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RESEARCH
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EFFECTS OF COVID-19 ON INDIGENOUS PRIMARY HEALTH CARE: PERCEPTIONS OF PROFESSIONALS

Efeitos da Covid-19 na atenção primária a saúde dos indígenas: percepções dos profissionais
Efectos del Covid-19 en la atención primaria de salud indígena: percepciones de los profesionales

Angélica Tais de Oliveira[1]
Larissa Hermes Thomas Tombini[1]
Jeane Barros de Souza[1]
Valéria Silvana Faganello Madureira[1]
Kelly Cristina de Prado Pilger[1]

ABSTRACT

Objective: to understand the effects of the COVID-19 pandemic on the Primary Health Care of indigenous people, in the perception of health professionals. **Method:** exploratory research, with a qualitative approach. Seven professionals who worked in a Basic Health Unit linked to the Special Indigenous Health District in Rio Grande do Sul, Brazil participated. Semi-structured interviews were developed in the first half of 2022. Data analysis was guided by thematic content analysis. **Results:** the effects of COVID-19 on the health of indigenous people in Primary Care involved the work process in the pandemic situation, comprehensive health care for the indigenous population, mental health of professionals and indigenous people. **Conclusion:** in view of the challenges experienced, the efficiency and responsibility of professionals working in Primary Care for indigenous people were highlighted, from surveillance to rehabilitation, for the preservation of the health of individuals and groups.

DESCRIPTORS: Primary health care; Health of indigenous populations; Covid-19.

[1] Universidade Federal Fronteira Sul, Santa Catarina, Chapecó, Brazil

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Corresponding Author: Kelly Cristina de Prado Pilger, E-mail: kelly.pilger@estudante.uffs.edu.br

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RESUMO

Objetivo: compreender os efeitos da pandemia COVID-19 na Atenção Primária à Saúde dos indígenas, na percepção dos profissionais da saúde. **Método:** pesquisa exploratória, de abordagem qualitativa. Contou-se com a participação de sete profissionais que atuavam em uma Unidade Básica de Saúde vinculada ao Distrito Sanitário Especial Indígena no Rio Grande do Sul, Brasil. Foram desenvolvidas entrevistas semiestruturadas no primeiro semestre de 2022. A análise dos dados foi norteada pela análise de conteúdo temática. **Resultados:** os efeitos da COVID-19 na saúde dos indígenas na Atenção Primária envolveram o processo de trabalho na conjuntura pandêmica, cuidado integral à saude da população indígena, saúde mental dos profissionais e dos indígenas. **Conclusão:** frente aos desafios vividos, destacou-se a eficiência e responsabilidade dos profissionais atuantes na Atenção Primária dos indígenas, desde a vigilância até a reabilitação, para a preservação da saúde dos indivíduos e coletivos.

DESCRITORES: Atenção primária à saúde; Saúde de populações indígenas; Covid-19.

RESUMEN

Objetivo: comprender los efectos de la pandemia de COVID-19 en la Atención Primaria de Salud de los indígenas, en la percepción de los profesionales de la salud. **Método:** investigación exploratoria, con enfoque cualitativo. Participaron siete profesionales que actuaban en una Unidad Básica de Salud vinculada al Distrito Especial de Salud Indígena de Rio Grande do Sul, Brasil. Las entrevistas semiestructuradas se desarrollaron en el primer semestre de 2022. El análisis de datos se orientó por el análisis de contenido temático. **Resultados:** los efectos del COVID-19 en la salud de los indígenas en la Atención Primaria involucraron el proceso de trabajo en situación de pandemia, la atención integral a la salud de la población indígena, la salud mental de los profesionales y los indígenas. **Conclusión:** frente a los desafíos vividos, se destacó la eficiencia y responsabilidad de los profesionales que actúan en la Atención Primaria de los indígenas, desde la vigilancia hasta la rehabilitación, para la preservación de la salud de las personas y de los grupos.

DESCRIPTORES: Primeros auxílios; Salud de las poblaciones indígenas; Covid-19.

