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"Because we are all sick": challenges of caring for people with obesity in Primary Health Care in times of Covid-19

"Porque nós estamos todos doentes": desafios do cuidado às pessoas com obesidade na Atenção Primária à Saúde em tempo de Covid-19

Abstract

Introduction: The Covid-19 pandemic has implied significant changes in the operation and demands of Primary Health Care (PHC), impacting the organization of work and care for people with obesity and other chronic diseases. ***Objective***: To describe the challenges and strategies for the care of people with obesity in the context of the COVID-19 syndemic from the perspective of PHC providers. ***Methods***: Semi-structured interviews were conducted with workers from a Basic Health Unit (BHU) in the city of Rio de Janeiro. ***Results***: Since the first cases of Covid-19, the work organization at the BHU has been modified by the recommendations of social distancing, fear of contagion, and worker overload. Routine care, as well as collective activities, including care for people with obesity, were interrupted. However, the identification of obesity as a risk factor for worsening Covid-19 has been prioritized with regard to monitoring and vaccination. ***Conclusion***: The resumption of the routines in the BHUs points to major challenges in the care of people with obesity, affecting the precarious living conditions of the population and impairing the organization of work in PHC.

Keywords: Obesity. Nutrition. Primary Health Care. Pandemic. COVID-19

Resumo

Introdução: A pandemia de Covid-19 implicou mudanças significativas no funcionamento e nas demandas da Atenção Primária à Saúde (APS), impactando na organização do trabalho e dos cuidados às pessoas com obesidade e outras doenças crônicas. ***Objetivo***: Descrever os desafios e estratégias para o cuidado às pessoas com obesidade no contexto da sindemia de COVID-19 na perspectiva dos profissionais da APS. ***Métodos***: Foram realizadas entrevistas semiestruturadas com trabalhadores de uma Unidade Básica de Saúde (UBS) no município do Rio de Janeiro. ***Resultados***: Desde os primeiros casos de Covid-19, a organização do trabalho na UBS foi modificada pelas recomendações de distanciamento social, pelo medo de contágio e a sobrecarga dos trabalhadores. Atendimentos de rotina, assim como atividades coletivas, incluído o cuidado às pessoas com obesidade, foram interrompidos. No entanto, a identificação da obesidade como fator de risco para agravamento da Covid-19 desdobrou-se em priorização no que tange ao monitoramento e à vacinação. ***Conclusão***: A retomada das rotinas nas UBSs aponta grandes desafios no cuidado às pessoas com obesidade, repercutindo na precarização das condições de vida da população e prejudicando a organização do trabalho na APS.

Palavras-chave: Obesidade. Nutrição. Atenção primária à saúde. Pandemia. COVID-19.

INTRODUCTION

The care of people with obesity has been considered a great challenge due to its complexity and magnitude.[1] Data from the Surveillance of Risk Factors and Protection for Chronic Diseases by Telephone Survey (VIGITEL) revealed that, in the 27 Brazilian capitals, the frequencies of overweight and obesity were 57.2% and 22.4%, respectively, in 2021.[2]

Primary Health Care (PHC) plays an important role in the comprehensive care of users with obesity, offering individual and collective treatment and team support with professionals from different backgrounds.[3]

In addition, the teams of the Basic Health Units (BHUs) carry out actions in order to promote healthy eating, physical exercise, space for exchanging experiences and obstacles, making it possible to analyze and recognize the situation of obesity in the territory and establish contact with users.[4]

In recent years, several materials have been published by the Ministry of Health to support the care of people with obesity aimed at professionals of the Unified Health System (SUS), including PHC, such as instructional and theoretical material for a collective approach and management of obesity.[5-7] To promote adequate and healthy eating,[8] issues 1 and 2 of the protocol of the *Food Guide for the Brazilian Population*,[9,10] aimed at providing nutritional guidance to adults with obesity, were also published.

