Fear when caring: reflections on a permanent education experience in Covid-19 times

O medo ao cuidar: reflexões sobre uma experiência de educação permanente em tempos de Covid-19

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ABSTRACT This article presents an analysis of the actions to support health teams in a small city in the State of Rio de Janeiro in the fight against Covid-19, in a university-municipal partnership. The cartographic approach of the micropolitics of work and health care was the framework that guided the work. Permanent health education workshops were held over the internet, with the healthcare teams and managers of the Primary Care teams, coordinated by the researchers. In these meetings, problem situations were identified and, among them, the fear of being contaminated, of contaminating others, and of dying emerged, negatively interfering with daily work. These fears were mapped, as well as their concrete implications and the potencies and tools to face them; Fear in times of pandemic was discussed, as a weakness and as a power, the recognition of intuition-intelligence and collective practice, as elements for facing difficulties, from which is possible to observe the passage from the state of hope as a noun to hope as verb, or 'hope-doing'.

KEYWORDS Continuing education. Covid-19. Empathy. Primary Health Care. Community-based participatory research.

RESUMO *O presente artigo apresenta uma análise das ações de apoio às equipes de saúde de um município de pequeno porte do estado do Rio de Janeiro no enfrentamento da Covid-19, em uma parceria universidade--município. A abordagem cartográfica da micropolítica do trabalho e do cuidado em saúde foi o referencial que orientou o trabalho de campo. Foram realizadas oficinas de educação permanente em saúde pela internet com as equipes assistenciais e gestora da rede básica, coordenadas pelos pesquisadores. Nesses encontros, foram identificadas situações-problema, emergindo, dentre elas, o medo de se contaminar, de contaminar outrem e de morrer, interferindo negativamente no trabalho cotidiano. Esses medos foram mapeados, assim como suas implicações concretas e as potências e ferramentas para seu enfrentamento. Como fragilidade, discutiu-se o medo em tempos de pandemia; como potência, o reconhecimento da intuição-inteligência e prática coletivas como elementos para o enfrentamento das dificuldades, e analisou-se a passagem do estado de esperança para o esperançar.*

PALAVRAS-CHAVE *Educação permanente. Covid-19. Cuidado. Atenção básica à saúde. Pesquisa participativa baseada na comunidade.*

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Introduction

In Brazil, the community spread of the Sars-CoV-2 virus is estimated to have started in the first week of February 2020, but it was only reported in March[1]. The first confirmed case of Covid-19 in the state of Rio de Janeiro was reported in the municipality of Barra Mansa, followed by the municipality of Rio de Janeiro[2]. As of April 2020, the process of internalizing cases generated concerns in populations and governments of municipalities with less than 100,000 inhabitants[3].

At the beginning of April 2020, a municipality in the interior of the state of Rio de Janeiro with just over 20,000 people confirmed its first case[4,5]. Two months later, on June 10, his Municipal Health Department published the news of the eighth death by Covid-19[5].

With the objective of supporting health teams on the front line of facing the pandemic in this municipality, a group of professors from a public university organized themselves into different work fronts[6]. In one of them, a virtual situation room was created – a virtual platform developed exclusively for regional monitoring of the pandemic, whose data, updated daily, attested to 408 confirmed cases of the disease and 16 deaths for this small municipality, in October 2019. 2020, on a date close to the closing of this work[7]. On another work front, a cycle of Permanent Health Education (PHE) was carried out, whose methodology was supported by weekly meetings/workshops, which took place remotely between university professors, workers and health managers in the aforementioned municipality, with special attention to territorially based services.

These PHE workshops began in the second half of April 2020, two weeks after the confirmation of the first case of the disease, and lasted until the first half of September of the same year. The meetings sought to discuss the main problems experienced in the process of coping with the epidemic at the municipal level, aiming at new strategies and possibilities for the organization of care, especially of primary care.

The notion of proximity care[8-12] was used as a grammar for the different modalities and models of care carried out as close as possible to the problems of community life, not only from a geographical point of view, but also from the affections built in the encounters of daily work in health[13], especially those that occur in the 'territories', understood in this article as the community spaces covered by the health teams and their articulations with other services in the production of care. Thus, the debate covered, from a territorial and community orientation, not only the primary care teams, or the 'minimum' team, which constituted the majority of the participants, but always considering also other professionals inserted in the health services in network, including those from the Expanded Family Health Center (Nasf) – a team that provides support to primary care professionals in the Family Health Strategy (FHS)[14] own units, and all other territorial, intersectoral and community offers that can be triggered through new network connections in care for the population in this pandemic period. An assumption of the collective that carried out the work, and this article, is that, in proximity care, there is a power that should not be disregarded in a scenario of calamity such as that configured with Covid-19.

