Promoção da Saúde
DOI: 10.17765/2176-9206.2024v17e12886

Collective care practices in Primary Health Care during the COVID-19 pandemic

Práticas coletivas de cuidado na Atenção Primária à Saúde durante a pandemia da covid-19

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ABSTRACT

Collective care practices are essential nursing care interventions. This study aimed to analyze how collective care practices nurses performed during the pandemic in Primary Health Care were established. Methods: This qualitative research was inspired by Michel Foucault's genealogical method, which adopted semi-structured interviews from 59 nurses working in Primary Health Care as a data production instrument. Results: Collective practices were discontinued during the pandemic, and we identified PHC's precariousness. Discussion: We live in a biopolitical situation in which several populations are subject to "precariousness". Conclusion: Preserving collective health practices in PHC strengthens the confrontation of life precariousness. By occupying the public space of Primary Health Care, collective care practices conjure deindividualization, weakening social medicalization.

Keywords: Primary Health Care. Nursing Care. Pandemic.

RESUMO

As práticas coletivas de cuidado se configuram como importantes intervenções de cuidado de enfermagem. O estudo objetivou analisar como se constituíram as práticas coletivas de cuidado realizadas pelas enfermeiras, durante a pandemia, na Atenção Primária à Saúde. Metodologia: pesquisa qualitativa, inspirada no método genealógico de Michel Foucault. O instrumento para produção de dados foi a entrevista semiestruturada respondida por 59 enfermeiras atuantes na Atenção Primária à Saúde. Resultados: Na pandemia as práticas coletivas foram descontinuadas. Identificou-se o processo de precarização da Atenção Primária à Saúde. Discussão: Vivemos uma situação biopolítica na qual diversas populações estão sujeitas ao que chamamos de "precarização". Conclusão: A manutenção das práticas coletivas de saúde na Atenção Primária à Saúde fortalece o enfrentamento aos processos de precarização da vida. Ao ocuparem o espaço público da Atenção Primária à Saúde, as práticas coletivas de cuidado evocam a desindividualização enfraquecendo a medicalização social.

Palavras-chave: Atenção Primária à Saúde. Cuidados de Enfermagem. Pandemia.

INTRODUCTION

Collective practices performed by establishing groups are essential approaches to nursing care in Primary Health Care (PHC). They aim to promote health and prevent disease.[1] In Brazil, creating the Unified Health System (SUS) and the Psychiatric Reform were decisive milestones in valorizing collective activities as critical therapeutic interventions. Thus, such activities were valued from mental health practices and knowledge, but also as essential nursing healthcare practices in Primary Care (PC).[2]

At this healthcare level, the articulation between individual and group care technologies aims to resolve the population's health demands and is provided for in the National Primary Care Policy.[3] PHC and PC are similar terms under this Policy. PHC is considered internationally as a strategic level of healthcare, with the potential to respond to the population's diverse health needs efficaciously and effectively.[4] The term PC, in turn, also refers to the first healthcare level but also to the history of the Brazilian Health Reform.[3]

PHC is organized per the tensions of two opposing models: comprehensive PHC and selective PHC. Comprehensive PHC emerged at the Alma-Ata Conference in 1978 from the understanding that health promotion and disease prevention are strongly related to the social and economic development of the country, highlighting the relevance of the population's access to the social determinants of health. SUS principles align with this model and, in this sense, advocate universality, social participation, and PHC as the first point of contact between people and public health services.[5] In turn, selective PHC emerges in opposition to comprehensive PHC as part of a critique of the breadth of the latter's actions. Selective PHC represents the World Bank's interests regarding the health systems of countries with more socioeconomically vulnerable populations, proposing a limited supply of services. This PHC model represents neoliberal policies and, during the 1990s, was linked to the actions of international organizations that supported and produced the implementation of neoliberal state reforms in Latin America.[6]

In this context, the Health Reform Movement adopted the term PC in contrast to selective PHC to distance itself from this neoliberal vision and reinforce SUS expanded conception of health.[5] This research seeks to highlight the use of the term PHC as a field of collective and individual care practices conducted in a multidisciplinary manner under the coordination and implementation of different professional groups, which, to a certain extent, tends to expand the potential of its approaches.[7]

