public's rights. They also mentioned that people were unaware of how the SUS functioned and of the flows in the system, which led to conflicts and tensions in their relationship with health workers:

It is important to provide good health education, but that has not been possible yet. People do not understand how prevention works and they come to the PHC centre for the same immediate care they would find at an ambulatory care centre.

Users in São Paulo reported that, despite the difficulties with system flows, when they did manage to gain access and were assigned to an FHS team, the care they received was of high quality:

Back then, I still didn't visit this health post here, I used to go to a post over on Estrada das Lágrimas [...]. I tried, but I couldn't use the post here. Only people living on the other side of the avenue could. Since about six months ago, everyone on this side can go there too. That other post didn't have the girls who visit your house like this post does. The marks I'd give these girls or the doctor who sees me now don't even exist. It would be much higher than ten.

Although the SUS is seen as able to promote health, the workers interviewed in São Paulo agreed on the difficulties of ensuring good care in the current situation. They pointed to issues including inadequate funding, insufficient staffing, the bureaucratisation that was weakening and deconstructing the SUS and PHC and demands for targets and productivity, all of which jeopardised their giving more receptive, sensitive care:

One of our doctor colleagues couldn't stand the routine. He's on leave, and there are others like him [...] Stress leave is happening and more than half the team has started taking medication."

Users in São Paulo were found not to perceive the SUS and PHC overall in terms of a discourse based on rights and politics; rather, their perceptions arose from their experience of the system. The relationship with the PHC was seen to be different before and after the pandemic: beforehand, the BHU was the network location with an open door to welcome and bond with them. The pandemic and reorganisation of the work process weakened those bonds and the relationship with PHC became more limited. The biggest obstacle for users in the municipality was the difficulty in accessing tests and specialists. Users with experience of having a private health insurance and then losing it alleged that, with health insurance, waiting times for tests and specialist appointments were shorter than in the SUS. They also stressed that when, after a long wait, they managed to get an appointment with a specialist or for an exam, they were still sent somewhere in the system a long way from where they lived. That distance meant that many were unable to attend, because they had to pay for travel costs. This barrier led

them to resort to inexpensive private services where they paid for care from a medical specialist and had the tests:

When I went to the Hospital Heliópolis, they referred me for varicose vein surgery and, in the preparatory exams, it turned out that I had arrhythmia. I was scared to death and had to do a lot of tests at the “Dr Consulta” [private service]. I spent more than R\$2,000.00 just in tests.

Interviewees in Rio de Janeiro perceived the SUS to be valuable. Some of the workers reported a new profile of user, whom they called “new PHC user”, people who had rarely used the services and began to realise the importance of a comprehensive health system:

...a lot of users started accessing the SUS, especially those who had contracted COVID and discovered that their private health insurance often did not cover intensive care. [...] This gave ordinary citizen’s a new perspective and way of seeing the SUS, which has always been seen as a public system by poor and black people.

Most users praised the work of PHC and the good care provided by personnel. Also prominent was the recognition given to the work of health personnel in monitoring COVID cases, especially using new care devices, including telemonitoring:

...it was said on TV that the SUS phoned for news. SUS really did call to find out how I was!

Another aspect in Rio de Janeiro was a conception of the SUS as a comprehensive right which, despite the various problems, proved to be fundamental in the pandemic in guaranteeing access to health services, treating diseases and preserving life:

Health is not just X-rays, prescriptions and medicines. Health is when the person is working, when the father has money to buy gas, when the mother has her son in school, going to the gym and walking on the beach, that is well-being.

Users regarded the Family Clinics (FCs) as the main gateway to health services, because they met their main demands. Almost all interviewees reported good relations and bonding with the health professionals of the teams, mentioning particularly the good work done by the CHWs. Although they pointed to problems, such as lack of medications and access to some tests and procedures, the reports from Rio de Janeiro generally gave praise and recognition for the work of the health personnel.

Users and workers in all three municipalities expressed concerns and uncertainties as to the future of the SUS, and especially PHC. To one worker from Campinas, these concerns relat-

ed to inadequate financing, precarious services, the possibility of working to a model centred on emergency care, and outsourcing framed by a policy of disinvestment in public policies:

I’m worried about the future, because I think there’s still going to be a lot of outsourcing and that service quality will get worse as a result. What I can see is that, unfortunately, privatisation is making great strides and the time may come when these people will manage to do away with public servants.

Area 4: Territory, organised groups and social activism

The State’s absence from the most vulnerable territories has led to the emergence of organised groups and social activism²³ with a view to meeting basic public needs in a socioeconomic crisis aggravated by a pandemic. This movement has taken place in different ways in the municipalities studied.