Considering the challenges presented by the Covid-19 pandemic, PHC was required to adapt to the needs of guiding prevention measures, monitoring vulnerable groups, organizing the supply of vaccines and tests, in addition to promoting adequate and timely care for people affected by the coronavirus.[11]

In this article, considering Covid-19 to be a syndemic – due to its synergistic and potentiating interaction with other epidemic diseases, such as chronic non-communicable diseases (NCDs), infectious diseases, and mental health problems – provides an opportunity to identify and face social and health inequalities related to it.[12-14]

This study aims to analyze the challenges and strategies from the perspective of PHC professionals in the care of people with obesity in the context of the Covid-19 pandemic.

METHODS

Research was carried out with a qualitative approach, based on a semi-structured interview[15] conducted with community health agents and with professionals of technical and higher level. The Basic Health Unit (BHU) consists of five Family Health Teams and a total of nine Community Health Agents (CHA), and six healthcare providers with higher education participated in the research, as shown in Chart 1

Chart 1. Profile of the care providers interviewed according to the code, sex, occupation, years of work in the BHU, and workload. Rio de Janeiro, 2022.

Code	Gender	Occupation	Years of work in the Basic Health Unit	Weekly workload
A1	Female	Community Health Agent	17 years	40 hours
A2	Male	Community Health Agent	9 years	40 hours
A3	Female	Community Health Agent	16 years	40 hours
A4	Female	Community Health Agent	16 years	40 hours
A5	Female	Community Health Agent	9 years	40 hours
A6	Female	Community Health Agent	15 years	40 hours
A7	Female	Community Health Agent	15 years	40 hours
A8	Female	Community Health Agent	4 months	40 hours
A9	Female	Community Health Agent	10 years	40 hours
B1	Female	Nurse	12 years	40 hours
B2	Female	Nurse	8 years	40 hours
B3	Male	Physician	3 months	20 hours
B4	Female	Physician	4 months	40 hours
B5	Female	Dentist	10 years	40 hours
B6	Female	Psychologist	1 year	30 hours

Source: The authors, 2022.

Data collection was carried out from March to April 2022, through semi-structured interviews based on questions related to contagion, guidance, the work routine of CHAs in the context of activities and barriers related to the care of people with obesity during the pandemic.

The interviews were later transcribed and analyzed according to the "meaning interpretation method", organized into three stages: (1) comprehensive reading of the material to get the whole and the

particularities; (2) reading to explore the material and interpret the interviewees' discourses; and (3) elaboration of an interpretativesynthesis.[16] Next, the data were organized by categories of analysis, based on significant expressions or words.[17]

Given the ethical aspects, it is noteworthy that the results presented in this article are part of research approved by the Research Ethics Committee of the Pedro Ernesto University Hospital, UERJ (Opinion No. 3,712,789) and by the Research Ethics Committee of the Municipal Health Department of Rio de Janeiro (Opinions No. 3,784,409 and No. 3,981,992).

RESULTS AND DISCUSSION

The interviews revealed important challenges that have changed over the more than two years of the health crisis caused by Covid-19. Initially, the routine was impacted by uncertainties and the need to adapt to the safety standards imposed by the previously unknown virus. Then, the greatest repercussion was the arrival of vaccines, an activity obviously elevated to the priority *status* of the teams. Finally, a third moment of resumption of activities, including those related to people with NCDs and obesity. The results are shown according to these three moments.

The arrival of Covid-19 in the territory

The relevance of PHC in recent years was pointed out through Covid-19 prevention actions and support in health surveillance activities in the territory.[18,19] As in other BHUs, at some point, most healthcare providers in the team were contaminated by Covid-19. The initial period was marked by a collective feeling of insecurity and fear related to their own health and the health of their families.

> I had covid, as well as my sister, my nephew and his wife. I had mild covid, I took the medicines at home. I was really afraid of walking on the street. I had covid in the end of 2020. (A5)

> [...] the registered patients themselves were afraid of us, you know? They said: no, you don't have to come here to my house, no. You are there in the focus of contagion. (A7)

The overload and intensification of demands focused on the care of people infected by the coronavirus resulted in sequelae both in the territory and in the healthcare providers who were on the front, mainly related to mental health issues. The pandemic has changed the organization and performance of the roles of PHC providers.

