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Female healthcare workers and the Covid-19 pandemic in Brazil: a sociological analysis of healthcare work

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Abstract *The article aims to discuss the care provided by female healthcare workers in Brazil during the Covid-19 pandemic, based on a sociological analysis by authors who discuss such care as devalued and poorly paid work performed to a large extent by low-income women. The work involves social constructions of emotions and has used the body as a work instrument in care for others. In addition, the increasingly precarious nature of health work in Brazilian society, aggravated in recent decades, with an increase in temporary contracts, loss of labor rights, overload of tasks, and adverse work conditions, among others, adds to the increase in medical and hospital care in the Covid-19 pandemic. In this context, female healthcare workers experience lack of personal protective equipment, fear of coronavirus infection, concerns with their children and other family members, and illness and death of coworkers and themselves. The article highlights the need for government attention and management of healthcare work and professional societies, analyzing the work conditions female healthcare workers are experiencing in confronting the pandemic.*

Key words *Work conditions, Pandemic, Women workers, Gender analysis in health*

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Introduction

The point of departure for this article was the author´s experience with contemporary healthcare work and gender relations, viewed as complex and permeated by power relations between recipients of care and care workers. Changes in the world of work such as increasingly precarious labor relations and work conditions will be discussed throughout the text, as well as the ways they affect both men and women. However, the main focus is on healthcare work by women, who constitute the majority in the frontline during the Covid-19 pandemic and have to reconcile their role in healthcare with family demands, considering that they are still viewed as responsible for the family´s care.

We will thus use the term female healthcare workers, defined as women conducting healthcare activities, that is, female physicians, nurses, nurse technicians, and others in this area, from the perspective of the sociology of work and gender studies.

From this perspective, the article analyzes salaried healthcare work by female healthcare workers who are on the frontline of care in the COVID-19 pandemic. The focus is the Brazilian reality including the social context, in which the country has a large contingent of unemployed, informal workers, persons living under crowded conditions in favelas, and healthcare policies that are insufficient to properly care for the population[1,2].

The statement on unemployment in Brazil is based on data from the Brazilian Institute of Geography and Statistics (IBGE): in the first quarter of 2020, there were 129 million unemployed people in the country[3]. Considering those who failed to seek formal work, that is, working at informal jobs, the figure is even more significant.

Brazilian society has suffered the impacts of neoliberal reforms on the labor market, such as increasingly precarious work conditions, growing unemployment, and expansion of the services sector and outsourcing. This scenario has aggravated the loss of social and labor rights, especially since the Labor Reform of 2017 (Law No. 13,467/2017)[4]. Capitalist society, based on its neoliberal nature, produces essentially and increasingly precarious work conditions, defined as "deregulation of employment, intensification and deterioration of work conditions, extension of the workday, wage cuts, worsening lack of social protection, dissemination of work-related physical and/or mental suffering, and structural unemployment"[5](p.5). The health area is not free of these influences and new management modalities, including in the public sector.

The increasingly precarious work conditions involving loss of labor rights and the accelerated process of outsourcing, and in the specific case of female healthcare workers, low wages, leads these women to seek and keep more than one job in order to survive. This has been corroborated by authors[6] who state that in the health area, for example in nursing, especially "nurse assistants and technicians live under increasingly precarious conditions with multiple jobs and insecurity in the work environment, preventing them from carrying out their work activities with dignity"[6](p.101).

According to the legislation on the Unified Health System (SUS), which addresses health as a Constitutional right for all inhabitants of Brazil´s territory, regardless of nationality, the state is responsible for taking actions in prevention, promotion, care, recovery, and rehabilitation of people´s health, viewed as a "fundamental human right"[7]. In the context of the COVID-19 pandemic, the guarantee of health should be prioritized as a public policy.