Since its inception, this work has been guided by the effects of the high contagion power of Sars-CoV-2, the high mortality rates[1], the uncertainties in the face of contradictory information in the management of the health crisis, the disputes regarding the meaning of social distancing and the protective measures required to face the Covid-19 pandemic, in addition to other components of a complex scenario, which is still in force, and which challenges this power of proximity care.

Health workers, daily exposed to contagion and prejudice based on misinformation, reported an intense fear, which was based on the ambiguity of feeling vulnerable as a caregiver, but also as a transmitter, therefore, a potential sick/sickening person. The experience of

fear, reported by these professionals in the PHE collectives, revealed the tensions, the paralysis, and also the ways in which it challenged the capacity of proximity services in the production of care, especially with regard to the continuity of care.

Fear, therefore, emerged in the field of work, configuring a recurrent and significant affection for the health teams in the territories of care: fear of caring. This primary affect[15], as it had been experienced and reported, was presented as totally justifiable in a scenario of calamity and mortality as overwhelming as that of the Covid-19 pandemic. However, as part of the experience of the subjects, it presented a certain ambivalence, as it both led to the paralysis of the assistance teams – sometimes reported in the PHE collective – as raised, in the face of the dangers of the pandemic, courageous auctions that focused on changes in the meanings of living in fear.

This problem summoned the PHE collective to discuss fear as a central element in the observation of reality, since, in the initial moments of permanent education, it was not possible to escape this affectation, and the ways in which affectations, in turn, began to organize the actions or inactions related to care, configuring a relevant problem for the health work process and, therefore, for the permanent education then in progress.

This article discusses 'fear in caring' as an important process of subjectivation within the scope of health care during the Covid-19 pandemic, linked to the realities and dynamics of territories and teams, with imminent efforts to demonstrate displacements of the fear from this paralyzing place to another, where it is possible to face them.

Material and methods

The following descriptions offer an insight into the material conditions in which the PHE workshops were held. The municipality of this experience is located in the North Fluminense region, whose economy depends on the collection of oil royalties and, more recently, on the diversification of its agricultural capacity and ecotourism[16]. According to the last 2010 census, it has a population of 20,242 inhabitants[4], 64.20% urban and 35.80% rural, in addition to housing a remaining quilombo. The average income is around 2.8 minimum wages and the Human Development Index (HDI) is 0.70.

Regarding the organization of the Health Care Network (RAS), it has 100% coverage of the FHS, with 9 teams in 10 units, and 1 Nasf composed of a physical educator, nutritionist, physiotherapist, social worker and psychologist. It also has a Specialty Center that offers 26 medical specialties; 1 Psychosocial Care Center (Caps) and 1 Mental Health Outpatient Clinic; 1 emergency service; and 1 hospital with 82 beds, including psychiatric beds and the Intensive Care Unit (ICU). And, to face the pandemic, the organization of the work process of the existing services was adjusted in order to reduce the risk of transmission of the disease, and a Respiratory Triage Center (CTR), 10 ventilatory support beds and 10 ICU beds were added.

Due to compliance with social distancing, PHE weekly meetings were held remotely, totaling 16 meetings with management and health care teams in the municipality in question and university professors/researchers. The meetings were held from April to September 2020, with an average duration of 2 hours each, at a time agreed between all. The activity was a response to a request from the municipal administration, which made the first invitations to its teams, renewed at each meeting held.

Fieldwork in PHE assumed 'Encounter' as a category of analysis concerning Spinoza's theory of affection[15] or, still, as something of the order of a becoming, a transversalization coefficient that is produced between the subjects[23], so that each 'scene of PHE'[17] could be captured as a powerful unveiling of realities. The analyzes of the main problems of PHE

were based on the theoretical and methodological framework of the micropolitics of health care and work, assuming the premise that the world of health work is like life, a locus of permanent learning permeated by personal and professionals from which dilemmas, annoyances, discoveries and inventions of everyday work can emerge and be problematized for the production of knowledge[13,17-19].

