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Impact of the COVID-19 pandemic under care in primary health care: perception of nurses

Impacto de la pandemia COVID-19 bajo atención en la atención primaria de salud: percepción de las enfermeras

Impacto da pandemia do COVID-19 sob o cuidado na atenção primária à saúde: percepção de enfermeiros

ABSTRACT
OBJECTIVE: To describe the perception of nurses about the effects of the pandemic on Primary Health Care. METHODS: Qualitative study, conducted through interviews, applied among 10 nurses who compose the family health strategies of a city in Alto Sertão Paraibano. All participants signed the Free and Informed Consent Form. RESULTS: Results were analyzed in three phases, and organized into five topics: impaired performance of essential activities; impaired comprehensiveness of care; impaired longitudinality of care; impact on the mental health of health professionals; and, perspectives for the future. CONCLUSION: The impact caused by the pandemic affects professionals and users. In mental health, the reports expose the increase in cases of anxiety, stress, and depressive symptoms. Considering the reorganization of the service, with less focus on prevention of other diseases, there is apprehension about future effects, such as late diagnosis, increase of comorbidities, among other aggravations generated in the long term.
DESCRIPTORS: Primary Health Care; COVID-19; Pandemic; Longitudinality; Nursing.

RESUMEN
OBJETIVO: Describir la percepción de las enfermeras sobre los efectos de la pandemia en la Atención Primaria. MÉTODOS: Estudio cualitativo, realizado a través de entrevistas, aplicado entre 10 enfermeras que componen las estrategias de salud familiar de una ciudad del Alto Sertão Paraibano. Todos los participantes firmaron el formulario de consentimiento informado. RESULTADOS: Los resultados se analizaron en tres fases, y se organizaron en cinco temas: deterioro de la realización de actividades esenciales; deterioro de la exhaustividad de la atención; deterioro de la longitudinalidad de la atención; impacto en la salud mental de los profesionales sanitarios; y, perspectivas de futuro. CONCLUSIÓN: El impacto causado por la pandemia afecta a los profesionales y a los usuarios. En el contexto de la salud mental, los informes exponen el aumento de los casos de ansiedad, estrés y síntomas depresivos. Teniendo en cuenta la reorganización del servicio, con menos enfoque en la prevención de otras enfermedades, hay aprensión sobre los efectos futuros, como el diagnóstico tardío, el aumento de las comorbilidades, entre otros problemas generados a largo plazo.
DESCRIPTORES: Atención Primaria a la Salud; COVID-19; Pandemia; Longitudinalidad; Enfermagem.

RESUMO
OBJETIVO: Descrever a percepção de enfermeiros sobre os efeitos da pandemia na Atenção Primária à Saúde. MÉTODOS: Estudo qualitativo, realizado através de entrevistas, aplicado entre os 10 enfermeiros que compõem as estratégias de saúde da família de uma cidade do Alto Sertão Paraibano. Todos os participantes assinaram o Termo de Consentimento Livre e Esclarecido. RESULTADOS: Os resultados foram analisados em três fases, e organizados em cinco tópicos: Desempenho de atividades essenciais prejudicado; Integralidade do cuidado comprometida; Longitudinalidade do cuidado lesada; Impacto na saúde mental dos profissionais de saúde; e, Perspectivas para o futuro. CONCLUSÃO: O impacto provocado pela pandemia atinge profissionais e usuários. No âmbito da saúde mental, os relatos expõem o aumento de casos de ansiedade, estresse e sintomas depressivos. Considerando a reorganização do serviço, com menor foco na prevenção de outras doenças, há apreensão sobre efeitos futuros, como diagnósticos tardios, aumento de comorbidades, entre outros agravos gerados à longo prazo.
DESCRITORES: Atenção Primária à Saúde; COVID-19; Pandemia; Longitudinalidade; Enfermagem.