INTRODUCTION

In Brazil, the right to health for indigenous peoples is in dialogue with different regulatory frameworks, including the Declaration of Alma-Ata, which proposes and values Primary Health Care (PHC) as a promoter of access and a way to minimize health inequalities; the Federative Constitution of Brazil (FC) of 1988, which presents health as a fundamental right; and Law 8080/90, which, in the Brazilian health sphere, establishes the Unified Health System (SUS). [1] In the context of the constitutionalization of rights, the FC stands out for establishing an exclusive chapter on indigenous rights, recognizing them according to their customs and traditions, with an identity marked by the right to otherness.[2]

The Subsystem for Indigenous Health Care (SASI) was created in 1999 and the National Policy for Indigenous Peoples' Health Care (PNASPI) in 2002, as strategies to guarantee access to health care for this population.[1] It is imperative to consider the peculiarities of the health of these peoples, who have long suffered from the effects of epidemics and pandemics, such as the flu, measles, and more recently, COVID-19.[3]

Pandemics are associated with a series of social and clinical stressors that create severe upheavals at various levels, related to confusion, fears, uncertainty, and the likely deaths of friends and loved ones.[2] COVID-19, as a social factor, exposed the multiple dimensions and tensions caused by the State's actions in the implementation of public policies directed at racial-ethnic minorities in Brazil. The implications of the pandemic involved issues that, in the case of indigenous people, range from food insecurity and fear of leaving the villages, to the symbolic violence of the impossibility of performing traditional funeral rites.[3]

In this sense, comprehensive care for indigenous people is necessary to maintain the well-being of this population. PHC has been considered a positive point in the Brazilian context, since it has the ability to focus care on the person and the community, being able to solve the difficulties and needs related to health, with strengthening of the Family Health Strategy (FHS). The last decades have marked the expansion of the FHS in Brazil and consolidated it as a priority for the reorganization of PHC in the national scenario, guided by the National Primary Health Care Policy (PNAB).[4]

Given the above, the question emerged: What are the effects of the pandemic COVID-19 on the PHC of indigenous people? It is noteworthy that the health crises evidenced by epidemic scenarios affect indigenous populations in the social, economic, and biological spheres, and it is of great importance to look at the specificity of these people, seeking to understand and find strategies to address public health issues that affect them,[3] which justifies this study. Therefore, we aimed to understand the effects of the pandemic COVID-19 on the PHC of indigenous people, in the perception of health professionals.

METHOD

This is a descriptive study with a qualitative approach, based on the assumptions of the National Primary Care Policy.[5] This article was organized according to the consolidated criteria for qualitative research reports (COREQ).

Professionals who worked in a Basic Health Unit (BHU) linked to a Special Indigenous Health District (DSEI) in Rio Grande do Sul, Brazil, participated in the study. This BHU served around six thousand Indians from 10 municipalities in the region. It is noteworthy that the participants of this study were not indigenous.

Inclusion criteria were professionals over 18 years of age who had been working in the PHC of indigenous peoples for more than a year. Professionals who were on vacation or on leave during the data collection period were excluded from the study. We invited all 14 professionals who worked in this PHCU. However, five of them did not meet the inclusion and exclusion criteria and two did not accept to be part of the study. Thus, we had the participation of seven professionals working in the indigenous PHC.

For data collection, each participant was interviewed using a semi-structured script, whose questions addressed the work in the FHS during the pandemic period, organization and flows of the work process in indigenous PHC. The interviews were scheduled through a previous telephone contact with the professionals, when it was clarified the study objectives and the invitation to participate was made. After acceptance, a date and time were scheduled for the interview, which was conducted by one of the authors who lived in the indigenous community studied, in a room available in the PHU where the interviewees worked.

The interviews, conducted in the first semester of 2022, lasted approximately one hour, were recorded and later transcribed. The transcribed data were organized and analyzed according to the thematic analysis,[6] which was developed in three stages: 1) Pre-analysis: floating reading of the data and organization of the material to be analyzed, with a priori definition of categories; 2) Exploration of the material: from the categorization of the data, we sought to reach the core of understanding of the text. For categorization, record units were identified and, after that, classification and aggregation of the data into categories; 3) Treatment of the results obtained and interpretation: interpretation of the categorized data, with theoretical basis. [6]

As for the ethical aspects, the participants signed and received the Free and Informed Consent Form (ICF), following the precepts of Resolutions 466/2012 and 510/2016, also authorizing the recording of the interviews. Data collection began only after approval by the Research Ethics Committee of a public university in southern Brazil, opinion number 5,134,917 on November 29, 2021. To ensure the participants' anonymity, we chose to identify them by indigenous expressions related to health care.

