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Work management and care in Primary Health Care during the COVID-19 pandemic in the city of São Paulo (SP), Brazil

Tatiana de Vasconcellos Anéas (https://orcid.org/0000-0003-1612-9071) [1]
Marcos Nunes de Lima (https://orcid.org/0000-0002-4518-8348) [1]
Fernanda de Jesus Ligeiro Braga (https://orcid.org/0000-0003-2796-7644) [1]
Thiago Loreto de Oliveira (https://orcid.org/0009-0007-4364-1034) [1]
Natalia Torres de Almeida Menezes (https://orcid.org/0000-0002-2187-8619) [1]
Mônica Martins de Oliveira Viana (https://orcid.org/0000-0003-3049-4518) [2]
Dário Nunes dos Santos (https://orcid.org/0009-0009-2923-9174) [1]

Abstract *The municipality of São Paulo has historically been marked by a heterogeneous implementation and coexistence of conflicting models of SUS management and Primary Health Care (PHC). The administration of health services management contracts was consolidated and associated with a productivist rationale. The selective PHC weaknesses tend to be pronounced during the COVID-19 pandemic. Thus, the present article aims to analyze work management and care in PHC during the COVID-19 pandemic in the municipality of São Paulo through a multicenter qualitative research anchored in the Paideia theoretical framework. We conducted 31 in-depth interviews with PHC clients and workers, along with participant observation. We noted the municipal management's authoritarian and managerialist stance when conducting the responses, with little room for listening and dialogue. We identified weakened collective spaces and service-community bond, bureaucratization and precariousness of work processes, and NASF's dismantling. In this setting, care was characterized by significantly reducing the expanded and shared clinical practice and the distancing from the territorial and community-based PHC guidelines.*

Key words *Primary Health Care, Health Management, Unified Health System*

[1] Universidade Estadual de Campinas. Cidade Universitária Zeferino Vaz, Barão Geraldo. 13083-970 Campinas SP Brasil. tatiana.v.aneas@gmail.com
[2] Instituto de Saúde, Secretaria de Estado da Saúde de São Paulo. São Paulo SP Brasil.

Introduction

Primary Health Care (PHC) plays a fundamental role in the organization of the health care network in the Unified Health System (SUS). The Family Health Strategy (ESF) model ensures consolidated and expanded coverage, including individual, family, and community actions toward promoting and protecting health, prevention, diagnosis and treatment of diseases and illnesses, rehabilitation actions, harm reduction, palliative care, and health surveillance. It is territorially and community-based and oriented to act from an interdisciplinary, interprofessional, and intersectoral perspective[1].

PHC played a fundamental role in some municipalities during the COVID-19 pandemic, emphasizing the multidisciplinary action of the ESF teams, with Community Health Workers (ACS) developing surveillance, active search, follow-up, and monitoring people's health[2].

Brazilian PHC was being de-characterized even before the pandemic, with the gradual dismantling of the ESF model, which strengthens the territorial and community approach, prioritizing the so-called traditional Primary Care, as observed in the unfolding of the latest edition of the National Primary Healthcare Policy[3]. At the federal level, the austerity agenda radicalized from 2016 – with Constitutional Amendment No. 95, which froze public spending[4]. The neoliberal and mercantile logic was advanced over the management of PHC in the SUS with the implementation of the Previne Brasil Program, changing rules for funding PHC and setting and regulating the Primary Healthcare Development Agency (ADAPS)[5,6].

The implementation of the SUS and the history of PHC construction are characterized by constant ruptures in São Paulo. While it was a pioneer between 1989 and 1992 in implementing the SUS, in 1996, under the administration of Paulo Maluf, the municipal management withdrew from SUS implementation and adopted the Health Care Plan (PAS) as a management model. The PAS follows the World Bank ideas that bring precedence of economic reason to social policies, in which production and services are delivered to medical cooperatives with public financing. In parallel, part of the UBS was owned by the state government and organized under Health Centers. In 1996, while the municipality had adopted the PAS model, which retrocedes its entry into total SUS management, the state government implemented the first Family Health Program (PSF) units in the far east of the city, Itaquera[7].