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INTRODUCTION

The current health context, marked by the new coronavirus pandemic, is reflected in health services, which in turn, are overloaded on the front lines in the fight against COVID-19. [1] Even though it is not the destination of hospitalizations for the most serious cases of the disease, primary care has a fundamental role with regard to the prevention of contagion, epidemiological surveillance and monitoring of milder cases, which comprise the vast majority of positive cases. [2]

In this panorama, the systematization of the work of Primary Health Care (PHC) is developed along four lines: territorial health surveillance, assistance to users infected with COVID-19, social support to vulnerable groups, and continuity of the interventions themselves. [3] And, despite recognizing the importance of preserving the routine actions of the PHC, the challenges that involve the need for this reorganization of the service can hinder the development of its work. [4]

PHC has four essential attributes: accessibility, longitudinality, completeness and coordination. These are worked and developed in a broader way, if compared to other levels of care. It can be said that the most important of them is longitudinality, comprising care that goes beyond continuity, strengthened by interpersonal relationships that are not only linked to disease treatment, but rooted in the knowledge of each patient's history and comprehensive care to its biopsychosocial context. [5]

Some of these attributes are harmed by the pandemic, due to the work overload in PHC, manifested by impacts caused by waves of course. The first wave refers to the immediate mortality by COVID-19, scaring the population and asking the PHC to give priority attention to health education and service reorganization in favor of contagion prevention. The second wave is caused by the demand for acute complaints with limited resources for their resolution. The third wave reflects the impact of the interruption of comprehensive care for the chronically ill. And the fourth wave, with the prospect of remaining high for a long time, is related to the impacts on mental health, experienced by professionals and users of Family Health Units (USF). [6]

Currently, Brazil has more than 16.500 confirmed cases of COVID-19, surpassing a total of 462.000 deaths from the disease until the last update of the Coronavirus Panel, on May 31st, 2021. The incidence of this disease in the Brazilian territory affects 7873,3/100 thousand inhabitants. [7] According to epidemiological data from the State Government, Paraíba has 330,965 confirmed cases, most of them female, between the age group of 30-39 years, of mixed race/color. The state of Paraíba has 7.672 deaths from COVID-19, with a fatality rate of 2,3% and according to the last update on 06/01/21 at 10:00:35, the municipality of Catolé do Rocha, in which the research was developed, currently occupying the 14th position among municipalities in Paraíba with cases confirmed by COVID-19, totaling 3.444 cases and 48 deaths. [8]

This study assumes that the current scenario of the COVID-19 pandemic contributed to hinder the longitudinality of the care provided by nurses in family health strategies, as it influenced the burden of these health professionals, and, in turn, disseminated fear among a large part of the population, who stopped looking for the primary care service to monitor comorbidities and/or care for new episodes of disease, for

fear of being exposed to contamination by the new coronavirus.

Therefore, the objective of the research was to understand the perception of nurses about the impact of the pandemic on the performance of family health strategies (FHS) that they integrate, as well as to assess the influence of this impact on the longitudinality of care in these services.

METHODS

This is a qualitative, descriptive research, carried out in the Family Health Strategies in the municipality of Catolé do Rocha, located in the interior of the state of Paraíba, with approximately 30.684 inhabitants. [9] In the current year of the survey, the municipality had ten USF, six in the urban area and four in the rural area.

The sample consisted of 10 nurses, who make up the total population of PHC nurses working in the city's USF. Nurses were invited to participate in the research individually and at their workplace, with the presentation of the theme, objective and methodology of the study and scheduling of interviews after acceptance. Data collection was carried out in April 2021, The content of audio of the interviews was recorded for further analysis of the common points raised from the individual reports. Participants had their reports identified by the letter "E" accompanied by a corresponding Arabic numeral, from 1 to 10 (Example: E1, E2, E3... E10) in order to preserve their anonymity, not exposing any name or document.