Thus, collective healthcare practices developed in PHC Units (UBS) or Family Health Strategies (ESF) and based on the situational diagnosis of each territory are expanded by multidisciplinarity. The different knowledge of the professionals who work in these services favors interdisciplinarity and comprehensive care for the population so that collective practices can constitute another therapeutic modality.[7] Care organized and performed by professionals from different areas can be a starting point for possible initiatives to build interprofessional care, which, despite already being considered the most productive for the qualification of PHC, still faces challenges to its implementation and sustainability, such as the difficult communication between the team and the development of strategies that can reduce power struggles between health professionals.[8]

However, in the PHC context, collective healthcare practices often focus on educational actions for prevention and health promotion and are mostly aimed at treating chronic diseases. Few initiatives enable actions to promote change and strengthen the autonomy of individuals and communities.[1] However, collectivized health demands can problematize issues involving the population's access to the social determinants of health and "make explicit the importance of keeping and expanding the SUS as a public policy of the State and other public policies."[9:2180]

Furthermore, interdisciplinarity in the composition of healthcare practices establishes nursing work as a social practice. Social practice is understood as those constructed "from the social health needs that emerge at a historical moment; they are constituted and transformed in the dynamics of relationships with other social practices that make up the SUS setting."[10:753] From this perspective, nursing is a social practice that

has brought other ways of composing care to PHC, above all, through the coordination of Nursing and Public Health, which brings to Nursing care practices references exceeding the technical-operational dimensions that derive from biomedical knowledge. In this sense, nurses produce knowledge and practices permeated by the intersubjective work processes, that is, in the worker-user encounters. Whether they are interactions in the care provided in the UBS or ESF or even in social control meetings, such encounters enable the construction of the vital user-professional bond so that health professionals can consider the users' statements for producing shared responsibilities around problems.[11]

Thus, nursing as a social practice fundamentally ensures that PHC can be established as a setting in which care practices can trigger movements that are contrary to the individualization found in the self-care health discourse, a discourse that emphasizes the ideals of health promotion in its behavioral aspect and reinforces the idea of the user's self-responsibility for their health status.[12]. In this context, although studies point to benefits implied in the implementation of groups as a therapeutic intervention in PHC[2] based on the user-health team bond, there is still a gap regarding identifying the elements that make up such practices and lack of indications about the conditions in which they develop.

Thus, this study aimed to analyze how nursing collective care practices in PHC were established. We expected this analysis to contribute to resistance to the SUS precariousness, which escalated from 2016 onwards with the neoliberal fiscal adjustment policies and the constant attempts to privatize PHC. To this end, we were inspired by the notion of assembly, as developed by Judith Butler[14] in her work "*Bodies in Alliance and the Politics of the Street – Notes Toward a Performative Theory of Assembly*". This notion valorizes collective healthcare practices in PHC as promoters of concretely collective care environments, in which one can resist the idea of individual responsibility attributed to people regarding the management of their health and tends to reaffirm the right to health, with access to the public and quality SUS.

METHODS

STUDY TYPE

This qualitative study was inspired by Michel Foucault's genealogical method.[15] Genealogical research proposes the elaboration of a diagnosis of the present, directing its analytical lenses towards disputes and plots, which, thought of as emerging events in a given historical context, end up constituting knowledge consolidated as practices.[15]

The empirical material was produced within the scope of the national research "*Nursing Practices in the Context of Primary Health Care (PHC): National Mixed Methods Study*", coordinated by a group of researchers from the Center for Public Health Studies (NESP) of the University of Brasília (UnB) in partnership with the Federal Nursing Council (COFEN) and public universities from all Brazilian states.[16]

STUDY SETTINGS

The study setting was the PHC services, characterized by the traditional UBS and ESF models. The typology proposed by the Brazilian Institute of Geography and Statistics (IBGE), published in 2017 in the document Classification and Characterization of Rural and Urban Spaces in Brazil,[17] on a municipal scale, was adopted to select the municipalities. Thus, the following types were defined for the municipalities: (1) Urban; (2) Adjacent Intermediate; (3) Remote Intermediate; (4) Adjacent Rural; (5) Remote Rural.