In 2001, under new management, São Paulo returned to total management of the SUS and began the UBS municipalization process with an expanded PSF to prioritize it as a municipal model. Then, partnerships with Social Health Organizations (OSS) were scaled up through agreements to recruit human resources. In 2005, a new service called Ambulatory Medical Care (AMA) was implemented, coupled with the UBS, hiring on-duty doctors. The UBS stopped responding to the walk-in demand, leaving it to the AMA based on a "treat-and-street" care model, disconnected from longitudinal monitoring, overly affecting PHC[7].

Furthermore, the managerialist and productivist logic is forcefully established in management contracts between the municipal secretariat and the OSS. Goals and performance indicators are now established arbitrarily, without the participation of workers and patients, and disconnected from local health needs. Thus, Hegemonic Managerial Rationality predominates, which escalates worker alienation and undermines care, with social stakeholders who no longer recognize the use value or purpose of their work process[8].

Considering the importance of PHC's performance during the COVID-19 pandemic and the complex history of health management in São Paulo, this article aims to understand work management in PHC in the capital of São Paulo state during the pandemic and analyze care offered from the perspective of clients and workers.

Methods

This qualitative research produced data through participant observation, with field diary recording and in-depth interviews. The research was anchored in the Paideia[9] framework, which operates with the triple purpose of expanding understanding of a topic, conducting an institutional analysis and an analysis of power relationships, enabling people to think of themselves as unique agents of this social network.

The present article is nested in the multicenter study "Strategies for approaching subjective and social aspects in PHC in the pandemic", which involved data collection in the municipalities of São Paulo, Rio de Janeiro, and Campinas. The results presented here refer to the city of São Paulo.

We adopted convenience sampling. The research coordination previously contacted one of the Regional Health Coordination Offices in São Paulo to facilitate access to the field. The UBS were selected with the management of the Mu-

nicipal Health Secretariat (SMS) and the respective OSS, under the following criteria: covering four distinct territories, having an ESF team, and being located in a socially vulnerable territory. The characterization of the UBS is found in Chart 1, and fictitious names were given to preserve anonymity: Ametista, Esmeralda, Ruby, and Turmalina.

Considering the active role of the researcher in this type of qualitative study, which values interaction with the subjects, an immersion and recognition of the functioning of the UBS was conducted initially, recording in a field diary, providing complementary data for the analysis[10]. Four field researchers were responsible for connecting to one of the UBS for immersion and conducting interviews. This process began in August 2021, and the interviews were completed in March 2022. We should underscore that the researchers entered the units during the onset of vaccination against COVID-19.

Once the researchers were immersed in the study context, key informants that could indicate participants for the interviews were identified among the health teams and clients. Informants had to consider the following inclusion criteria: 1) for clients: men and women, aged eighteen or over, residing in the territory assigned by the UBS; preferably, women family leaders or activists, dwellers in situations of social vulnerability related to work, income, and low-income family and social ties; violence victims; with difficulty accessing social protection policy equipment; Black population; people with disabilities; LGBTQIA+ people or individuals with some psychological illness. 2) for workers: professionals from UBS with the ESF model, from the Expanded Family Health Center (NASF), and Street Office, with at least one year of working experience in the territory and linked to the care of the indicated clients.

In this way, 15 workers and 16 clients participated in the interviews. We adopted theoretical saturation as a criterion for finalizing data collection after redundancy and repetition of the contents of interest.

The interviews started with a triggering question: workers were asked, "What do you, SUS and APS worker, believe has changed in your work after the pandemic?" and for clients, "What happened to you and your family after the pandemic?". A thematic map that addressed subjective and social aspects guided field researchers to sensitize them to listening and deepening the experiences brought by the respondents.

The number of meetings necessary to go through the proposed roadmap varied between one and three in each interview, as some cases required resuming dialogue to analyze further or clarify a point. All interviews were recorded and transcribed after the participants' consent.