A simple questionnaire was used for the sociodemographic characterization of the participants and an interview guided by a semi-structured question script as a technique for data collection. The script contained six questions related to the performance of activities in the unit during the pandemic, the reaction of the pandemic population to the changes, the impacts of the new scenario on professionals, the community, and the principles of PHC, such as the integrality and longitudinality of the Caution. To obtain greater reliability, interviews were recorded.

For data arrangement, the obtained results were systematized from the content analysis, guided by three determined moments: pre-analysis, material survey and debate of the obtained results and their interpretation. [10] In the pre-analysis, the content to be analyzed is aligned, making it functional. The second stage comprises the investigation of the material, with the description of categories. The third phase portrays the treatment of results, conclusion and interpretation, taking place in it the solidification and enhancement of information for analysis, reaching specific interpretations. It is time for intuition, reflective and critical analysis. The results were organized into five categories: Impaired performance of essential activities; Committed comprehensiveness of care; Longitudinality of injured care; Impact on the mental health of health professionals; and, Perspectives for the future.

The project was submitted and approved by the Research Ethics Committee of Faculdade Santa Maria under CAAE number 43463021.4.0000.5180 (Opinion No. 4.641.731) in accordance with Resolution 510/2016 of the National Health Council. Each nurse from the participating institutions received an envelope containing the interview script with the invitation letter and the term of responsibility, offering details and reiterating the confidentiality of the information obtained, anonymity and free and spontaneous participation in the research.

To sign the Informed Consent Form (FICF), the research participants received the document, filled it out and signed two copies. One of the copies was returned to the researchers, and the other remained in the possession of the participants.

RESULTS AND DISCUSSION

At the first moment of the interview, the nurses filled out an objective questionnaire, aimed at their socio demographic characterization. The data obtained were shown in Table 1.

Table 1 – Sociodemographic profile of nurses in the Family Health Strategy. Catolé da Rocha, Paraíba, Brazil, 2021.

VARIABLE	N=10	%
Sex		
Female	10	100%
Male	0	
Age group		
Up to 35 years old	4	40%
36 - 45 years	6	60%
More than 45 years	0	
Marital Status		
Single	4	40%
Married	3	30%
Stable Union	1	10%
Others	2	20%
Family wage income		
Less than 1 minimum wage	0	
1 minimum wage	0	
2 minimum wages	1	10%

3 minimum wages	5	50%
4 minimum wages	3	30%
Up to 10 minimum wages	1	10%
Above ten minimum wages	0	
Acting in areas other than FHU		
Yes	4	40%
No	6	60%
Specialization title		
Yes	6	60%
No	4	40%
Employment Relationship		
Public server	8	80%
CLT	2	20%
Length of experience at FHt		
Up to 1 year	3	30%
From one to five years	4	40%
Six to 10 years	0	
More than 10 years	3	30%

Caption: (n): Number of participants (%): Percentage corresponding to the number of participants. FHU: Family Health Unit FHt: Family Health Team. Source: Survey data

The sample was predominantly composed of female participants, aged between 36 and 45 years. Half of the components had a salary income above three minimum wages, and the other fifty percent were subdivided into two (10%), four (30%) and up to ten minimum wages (10%). Six of the ten participants had a single link with the Health Strategy in which they worked, and another four also worked in other health points.

Of the ten participants, eight had an effective link with the unit, and six participants had a specialization degree. Three nurses had been working in the respective strategy for more than 10 years, and four had been working for at least more than a year. This aspect was observed so that the relationship between the length of stay of the professional and the longitudinality of the care provided could be identified. In this context, it could be seen that nurses with longer experience had a broader perception of the community and the impact that different groups suffered with the pandemic and the reorganization of the service.