PARTICIPANTS

The study participants were nurses who worked in PHC in Rio Grande do Sul. The inclusion criteria were being a nurse and developing care or management practices in family health teams in PHC for at least three years. The exclusion criteria were preceptor nurses, consultants, professionals without a formal employment relationship with the health service,

and nurses absent due to vacation or leave of any nature.

The selected municipalities had different typologies: 78 (44.83%) were classified as urban, 46 (26.4%) as Adjacent Rural, 40 (22.99%) as Adjacent Intermediate, 7 (4.02%) as Remote Rural, and 3 (1.72%) as Remote Intermediate.

Fifty-nine nurses from Rio Grande do Sul participated in the study. Twenty-seven were from Porto Alegre, 7 from Nova Petrópolis, 6 from Três Cachoeiras, 5 from Flores da Cunha, 4 from Maçambará, 4 from Teutônia, 3 from Garruchos and 3 from Chuí. Nurses were identified with the letter E followed by increasing Arabic numerals, from E1 to E59, as per the sequence of the interviews to ensure the confidentiality of their reports.

DATA PRODUCTION INSTRUMENT

This study used semi-structured interviews as a data production instrument. Fifty-nine nurses working in PHC in Rio Grande do Sul answered the interviews from November 2020 to February 2021. The interviews were conducted through online videoconferencing platforms (Google Meet). Previous contact was made with the participants via email or WhatsApp to arrange the most convenient time for this activity. Interviews were recorded and later transcribed in full for data analysis and interpretation.

The semi-structured interview was organized into three blocks. The first block referred to social data, the second focused on professional training, and the third contained questions that aimed to understand the care practices nurses developed in the health unit. This article will use excerpts from the nurses' reports that bring elements that foster the analysis of collective nursing practices in PHC.

DATA ANALYSIS

Data analysis was based on Foucauldian Studies and Feminist and Gender Studies, which are based on Judith Butler's philosophy, which articulates politics, philosophy, and ethics. These perspectives offer theoretical inputs that allow us to consider the power relationships underpinning nursing care practices in interface with the profession's social role.

ETHICAL ASPECTS

The Research Ethics Committee of the University of Brasília approved the project under CAAE: 20814619.20000.0030. In Rio Grande do Sul, the Research Ethics Committee of the Municipal Health Secretariat of Porto Alegre approved the project (CAAE: 20814619.2.3031.5338).

RESULTS

The pandemic context led to the discontinuation of nursing collective practices with other PHC professionals. The reports of the 59 nurses reflect the institutional health contingency discourse related to the COVID-19 pandemic, such as social distancing, which included the suspension of collective healthcare practices, as clearly shown in the following reports:

> During the pandemic, we had no group activities; the services were individual. (E9)
>
> Now, at the moment, we are not doing anything in groups. So, all group services are suspended. (E18)
>
> (...) we are no longer doing these groups with the pandemic. (E20)
>
> (...) we are not doing [group services]; we are now working with social distancing. (E12)

However, the interview contained a specific question about the implementation of collective practices, which was: "Do you provide collective care to groups of the population in the health unit? How often? What type of action/actions do you develop?" Collective healthcare practices are essential because they appear as a question anticipated by the interview and emerge in the nurses' responses. They described frequency, themes, and how collective practices were performed in PHC before the pandemic. However, some reports indicate that collective practices in PHC were infrequent or

even not carried out at all even before the pandemic:

> We struggle with groups here. We can even do it when there is a larger program, like a city anniversary because most of them [the UBS users] live outside and depend on transportation and schedules. So, sometimes, we schedule a meeting, and they don't want to stay because everyone has a specific time to go home. They are carpooling and using public transportation. (E8)
>
> Here in our unit, the group issue is challenging. We start a group one week with 40 people. The coming week, ten come, and no one comes the week after that... people can't come: they are workers. (E34)
>
> Twice a year... I can't do more than that. When it's not the agricultural season, I can do these meetings when they are less employed. However, other than that, it's more individual. (E9)

Among the reasons for not performing collective practices is the difficulty of people's mobility, especially those who live in rural regions. Getting to the UBS depends on carpooling, as public transportation does not always serve these populations. In these regions, agriculture work tends to hamper people's visits to the health service. However, work, in general, has also been reported as preventing people from attending activities in the PHC.