Based on their immersion in the units, the field researchers invited workers directly to be interviewed after presenting the project and agreeing with local management on conducting the interviews at the UBS premises during working hours. Regarding clients selected from the criteria mentioned above, with the support of health teams, the invitation was made during home visits to present the research and offer the possibility of participation. Several community spaces were used, from public spaces to the environment of their homes. See Chart 2 for a more detailed understanding of the characteristics of the interviewed population.

For the analysis, we constructed narratives and proceeded with validation by peers, field researchers, and project coordinators[11,12]. Field researchers were responsible for building a narrative (regardless of the number of meetings held) for each subject they interviewed. Another research group member listened to the interview's audio recordings, read the narrative, and suggested changes to its form or content[11,12]. The final version was presented to the entire São Paulo field research group.

Subsequently, the narratives were inserted into interpretative grids and distributed into seven argumentative cores. We selected four to discuss in this article: i) social and subjective aspects during the pandemic: factors that produce subjectivity and healthcare; ii) illnesses associated with the pandemic; iii) client-professional-PHC/SUS relationship: power relations, institutional democracy, management, and healthcare; and iv) potentialities and obstacles to conducting an expanded and shared clinic in PHC.

The analysis was performed from triangulation between the material from the interviews and the researchers' field diaries and then discussed in light of documents published by SMS-SP and the Paideia framework.

We followed the procedures provided for by resolution No. 466/2012 CNS/MS and complementary procedures. The Ethics Committee of the State University of Campinas and the SMS-SP Ethics Committee approved the research, CAAE: 40699120.2.0000.5404, under Opinion No. 4.520.254.

Chart 1. Characterization of the PHC Units researched. São Paulo, 2023.

UBS	Ametista	Esmeralda	Ruby	Turmalina
No. Family Health Teams (eSF) and similar	3 eSF 1 eSB 1 NASF 2 ECR	3 eSF 2 eSB 1 NASF	6 eSF 1 NASF	3 eSF 1 eSB 1 NASF
Professional staff	218 health workers (AMA/UBS); among them 21 ACS; 4 NASF professionals; and 39 from ECR.	56 health workers; among them, 18 ACS and 6 NASF professionals.	82 health workers, among them, 36 ACS and 4 NASF professionals.	59 health workers; among them, 15 ACS and 6 NASF professionals.
Area covered	3,048 km²	8,400 km²	3,000 km²	3,040 km²
Population	18,679 people (concentration of older adults and young people)	9,187 (concentration of young population)	20,917 people (concentration of older adults and young people)	9,254 people (concentration of young population)
Social vulnerability characteristics	- Substandard housing, with a predominance of slum constructions; - Exponential increase in the homeless population throughout the sub-prefecture; - Immigrant population in jobs with unhealthy or subhuman conditions. - High job offer rates than other districts in the same sub-prefecture; - Lack of significant vegetation cover throughout the sub-prefecture and high surface temperature levels in the Administrative District.	- Good vegetation cover and biodiversity conservation rates, but with precarious settlements and irregular subdivisions; - High incidence of arboviruses; - Low rates of people's access to health services; - Lack of SUS hospital beds in the Administrative District; - Lack of social assistance and education services. - District with the highest concentration of economic activity compared with the sub-prefecture.	- It is home to an important favela in the municipality and has high rates of population at risk from landslides. - High demographic density, with a growing number of homeless people; - Includes areas with soil contaminated by highly toxic substances; - High rates of flooding and flooding points; - Good economic activity rates compared with the municipality, with incentive policies.	- Low level of economic activity in the sub-prefecture compared with the municipality; - High demographic density rates; - Includes areas at risk of landslides; - Includes precarious settlements and more significant predominance of favelas in the Administrative District compared with the sub-prefecture. - Sub-prefecture with low hospital bed levels but a growing increase in access rates to UBS. - The Administrative District has a high demand for assistance and education services.