In addition, the professionals with an effective link in the Family Health Strategy demonstrated greater knowledge of the enrolled population, due to their longer experience, being able to report more clearly the information related to the outcomes that reached the users under their responsibility, compared to the professionals celetists, reflecting the importance of the care developed by the same professional over time, considering the turnover of individuals in the service as a factor that affects the longitudinality of care. [22]

Impaired performance of essential activities

When the new coronavirus pandemic hit Brazil and confirmed cases grew in geometric progression, anxiety and concern set in among health services, especially in Primary Care (PC), which is the main gateway to the Health Care Network (HCN). Given this, and since then, the Ministry of Health (MH) has been publishing recommendations for reorganizing the flow of care in the FHS, [11] which, despite promoting the fight against the pandemic and measures to prevent contagion, is being reflected in a loss in the performance of essential activities inherent to this point of the network, as can be seen in the reports below:

> *E1:"At first we had to suspend essential activities such as prenatal care, cytology, which came back later with an appointment [...] The population felt injured."*
> *E2: "We had to suspend some appointments right when we, right, found ourselves in the pandemic [...] then we returned by appointment. So we had to schedule vaccines, prenatal care and some other services remained suspended. Cytological? We spent six months without a collection [...] Home visits were suspended and still are."*
> *E5: "We postponed as much as we could, with that care, we know that not only COVID kills."*

In this scenario, teleservice in PHC has been massively encouraged, as a contributing factor to reduce service overload, in addition to increasing the system's support capacity, so that professionals work remotely, without the risk of contagion or exposure to users [12,13] also mitigating the negative effects on the mental health of health workers. [14] However, this is still a distant reality in small cities, especially when it comes to rural regions, where digital inclusion is not yet universal, and professionals do not receive training to work in this area, as shown in the following report:

> *E6: "I think the biggest harm was in the monitoring of children and mothers [...] They send doubts, but it's one thing for me to be saying it on the cell phone and another thing is for me to be there with the mother, touching the breast, putting it in the mouth of the boy and*

showing position. Because that's when the mother learns. Something I noticed was that, after this pandemic, this issue of exclusive breastfeeding dropped a lot, they stopped in those first fifteen days."

Here, it is worth highlighting the importance of Exclusive Breastfeeding (EBF) for the minimum period recommended by the MS for the adequate growth and development of the baby, as well as for the prevention of bone and dental deformities, myofunctional, orofacial, gastrointestinal alterations, among others. [15] In this context, the PHC, more precisely in the figure of the nursing professional, performs a very important job for greater adherence of mothers to EBF, through the first consultations, guidance and support that these women need when dealing with breastfeeding. [16,17,18]

Even with the gradual return of suspended care, the services aimed at prevention and promotion took a back seat with the arrival of the vaccine, adding another burden to the local eSF team, which manages human resources in order to contemplate both demand for vaccination, as well as other daily activities of the unit:

E4: "It is impracticable for us to continue doing the other appointments, because there is no way for us to account for the vaccine and the other appointments."
E5: "There is no day, sometimes you have something scheduled, but leave everything and go to the vaccine, it even messes with our minds."

On the other hand, activities such as routine and prenatal vaccination were compromised by the population's fear of going to the unit, fearful of exposure to health professionals. Thus, they only sought the service for punctual, urgent care.

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E5: "Some mothers didn't accept it, we made an appointment and they were afraid, we had to call convincing [...] some looked when they had complications, but if everything was fine, they wouldn't come at all."

The fear among the population regarding the sanitary collapse is something common. However, it is necessary to pay attention to this effect and the more serious consequences that can arise from it. Although there are some established protocols, most health professionals do not receive training to ensure the mental health care that the population so much needs at this time, with the work of multidisciplinary mental health teams and the provision of safe psychological counseling services. [19]

Committed comprehensiveness of care

Law No. 8.080/1990 defines comprehensive care as a doctrinal principle of the Unified Health System (SUS), corresponding to individualized care, focused on the user, in a multidisciplinary and interdisciplinary perspective, considering biopsychosocial aspects, inherent in a particular way to each person served. In this panorama, comprehensiveness comprises the user's right to be assisted in the totality of their needs. [20]

The service to some users in particular (such as those with chronic diseases) saw this principle strengthened in activities such as HIPERDIA, which covered users with Hypertension and Diabetes and where, in addition to consultations and drug dispensing, health education was also worked on for this population, characterizing a moment of sharing and interaction between users and the team. With the pandemic, this care was reduced to punctual care and drug delivery, for different reasons:

E9: "The greatest difficulty evidenced was the non-attendance of this user at the unit, due to the fear of contagion by the virus, thus making it difficult to monitor this patient."
E10: "We found resistance from patients to attend the unit, out of fear."