Although Brazilian legislation guarantees the right to health[6], investment in health and education in recent years has suffered the impacts of Constitutional Amendment No. 95, which places a freeze on spending in the SUS and thus represents a setback in the guarantee of rights. According to data from the National Health Council (CNS), the twenty-year freeze on spending means the possible elimination of up to BRL 434 billion (U$ 82 billion) from the SUS alone. The policy directly affects the maintenance of services in the Family Health Strategy (ESF), urgent and emergency services, AIDS care, cancer care etc[8]. This undermines the guarantee of the right to public health through the major cut in budget investments in health services. The result is a negative impact on the Brazilian population, including the work conditions of these healthcare workers, with lower investment due to the fiscal reform.

Since the beginning of the Covid-19 pandemic in February 2020, protective measures, based especially on social distancing, have not been totally supported by the Brazilian government, having adopted a denialist discourse towards the seriousness of the disease, which had already led to thousands of cases and deaths outside of Brazil. According to the Administration´s discourse, social distancing would hurt the econ-

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omy, which could not be allowed to stop[9]. The groups at greatest risk of infection are people in long-term institutions, the prison population, people that depend on the public healthcare system, and residents of low-income communities, plus female healthcare workers, who are in direct contact with those most vulnerable to the coronavirus. This requires a health system with the proper conditions to treat the population efficiently and decently, especially given the severity of Covid-19[10].

Given the growing demands on health for prevention and care during the pandemic, it is obvious that healthcare workers´ care for persons with Covid-19 tends to increase. This may explain why in April and May 2020 the Brazilian news media (G1 and Uol) covered the precarious conditions in the health sector, such as lack of personal protective equipment (PPE) or repeated use of the same equipment (when available), in addition to work overload due to the increasing demand for care.

This scenario underlines the necessity of care work, both in hospital and clinical settings and in the family environment. The social perception is that care is central to human life, highlighting care as work, especially care performed in the health area by multiple professions (nursing, medicine, occupational therapy, psychology, nutrition, physical therapy, and speech therapy, among others). The scenario also shows that women are largely responsible for this work, centering attention on the physical, biological, and emotional needs of others[11-13].

Healthcare work is thus part of the capitalist mode of production, exploiting women, which has been essential and necessary for the rise of capitalism based on unpaid work in the sphere of reproduction[14].

Taking female healthcare workers as the current article´s focus, we find that they comprise the majority in the health field, especially in nursing, where 85.1% are women according to a recent Brazilian national survey[15]. In addition, when women leave their shifts, they return home to continue to provide care, thus having to reconcile family life and work[16].

The article has two objectives: a) to discuss the contributions by gender studies for analyzing care work by women, especially healthcare, in its dual dimensions, productive and reproductive, emphasizing the specificities of care as work and b) to analyze work conditions, illness, and death of female and male healthcare workers in the context of Covid-19 in Brazil. We draw on the concepts of the sexual division of labor and care work, problematizing the inequalities between men and women and the conditions to which women are exposed in healthcare. We then proceed to discuss healthcare and the reality of female healthcare workers in the Covid-19 pandemic.

Sexual division of labor and healthcare

Our point of departure is that work is central to life in society, involving social and power relations and thus relations of domination. The concept of sexual division of labor is thus equally central for understanding gender inequalities and the ways women have participated in the market[16], based on the understanding of manhood and womanhood as social and historical constructs, beyond the biological dimensions[17], consequently social gender relations with work as the basis[16].

The sexual division of labor as an analytical concept allows elucidating that men participate in the productive sphere in which they largely perform paid activities. Meanwhile, women perform the reproductive work, which is not always paid, hence it is a free activity. It is also through this division that we find that men receive higher salaries and generally occupy positions that are more highly valued socially and include decision-making roles[16].

The sexual division of labor was essential for the development of capitalism in modern societies, exploiting women through a discourse that takes the reproductive function for granted, based on its distinction as "for love", that is, almost the essence of the very idea of femininity to "know and be available" to care for others[14].