Source: *Caderno de Propostas dos Planos Regionais das Subprefeituras* (2016). Available from: https://gestaourbana.prefeitura.sp.gov.br [cited 2023 aug 12]; *Cadastro Nacional de Estabelecimentos de Saúde* (CNES) (2023). Available from: https://cnes.datasus.gov.br/ [cited 2023 aug 12]; *São Paulo. Secretaria Municipal de Saúde. Área de abrangência das Unidades Básicas de Saúde* (2022). Available from: https://www.prefeitura.sp.gov.br/cidade/secretarias/saude/epidemiologia_e_informacao/geoprocessamento_e_informacoes_socioambientais/index.php?p=265863#dados [cited 2023 aug 12].

Results

The workers' and clients' narratives point to significant changes in the organization of work at UBS in the city of São Paulo, resulting in losses in care production.

Work management

In March 2020, the UBS received municipal recommendations[13,14] to suspend scheduling routine appointments, educational groups, and referrals to specialties and elective surgeries. There was no type of alignment or explanation for workers and clients:

Chart 2. Characterization of research participants. São Paulo, 2023.

UBS	Ametista	Esmeralda	Ruby	Turmalina
No. of workers and clients interviewed	4 Workers 4 Clients	4 Workers 4 Clients	3 Workers 4 Clients	4 Workers 3 Clients
Professional category of interviewed workers	2 ACS 1 Doctor - ECR 1 Physiotherapist - NASF	1 ACS 1 Nurse 1 Doctor 1 Social worker - NASF	1 ACS 1 Doctor 1 Social worker - NASF	2 ACS 1 Dentist 1 Speech therapist - NASF
Gender identity of respondents	Workers: 4 Cisgender women Clients: 3 Cisgender women 1 Cisgender man	Workers: 3 Cisgender women 1 Cisgender man Clients: 2 Cisgender women 1 Cisgender man 1 Non-Binary Transgender Person	Workers: 3 Cisgender women Clients: 3 Cisgender women 1 Cisgender man	Workers: 4 Cisgender women Clients: 2 Cisgender women 1 Transgender man
Percentage of total respondents who reported COVID-19 infection	25% of participants indicate that they have been infected	37.5% of participants indicate that they have been infected	28.6% of participants indicate that they have been infected	42.8% of participants indicate that they have been infected

Source: Authors.

On Friday, everything was working. The following Monday, there was no more service for everyone when clients arrived. Every day had a different protocol, with different symptoms and ways of organizing the flow [...]; everything changed quickly (Worker 2 Narrative, UBS Esmeralda).

The PHC flow was reorganized to care for people with respiratory symptoms suspected of being infected by COVID-19. This type of care increased exponentially and required the removal of patients, given the severity of the cases:

Until a phase arrived between May and July 2020. We started to treat 30, 40, or 50 suspected COVID cases weekly. Soon enough, we started activating Removal three, four, or five times daily (Worker 2 Narrative, UBS Esmeralda).

A progressive reopening of agendas[15] was observed in the second half of 2020. The guidelines aimed to prioritize care flows for mild respiratory symptoms and focused on prevention and health promotion actions such as individualized guidelines via telemedicine, teleconsulting, and telemonitoring; community management, with health education interventions for the population; keeping flows to separate people with respiratory symptoms from the rest of the population. Moreover, specific services were resumed for some priority groups, such as pregnant and puerperae, children (childcare), people with chronic non-communicable diseases (NCDs) and notifiable diseases, and the extended validity of prescriptions for continuous use medicines (from 2 to 6 months). According to the workers, these guidelines were incorporated by each team heterogeneously and uniquely.

In 2021, with new virus variants, regulations[16,17] resumed the previously imposed restrictions. In parallel, vaccination began in January 2021 with the first dose, and the vaccine was also made available to children at the end of 2022, along with the distribution of the third dose to adults and older adults. Changes and guidance and the publication of guideline documents accompanied epidemiological changes in transmission.

The work process of ACS, who play a fundamental role in the ESF proposal, needed to be more characterized. Besides changes in the home visits, in which ACS could no longer enter families' homes, ACS began to assist with vaccination, providing administrative support in 2021.

Another process that weakened teams and care was dismantling the NASF proposal. Amid the pandemic, municipal management relocated psychologists and psychiatrists who worked in PHC to establish Mental Health Centers, while

the rest of the NASF professionals were allocated to specific units[18]:

[...] it seems that a multidisciplinary team is being structured in an outpatient model, opposite to what we tried to build as NASF. Matrix support is ending. They want us to avoid organizing ourselves to discuss cases, perform visits, and organize feedback (Worker 4 Narrative, UBS Turmalina).