During health crises like this, it is important that the health system develops resilient teams, with the capacity to meet emergency demands, while maintaining its essential activities. [21]

The MH reinforces this aspect through technical notes guiding the continuity of comprehensive care in childbirth and puerperium, cancer prevention in this population, family planning, etc. However, this objective has not yet been fully achieved, as we see that we are facing a pandemic of inequities, and that, inevitably, there are inequalities in the confrontation in different territories. In this sense, women's health was another area that was greatly affected by the suspension of routine cytological examinations, nursing consultations, etc.

> *E5:"I'm very worried, I confess, about women's health [...] Some had a cytology test in October, showed considerable changes and are unable to repeat an exam. If we don't act, it will evolve, how are we going to find these women?"*

Some units managed to maintain a flow of functioning that was adequate to the circumstances of the pandemic, with the scheduling of some of the most requested services. However, the impact of the restriction time reflected in an overload of the team's work:

> *E7: "The population complained a lot, as they felt the need for this follow-up, in addition to that, many traveled to the Unit and returned without care because it was suspended. When we returned to the Prenatal Follow-up appointments it was crazy."*
> *E8: "There were complaints and complaints by some. Some activities are still suspended so far."*

As pointed out by the study by Savassi et al. (2020), the second and third waves of impact on the FHt are a consequence of the interruption of care, reflected in the worsening of morbidity in the population, whether of users with chronic or acute health problems.

Longitudinality of injured care

The longitudinality of care is defined as health care that includes the formation of a bond and trust between the team and the patient. [22] Longitudinal care is a time-consuming process, involving the development of a feeling of acceptance and trust between the community and health professionals. [23]

In the perception of many nurses, this is established not only because care occurs at various times in life, in the individual's episodes of illness, but also because care is materialized in constant prevention and health promotion actions, which are the essence of PHC. In addition, this care, within the scope of the FHt, is structured on the principle of integrality, considering the individual in their uniqueness, observing biopsychosocial aspects, in the different cycles of life. [5]

In the pandemic scenario, which has been going on for more than a year, we see that, in communities with limited resources, even the most consistent attribute of PHC ends up being weakened, a fact that is noticeable when we question them about the impact at this point in specific:

> *E2: "Everything is very limited[...] what was most affected was health education, prevention[...] which is what we most have to preach in a health unit[...] and I think that our hands are tied about this."*
> *E9: "Yes, the main impact is the difficulty of monitoring, evaluating and evolving this patient."*
> *E7: "Yes, I identify negative impacts, the biggest of which are collective activities, which were suspended. Pregnant women's groups, lectures, conversation circles, elderly groups, could no longer happen. The collectivity, discussion and protagonism in direct dialogue with community members was harmed, and this loss is incalculable in the short and long term."*
> *E10: "An impact on longitudinality that can be highlighted is the weakness in the communication process due to the accessibility of some users at the UBS, considered a limitation for care over time, as they stopped coming to the unit respecting social isolation and fearing exposure to the virus."*

Although better evaluated in cities with a lower population size, longitudinality is susceptible to weakening in the face of factors that compromise the integrality of care, the professional preparation to meet the demands of the area with quality and the obstacles to building and strengthening the interpersonal relationship between the team members and the user. [24]