As reaffirmed by Hirata[18], from the perspective of the sexual division of labor, housework, in which women participate symbolically and in practice, should thus be addressed by gender analyses and their confluences in the market.

According to Hirata and Kergoat[19], women´s condition of bipolarization is relevant for analyzing their situation in the market, since the purchase of the domestic role in recent years has been fundamental for the middle classes to build and develop their careers, a fact that complexifies gender relations and thus power relations among women to participate in work. Furthermore, motherhood has come under women´s responsibility, and not evaluated as a social issue requiring effective help from the state, public policies, and the exercise of conscientious fatherhood,

with men sharing household chores with women, including childcare[20].

Based on this approach, we highlight the feminist theoretical and methodological contributions of studies on care, especially from authors such as Helena Hirata[12], Natacha Borgeaud-Garciandía[13], Ângelo Soares[21], and Pascale Molinier[22-24], who consider care as work.

The approach to this theoretical field[12,13,21-24] allows unveiling the work conditions to which female healthcare workers are exposed, the ways they enter and remain in the market, their wages and workdays, the forms of reconciliation between the productive and reproductive spheres (care for the children and other family members, housework etc.). Added to this is the perspective of subjective constructions and the challenges posed for women, especially in relation to healthcare during a pandemic, such as fear of illness and death, having to deal with the overload due to the increase in the number of persons needing care, physical and mental fatigue, and feelings of compassion and responsibility.

Healthcare work is complex, since it involves interactions between those performing and receiving care, besides engendering social relations to meet human needs with a view towards well-being and comfort, soliciting the responsibility for action from care workers[13,21-24].

Care workers experience their own feelings in the face of death and illness, perform procedures to anticipate the persons´ needs, that is, elaborating strategies to meet the demands for care. In this sense, "the felt solicitude and responsibility, as well the meanings they entail, are given and naturalized"[13](p.44).

Borgeaud-Garciandía[13] contends that such feelings are built in the dynamic and tensions of work relations in care in the public or private spheres. It is therefore necessary to deal with death and the moral dilemmas for making or refraining from making decisions. Yet at the same time, there is an interaction of intimacy between those receiving and those performing care, since recognition of the other´s vulnerability is necessary to care for their needs[13].

Since care is required in all societies by persons whether in situations of vulnerability or not, whether by specialists or not, it expresses a subjective extension beyond the sale of work in capitalist society. Based on considerations on subjective constructions and care, Pascale Molinier[24] addresses the experiences of suffering, compassion, creative processes, and affects in the interactions with a view towards preservation of the life of those receiving care.

The perspective of subjective constructions in and through healthcare work contributes to the analysis of its facets and complexities, since according to Molinier[22-24], an invisibility exists in the knowledge and practices of care. One of Molinier´s contributions is the concept of discrete know-how, in which the anticipations to provide comfort and well-being are always present in the care worker´s actions (paid or unpaid), without persons perceiving a gesture, zeal, or prevention of a complication, for example, without voicing concerns over the physical and emotional comfort of the person receiving the care. There is also a know-how that involves learning through technical training, but also in the adversities of daily work, such as finding solutions to a given problem[24].

In addition to care for the other´s body, healthcare work, especially by those in direct contact with persons, is permeated by use of one´s body. The concept of bodily work, which for a long time was not central to the sociology of work, now appears indispensable, especially in research on work and the body, in which the experiences of social relations can grasp the ways female healthcare workers deal with and connect to their bodies and to those of others[25].

The bodily dimension of care is also addressed by Soares[21], since moving, turning, lifting, carrying, or changing patients in a bed, for example, are used to provide well-being and comfort. That said, various studies have analyzed illness in healthcare workers related to use of the body, such as musculoskeletal back disorders caused by constantly lifting weight and moving people in hospital beds[26].

Another key point in studies on care is emotions. According to Soares[21], care is a kind of activity in which emotional and relational aspects are built socially and collectively in and by the profession, where feelings of love, compassion, trust, and affect are present. However, hostile, sad, and other negative feelings can surface in professional exercise[21].