Care: reflections on the relationship with clients and between workers

Although all units organized the flow of in-person care for people with respiratory symptoms, different forms of restrictions were observed regarding meeting the population's other demands and needs:

For known cases, we told them to continue taking the medicine. For those who hadn't yet been diagnosed, now wasn't the time to find out (Worker 1 Narrative, UBS Esmeralda).

On the other hand, the Street Office had a different guideline, preserving its daily actions and monitoring suspected and confirmed COVID-19 cases via active search, with individual and collective actions in the territory. The team's work was escalated after SMS imposed weekend shifts.

At the UBS, people seeking care for other health demands and needs also faced the impossibility of coordinating care within the network. Even with the return of appointments, clients noticed changes in how this service was offered:

Appointments and tests have stopped. I have hypertension, hepatitis, herniated disc, stomach ulcer, varicose veins, and need a tooth removed [...]. I haven't taken medication for hepatitis for a long time, as it is necessary to undergo a test first [...] I can't even get money to eat, much less pay for a bus fare to take the test [...]. People die before taking a test (Client 1 Narrative, UBS Ametista).

The professionals interviewed indicated that the reopening of agendas triggered an increase in the number of people with psychological distress and deteriorated NCDs from several changes in psychosocial dynamics introduced by the pandemic, such as social distancing, increased unemployment, and changes in the UBS offerings:

I identify a massive increase in the population's mental health demand. Many people suffer from depression, triggered mainly by financial difficulties and social distancing. Many UBS patients started psychopharmacological treatment after the pandemic (Worker 2 Narrative, UBS Ametista).

Already disoriented by the variety of guidelines and changes in the organization of the service, workers began to face overload due to their expanded activities, which now include telemonitoring actions, care for mild respiratory symptoms, vaccination within the UBS and in some public places, reception and attending to people's other health issues with the gradual return of appointments:

Despite wanting to help them, it is impossible to take care of everything left unattended in these two years in a single appointment (Worker 2 Narrative, UBS Esmeralda).

Workers' dismissals, removals, illnesses, and deaths aggravated the shortage of professionals. Also, vacations for healthcare professionals were canceled for a year. The right to removal did not seem equitable, with unequal treatment in case of comorbidity for those in the risk group. The increase in bureaucratic and administrative work in daily work was cited. In their opinion, the confluence of these factors generated the fraying of work relationships between peers, vis-à-vis the employing institution, and even with the population:

Besides the chaos and uncertainty brought by the pandemic, there were also thousands of administrative monitoring spreadsheets and the computerization of fundamental and already deeply rooted ESF daily processes. I love being a nurse and the ESF. However, I see myself much more as an administrative nurse today (Worker 1 Narrative, UBS Ruby).

Also highlighted was the suffering caused among professionals regarding the fear of becoming ill, given the constant exposure and lack of Personal Protective Equipment (PPE), which also triggered the fear of bringing the disease into their homes. The equipment arrived late, and the workers reported purchasing the PPE with their money:

[...] Initially, we needed to have adequate and sufficient PPE [...]. I even bought N-95 masks with my money as I arrived (Worker 2 Narrative, UBS Turmalina).

Professionals engaged in some mobilizations in this substandard work setting, and the most well-organized were those of ACS who publicly protested on the street, demanding better wages and working conditions. However, in early 2022, other professional categories denounced the unhealthy working conditions and demanded improvements through an open letter published by the Health Union[19], which generated media repercussions:

We also went on strike during the pandemic, as they did not want to pay the rights we agreed on in the category. We staged a strike in downtown

São Paulo. I was apprehensive because it was still a pandemic, and there were many people. Despite wearing a mask, I was afraid [...] (Worker 3 Narrative, UBS Turmalina).