RESULTS

The seven study participants were between 22 and 42 years old, all female. As for the area of work: three (43%) were nursing technicians, two (29%) nurses, one (14%) doctor and one (14%) pharmacist. From data analysis, three categories were organized, namely: 1) Work process in the pandemic context; 2) Rescue for integral care in indigenous PHC; 3) Mental health of professionals and indigenous people in the pandemic context.

In the first category, work process in the pandemic situation, it was evident some limitations imposed by COVID-19 in the monitoring of individuals with previous diseases, or with specific conditions that required specialized care and/or collective orientations in groups.

> [...] *That longitudinality that we had with patients, to see periodic exams, to request and follow up on comorbidities, ended up being left aside a little bit. So, suddenly, we had patients that didn't seek care* [...] *we had to put it aside a little bit to prioritize the COVID.*(Guyrai)

It was revealed that the effects of the pandemic on the professionals' work process shifted the focus from health promotion actions in group activities, strongly developed in the period before the pandemic, to individual care, with priority to urgent and emergency health care, maintaining the social distance.

> *What changed was the issue of holding groups* [...]. *The services at the unit have to take care of the number of people, the flow, so as not to accumulate.* (Narã)

> [...] *In the unit, we make restrictions; when there is a symptom, we ask people not to walk around the clinic and have contact with more people* [...]. *We prioritize urgency and emergency* [...] *not that the others are not attended to, but the service is more restricted to people who have respiratory symptoms.* (Manoi)

Although the pandemic caused changes in the flow and work process of professionals, the access of indigenous people to the BHU remained adequate in this period.

> *I think the access was good, things were moving along, but with the pandemic I attended more to those patients with respiratory symptoms* [...]. (Ipoty)

The participants revealed the importance of the role of PHC in the care of indigenous people during the pandemic and the necessary articulation between the levels of care.

> *If it wasn't for primary care, the hospitals would already be crowded with the most severe cases* [...], *I don't know what would have happened, because the first contact was ours, so that first care when well done, avoids many cases of hospitalization. I think it is fundamental for both parts, hospital and primary care, to be articulated and doing their part well.* (Ipoty)

The second category, rescue for integral care in indigenous PHC, revealed that the pandemic impacted the provision of care, since the focus of assistance was on people diagnosed with COVID-19.

> *The pandemic impacted the lack of care with other things that needed* [...] *suddenly, you needed a specialist, but the specialist was not attending. Needed a surgery that was alre-*

ady scheduled, but the surgeon was not attending because all the beds were for COVID. (Guyrai)

The professionals revealed that at the time of data collection they were more focused on immunization against COVID-19.

Now, we are focused on vaccination,[…] the service is focused more on vaccination and prevention, orientation. (Yvyara)

After two years of the pandemic, the professionals' work began to resume, developing some activities as before the pandemic period.

Now we are starting to get back to normal, we are managing to follow up on comorbidities and other diseases that are not linked to COVID, or sequels that were left. (Guyrai)

In the third category, mental health of professionals and indigenous people in the pandemic context, the participants addressed that COVID-19 affected the mental health of health workers immensely, mainly due to the fear that prevailed in the initial period.

[...] *In the beginning we were very afraid. It disrupted our mental health a lot.*[...]. (Ipoty)

The worst thing was fear. Everyone was apprehensive. (Yvyara)

The professionals stated that they were shaken in facing COVID-19, especially in the face of the death of relatives and infection of family members. In addition to this, the health teams were depleted due to the contamination of several professionals.

I think that on the mental health issue everyone was a little shaken, many lost relatives, many got COVID. And the teams were a little bit depleted. (Narã)

The interviewees evidenced that COVID-19 affected the mental health of the indigenous population, bringing them fear.

[...] *The patients themselves started to be afraid to go to the health center* [...] (Ipoty).