According to the nurses' reports, collective practices were mostly related to preventive or prescriptive activities such as Hiperdia (a monitoring activity for hypertensive and diabetic patients instructed by the Ministry of Health). As we can see in the following excerpts, Hiperdia groups are widespread in PHC collective practices:

> Hiperdia and pregnant women are monthly, and smoking cessation is weekly. (E35)
>
> With the pandemic, our daily routine is without our Primary Care activities, Hiperdia, smoking cessation groups, and self-help groups. So, now everything is locked down. (E20)
>
> We had groups before the pandemic. We had a group for pregnant women, a Hiperdia group with diabetics, and sports activities such as walking groups. (E44)
>
> We had a group for hypertensive and diabetic people, sequential visits. (E48)
>
> (...) we had a group for hypertensive and diabetic people, which was weekly. It was more of a prescription renewal group. It wasn't characterized as a group. It didn't have that group identity, which we were trying to change before the pandemic (...) we started to change. However, we had one or two meetings before the pandemic started. (E52)
>
> We can no longer form groups after the pandemic. We are under this restriction. However, the unit had groups for older adults, smokers, hypertensive people, and diabetics, and this was done collectively. (E19)

Besides the types of collective practices related to the most prevalent diseases, groups related to women's health, specifically on female reproductive health and childcare, are also very common:

> Outside of the pandemic, we have weekly childcare groups and pregnancy groups. (E22)
>
> Once a month, we would do (...) For example, if there were pregnant women, we would gather

> the pregnant women, do a presentation or a study group, or answer their questions, depending on their gestational age. (E44)

Collective care practices in PHC were reported to include more prescriptive, biological, and preventive approaches, which use more expository methodologies and aim to streamline the service provided regarding the demand of people seeking services. However, the nurses' reports also indicate that collective practices addressed topics such as interactions among older adults, physical practice, crafts, and even creative writing before being suspended due to the pandemic. In the latter, more participatory methodology is usually used, forming support networks for exchanging experiences on health education. According to the following reports:

> Our units provide care. One of our indicators is the number of educational activities developed. So, we work with children and pregnant women. We have a Local Health Council in the unit made up of residents. Each team has its specific part: some have a representative for each street, and others carry out an electoral process to elect their Local Health Council. (E36)
>
> Now, with the pandemic, we are not doing this, but we had groups for teenagers, crafts, hypertensive people, and diabetics. (E11)
>
> (...) in the collective activities (...), we tried to think of a more participatory methodology so that it would not be like a boring lecture (...). We tried to build on each user's experience from what they already knew and had already done. We would clarify some doubts more from an educational perspective and propose changes according to people's possibilities. (49)
>
> So, before the pandemic, I had a group of older adults, and we had weekly meetings; it is a group very focused on interactive relationships. (E51)
>
> Yes, I coordinate two weekly groups in the unit. A creative writing group and a meditation group are now suspended due to the pandemic. However, when the groups are open, yes. (E30)

Interdisciplinary work is also typical of collective health practices in PHC:

> We had this open group. We didn't have it specifically: "Right, it's a diabetes group for people with diabetes or a group for people with hypertension or obesity". It was a monthly open group for adults. With a multidisciplinary team, the one who coordinated this [group] was the nutritionist, who coordinated the groups, and we participated in turns; each professional participated once a month. (E24)

The precariousness of PHC services in the SUS hindered work during the pandemic due to the lack of workers and, therefore, poorly sized teams, and the lack of materials to provide care. Thus, when asked about the most significant challenge faced during the pandemic, nurses respond that they are concerned about issues related to human resources and supplies:

> The physical space and the lack of staff! The lack of staff and the fact that we had the same vaccine employee having to screen patients with flu symptoms! So that was the difficulty. In the beginning, we also struggled with the lack of PPE. (E31)
>
> It is impossible not to see that the SUS is shrinking, that funding is shrinking