> Yes, those in the risk group stayed at home, so the teams were even more reduced. So those who stayed at the clinic worked hard because it was non-stop. I had to do my job and that of two where were in the risk group. (A3)

> I think demands increased a lot. We were overloaded, and then it really also makes it difficult for you to be able to offer care to this population that needs it so much. We know that the demands were really great and then, during our shift, we were practically involved in the care of Covid. (B-6)

> We need help from providers to providers because we are all sick, everyone. I'll tell you that everybody has been sick. Except for the doctor who came in now, but whoever is here like me, I have worked here for 10 years, has mental issues, we need to be treated somehow. (B5)

Other studies identified these same challenges, pointing out that healthcare providers experienced several aspects in their work process, such as moments of stress, overload, reorganization of work dynamics, lack of personal protective equipment (PPE), fear of contagion and little support.[20]

The safety protocols related to Covid-19 were provided as general guidance by the BHU manager herself and other team members, highlighting social isolation, the use of hand sanitizer and the use of masks

> It was all our manager and another doctor here who guided us with the basics that they knew [...] (A2)
>
> We were oriented to ask people to always wear masks. (A6)
>
> [...] there was a welcoming shift, we did a training to have a more careful look [...] (A1)

The performance of the CHAs was pointed out as relevant in other works that identified the performance in health surveillance, in the dissemination of information on prevention and in reception, in order to avoid agglomerations in the BHU as the main activities carried out in the most acute phase of the pandemic.[21]

The interviews showed that the teams were aware of the correlation between obesity and the worsening of Covid-19 symptoms,[22] which guided a monitoring strategy through the inclusion of people with obesity in the list of the most vulnerable residents. Activities such as home visits (HV) and telephone contact were provided for groups recognized as among the most vulnerable ones.

> [...] we heard that obese people were more likely to get this because of immunity, hypertension, this stuff. (A7)
>
> Some had Covid and others died, but most of the list we made [...] with obese, seropositive, and hypertensive people and decompensated diabetics, which we kept monitoring. But it worked out fine. When we saw something, we guided the person. (A2)

The use of the telephone and internet was an action strategy used in different territories, as pointed out by Lima.[23] The use of the CHA's own account and cell phone was observed in this location, as well as in other studies.[24]

> [...] we couldn't visit the patients because we couldn't expose people, right? [...]. So, our main contact was via telephone, when possible, we were under surveillance [...]. When it was necessary, we would visit them, when they did not answer the phone [...]. (A1)
>
> I worked from home because I had my cell phone - and those registered had a cell phone. I kept in touch mainly with the little ladies, right [...]. (A6)

Other research identified that, as a way to maintain care actions in the face of the Covid-19 pandemic, the BHUs used some tools, namely: telephone contact, to establish communication with users, message exchanges, teleconsultation, scheduling consultations, to reduce the exposure of people to the virus, to safely offer health actions to users, and it is not necessary to go to the BHUs.[25]

Facing great challenges and the structure of the BHUs, not always adequate to the adaptations required by the context of the syndemic, the teams found their own coping strategies. This can be highlighted as another expression of the inventiveness and commitment of the PHC teams.[26,27] However, and in addition, given the great precariousness of services and the growing precariousness of the work of healthcare providers favored by the neoliberal logic of life management, the interviews show the impact on the mental health of these workers, as well as the commitment of the care offered, corroborating the literature.[28,29]

Anyway, the vaccine has finally arrived!

With the distribution of vaccines in the BHUs, a new routine was organized.[30] As the Unit in question had limited physical space, it had to use a specific location for vaccination, which was carried out in tents. In addition, an active search was performed when elderly people with NCDs were prioritized.

> We stayed downstairs in a tent. When these people arrived, and were well, they were taken care of downstairs. They would go upstairs to get the vaccine [...] (A4)

Although coping with the syndemic has demonstrated the importance and power of SUS at different levels of care, it has also revealed the need for adequate financing for the health sector. In many cases, the UBS structure no longer adequately met local needs, which was more evident in view of the exceptional needs generated in the context of Covid-19.