[…] People were afraid to come to the unit and get the disease. So I think mental health is being harmed because of the pandemic. (Yvyara)

They said that one of the effects of the pandemic was that people moved away from each other, not gathering together anymore, which also affected the mental health of the indigenous people.

[…] Everybody ended up moving away. They didn't get together with their neighbors anymore [...] *[the pandemic] ended up pushing people away* [...] *It's bad for the mind.* (Ipoty)

During the pandemic, PHC was shrouded by social, economic, and health uncertainties, which generated fears for professionals and for the indigenous people.

DISCUSSION

Facing the pandemic of COVID-19, PHC needed to (re)organize the professionals' work process. Several previously developed actions needed to be readjusted through new approaches, in order to ensure safety in contact with the population. It is worth remembering that the health demands of the population were not paralyzed and, in the pandemic context, many were dammed, which is a warning for the actions of professionals regarding the worsening, from now on, of these conditions.[7]

From the pandemic of COVID-19 on, there was the need to change the work process in PHC for individual and priority care to people with COVID-19. The professionals' schedules were reorganized in order to expand access to spontaneous demand. The teams' attendance flow was organized aiming at the immediate identification of the person with respiratory symptoms still at the reception desk of the BHU, a differentiated place to wait for an appointment and prioritization of care.[8] Therefore, the essence of PHC work, especially regarding health promotion and prevention,[5] was compromised during the pandemic period.[9]

In the context of indigenous health, professionals working in PHC faced several challenges, such as logistical, labor, geographic, personal and family challenges to develop actions in the territory. It was necessary to consider the sociocultural specificities of the people and their limitations of access to information and health services to control the advance of the pandemic in most ethnic groups. Another limitation of the professionals was to maintain control of pre-existing morbidities, such as infectious and chronic non-communicable diseases that, in turn, made indigenous people even more vulnerable to COVID-19.[10]

It should be noted that being indigenous in Brazil means living under precarious sanitation and housing conditions; facing confrontations with invaders and the damage they cause in their territories; dealing with food insecurity and lack of access to potable water in their daily lives; living with high infant mortality; having their presence invisibilized in the urban context; having a childhood marked by chronic malnutrition, in addition to infectious and parasitic diseases such as diarrhea and pneumonia, the main causes of illness and death in indigenous children. These and other examples point to profound health inequities of ethno-racial cut, feeding the conditions for "a perfect epidemic", such as the pandemic situation imposed by COVID-19.[4] It should also be emphasized that historically indigenous populations have been more vulnerable to viral infections, especially respiratory threats, which devastated a large number of indigenous people living in Brazil decades ago.[11]

The pandemic situation called for the reorganization of services and the development of articulated and integrated actions in indigenous communities. For health surveillance, actions were proposed aimed at professional qualification, monitoring

suspected and confirmed cases, updating and adapting guidelines, implementing protocols, immediate notification of cases, guaranteeing rights, and meeting specific clinical demands. For PHC, in the field of health promotion, health education actions were recommended, considering the specificities of the territories in an attempt to support the indigenous community and their leaders.[10]

Collective activities, such as operative groups, were suspended during the pandemic. However, different health education strategies were sought, such as the development of support materials for the population, as well as protocols and other permanent education actions with the teams, focusing on the COVID-19 theme.[12]

COVID-19 rekindled discussions about integral care and the necessary articulation of the Health Care Network, which was not limited to PHC. Aspects related to health information and prevention, essential functions of the primary level of care, up to the highest specialized care in Intensive Care Units were also pointed out as necessary for the containment of cases and deaths as a consequence of the disease. Likewise, the socio-economic impacts involved health, economy, work, income, education, and many other sectors and segments in the field of caring for the lives of people and groups, especially the most vulnerable, such as the indigenous peoples.

From the perspective of comprehensive care, communication between the different levels (primary, secondary and tertiary) was necessary to obtain an effective and efficient response to people's care, with the PHC at the center of communication with the entire network.[5] The performance of the FHS teams was crucial in all stages of the pandemic, but some limitations were observed, such as the scarce articulation between these teams and the Health Surveillance in the confrontation of COVID-19.[12]

In this sense, it is necessary to develop intersectoral actions and, above all, strategies to ensure the continuity of activities of health promotion, prevention, and recovery, according to the PNAB guidelines.[5] This means that, in addition to an effective PHC, it is essential to have access to hospital services in the intermediate and severe cases that are identified. For this, the articulation and operation of the entire network is essential, involving not only PHC, but also specialized care.