> (...) we realize that limitations are being imposed. (E49)

Furthermore, the precariousness of the lives of people enrolled in PHC services shows how health needs involve social markers of exclusion, such as gender, as described in the report below:

> (...) we see much violence, much mental health demand, and many sick people, even before the pandemic. The population lacks perspective; many women get sick because they don't have their income. They don't have a perspective of autonomy and independence from their husband, and they end up in an unhealthy relationship. (E57)

Given this scenario of precariousness in PHC and people's lives, the increase in isolation and the dissolution of their support networks and community ties is a concern. Although the pandemic has made social distancing a recommendation for controlling the spread of the coronavirus, the individualization that results from such a recommendation is essential for implementing the neoliberal strategy of controlling bodies and regulating subjectivities, which is because the individualization and dissolution of collectivities upholds the neoliberal capitalist world model hegemony.

DISCUSSION

The discontinuation of collective health practices followed the social distancing standards and protocols created during the COVID-19 pandemic. During the first year of the pandemic, this was the most effective measure due to the lack of vaccines, specific medications, and the high transmissibility of the infection.[18]

Despite the importance of hospital care, such as treatment in Intensive Care Units, the COVID-19 pandemic required the reorganization of PHC as the care level of the SUS responsible for treating people with respiratory symptoms. The Brazilian model, whether UBS or ESF, could contribute to territorially based, problem-solving care with a community approach necessary to face any epidemic.[18] The community approach in the PHC work process is fundamental in epidemic contexts, as it reduces the transmission of infection and the demand for hospital services since they test, diagnose, and treat mild cases of the disease in the territories where people reside.

Another significant ESF contribution to the healthcare of the population in the territories was to identify and manage situations of individual or community vulnerability, ensuring access to other levels of the health system in more severe cases. This contribution was facilitated because the work process in the PHC includes longitudinality, comprehensiveness, and coordination of care and, in particular, considers user subjective aspects such as cultural issues and family and community guidance.[19]

Although the PHC has the above potential, this point of the healthcare network faces significant hardships in acting adequately in confronting the pandemic, which, as reported below, are related to the SUS precariousness:

> Attempts to dismantle the ESF since 2017, with a reduction in the number of community health workers, flexible working hours for professionals, abolition of priority for the ESF, extinction of the Expanded Family Health and Primary Care Center (NASF-AB), loss of professionals with the end of the Mais Médicos Program, disincentives to the territorial approach with the new financing model for primary care based on the number of registered patients, weakening the community focus, among others.[18:3]

Added to this precarious situation in the health system, especially in PHC, are the precarious labor relationships, aggravated by the recruitment of social organizations and other forms of privatizating the management of public health services. Such measures lead to commercialized relationships, weakened ties, and

organizational issues with low integration between PHC and other care levels in the health network, which compromises the coordination and continuity of care, as it tends to fragmented care and insufficient intersectoral actions, which are extremely important to reduce social inequalities.[18]

In the theoretical-methodological framework used in this research, biopolitical strategies refer to the set of practices and mechanisms for managing the bodies of individuals and the lives of populations. They form a set of control devices intended to guide how people will live and act.[20]

Due to the significant influence of these strategies on the practices and discourses that constitute how care is performed in contemporary times, collective practices are often guided by prescriptive and normative protocols, with medicalization effects in all life dimensions.[9] Thus, the hegemony of neoliberal ideals permeates health and takes shape through the self-care health discourse. This discourse produces regimes of truth about which behaviors and conducts individuals should follow and which they should avoid in order to live healthily as if all people had access to supposedly healthy lifestyles.[21]

We can analyze contemporary health discourse as an update of biopolitical strategies for managing the individual body and the social body that characterizes the population, as Foucault[15] pointed out in the conference The Birth of Social Medicine, given at the State University of Rio de Janeiro (UERJ), in 1974, in which he analyzes social medicalization as one of the central devices in the exercise of biopolitics, through the pathologization of aspects related to life and bodies. Furthermore, Foucault brings two meanings to social medicalization, which, while inseparable, occur at different stages. The first, located in the establishment of Modern States, occurred through the normalized bodies, spaces, cities, and populations. The second, a derivation of the first, known as indefinite medicalization, emerged in the post-Second World War period and concerns "the impossibility of describing experiences with the human body that do not, in some sense, involve medical knowledge".[22:1861]

We can say that the contemporary Brazilian outlook includes a set of biopolitical strategies, especially in the context of public health policies, which aim to influence and regulate the population's lifestyles. Such strategies, however, have coexisted in the country since 2016 with necropolitical attacks. The latter are, unlike biopolitics, measures that cause the death of specific population groups undesirable to neoliberal capitalism[9,23] through precarious public policies.

According to Judith Butler[14], we are in a situation in which diverse populations are increasingly subject to what we call "precariousness". This condition is not distributed equally in society and increases the feeling of being dispensable or disposable, leading to precariousness. The author affirms that precariousness is induced and reproduced by governmental and economic institutions as a process that adapts populations to insecurity and hopelessness. Therefore, precariousness structure is established through the "general erosion of social democracy active vestiges in favor of entrepreneurial modalities supported by strong ideologies of individual responsibility and the obligation to maximize the market value of each person as the ultimate goal in life"[14:23]. In this context, the processes that make a life immersed in precariousness involve

> (...) an escalation of anxiety about one's future and about those who may depend on one; it imposes on the person suffering from this anxiety a framework of individual responsibility and redefines responsibility as the requirement to become an entrepreneur of oneself.[14:21]

This accountability imposed on each person for managing their lives delegitimizes the right to health and access to decent living conditions, exposing lives to precariousness. Fulfilling this responsibility becomes impossible because neoliberal rationality demands self-sufficiency as a moral idea. However, at the same time, neoliberal power forms work to destroy this possibility at the economic level, using the ever-present threat of precarity to justify a heightened regulation of public environment and the

deregulation of market expansion. So much so that,

> (...) when someone is incapable of conforming to the norm of self-sufficiency (when someone cannot afford healthcare or avail themselves of private medical care, for example), that person becomes potentially dispensable. Then, this dispensable creature is confronted with a political morality that demands individual responsibility or operates on a "care" privatization model."[14:20]

By prioritizing market values over social justice, neoliberal policies expose many lives to distress, hampering living with dignity and producing health inequalities for some populations.[6] In this logic, the privatization and destruction of public services by neoliberal rationality forms shape a world in which the support necessary for bodies to exist becomes highly precarious for a growing number of people, and this precariousness unites these bodies in assembly.[14]

In this outlook of poor health and life, one of the most potent actions is gathering bodies in the public scene, which Butler calls an assembly. It "transmits a bodily demand for a more bearable set of economic, social, and political conditions, no longer affected by the induced forms of substandard conditions".[14:20] The assemblies, therefore, occur with the collective appearance of bodies that are unimportant to the State, over which there is no interest in improving life. On the contrary, the bodies and lives that suffer from precariousness are silenced and made invisible.

Based on the idea of an assembly as a gathering of bodies that, by occupying a public space, seek political expressiveness and resisting the aggressive life precariousness process, we can consider collective practices in PHC as a way specific bodies can and actually access a public health service, because the gathering of bodies also marks the legitimacy of these existences in society since what we see "when bodies gather in an assembly in the streets, squares, or other public places is the – so-called performative – exercise of the right to appear, a bodily demand for a set of more livable lives".[14:31]

In this sense, when groups of people gather in collective health care practices in PHC territories, such as in health academies or community gardens, they are reconfiguring the materiality of the public space and producing or reproducing the public nature of this environment. Furthermore, collectivized health demands put the ideals of neoliberal capitalism under pressure because they problematize issues involving the social determinants of health and show the relevance of strengthening the SUS and intersectoral policies to enhance the population's quality of life.[9]

In this regard, we underscore that precarious public health services emerge in several ways, related to the unstable employment relationships of professionals in public health institutions and due to outsourcing and insufficient financing of the SUS.[24] Moreover, the populations that depend on this service also live under more or less intense life precariousness, which is intensely deepened by commodified healthcare.

In meetings made possible by collective healthcare practices, people can question policies related to their problems by agreeing.[14] In this sense, occupying the substandard PHC public space with their precarious bodies and existences evokes a deindividualization, which breaks with some modes necessary for social medicalization. Thus, the bodies in assembly form communities, even if temporary. Allied with each other, they can exercise freedom forms that overcome narrow versions of individualism.[14]

SUS territories are public spaces that represent movements contrary to mercantilist interests in health, not only regarding profit from disease but also concerning social medicalization, as an essential strategy to guide and regulate the population per neoliberal interests perceptible in some health promotion practices such as health promotion and education directed at women's, workers', and children's health.

Women, workers, and children are fundamental populations for maintaining power and dominance relationships marked by gender, race, and class, as they guarantee the availability of bodies ready to generate the power of

productive labor. Furthermore, women are overburdened by reproductive work, which involves caring for others without pay and is considered a biological attribute subject to moral assessment. As a result, work involving care is devalued, although it is fundamental to upholding the hegemony of the capitalist model of the world, including in its neoliberal phase.

Collective practices related to the treatment of highly prevalent chronic diseases such as hypertension and diabetes are conditions strongly related to the inability of most of the population to access their rights to food, aggravated by the COVID-19 pandemic in 2020. In such a setting, we can understand how fallacious the demand for responsibility and self-sufficiency propagated by neoliberal rationality is because the more socially isolated we are, the more vulnerable and precarious our lives become, and "the more social support structures cease to exist for 'economic' reasons, the more isolated these individuals feel in their heightened anxiety and "moral failure."[14:21] Precariousness incorporates into our lives an escalation of anxiety regarding the future and regarding those who depend on us. It also imposes a burden of distress that leads us to seek individual responsibility, through which we begin to redefine ourselves as entrepreneurs of ourselves; however, in substandard conditions that hamper this vocation.[14]

Collective practices, therefore, can produce effects similar to those produced by public assemblies since the experience of one's body collectively occupying spaces that are increasingly targets of privatization, such as streets, squares, or even a UBS, is already, above all, a power for opposing individualized bodies and legitimizing their presence in public spaces.

> (...) over and against an increasingly individualized sense of anxiety and failure, the public assembly embodies the perception that this is a shared and unjust social condition. The assembly plays the role of a provisional and plural form of coexistence that is an ethical and social alternative distinct from "accountability".[14:23]

Therefore, collective practices position the body less as an entity and more as a living set of relationships, which, gathered in their plurality and occupying the public space, will transform this space. Thus, joint action on the material environment actively reconfigures and refunctionalizes it.[14]

CONCLUSION

This study has identified that collective practices during the COVID-19 pandemic have been discontinued. In this regard, we should consider that neoliberal rationality requires us to produce self-sufficiency, for which we are morally evaluated, and, at the same time, neoliberal forms of power prevent the realization of this possibility at the economic level, making many lives potentially or actually precarious.[14] The SUS has been a disputed territory. We can see that precariousness has escalated and made unfeasible nursing care and healthcare practices in general and access to dignified living conditions, causing many lives to be exposed to distress and even death.

Social distancing has affected social segments differently.[25] Intense social inequality means that many lives are spent under substandard work, income, housing, and basic sanitation conditions, among other social health determinants, to such an extent that they are unable to comply with individual adherence to the protocols for preventing COVID-19 infection.

In this setting, the capillarization of PHC in the territories and the knowledge nurses have produced throughout SUS existence can activate ways for us to create groups and communities so that nurses' knowledge and the knowledge of the people of the territories meet. Furthermore, occupying the PHC's precarious public space conjures deindividualization, which weakens social medicalization. [25]

Encounters fostered by collective healthcare practices can create conditions for nursing and healthcare to produce empowering experiences for creating modes not subject to contemporary biopolitical strategies and occupying the PHC's precarious public space, evoking deindividualization that can weaken social medicalization and thus de-potentiate

neoliberal capitalism's hegemonic power and domination relationships.

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Received: 20 june. 2024
Accepted: 22 july. 2024