> The clinic's structure is quite limited. Both physically and professionally. And with the lack of doctors, of healthcare providers here, it is very difficult to provide quality, because we have to meet a very large demand. (B4)

Another relevant element was the change in both demand and supply of services in the unit. If on the one hand part of the population stopped attending health services for fear of contagion, on the other hand, the adaptation of the service offer did not suit all groups and their demands, including in this case actions aimed at people with obesity and NCDs, as shown in the following statement:

> [...] appointments and care were practically minimized for children and the elderly. [...] because of this difficulty of accessibility, there were no home visits either. We know that in fact there was a natural departure in this process. [...] the majority of the activities that were in a group [...] had to take place on the internet. We had to try using WhatsApp and we know that not everyone has a good connection. (B6)

Thus, as in other studies, it was identified that, with the Covid-19 pandemic, the treatment and monitoring of NCDs faced difficulties such as the reduction or stoppage of actions aimed at subjects assisted by health services,[31,32] due to the prioritization of the fight against the coronavirus and the application of vaccines.

Another relevant aspect was that care for people with obesity was benefited in this territory, due to its identification as a vulnerable group, representing the possibility of prioritizing vaccination.

> The obese people were also in the risk group, so we had no difficulty because most of these people were vaccinated at home, right? We did a campaign, then the CHAs would take and vaccinate these people specifically at home [...] (A3)

This recognition, however, did not mean prioritizing other activities, and this factor is probably related to the existence of weaknesses prior to the pandemic.

> There was no activity, right? Because everyone was working with Covid. There was vaccination, and all that stuff. (A3)

> [...] before the pandemic[...]. Each team had its own group: hypertension, diabetes, pregnant women orientation group. Many groups did not go forward, because many people were absent. [...] very few people attended the group. (B1)

Thus, it is noteworthy that there was discontinuity in the provision of care to people with obesity – for example, nutritional guidance and health promotion groups – due to the lack of priority of actions to this comorbidity. In addition, as in the pre-pandemic period, the teams did not provide specific care for obesity, they created guidance groups for exams, food, and physical activity.

Similarly, other studies have found that Covid-19 contributed to the discontinuity of treatment for people with NCDs, since previously, when there was no pandemic, gaps in the availability of these services were visible.[19,33]

The "new normal": a syndemic that has not ended!

With the advancement of vaccination, expansion of testing, greater knowledge about the disease and, consequently, the stabilization of the number of deaths, several activities in society began to be resumed. For health services, major challenges related to the resumption of their essential activities and living with sequelae and complications related to Covid-19.

When asked about the challenges related to the care of people with obesity, the providers pointed to the issue of lack of time and overload as a major challenge.

> [...]when these pandemic peaks occurred, these lines of care were lost a little, we ended up prioritizing covid and deprioritizing the other lines of care... So, people who had follow-up and were having benefits from the program lost follow-up having relapses, and this is very demotivating for the patient, [...] Then, they did not come for a while and now they are coming again to be followed up... It seems that we are starting a lot of things from scratch again [...] And I think this is our main challenge, people are coming back with demands that have been backlogged for a while... (B3)

There is concern about the fact that NCDs, which were part of the risk group of the severe form of Covid-19, almost had the care interrupted by the discontinuity of care lines.[14]

> Unfortunately, we always owe people with overweight and obesity. It would be something that would happen even because not everyone who is hypertensive, or diabetic is overweight and obese... But for the sake of time and schedule, we approach these people if they were part of a general set, [...] because we had neither space nor time to have specific groups [...] (B1)

Given this scenario, healthcare providers had to reinvent themselves with regard to obesity care, considering that some practices were implemented as measures to prevent and control the virus, including social distancing. As a result, remote monitoring has become a strategy to classify, monitor, and treat overweight individuals.[34]

> I think the appointments were via telephone because we could not visit the patients. We could not expose people to covid because we were on the front lines and people were isolated at home, so our major contact was via telephone. When possible, we would stay on surveillance because we had a table in front of surveillance. People would come here for an appointment; we would write down their phone numbers and address. When it was necessary, we would visit the person, when the person did not answer the phone or other types of contact. (A1)

It should be noted that some providers reported as obstacles to the treatment of obesity the lack of professional qualification, great demand for individualized care, presence of multiple diseases, scarcity, lack of access or lack of knowledge about teaching materials.[35]

> I think training would be interesting within a reality that most people are usually vulnerable to [...] training to foster this knowledge for us to apply in the office (B2)

It is noteworthy to recognize the complexity of care for people with obesity, especially by identifying their coexistence with other symptoms and diseases.