The cartographic approach was operated both in the problematizations carried out and in the presentation of the results and in the analyzes that will follow in this article, justifying the use, in certain passages, of the first person[20-22].

The concept of 'device' was also used, which, according to Foucault, refers to a network that extends between different elements, being a multilinear and multidimensional power mechanism that encompasses a heterogeneous set of elements, causing changes to happen in the social scenarios[23]. For Deleuze[24(167)], a device would be "a compound of relationships of forces" that concretely establishes relationships, and through which meanings are generated in society. In this perspective, fear in care was taken as a paralysis device; and the encounter as a device for creativity, confrontation and the production of new actions of care for oneself and for the other.

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Results and discussion

Participation in weekly meetings was fluctuating. At first, the local management invited the participants of the first meetings; later, there were alternating presences of members of the 12 primary care teams and Nasf. With the exception of some sporadic male participation, the other participants were women.

In the first meetings, there were mutual presentations and exchanges of experiences about the reality faced by the teams, aiming to understand how the pandemic was received, how it impacted services, workers, the community and the very possibilities of PHE, and an acknowledgment by the municipality from the PHE teachers/facilitators.

Permanent education on the internet called for attention and raised questions about bodies and subjectivation in times of a pandemic. Some of these were: what was being produced in these interactions full of 'absences of physical bodies', distanced by the epidemic? What subjectivation processes emerged from virtual encounters? What is the symbolic power of social distancing for workers? Finally, how did all this affect the parties involved in the front line of facing the pandemic?

In the emergence of social isolation, considering the removal of bodies and interactions crossed by the exacerbation of safety protocols (faces covered by masks, glasses, caps, robes, cloaks), impositions of an ethic of distancing, and for the context of exclusively remote work in the university, it was considered about the risks of a 'solitary contractuality', in Augé's terms, that is, the risk to which one is submitted in the establishment of interactions that take place in 'non-places', such as the internet, in what is called relationships of 'solitude'[25]. These considerations continued to be observed, given that they could determine important contingencies, judging the tradition of face-to-face PHE and proximity of assistance.

A little about daily life in the report of the workshops

The reference municipality of this work, as well as others in its region in which the group of teachers worked[6], organized the initial response to the pandemic marking a centralization of care for people with Covid-19, with this assistance model linked to state funding, primarily applied to the feasibility of CTR, urgency/emergency services, hospital beds and field hospitals specific for suspected cases,

according to reports in the workshops. The other health services suffered other impacts and had their work processes reconfigured, considering that, in addition to the new pandemic context, many professionals needed to be removed because they were infected, or were working reduced hours because they belonged to groups considered to be greater risk, significantly reducing the availability of primary care teams and medical specialties.

Other reports also brought, as difficulties and concerns, the lack of supplies for testing, difficulties in acquiring Personal Protective Equipment (PPE) and in accessing intensive care beds, in addition to the suspension of the schedules programmed in the FHS. Pap smear tests, prenatal care, care for chronic patients and preventive health actions were the activities whose postponement and interruption most worried workers in the municipality's basic network. There were specific concerns regarding Community Health Agents (ACS) and Endemic Agents (AE) given the characteristics of their work as members of health teams with direct action in the territory and greater exposure to the virus.

The professors, from their role as facilitators, opened the field for problematization with the question: 'what is the most important problem, today, in daily work?' Initially, the organizational complexity and dynamics of the teams' work gained importance, as well as that of each worker, given the risks of contamination by the new coronavirus. Anguished speeches also emerged that considered the need to qualify work processes, the workers themselves, as well as the construction and implementation of care strategies, due to changes in the daily work due to the pandemic. When the participants felt that they could express themselves, it became clear that being in their own communities caused a lot of tension at that moment, even though many sessions were not face-to-face.

The debates were then guided by considering the demands of the pandemic and those existing before it, making an effort to rethink the health needs in the pandemic from primary care. Thus, the role of territorial actions in facing the pandemic was analyzed. Among outbursts, opinions, reports and doubts, and from all these elements, other questions gained relevance, for example: 'How to take advantage of the power of the primary network in facing the current pandemic, while taking care of users who demand care for non-Covid-19 chronic or acute diseases, and protecting teams and users from the risk of contamination by Sars-CoV-2?'

Talking about proximity in this context is also talking about the power of primary care. Being close, in turn, was reported both in its physical and relational dimensions, sometimes highlighting situations that demarcated knowledge of the territory and the bond with people, since those who work in a community tend to know the enrolled population a lot, the culture and locally established relationships, its social movements, institutions and leadership. In addition, doubts about PPE, about the risks with asymptomatic citizen-users, about adherence to protective measures, about being in the risk group and being a caregiver, among others, emerged.

The PHE scenes, in the debates, were composed by reports of the daily life routine, such as going to work, returning home and protecting family members, almost always in tension with the technical issues regarding the use of PPE, the need for agility in the updates of official protocols regarding Covid-19; as well as the excess of uncertainties and the low reliability of the information available to health workers/caregivers.

Being a health professional so close to the community meant very different things at the same time, after all, they were in the midst of conceptual confusion and disputes over the meanings for the pandemic. Among them, the surprising lack of definition of protocols and guidelines to contain the transmission of the virus within the scope of national coordination; the daily interpellation of fake news; and a frank and broad social process of scientific

denialism[26]. The lack of a firm and planned ground for a situation of high transmission of the disease strongly indicated that caring in close proximity meant, quite forcefully, being a reference for care and guidance, but also being someone potentially ill and a source of contamination by Sars- CoV-2.

In that scenario – which resulted from an initial understanding, in the national-state-municipal management of the crisis – of a retreat from primary care actions to care for symptomatic and/or suspected cases of Covid-19, and in the midst of structural and communicational problems, as well reduced teams, it was decided to share various publications and news about how territorial and care actions in the territories would play a strategic role in the pandemic. An 'act/not act' tension began to grow in the agendas that followed, for example, on how to organize a specific environment for Covid-19 in primary health units. This tension gave voice to new requests, both from those who were working directly in assistance and from those who were in institutional management, such as the demand for new technical training. Finally, a consensus emerged on the fundamental problem that inhibited action: there was too much fear in the air. This was the affection that paralyzed the teams, even in the face of the utmost urgency in resuming their essential work for the community.

Fear in caring: naming and other meanings

It is the fear of contaminating oneself and contaminating one's own family or of unwittingly help to spread the virus, in addition to the fear of death by Covid-19. A feeling that, according to the reports, walks with 'emotional fragility', 'anxiety', 'concern', and that could not be separated from an experience of deep uncertainty about the course of the pandemic in the local reality. In addition, there were already serious problems related to social distancing, which is very controversial in the communities, aggravated by socioeconomic difficulties such as the reduction and/or interruption of the monthly income of many citizens.

The fear intuited at each moment of the experience of exposure to the Sars-CoV-2 virus and the apprehension about all the possible consequences of one's own contamination and of those around us are real sensations, of an individual and collective dimension; and that's what paralyzes us. Fear, thus produced by an intuition, in the Bergsonian sense[27], is a memory that updates the past in the present time, a past loaded with other experiences and knowledge that, by feeding our intelligence, do so in dependence on emotions, and only in this way can we learn what changes are happening in life at a certain time. Intuition is not restricted to cognition, we know that, and that's why it accesses fear and is accessed by it. However, if, on the one hand, an emotion – such as fear – can enter the scene to disorganize and lower our ability to act, on the other hand, could it not be precisely the source of a new potency, of something that, at that exact contingency of life, do we need to live? Here, permanent education sets the task of penetrating the layers and naming this fear.

Naming fear, saying what we are afraid of and discussing it was what led us to a path of recognition, of mobilizing affections, allowing us to build an initial 'map' of fears. The ideas of risk and danger immanent in the work process during the pandemic were problematized, favoring more concrete contours so that fear then took public faces within the scope of the PHE collective. This fear crossed all scenarios of professional and extra-professional practices, such as the fear of crowds in the waiting rooms of the units, or the proximity of the 'symptomatic patient' to groups at high risk for Covid-19, the constant possibility of contamination with asymptomatic people, the dangers of the reintegration of ACS into the territories, or the resumption of care for non-Covid health needs, among others.

There are no shortages of crossings. Social isolation established a new framework for relationships, now immersed in the notion of

danger, according to which 'dangerous' can be any subject, including 'me', even if asymptomatic. In addition, an idea that approached 'purity' would be reserved for those who, although outside the health services – as the case of family members –, would be exposed to greater danger through contact with any party involved in these health flows. Furthermore, designing the organization of care provision based on a classification of patients as 'positive' or 'negative' Covid, in a scenario of low testing and problems in the collection and quality of available tests, was to work with a large margin of error and uncertainty, which required even more courage and creativity on the part of the management and assistance teams.

Undressing the fear allowed us to generate reflections on the possibilities of each one, and what each one would have at that moment to deal with fear, in the way of its private and collective representation. At this stage of the work, fear was still among us, but now in a different way. In each workshop, a change was pointed out, for example, the fear that paralyzed the service at the beginning of the pandemic shifted to the fear of remaining paralyzed. The fear of contamination shifted to a certain fear of apathy in doing/caring, of the very feeling of impotence and suffering. These and other shifts raised reflections on the governmental role and work processes, of each one and their teams, but especially of the basic network itself and proximity care and its connections.

Such movements pointed out, for example, the theme of bonding as a power of proximity care in coping with the pandemic[12,28]. For workers, the pandemic made it even clearer that the daily and lasting relationships between users and health workers, when 'affective coexistence', based on mutual trust and the ability to manage conflicts, among other daily demands, confer the better possibilities of care and, therefore, of preventive actions for Covid-19. In the scenes in which the mediation of the bond was clear, the teams found themselves increasingly able to respond to the challenges, continually updated in the scenario of a health crisis, requiring creativity and management support.

The fear treated here has an intimate relationship with the present time – as stated in the activation of the notion of intuition – and this relationship of affection with the present is a problem already addressed by Spinoza[15(112)] in the 17th century, when he wrote that "during all time in which man is affected by the image of a thing, he will regard it as present, even if it does not exist". From this point of view, the possibility of acquiring Covid-19, especially for those who are focused on the care of positive and/or suspected cases, is a real probability of contamination and illness.

One could argue that if we don't have symptoms of Covid-19 right now then it would be a fear regarding a future possibility, albeit a close one, but so close that it would already be present for any of us right now. It is an intense mode that can be understood as the ability to be affected by what is a future so imminent that it is already present:

> The affection related to a thing that we presently imagine to exist is more intense than if we imagined it as future, and it is much more vehement than if we imagined that this future time is very distant from the present[15(166)].

Spinoza positions joy as the 'free self' in its power relationship with the world, a becoming that gains more mobility and ways of acting, expanding from the inside out. In contrast, he considers sadness a state of impotence, in which our horizons contract and we move away from ourselves. However, for the philosopher, nothing is bad or good a priori, everything is made up in moods and in the way we let ourselves be affected by them.

Letting yourself be carried away by affections that imply possibilities, 'omens' as imminent as those that are now experienced in this pandemic, can make you succumb, give ballast to 'bad omens', space to experience fears, and as an effect of them, allow – at the

best scenery – hope to grow ('good omen'). Considering that for the author there is no way to live these affections separately, that is, there is no hope without fear or fear without hope, both mobilize each other as complementary opposites. If we follow Spinoza's thinking, fear in the pandemic admits, at the same time, greater introspection and less action in the *socius*, raising an impotence in acting, a 'impotent spirit', and we can only bet on the possibility that the worst does not happen: the hope.

In the present analysis, the association of health work in the current conjuncture with ideas such as courage, bravery and heroism was avoided. However, how can a 'free self' be superimposed on this other who inevitably experiences impotence? If 'everything' derives from the mood, if everything is affect (good or bad), our attention turns to the origin of affects, their modulations and their displacements from everyday experience. How to find life power in fear, using a Spinoza language?

We could, for example, shift the understanding of hope from the sense of waiting, a passive attitude, to that of 'hope-doing', an active positioning that implies acting for change, obviously in what depends on us as a collective, as proposed by Paulo Freire[29]. Furthermore, what paths would there be for our 'hope-doing' at that moment?

A first path would be the scientific information already accumulated during the pandemic, for example, including those related to self-care, were identified as important for the contingency of risks and increasing the degree of training of teams and management, subsidizing the bonding and creativity as powers capable of measuring risk and counteracting fear. If thinking about death is losing power, and this was not possible to be circumvented in that situation, life asks us to be able to build some kind of 'fortress', as it was understood by Spinoza[15(129)]:

> I refer all the actions that follow from the affections that are related to the mind as it understands, to the fortitude, which it divides into firmness and generosity. By 'firmness' I understand the desire by which each one strives to preserve his being, by the exclusive dictate of reason. By 'generosity', on the other hand, I understand the desire for which each one strives, by the sole dictate of reason, to help other men and to unite with them in friendship. [emphasis added].

It is easy to conclude that, in this line of thought, any courage in the face of danger would approach that firmness about which the author writes, but it is also clear that this is not enough, and loses meaning, without the sense of preservation for oneself and the other. Talking about fear made this feeling coexist with firmness and generosity, or solidarity, we would say. This is because, based on sharing and the feeling of a team, the struggle to linger in small daily collective meetings to find paths together was the affirmation of a 'we' that is always more than an 'I'.

However, such speech demands speech space-time, and the PHE meetings were pointed out by participants as examples. If intuition, in the sense we gave above[27], brings fear into our bodies, it can also be a now collective power for making fear explicit and fading its shadows, a now collective intuition, much like the PHE.

In this way, PHE made it possible to recognize in its own virtues and daily practices the solutions, which had always been tried, for the problems that coexisted with fear, for example: teleservices, support to the community through communication mediated by messaging applications and multimedia platforms, in addition to the inclusion of Covid-19 cases in the territorial flow and their transit through the network, and the resumption of treatments for non-Covid cases.

This is what the collective may have rehearsed in the meetings: affection-fear was not denied to put in its place a sovereign reason that would have the mission to govern our actions unharmed and save us from the vision

clouded by emotions, as if that were possible. On the contrary, PHE may have facilitated a look at our affections, welcoming them collectively, in order to produce a new meaning in caring for oneself and for others in health care, especially in times like this of the Covid-19 pandemic.

Final considerations

This was a work on fear and uncertainty in the context of care in the Covid-19 pandemic; and, in addition to what has already been shared, it must be considered that it constituted a field of uncertainty for the PHE itself, given that the actions of this field traditionally value the materiality of the meeting, with problematizations that arise from the presence of bodies and the material and oral history of places, in the places of and by people.

Thus, holding PHE workshops entirely on the internet during the pandemic was a challenging novelty for all participants. Digital technology and the communication mediated by it, although they are constant in most people's lives, paradoxically, they were not incorporated into the dynamics, or as a locus of PHE in our specific routines, not being a consolidated reality. However, it is not strange for PHE to adapt, because it incorporates and processes changes, it is interested in novelties, which limits or enhances actions, including its own. And so it was. The ideas of an extended body, of a disembodied presence and a digitized body were also potent in the context of the pandemic, producing as much intercessory encounter as subjectivations, overcoming the initial questions about distancing and the risks of solitary contractuality, for other modes of embodiment and subjectivation[26].

After this experience, we concluded this work with the certainty that there was potency, emotions, affections and change, despite all the damage immanent to the physical distance, which gave rise to other potencies.

Being a health professional, in territorial work or in communities, in these times of the Covid-19 pandemic, is to be challenged by the need for social distance. In this sense, technology has also defined a path for a cautious coexistence with risk, allaying fears, providing security in not being contaminated, even though this reality is the limit for an activity that ideally demands to be, more than close, perhaps, together.

The main object of this analysis was fear as a paralysis device in acting, especially in the health services of the basic network during the Covid-19 pandemic. However, this did not emerge in the PHE collective as an individual characteristic, or restricted to minimal teams in the care territory, on the contrary, it revealed a general fragility in the management of the health crisis, which favored an environment of many insecurities with false information, denialism and the uncertainties. In this scenario, fear was intuited as a process of subjectivation of the reality immanent to the subjects, assuming a collective dimension, which informs about the structure currently offered for health work.

The PHE meetings, however, allowed the problematization of several issues, which is an important way to name fear as a paralyzing affect, to map its various facets, the risks and dangers, its public and private dimensions, and the possible tools to deal with what it actually represents. Fear then changed for us, but we also changed our relationship with it, we relocated fear to a place of closer and more linked relationships. In this way, the fear that previously paralyzed the primary network, now tensioned by the power of the encounter, gave way to other affections, not being a matter of overcoming, but in a cautious and safe way to live with the dangers and risks and resolve – or soften – fear as an act of self-care, a hope-doing at last.

The PHE once again opened the way to other dimensions of the subjects, such as competence, courage, strength, and satisfaction, insofar as they were achieved by the collective, and collectively enshrined that, if fear is an

emotion that emerges, and the idea of death drains our potency at this historical moment, it is inevitable, on the other hand, that life asks for the care of oneself and the other, in turn dependent on live work in action and intercessory encounters, movements that ask for intelligence, intuition and an ethics of life. Other studies and new analyzes may place under review each possibility among those listed here.

Collaborators

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