The pandemic has reaffirmed the need for communication and coordination between sectors and services, instigating discussions about intersectoriality and intrasectoriality for comprehensive care. This is an opportunity for adjustments and new propositions for the work processes of the teams, together with the population, to exercise solidarity and strengthen networks.[12]

The pandemic scenario challenged the work organization of the health teams. The managers and the multiprofessional teams needed to value the work of each specialty, prioritizing communication, requiring the construction of strategies between sectors and services to ensure a comprehensive and effective health care.[9] It is also worth remembering that the pandemic revealed the unequal distribution of health services in Brazil, including the indigenous peoples, which highlights the need to expand and strengthen the regionalized health care networks.[13]

In the confrontation of COVID-19, in the context of PHC, immunization has emerged in the work of professionals, especially the nursing team. It is emphasized that with timely immunizations, individuals and communities remain protected and the likelihood of an outbreak of immunopreventable diseases decreases. Consequently, it requires fewer resources than an outbreak response and helps to reduce the strain on an already overburdened health care system, such as during the pandemic of COVID-19.[14]

The pandemic context also demanded more attention to the mental health of health workers, with an increase in symptoms of anxiety, depression, drug use, loss of sleep quality, fear of getting infected or transmitting to family members, among others. It is worth remembering that the exposure of health professionals to the risks of contamination in their work can trigger psychological distress, anxiety, stress, and depression. This context affects the mental health of the professionals, and may generate dissatisfaction with the work, and consequently, result in losses in the quality of care[15] to the indigenous people.

In the nursing field, the professionals became ill due to precarious working conditions, such as the lack of individual protection equipment. In addition, they faced an increase in demand and a decrease in the number of workers, resulting in work overload. These factors had negative repercussions on the mental health of these professionals, since they were exposed to a higher risk of contamination, with the fear of being on the front line of care, as well as of contracting the disease and transmitting it to their families. Therefore, the pandemic brought out fear and distrust: fear of being contaminated, of getting sick, and of dying; fear of having their income reduced/eliminated; fear of losing a loved one and that they will suffer; fear of not supporting the isolation period.[16]

As for the health of indigenous people, the pandemic impacted the social and economic quality of life of this population, who needed to maintain social distance from their families and acquaintances, which caused concern for the fear of their loved ones catching the disease, affecting the mental health of this public. In addition, before the pandemic period, it was common for Indians to travel between villages to visit family and friends, or between territories to sell their handicrafts. Since the need for social distance imposed by the pandemic, there was a significant financial impact for the indigenous people, greatly compromising the sale of handicrafts, the source of subsistence for this population.[17]

As limitations of the study, we mention the difficulty in reconciling interview schedules, since the professionals were working hard to deal with COVID-19. The results of this study contribute to the evidence-based practice of nurses working in the PHC to indigenous people, instigating reflections about the effects of COVID-19 in the care of this population.

CONCLUDING REMARKS

The actions developed in PHC, from surveillance to rehabilitation, are relevant for the preservation of life and health of individuals and groups, especially when it comes to the care of indigenous people in times of pandemic. The effects of the pandemic COVID-19 on the PHC of indigenous people mainly involved reorganization of the work process, the need for integral care of the population and the mental health of professionals and indigenous people.

At the work level, professionals needed to reorganize their routines and activities in the PHU in order to avoid crowds; the attendance flows changed, the focus of care turned to respiratory symptoms, leaving aside other morbidities and other vulnerabilities of the indigenous population. The care for all was preserved, however, with prejudice to the longitudinal integral care as advocated.

In the face of COVID-19, fear emerged among professionals and also among the indigenous people, affecting mental health. With the arrival of the vaccine against COVID-19, the efforts of PHC turned to this strategy of case control. And little by little, PHC seeks to return to its functions of ordering the Health Care Network, coordinating care and health responsibility in a universal, equitable and integral way to indigenous people, according to the principles of the SUS.

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