Reflecting on the context of the Covid-19 pandemic, the emotions of care workers in health should be viewed from the theoretical framework considering them as signaled by Fortino et al.[27]. According to the above-mentioned authors, the work requires fulltime management of emotions in the face of hardships, situations of violence, injustices, and rage, among others (likewise, the pleasures, contentment, and earning of trust). While expressions of emotions are required in certain moments, there is also a dissimulation of feelings that could compromise the work´s

development or jeopardize the job, since such management may dictate what should or should not be expressed externally by female healthcare workers[27].

It is thus crucial to address the panorama of emotions in care, especially during the pandemic. Research in China had already signaled problems in patient care, including physical and emotional exhaustion, difficulties in decisions on the health of persons receiving care, and fear of coronavirus infection and death. There is also the family context: care workers often fear infecting their family members (elders and children)[28].

Although the current article focuses mainly on paid healthcare work, it is relevant that care work does not include only the productive sphere, but also the private sphere, where many families hire home care workers, an aspect discussed by Borgeaud-Garciandía[13], such as nannies, care workers for the elderly, domestic servants, and cleaning workers, thus employing care that does not always require professional training. In this scenario, female healthcare workers make their decisions in this moment of the pandemic concerning who will care for their children and family members in general, since daycare centers, preschools, and schools are closed to contain the spread of coronavirus, creating difficulties for reconciling productive and reproductive work.

Female healthcare workers: illness and death from Covid-19

Female healthcare workers, unlike a major portion of the population, who are in social isolation or distancing due to coronavirus control, are leading the high-risk care, since the virus has intense and extensive global spread[28].

As discussed previously, the increasingly precarious work conditions, including in healthcare, associated with the intensification of activities according to productivism, can trigger physical and/or psychological illnesses and consequently foster the use of psychoactive drugs to deal with the "pains of the profession"[29-31]. Based on this perspective, the exposure to work hazards such as work-related accidents and illness in their bodies, tends to be part of daily reality of most women who work in healthcare[32], with the ultimate purpose of producing life.

If we associate this scenario with care during the Covid-19 pandemic, it is evident that the increase in the number of cases intensifies the healthcare workday. Although there are few studies on the pandemic´s influences on the health and work conditions of female Brazilian healthcare workers, the existing data show an increase in the demands on healthcare work.

A recent study on the supply of beds and mechanical ventilators in Brazil revealed the importance of containing the spread of Covid-19 to avoid overloading the health system, besides increasing the number of hospital beds and building field hospitals for the population to be assisted, especially in places without a health system that can meet such serious demands[33].

Visiting the websites of professional societies such as those in nursing and medicine reveals the adverse conditions faced by female healthcare workers. Brazil is the country of the world with the most deaths from Covid-19 among healthcare workers, according to the Brazilian Federal Council of Nursing (COFEN) and the International Council of Nurses (ICN). As of October 27, 2020, there had been 454 confirmed deaths of healthcare workers in the nursing workforce (nurses, nurse technicians, and nurse assistants) in Brazil, and 41,926 reported cases[34].

A recent study on work conditions in Brazil detected 17 thousand cases of non-compliance with protocol in care for Covid-19, reported by 1,563 participants (56% of whom were women). The worst problems were absence or shortages of the following: a) PPE, cited by 38.2% (masks, gowns, face shields/googles, gloves, etc.); b) inputs, tests, and medicines (Covid-19 test kits, drugs, etc.), by 18.9%; and c) healthcare staff (nursing, medicine, cleaning, nutrition, and physical therapy), by 13.7%. The study also reveals the shortage of hospital products, such as alcohol (liquid and gel), paper towels, soap bars, disinfectants, and hospital beds, among others[35].