The work process of ACS, who play a fundamental role in the ESF proposal, needed to be more characterized. Besides changes in the home visits, in which ACS could no longer enter families' homes, ACS began to assist with vaccination, providing administrative support in 2021. The changes in the ACS work produced the perception that they needed to provide quality monitoring to users:

We were insufficient during this period, even more so when vaccination arrived. We all went to provide support, and although this was very important for us to reach the hopeful situation we are in today, we needed to leave another side uncovered: that of care (Worker 4 Narrative, UBS Esmeralda).

Clients still demand a lot and question why visits must be implemented. I'm not doing what I should because our work is on the street, and we instead worry about meeting goals for administrative and bureaucratic activities. It's regrettable; sometimes, it makes you want to give up (Worker 2 Narrative, UBS Ametista).

The distance between the teams and the community was exacerbated by the re-territorialization process, determined by the municipal management, which consisted of reorganizing the number of registered people to 4,000 people per ESF team. We should mention that this measure was not associated with COVID-19, but overly affected the ACS-territory bond, which is fundamental in confronting the pandemic:

Moreover, it didn't just change the area; it also changed our reference professionals: another doctor, another nurse, everything. This change affected our work. I feel bad because it's my job to connect with the territory and build a bond. When that doesn't flow, we feel bad we're not working correctly (Worker 2 Narrative, UBS Turmalina).

Some clients confirm and resent the weakened link with UBS. They felt abandoned, helpless, and unwelcome during the pandemic, while the fear of infection grew:

So, we started to avoid health services and isolate ourselves, even if that meant a lack of assistance (Client 2 Narrative, UBS Esmeralda).

Changes in the work process during the pandemic also affected the planning and monitoring of ESF actions due to the need for team meetings, general meetings, and matrix support spaces for discussing cases:

Before, we worked on a topic every month based on identifying what was happening in the territory that worried us ACS. We had meetings to understand this subject and clarify our doubts together with the rest of the team. A training space helped us act and put our efforts into practice in the territory [...] This loss of planning was also due to the difficulties in holding team meetings, often due to a lack of professionals and because we no longer have permission for general meetings with the entire unit (Worker 3 Narrative, UBS Turmalina).

At one of the UBS, at the onset of the pandemic, some professionals tried to keep the meeting space outside, in the open air, to discuss technical guidance documents regarding COVID-19. Another UBS held matrix support meetings via videoconference with CAPS. In both cases, however, we speak of not very comprehensive, non-regular, specific meetings. Even with the resumption of meetings after months of the pandemic, workers report changes in the dynamics of this space:

[...] Before, we had a team meeting to discuss the cases and pass it on to the nurse and doctor with the active participation of all team workers. Today, people are silent in the meeting space [...] (Worker 2 Narrative, UBS Turmalina).

This range of changes also produced emotional distance between workers, producing significant conflicts during great fear and suffering:

Furthermore, gossip began without a space to think together and know each other's opinions [...] We had fights within the team: shouting, crying, arguing in front of everyone, and physical abuse threats [...] Affective relationships were broken, and professionalism needed to be improved. We had conflicts, and professionals were defamed [...] From that moment on, work was carried out by collusion, where some were favored over others. The partnership ended. The flows were tangled up [...]. This is one of the consequences of the pandemic, which will take a long time to heal, as these are deep wounds (Worker 2 Narrative, UBS Esmeralda).

Besides the collective spaces between workers, as a strategic device for the exercise of democracy within health institutions, the Managing Board was also affected. Respondents point to modified meeting formats: sessions were held virtually; they were shorter and less frequent.

The incorporation of new technologies was a legacy of the pandemic. It simultaneously brought challenges and introduced a new working instrument unavailable in PHC. The teams began with telemonitoring suspected cases of

COVID-19 to isolate and observe suspected cases and monitor signs of symptom severity. Due to the units' lack of infrastructure and resources, the teams had to have their resources at the onset of telemonitoring:

Initially, all these calls I mentioned were made through the professionals' cell phones. We sometimes made video calls or contacted them via WhatsApp. No one was prepared for a pandemic or making calls that way (Worker 3 Narrative, UBS Ametista).