Impact on mental health of health professionals

During the pandemic, we followed the apprehension of the entire community with the reflexes that were emerging on the population's mental health, with effects arising from isolation, social distancing, suspension of classes, closing of commercial points that evidenced the crisis, progressive increase in cases, among so many other factors. [25] This wave of damage to mental health has been prospected in health professionals, who are on the front line, receiving, welcoming, caring for and accompanying people with suspicion or confirmation of COVID-19, in a constant search for the development of resilience. [26]

This impact has been perceived by the high levels of anxiety, anguish, stress, fear, depression, sleep disorders, among others. These psychiatric manifestations can lead to other physical harm to workers, and, despite these issues permeating occupational health for years, we believe that it has intensified with the onset of the pandemic, [27] as can be seen in the following reports:

> *E1: "I was afraid of death at the beginning [...] I never stopped*

working, I was the one who was most present here, I felt alone, because the doctor and technician were away. At work we feel tired, it's like being alert all the time, even though the normal flow hasn't returned yet."
E2: "The impact is more the matter of fatigue, physical fatigue, mental [...] the pressure of the population."
E3: "Some yes, they needed psychological support and are still in need, in general, it's something that has affected a lot [...] for those on the front lines."
E4: "It had a very negative impact [...] We have some people undergoing therapy, others following up with a psychiatrist, psychologist, it affected everyone a lot."

Similar findings are found when searching the literature for studies on the impacts on the mental health of the population during the pandemic. It is estimated that psychosomatic symptoms developed more aggressively in society in general, but especially among health professionals, directly or indirectly exposed to contagion. [28]

Perspectives for the future

The pandemic is not over, on the contrary, despite the vaccine's development being achieved, many concerns still arise, given the identification of new mutable variants of the coronavirus, even more aggressive. [29] Thus, the work at the FHUs is still undergoing adaptation, seeking to minimize the negative effects of the restrictions that needed to be imposed, but prospecting for negative consequences generated by the weakening of this link with society and the commitment to health prevention:

E2: "This reflex I think we'll see ahead [...] Mammography, for example, hasn't stopped, but many people out of fear can go more than a year without doing it, and then other problems may arise."
E4: "The break was necessary, but if we had had a support team, we could have continued with some assistance. For example, prevention is an elective thing [...] but we are already in a year of pandemic, a year without cytology... In a year you discover some cervical cancer, STD, breast cancer, so the reflection will be in the long term."
E5: "The gap that this left, we will only see further ahead."

The COVID-19 pandemic brought great changes and required the reorganization of the entire SAN. In the scope of Primary Care, this rearrangement had important impacts both for the assisted community and for professionals.

In a scenario like this, emphasizing a care model with a predominantly hospital focus can bring many losses to the community in the medium and long term. In this sense, the prolonged suspension of the work of the FHt that prioritizes the prevention of other diseases, health promotion and comprehensive health care can contribute to the increase in morbidity and mortality of the affected population. Therefore, devising strategies to continue this primary care with effective quality is essential to mitigate the existing and potential negative impacts, strengthening the role of these FHU in fighting the pandemic. [30]

CONCLUSION

The COVID-19 pandemic brought great changes and required the reorganization of the entire SAN. In the scope of Primary Care, this rearrangement had important impacts both for the assisted community and for professionals. The study allowed us to identify that the common conception among FHS nurses is that the greatest impact among professionals is reflected in the increase in cases of mental health problems, such as anxiety, depression, stress and panic syndrome. In his perception, the community is harmed not only by the psychosomatic outcomes resulting from the pandemic, but also by the various services and assistance from which they were deprived due to the established norms for social distancing.

Dealing with this situation requires strategies designed not only to contain the spread of the virus, but also to mitigate the damage caused by the removal. In small towns, especially, where human resources may be scarce and the population more vulnerable, it is vital that, in addition to health education for prevention against the coronavirus, activities aimed at preventing other diseases are maintained, with appropriate organization, in addition to comprehensive care for risk groups, patients with chronic comorbidities, pregnant women, postpartum women and children. ■

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