The Federal Council of Nursing (Cofen) issued a communiqué emphasizing the profession´s fear of infection, fear of transmission to family members (children and ill parents), limited self-care due to time constraints and intensification of activities, and experiences with the death of coworkers and patients. The note also underscores the evident physical exhaustion from standing for hours on shifts, with little or no time to rest[36].

Such conditions permeate or at least are related to illness in these female healthcare workers. These experiences with care portray the violent conditions they are exposed to, involving "[…] neglect towards work conditions, omission of care, assistance, and solidarity in the face of some misfortune, characterized by taking work-related illness and death for granted"[37](p.30).

We thus call attention to gender relations and women´s disadvantages in the labor market. These have been the object of studies, and according to the European Union, women are the most exposed to occupational illnesses, work accidents, violence, harassment, precarious jobs, and low wages, as well as more exhausting workdays and wage devaluation when compared to men. Without a doubt, "gender inequality influences work conditions and the way actors rationalize them"[38](p.15), reiterating that work conditions for women are related to sexual segregation (men and women´s work) in the work market positions[38].

Considering that we still lack a prognosis for the coronavirus, even though protective measures are adopted by the population and can decrease the risk, such as hand hygiene with alcohol gel hand sanitizer and washing with soap and water, besides social isolation and distancing, numerous healthcare workers have been infected and do not know how they acquired the virus. Thus, emotions such as fear of dying, concern over infecting family members, and anxiety over not knowing what tomorrow will bring tend to intensify the emotional pressure they experience.

Healthcare workers´ bodies become numbers, as one worker told when interviewed about her work, feeling sad as she saw lives that mattered turn into numbers of "gravestones" due to the burgeoning daily deaths: "Today we are numbers. Our job enrollment numbers are being replaced by numbers on gravestones" (healthcare worker)[39].

The sentiments generated by the pandemic have transformed the social reality, as well as women´s subjectivities. The uncertainty created by COVID-19 already existed, considering the consequences of the project for modernity[40] vis-à-vis the limitations of scientific knowledge to respond to the future. In Weberian terms, this knowledge already presented limitations to the extent that it failed to respond to questions concerning the meaning of human existence, that is, what we should do and how we should live[41] in the prevailing social reality.

In the anthropocentric context, in which modern science was considered a human conquest that would solve all dilemmas faced by society, religious principles and all other types of knowledge were largely set aside[41], since science emerged as modernity´s only true source of knowledge. This affirms the hegemony of Western, white, male knowledge. The knowledge produced and developed by women on the female body and reproductive work were ignored in the history of modern science, which contributed to the development of capitalism by exploiting women based on the work of social reproduction[42].

However, science should be understood as a type of knowledge that was consolidated in a favorable scenario and thus has a shared history based on certain paradigms that can suffer crises, depending on the degree of acceptance by members of the scientific community according to the historical period in question[43].

The word crisis was used here in the sense that society will transform itself, since all persons regardless of class, race, gender, or nationality experience expressive changes in their ways of life and of dealing with the temporality of their bodies and emotions, since there is still no prediction on how social relations will be built in the post-pandemic or which marks will generate life in persons, especially in the wake of deaths due to Covid-19.

It is said that life "will never be the same". This idea of no prediction of the future may leave many men and women with major emotional problems, considering that we are socially conditioned to think of tomorrow. We thus have difficulty dealing with the experience of the here-and-now in order to translate it; as a result, much knowledge in this situation can be wasted[44] if we are not alert to the new reality.

The coronavirus pandemic has undermined the idea that we have a framework of explanatory (and thus "rational") references for dealing with tomorrow´s problems; the idea of crisis is accentuated in this context, weakening all the modern references we inherit, shaped by a biased rationality based on the dichotomy of us-versus-others[45] (that is, the tragedies experienced by others do not affect us).

This rationality of the Western capitalist world was established while extinguishing many human populations[46], and in the contemporaneity of the 21st century, capitalism has affirmed itself through immediate consumption or the "enjoy it" concept, allowing the individual to mobilize the mechanisms for withstanding and the devices for regulation of sensations. This creates the sensitivity policy, that is, organizing daily life so as not to reflect on the social inequalities generated and sustained by capitalism[47].