Despite the challenges regarding the lack of resources and structure to start telemonitoring and teleconsulting at UBS, most respondents understood that incorporating these resources should become permanent in the teams' daily lives.

Discussion

The São Paulo PHC management model caused significant repercussions for workers and users of UBS with ESF, as the results demonstrate. We observed a verticalization process of building work and care standards without coordination between municipal management, workers, and the population. The managerialist, Taylorist, and bureaucratic model was maintained during the health emergency. Workers affirm this system was already in place before the COVID-19 pandemic[20]. Also, the authoritarian bias in building care is reproduced in the clients' accounts. The emphasis is on the administrative, management, and care dimensions, with little room for listening and accepting the dilemmas and demands of professionals and, above all, the population.

The suspended team meetings hampered planning actions to monitor the population. They contributed significantly to deconstructing collective work, not only weakening it in its technical dimension but also in its affective role of promoting exchanges and empathy between workers at a time of great suffering, fear, and overload among health workers when such characteristics could have been useful protective measures. The rupture occurred not only in teamwork but in the relationship with the population and social control, with profound impacts also resulting from the modified Managing Board meetings, the canceled activities, and the re-territorialization and deconstruction of the NASF.

The ESF plays a fundamental role during a pandemic that significantly affects the most socially vulnerable population due to its reach and proximity to the population. A "strong PHC", a term used by PAHO, must assume its surveillance role in screening suspected cases, monitoring cases in the territory, contact tracing, testing, and prevention and health education actions for the population. On the other hand, the results show the lack of this type of PHC strengthening, weakening its potential in epidemiological surveillance in the territory[2,21,22]. The fragility and discontinuity of this care were observed in São Paulo, especially for people with chronic diseases[23-25].

It is worth noting that these NASF mischaracterizations and re-territorialization occurred in the São Paulo PHC during the pandemic but were aligned with the Federal Government's policy. Amid a health emergency, family health teams were compelled by *Previne Brasil* to register 4,000 people, which mobilized re-territorialization. It is an example of bureaucracy-based decision-making, which does not consider the territory's reality and context and is not taken in shared management with the population and health professionals. The same reasoning applies to dismantling the NASF teams, whose funding was suppressed in the new model, Previne Brasil. Thus, instead of strengthening interdisciplinary work from the perspective of an expanded clinic, which is fundamental for the response to the pandemic, what happened was precisely the opposite[2,26,27].

Although municipal management has made efforts to organize updates to ordinances, we considered that the set of guidelines and training spaces were inadequate since, as suggested by Biscarde *et al.*[28], teams could have received specialized support from management using virtual meetings or video classes through continuing education and matrix support.

Conclusion

The study identified the weakening of PHC attributes in São Paulo: care coordination, longitudinality, comprehensiveness, access, family and community approach, and cultural competency[29]. This fragilization appears closely linked to a managerialist and bureaucratic PHC management model, which mischaracterizes ESF's work, approaches an individualistic selective model, and erases crucial aspects of health responsibility towards the enrolled population. Although these weaknesses have been reported in previous studies, their exacerbation was identified here during the pandemic.

The ESF model, historically in dispute in the municipality, added to the performance targets, which have always been present in relationships with the OSS and were later endorsed by Previne Brasil[2,30,31], emphasize appointments and individual care and seem to relate to precarious work and care, generating harmful effects among workers and users. Even with experiences showing the relevance of enhancing PHC to guarantee all necessary care for the population, this did not become the rule in São Paulo, and such poor conditions mobilized professionals for better working conditions, but with an incipient response[20,32].

Thus, we conclude by saying that São Paulo's municipal management model significantly and adversely affected the construction of care during the COVID-19 pandemic, further weakening and mischaracterizing ESF's work that was already at an accelerated pace of deconstruction by the municipality and then the Federal Government.

Collaborations

TV Anéas worked on project administration, conception, drafting, and review of the article. MN Lima and FJL Braga worked on the conception, drafting, and review of the article. NTA Menezes and TL Oliveira worked on the conception and drafting of the article. MMO Viana worked on drafting the methodology and reviewing the article. DN Santos drafted the article's introduction.

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