> It is really difficult! Access to basic medication right... it is common for people who are overweight and obese to have reflux, stomach disease, heartburn, these things... It is very common for these patients to have anxiety, associated depression (B3)

> Many people gained a lot of weight during this period of the pandemic, due to anxiety or because they had nothing to do and became completely sedentary (B4)

The Covid-19 health crisis arrived at a challenging time in the territory, as it overlapped with the political and economic crisis experienced throughout the country. The difficulties encountered by informal workers to maintain their activities, unemployment, and the dismantling of social policies aggravated the difficulties related to access to food and health.[36]

> I think the first thing is the economic issue, a lot of people lost their jobs, a lot of people have this limitation of having access to things financially... [...] I think people have entered an inertia of staying at home, of quarantine, and they are still in kind of this inertia, you know, they are still slowly getting out of it. (B3)

In the current scenario, it is observed that the expansion of food and nutritional insecurity in the context of Covid-19 is interconnected with determinants such as lack of income, lack of employment/unemployment, employment without employment, lack of housing, deprivation of access to education, and insufficient access to health services.[37] It is noteworthy that these factors influence malnutrition, which is triggered by inaccessibility to nutritionally rich foods, and obesity is an expression of this condition.[38,39]

> [...] we deal with people who have difficulty with purchasing power, including having food at home, right...(B2)

> The vulnerability of the patient, who has to maintain a very low quality of life, is for me is the greatest difficulty (B4)

The actions of the daily life of the BHU in its entirety are expected to fully return, especially to users with NCDs who had their line of care impaired through the reduction of care in the period of the Covid-19 pandemic.[40]

> We are in a process of actually resuming the groups, the collective activities, so I think it is important to emphasize that we went through a very complicated moment in relation to the issue of the vaccine, covid, then with the flu outbreak. Even because we are a clinic that has a small space, we have a little more difficulty to develop some actions, but then we usually use the territorial bases. (B6)

> Groups, in primary care, are a fundamental thing [...] They are coming back slowly, but I think groups are fundamental. One identifies with people who have the same problem as them, this support... We can do these behavior change practices, talk about nutritional issues. (B3)

The many and complex challenges related to the current scenario are identified by the speeches of the providers. It is possible to notice that there is a recognition that this third moment does not mean the end of living with the coronavirus, much less the end of concerns about symptoms and sequelae of Covid-19.

CONCLUSION

Becoming aware of obesity as a risk factor for Covid-19 had relatively little impact on the prioritization of care in the face of the overload generated by changes in the organization and work process of PHC teams during the pandemic. On the other hand, it is worth emphasizing the relevance of making telephone calls and the priority of vaccination for this public. This aspect highlights the commitment of many SUS (Unified Health System) providers who, using their own resources – such as their cell phones and internet data –, put themselves on the front lines to face Covid-19. In this sense, it is essential to highlight the impact of neoliberal logic on work processes acting in the field of subjectivities and in daily life.

Food insecurity, lack of income, discontinuity of treatments, and mental health are among the main challenges presented. With regard to strategies, the performance of collective and health promotion activities were marked as relevant actions but were difficult to implement. In this way, the importance of institutional support through partnership with the University for various actions – including permanent education - is identified.

The resumption of routines in BHUs points to major challenges in the care of people with obesity, especially regarding backlogs, the current food scenario, and more complex lives. It is also important to look at the providers' health, who were affected by both the coronavirus and the NCDs.

The need to improve the work processes of PHC is evident, aiming to advance approaches in the care of people with obesity, investing in the work carried out by a multidisciplinary team and expanding the link between health professionals and users, so that a humanized and welcoming treatment is provided.

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