Importantly, the care of bodies after death is also a task that falls to healthcare workers. Following Covid-19 deaths, corpses are sometimes placed in plastic bags, with no clothing, the cof-

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fins sealed, with no possibility for families to say goodbye to their loved ones or even choose the clothing for the farewell ritual. And those who witness the large number of deaths in hospitals, both of coworkers and patients, and who encounter people who seek a word of consolation because they have lost (or are losing) a loved one, have been healthcare workers, who need to deal with their emotions in order to "lend a word of comfort" to those who will never again see the body of their family member. This exemplifies the emotional dimension[21] involved in healthcare work, as discussed above.

Elias[48], analyzing emotions in the face of death and the deceased, states that terror and fear are awakened in the conscience of the living, since it is the living who suffer (i.e., we can know nothing of the sentiments, in scientific terms, of those who have passed).

In parallel with the scenario of countless deaths, there is a ritual of celebration in hospitals when patients recover from Covid-19, with white balloons and applause. In this context, the body is understood as a "machine" that has succeeded in recovering, that has resisted, thus meriting commemorations, and this becomes even more evident following the recovery of elderly patients. A positive representation of the discourses of the resistant body appears as the idea of better health to recover from the disease.

The idea of bodily finitude, the losses and limitations expressed in the body, reveal to us that all human crises have the body and emotions as the focus[49]. Still, the emotions related to healthcare work[21] provided to others are evidenced in the feelings of joy towards a person´s recovery or of sadness when the body that has received care has proven unable to withstand Covid-19.

The daily applause emerges as a form of collective gratitude[49], affirming the primordial need for acknowledging these female healthcare workers. However, the representation of a collective of healthcare heroines can contribute not only to their social valorization but to increasing the pressure to be invincible bodies that provide the care, thereby diluting the individual being, the body that has a life beyond the work.

From this perspective, the context is also favorable for capital to continue its inhumane exploitation of these bodies. Praise for their heroism can be a ruse to silence voices that want to work, but that need adequate conditions to develop their activities that have been viewed as necessary, essential, and valuable in the context of this pandemic. The heroines become "simply nurses"[49], thus persons that also need care, especially in the Brazilian reality of precarious work. As we have analyzed above, the increasing demand for Covid-19 care and the precarious work conditions allow us to question the weight of the "heroine" image these women are bearing in the pandemic.

Conclusions

In the grave health crisis Brazil is facing, the illness and death from Covid-19 reaffirm the need for a public health system with quality, as proposed in the Unified Health System (SUS), to provide comprehensive and universal care from north to south in the country, and for all social classes.

The pandemic also evidences the centrality of healthcare work, producing and maintaining social life in the productive and reproductive spheres, but with its contradictions at the same time. Such contradictions range from commodification (i.e., who pays for and who supplies care, who has access and who lacks access to professional care, who performs professional training and who pays for it) in an unequal country like Brazil to the activity´s concrete reality, largely performed by low-income women.

This reflexive article thus highlights the need for government attention to healthcare work and professional societies, perceiving the adverse work conditions in confronting the pandemic. Such conditions cannot be ignored in the face of so much illness and death among healthcare workers.

Thus, the sociological analysis of healthcare work allowed understanding that many women, as healthcare workers, are experiencing countless challenges, including illness and death of coworkers, in addition to precarious conditions and dwindling investments in public health that were impacting the sector even before the pandemic.

In addition, the fears and emotions related to these experiences need to be addressed so that the healthcare provided by these workers is guaranteed collectively in a time of science denialism such as Brazil is experiencing and the intensification of work demands, both at home and in the health field.

Collaborations

SM Bitencourt and CB Andrade also worked on the design, analysis, writing, revision and approval of the version to be published.

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