In Campinas and São Paulo, spaces for social participation, such as local health councils in Campinas and management councils in São Paulo, could be seen to have become less active. This was attributed, in São Paulo, to the cancellation of face-to-face meetings and difficulty of applying the online model. This weakening had already been taking place beforehand and was merely aggravated by the pandemic:

The council is weak. Even though there is a good manager here, who always tries to share information, shared management is not making any headway. [...] So, how am I going to help?

In past administrations, the work of the FHS was done with the people, thinking about local people’s needs, bringing social actors in to dispute projects on the council. People were invited in, we held meetings at the PHC post. We organised so many plenary sessions. Now it’s different: the PHC post is empty of people. A large part of the community doesn’t even use the ombudsmen any longer.

In São Paulo and Campinas, the intention to produce collective, community organisation had shrivelled and collective action was lacking. Health workers reported an individualised form of solidarity action by local people, most of whom spent most of their time outside the territory:

Here in the territory we have a majority of young adults who are unaware that they are the force. These people work and only come to the PHC centre in a hurry, when they really need something. They don’t realise that this service has to do with their lives, that they can help improve things.

In these municipalities, there were few reports of collectives that had organised to work with PHC to help with community-oriented projects. There was some occasional action between the BHU and the inter-sector network to distribute basic food baskets, alcohol gel and masks, and some specific educational activities to give guidance on preventing COVID-19 infection. Other than that, there were reports of leaders, as well as some associations and religious entities, especially evangelical churches, who did some voluntary work, but without involving and coordinating with the local PHC facility:

Here in the neighbourhood, we got help from religious people, Catholic and neo-Pentecostal churches, community leaders, agents from the city government and particularly from a group of researchers from Mackenzie [college].

The panorama was different in Rio de Janeiro. The organised groups that emerged in the territories during the pandemic were identified as a fundamental strategy for social activism, given the conspicuous lack of action by the public authorities to protect the population.

These organised groups worked mainly by distributing basic food baskets and supplies, such as masks and alcohol gel, together with community communication strategies as a way of coping with the impacts of the pandemic in these vulnerable territories. The LabJaca collective²⁴ was set up as a data observatory in Jacarezinho, as a result of the “Jaca against Corona” project. In this territory in particular, the PHC facility participated actively in this mobilisation, both as a support centre for the actions and in identifying the most vulnerable families:

There was also a project, “Jaca against Corona”, which was mobilising, donating basic food baskets, toys, clothes. There were a lot of donations. So we, here at the clinic, ended up supporting it, because we know the territory; we spread the word and selected the most vulnerable families.

The “We’re in this together” (*Tamo Junto*) collective in the Rocinha was awarded a Medal of Merit from the Rio de Janeiro City Council in recognition for the work it did to keep the *favela* supplied, informed and educated during the pandemic²⁵.

Final remarks

Although there were PHC services in the territories and these had formed bonds with local communities in the three cities studied, the pandemic took place in a context where the SUS and PHC were already being undermined, which prevented their actions from combating it any more effectively. This situation was aggravated by the federal government’s attitude to the pandemic: it failed to fulfil its guiding role at the national level, which left states and municipalities adrift.

For health workers, the environment was one of fear, doubt and exhaustion, none of which prevented them from persevering and reinventing their practices. Users, in addition to fear, faced service access barriers, the breakdown of longitudinal follow-up and heightened social and territorial vulnerability, all of which made it difficult to comply with health measures.

The different management models adopted, involving either direct service provision by the municipality or through OSSs, was not found to influence the results. Another highlight was the powerful social activism in Rio de Janeiro, which, in partnership with the PHC, did make a difference in coping with the pandemic in the territories.

The authors thus reaffirm that robust, capillary PHC with bonds to the territory is fundamental in addressing emergency health situations, such as witnessed with the COVID-19 pandemic.

Collaborations

AR Campos and GWS Campos: conception, data production and analysis, fundraising, field research, methodology, research management, drafting and final review of the article. AC Gutiérrez, PS Costa, TV Anéas and ACD Rosa-Cómitre: conception, data production and analysis, field research, methodology, research management, drafting and final review of the article. JA Nahoum: drafting and final review of the article.

Funding

This study, conducted during health emergency lasting almost 3 years, obtained funding from the Open Society Foundation and executive support from the Associação Brasileira de Saúde Coletiva (ABRASCO).

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Article submitted 21/05/2023

Approved 25/07/2023

Final version submitted 27/07/2023

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva