**COVID-19 and health promotion in Brazil:**

**Community health workers between vulnerability and resistance**

**Abstract**

Health promotion in Brazil relies on community health workers (CHWs), frontline providers linking the health system and vulnerable groups. Brazilian CHWs are overwhelmingly women from poor backgrounds, with precarious and sometimes hazardous working conditions, as well as fragmented and unsystematic training. This paper evaluates how the COVID-19 pandemic exacerbated pre-existing vulnerabilities of CHWs (pertaining to low salary, precarious and hazardous working conditions and inadequate training) and created new ones, with a profound impact on their ability to carry out health promotion activities. Drawing on testimonials of dozens of CHWs and online discussions promoted by their unions, the paper reveals that during the pandemic CHWs were asked to continue their work without adequate training and protective equipment, thus exposing themselves to the risk of infection. It further shows how the pandemic rendered dangerous the close interaction with patients that is at the heart of their health promotion role. Nonetheless, CHWs sought to adapt their work. In the absence of leadership and coordination on the part of the federal government, CHWs mobilized different forms of resistance at the national and individual levels. Notwithstanding this, COVID-19 contributed to a trajectory of erosion of health promotion in Brazil. Findings from this case signal the difficulties for health promotion in low- and middle-income countries relying on CHWs to bridge the health system and vulnerable users.

Keywords: Brazil; community health workers; health promotion; vulnerability; resistance

**Introduction**

Health promotion has been an integral part of Brazil’s public health system (*Sistema Único de Saúde,* SUS) since its creation in the 1988 Constitution[[1]](#endnote-1). It focuses on: tobacco control; alcohol abuse; safe and sustainable mobility; peace and human rights (including prevention of domestic, gender-based and sexual violence); healthy nutrition; physical activity; and sustainable development[[2]](#endnote-2). Community engagement and user participation have also been included within the remit of health promotion, in line with the commitment of the SUS towards the humanization of policy and the fostering of solidarity, equality and respect for diversity [[3]](#endnote-3) [[4]](#endnote-4).

These faces of Brazilian health promotion stem from its origins as part of an effort to tackle socioeconomic and political inequalities – thus speaking to the goals of democratization, recognition of rights and civil society participation in the period after the military dictatorship. This expansive interpretation of health promotion – recognizing the importance of disease determination and the responsibility of the state in redressing underlying causes of ill health - has remained in tension with a restrictive focus on disease prevention. Nonetheless, the National Health Promotion Policy (*Política Nacional de Promoção de Saúde*, PNaPS), in place since 2006 and subsequently revised, recognizes the need to distinguish individual “life styles” (*estilos de vida*) and collectively-experienced “ways of life” (*modos de viver*), the latter calling for the redressing of inequality and injustice through public policies[[5]](#endnote-5).

Despite these ambitious goals, Brazil’s health promotion was hit by the severe political, economic and institutional crisis raging in Brazil since the process leading to the impeachment of president Dilma Rousseff in 2016[[6]](#endnote-6). This crisis resulted in budget cuts and restrictions, the demise of the regulatory power of the state and the growing influence of corporate lobbies. The confluence of these factors led to the weakening of the National Sanitary Surveillance Agency (*Agência Nacional de Vigilância Sanitária,* ANVISA), responsible, among other things, for the regulation of the use of pesticides and trans fats[[7]](#endnote-7). Health promotion in Brazil has also suffered from policy fragmentation[[8]](#endnote-8). Owing to the decentralized nature of the SUS, policy implementation is heavily dependent on the municipal level. Originally, this was meant to ensure flexibility in the face of Brazil’s epidemiological, territorial, socioeconomic and ethnic heterogeneity. In fact, it led to coordination problems and inequalities in access to health services. Decentralization also led to duplication of efforts, particularly when private and third-sector partners are involved in implementation, and to lack of transparency in the use of public funds.

Owing in part to a failure of leadership and coordination on the part of the federal government, the 2020 novel coronavirus disease (COVID-19) had a devastating impact in Brazil, both in terms of number of cases and deaths. This paper sets out to assess how the pandemic impacted upon the implementation of the country’s health promotion policies. To do so, it takes the standpoint of the country’s community health workers (*agentes comunitários de saúde*, CHW). CHWs work on the frontlines of the SUS and play an essential role in day-to-day health promotion. They are an excellent indicator of the ability of the SUS to effectively reach out to users and deliver on its health promotion promises. The paper asks whether COVID-19 added to existing obstacles to health promotion in Brazil, by exploring the extent to which it exacerbated vulnerabilities in the lives and work of CHWs, and whether it created new ones. To understand the shifting policy landscape of Brazilian health promotion during the pandemic, the argument also explores attempts by CHWs to adapt their work and push back against the government’s failings and neglect.

The article begins with an assessment of the situation of Brazilian CHWs prior to the COVID-19 pandemic. Considering prior vulnerabilities of these workers allows us to evaluate long-standing obstacles to health promotion faced by the SUS. We then describe the methodology of this study and present its findings along two dimensions: the impact of the pandemic on the vulnerabilities of CHWs; the adjustments made by CHWs in their work. In the discussion, we evaluate the impact of the pandemic against the background of the long-term trajectory of health promotion in Brazil. We also reflect about the prospects for health promotion in low- and middle-income countries in the post-pandemic era.

**Health promotion before COVID-19 and the vulnerability of CHWs**

In Brazil there are over 286,000 CHWs, frontline healthcare providers whose role is to bridge the health system and its users, particularly the most deprived and vulnerable[[9]](#endnote-9). Their responsibilities include: keeping records of individuals and families; making regular household visits to monitor the vaccination of children; scheduling specialist appointments; advising on the correct use of medication; contributing to mosquito-control campaigns; and community mobilization[[10]](#endnote-10). CHWs are essential for the implementation of health promotion in Brazil.

The lives and work of Brazilian CHWs are traversed by vulnerability. They are overwhelmingly women, with percentages above 75% and in some cases up to 95%[[11]](#endnote-11). Many are poor and from non-white backgrounds. They are normally recruited from the communities where they work, the assumption being that they should hold an insider knowledge of territories. CHWs are tasked with tackling vulnerabilities while often living in deprivation and while facing the same health risks as other health system users[[12]](#endnote-12). In many cases, CHWs do not have preferential access to the services provided in the clinics where they are embedded, and thus face difficulties in accessing healthcare. Gaps in the provision of occupational health and mental health aggravate their situation of overwork[[13]](#endnote-13). Proximity to the community means that CHWs face constant demands from community members outside regular working hours[[14]](#endnote-14). Overwork is one of the factors leading to burnout, stress and other psychological and physical problems among CHWs[[15]](#endnote-15).

Despite a federal law (13.595/2018) instructing municipalities to hire CHWs as public servants, the profession of CHW in Brazil is overwhelmingly precarious, with different (formal and informal) selection processes leading to various contractual arrangements where labour rights are normally scarce[[16]](#endnote-16). Moreover, the role of CHWs is marked by high turnover and is seen as a “stop-gap” by many of the workers themselves[[17]](#endnote-17). The prevalent view within the SUS of CHWs as unqualified, easily replaceable workers, whose main asset is their link to the community, is one of the reasons why training is fragmented, unsystematic, uneven across the country and often deployed when CHWs are already on the job[[18]](#endnote-18). In addition to impairing their effectiveness, inadequate training also adds to the precarity of CHWs.

Health promotion relies upon the ability of CHWs to gain the trust of their communities and engage in day-to-day interactions, which normally occur in the domestic context. The underpinning rationale is that this engagement, when associated to community mobilization efforts (for example, of people with similar conditions like diabetes or hypertension, or similar sociodemographic background like the elderly or teenagers) will redress inequalities in access to health services and work towards addressing determinants of health. However, the reliance on vulnerable CHWs has meant that the promise of health promotion has been left unfulfilled. Health promotion activities depend upon, and in turn help to reproduce, traditional visions of women as carers which permeate Brazil’s highly patriarchal society, with female labor perceived as a natural extension of domestic work[[19]](#endnote-19). Female CHWs, already living in position of vulnerability, are expected to deliver assistance to their communities while receiving little recognition, meagre economic rewards and no job security.

In sum, Brazilian health promotion is ostensibly directed at the reduction of health inequalities and socioeconomic vulnerabilities. Nonetheless, it is also complicit in the reproduction of vulnerabilities by relying upon a cadre of CHWs who are subject to precarious working and life conditions.

**Data and methods**

This study draws on three sources of data. The first is secondary data from an online survey on the impact of the pandemic on CHWs, conducted by Fundação Getúlio Vargas (FGV), Brazil, between 15th April and 1st May 2020[[20]](#endnote-20). It was disseminated through social media (Facebook and WhatsApp). The (online) response rate was 20%, with 860 CHW respondents from all over Brazil. 32 questions were organized into four topics: sociodemographic profile; feelings during the pandemic; access to resources and support; changes in work conditions. 27 questions had multiple choices, and 5 were open questions. Most questions were adapted from previous research. The survey was pre-tested by 3 CHWs. For this paper, we used data from the following questions: 1) did you receive PPE? (Y/N) 2) did you receive training? (Y/N) 3) do you feel that your manager supports you? (Y/N) 4) do you fear working during the pandemic? (Y/N) 5) did your work change during the pandemic? (Y/N) 6) Can you give us some examples of how your work changed? This paper used descriptive data from questions 1-5 and some information from question 6. Due to the limitations imposed by the pandemic, the sample was collected by convenience and not by probabilistic sample design. Therefore, survey data cannot be generalized, and is here triangulated with data from other sources.

The second source of data was an online ethnography with a public Facebook group, one requiring approval for participation. Researchers asked for permission to participate and collect data. Data draws on posts created by CHWs in the period March-May 2020. This included 112 discussions related to the pandemic, involving 600 CHWs.

The third source of data was interviews with two CHW union representatives: the president of a municipal union and the president of the National Confederation of Community Health Workers (*Confederação Nacional dos Agentes Comunitários de Saúde*, CONACS), the federation of all CHW unions in Brazil. Interviews were conducted online (using Zoom) in May 2020. We asked the representatives how CHWs were dealing with the pandemic; if they had access to resources; how the pandemic changed their work; and how the unions reacted to the new context. Each interview lasted about 1h30 hours. Interviews were transcribed and supplemented by an analysis of public videos and posts from Ilda Correia, the president of CONACS, on social media.

All discussions in Facebook groups, interviews and posts from CONACS were analyzed in NVivo using axial codes: fear; feeling of support; working conditions (access to PPE and training); changes in tasks; forms of resistance.

Except for the interviews, we base our discussion on publicly available and secondary data. To preserve anonymity, we do not cite names of participants in the Facebook group. The research follows ethical guidelines and was approved by the Ethics Committee of FGV.

**Findings: CHW vulnerability during the COVID-19 pandemic**

The first COVID-19 case in Brazil was notified on the 26th of February 2020, almost two months after the first cluster of cases was identified in China. Jair Bolsonaro’s government denied the severity of the crisis and failed to assume a coordination role. Brazil saw two Health Ministers leave the post during the pandemic and was without a Health Minister for 20 days after the second departed (when Bolsonaro appointed a military as interim minister). State and municipal governments assumed the responsibility for the response. While some regions adopted social distancing measures and others remained “open for business”, Bolsonaro acted as an agent of destabilization, going against the advice of health authorities, casting doubts upon official notification data and criticizing politicians adopting harsher measures against the virus.

 Lack of political leadership at the federal level was an unprecedented challenge which decisively impacted upon the lives and work of CHWs. It led to disarray on the frontlines, with CHWs being particularly affected. The Health Ministry published the first regulation about how CHWs should work during the pandemic only on the 20th March, that is, nearly one month after the first case[[21]](#endnote-21). This regulation was vague and contradictory, leaving CHWs in doubt about their role and fearful for their own health. On the one hand, they were told to stop doing house visits and reduce or halt activities based on proximity and direct interaction with citizens. On the other hand, the regulation established that CHWs should play an active role, following up cases of infection while continuing to assist priority groups, such as patients with chronic diseases and pregnant women. No explanation was provided as to how CHWs should offer these services while keeping away from families. No national-level training was provided about the specific challenges of dealing with patients infected with COVID-19. To make the situation more complicated, the regulation stated that CHWs should use personal protective equipment (PPE) – but no resources were provided by the federal government for its purchase. The nationwide survey of CHWs revealed that 80% did not receive any PPE until May; and 89% did not receive any training or official information explaining how to act during the pandemic.

As a result, 88% of CHWs said they did not feel supported by the federal government and 93% reported they did not feel prepared to face the crisis[[22]](#endnote-22). Posting on Facebook, one CHW captured the prevailing mood:

*we are living in the middle of the chaos and we are alone. The government wants us to go to the streets in their name, but they do not care about us. They just want to be re-elected. But we are dying. People are dying. And they* [the authorities] *don’t care.*

Given the lack of training and PPE, CHWs were at great risk of becoming infected – at least fifty have died since the onset of the pandemic[[23]](#endnote-23). The fear of acting as disease vectors also contributed to great stress among workers and put pressure on families. As one CHW reported on Facebook:

*I fear going back home and contaminating my family. I asked my daughter to leave home and stay with her father. I have not seen her for many weeks because I am exposed to risks and don’t want to put anyone else at risk*.

In what constituted a novel challenge, COVID-19 put into question a core condition and specificity of CHW work: that of proximity to the communities. Given how the disease was transmitted, the interactive nature of CHW work became a risk for themselves and those in contact with them. This impacted disease surveillance and contact-tracing. With access to PPE, these tasks could only have been done in part, in open spaces or helping teams in health units. Nonetheless, the necessity of entering people’s homes – most of which are small and poorly-ventilated – meant that these tasks were hazardous even for those few CHWs who had access to PPE.

COVID-19 also exacerbated the gender-based vulnerability of Brazilian CHWs. Women have borne the brunt of the pandemic: in the economic sense since they generally earn and save less; in its health implications given the reallocation of resources away from women’s health; in the increase in unpaid care work and gender-based violence[[24]](#endnote-24). Brazilian CHWs, overwhelmingly women, were overburdened to unprecedented levels. They had to deal with COVID-19 responsibilities in addition to their regular tasks. They were prevented from working from home or having flexible working hours, in a situation of school closures which has meant that many had nowhere to leave their children.

Other long-standing vulnerabilities of CHWs were exacerbated. The job precarity of many CHWs means that they are vulnerable to employer demands that put them at risk. During the pandemic, as confirmed in Facebook discussions, many CHWs were forced to work without PPE in very risky environments. The union of the city of São Paulo received reports of CHWs in risk groups – like pregnant women, elderly and with chronic illnesses – who were forced to continue their work under threat of being sacked. Posting on Facebook, a CHW reported on these pressures, revealing how they are highly gendered:

*I am pregnant and the municipality said I have to keep working. However, my priority now is my baby and I am terrified of the disease. I cannot work like this. (…) Fear is dominating everything. Only God can save us now.*

The pandemic also exacerbated pressures upon the already-meagre salary of CHWs. In May 2020, in response to a mounting economic crisis, the government decreed a salary freeze for all public servants. Subsequently, an exemption to health professionals was approved by Congress, which also forced the government to pay an increment to their salary during the pandemic. CHWs found themselves outside the remit of this exemption. Even though they are an intrinsic part of primary healthcare teams in the SUS, CHWs are not recognized as a professional category, due in part to the absence of technical training as a prerequisite for appointment. As a result, CHWs do not have the rights and guarantees of other health professionals like doctors, nurses or nursing technicians. The ambiguity surrounding the profession of CHW meant that during the pandemic hundreds of thousands of CHWs saw their wages frozen and were prevented from receiving a salary increment to reward increased work and risk.

**Findings: CHW resistance during the COVID-19 pandemic**

Despite their vulnerability, Brazilian CHWs can exercise considerable power. This ability stems from the discretion enabled by the health system, which relies on the capacity of frontline workers to adapt, improvise and make decisions in a context of informality and resource scarcity[[25]](#endnote-25). While COVID-19 exacerbated the vulnerabilities of CHWs and brought about new ones, it also provided a space for CHWs to push back against the neglect and failings of the federal government. Even in a situation of great vulnerability, CHWs exercised their agency and capacity to undertake strategic action. Multiple forms of CHW resistance were visible.

CHW resistance was spearheaded by state unions and their federation, CONACS. Relying on social media, these organizations sought to reinforce a collective sense of resistance. Weekly webinars were organized with the president of CONACS Ilda Correia, and with leaders of state-level unions and politicians – one example of the latter was Henrique Mandetta, who had recently left the post of Health Minister after disagreements with Bolsonaro over the pandemic response. These webinars focused on political strategies to deal with the crisis, and how to protect CHWs from risks. Correia also recorded videos aimed at CHWs, explaining the strategies used by the union and the rights of CHWs during the pandemic. Some of these videos had more than 27,000 viewings.

In the context of a nationwide struggle against the wage freeze and the denial of a salary increment during a pandemic, CHWs activated contacts in Congress and lobbied (unsuccessfully) for their recognition as health professionals. They lobbied Mandetta when he was still Health Minister. They turned to the judicial branch with this demand, also supporting legal actions by individual CHWs claiming labor rights. Judicialization – resorting to courts to render effective rights that are enshrined in law but denied in practice – has been one of the strategies used by individuals and civil society organizations in Brazil, even if its long-term success is mixed[[26]](#endnote-26).

National-level resistance had to face up with the fact that CHWs were not seen by authorities as central in the response to COVID-19, which was mainly focused on hospital-based care to those already infected. In this context, CHWs were unable to claim a more prominent role. Faced with mounting vulnerabilities among CHWs, unions had to change their position and curb expectations. The tone of the resistance of unions changed over time. In the beginning of March, Correia recorded videos mobilizing CHW to “fight” against the disease. She argued:

*Now we have to show how important we are. Families trust us, our recommendations are always the most correct and trusted. We have to show how strong we are. We are the frontline. We won other wars, and this is only one more. A good soldier does not run away from the fight.*

Drawing on a war analogy, she advanced a narrative of heroism to motivate CHWs and ensure that they remained important during the pandemic. Some weeks later, after receiving news of many infections and casualties among CHWs, the federation changed tack: CHWs should now stay away from the fight if they did not have adequate PPE. As a CHW posted on Facebook: “*there is no purpose in being a dead hero*”.

CHW resistance evolved in a context of increasing localization of the response. Given that the federal government did not design a strategy for CHWs, municipalities and clinics had to decide what to do. Some municipalities decided to produce their own PPE for CHWs, thus ensuring that they could continue doing some of their core tasks, such as household visits. Other municipalities and clinics mobilized CHWs in vaccination campaigns, in the establishment of sanitary cordons, and even in activities of information and prevention, such as campaigns in local radios or using sound cars in neighbourhoods. In other places, simple telemedicine technologies were implemented to ensure that CHWs could remain in touch with families. Some municipalities deployed CHWs to call on new arrivals to the territory, checking whether they developed COVID-19 symptoms.

Even though municipalities normally failed to include CHWs in their decision-making, local and individual initiatives reveal some resilience of the lower levels of the health system, which were able to adapt and mobilize in response to the specificities of the territory, the demands of population and the resources available. However, local-level resistance could only achieve so much. Attempts by some municipalities to implement sanitary cordons and stop people from entering territories were opposed by the judiciary because they interfered with the right to free circulation. As a result, checkpoints were reduced to providing information or checking for health conditions. Another example is contact-tracing, rendered impossible due to shortages of equipment and Internet connections.

The shortcomings of municipal-level adaptation help to explain why resistance also happened at individual level. The day-to-day activity of CHWs is, like that of other frontline workers, characterized by a high-level of discretion, which means that CHWs can develop “pragmatic improvisations” to arrive at solutions and get things done[[27]](#endnote-27). On Facebook, many CHWs reported on their own innovations, such as: creating PPE for themselves and their patients; organizing Whatsapp groups with patients to stay in touch when physically distant; or compiling lists of the most vulnerable patients in order to contact them periodically.

**Discussion**

The disarray on the COVID-19 frontlines added to a long-standing erosion of the status and working conditions of Brazilian CHWs. The pandemic exacerbated existing vulnerabilities pertaining to socioeconomic status and gender of CHWs. It also brought further pressures for CHWs, which impacted upon their ability to carry out their work. COVID-19 transformed the interactive nature of their work, and their proximity with communities, into a possible site of disease transmission. Inexistent coordination and leadership, vague regulations, lack of adequate training, and insufficient PPE provision imperilled their lives and wellbeing and made their work extremely difficult. This is particularly true for health promotion activities, which require proximity with the population.

In addition to adjusting to the demands of the pandemic, CHWs attempted to push back against the failings and neglect of the federal government. Nonetheless, however well-intentioned, CHW efforts had a limited effect. Given their frontline role, CHWs became for many Brazilians the face of a failing system, and a potential spreader of the disease. In the balance of power between health professionals, CHWs lost ground *vis à vis* nursing technicians, for example, who were seen by the population as more effective since they were able to deliver biomedical solutions. The credibility of CHWs, and the specificity of this profession – its ability to establish relations of trust with the population – was put into question.

The difficulties faced by CHWs are partly a reflection of the precarious situation of the SUS. COVID-19 placed extraordinary pressure upon an already burdened public health system. CHWs are in many respects, the “canary in the coal mine” of Brazilian public health[[28]](#endnote-28). Their low salary and precarious working conditions reflect the perennial resource difficulties of the health system. Within the SUS, the CHW programme is in a situation of particular risk. It has long been the target of criticism from both the health and political sectors. The National Confederation of Municipalities, for example, has resisted increases in the salary floor for CHWs, arguing that they are not a cost-efficient solution to health problems given their lack of technical expertise and high numbers[[29]](#endnote-29). The widespread idea of CHWs as an economic burden reveals a misunderstanding of the attributions of CHWs and of their long-term impact, as well as a reductionist view of health outcome as something that is only relevant if it can be measured or quantified – preferably in the short-term. Recent revisions of the country’s primary healthcare policies reveal the erosion of CHW responsibilities in the areas of health education and promotion. In 2016, the Ministry of Health issued a directive authorizing the replacement of CHWs with nursing technicians, who can also carry out more specialized tasks like taking blood pressure or the temperature of users – but who need not come from the communities and whose work is not oriented towards health promotion. Vector control agents, who are part of the health surveillance branch of the Health Ministry, are now taking up some of the core responsibilities of CHWs. The latter are gradually being reduced to tasks related to administration and data collection[[30]](#endnote-30).

In recent years, unions have realized that the very existence of CHW as a profession is at risk. At the height of the pandemic, Ilda Correia argued that:

*This is the time for us to prove that our work is fundamental. If we are not in this frontline, we will be showing the government that they do not need us. And our struggle will be weakened*.

The current dilemma facing CHWs and their representatives is that, in the pandemic situation, being on the frontlines is extremely dangerous and can prove counterproductive to their struggle by making them susceptible to being identified as carriers and spreaders of disease.

 The vulnerability of CHWs during the COVID-19 pandemic epitomizes the increased fragility of health promotion – which in Brazil was originally conceived not simply as health education and disease prevention, but more broadly as community mobilization towards the alleviation of socioeconomic inequalities. As the pandemic became the priority, the country’s resources were mobilized in a haphazard way towards dealing with the mounting number of cases. In the absence of central-level coordination, interventions became disjointed and, despite some local successes, the public health effort can be described as an attempt at damage control. In this context, health promotion quickly took the back seat in the concerns of policymakers, health authorities and even health professionals. During the pandemic, health promotion was restricted to attempts to convey simple messages to the population – “wash your hands”, “wear a mask”, “stay home”, among others – and even the success of this was impaired by the absence of an overarching strategy and coordination, and by the federal government’s repeated attempts to spread confusion about the benefits of masks and social distancing.

Meanwhile, more expansive understandings of health promotion fell by the wayside during the pandemic. Fundamental ideas in Brazil’s health system like universality and integral care – that is, the principle that everyone, regardless of their income, should have access to a broad range of services, from health promotion and education to curative medicine and rehabilitation – are being lost. In Brazil’s public health landscape, health promotion has increasingly been relegated to the background, while all expectations and resources are directed towards technical and pharmacological fixes. The ongoing defunding and privatization of the SUS discredits health promotion and other CHW activities that are not easily quantifiable and measurable, and whose results are long-term. Biomedical and hospital-based understandings, privileging evidence-based curative medicine, are gaining ground. The pandemic has contributed to this trajectory.

The Brazilian case holds valuable lessons for other low and middle-income countries relying on CHWs for health promotion. A cadre of precarious frontline workers may be a short-term solution for resource-poor health systems. However, failing to provide adequate recognition and working conditions for these workers undermines the long-term stability in policy implementation that is required for the success of health promotion activities, particularly those that follow an expansive understanding and look to address socioeconomic inequalities. Furthermore, as the Brazilian case shows, the pandemic has fundamentally questioned the interactive nature and the proximity with vulnerable users that are at the heart of many CHW-driven health promotion activities. Even when the pandemic is over, rebuilding trust between CHWs and the population will take some time. This should not be used as an excuse for dispensing with CHW programmes, but rather as another argument for enhanced training and better resourcing that can ensure the safety, wellbeing, stability and motivation of these important workers.

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