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# Primary Healthcare workers' discourses in the context of syndemic: psychosocial risks and repercussions

## *Discursos de trabalhadores da Atenção Primária à Saúde em contexto de sindemia: riscos e repercussões psicossociais*

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**ABSTRACT**

The study aimed at understanding the psychosocial repercussions of the syndemic context on Primary Healthcare workers during the COVID-19 pandemic and the period of labor deregulation. This qualitative research explored the psychosocial repercussions of the COVID-19 pandemic on Primary Healthcare workers in Fortaleza, Ceará. Discourse Analysis was used to examine the reports of 21 workers from three Primary Health Care Units (*Unidades de Atenção Primária à Saúde – UAPS*), highlighting the risks of urban violence and the biological and psychosocial effects of the syndemic. The results indicated that the pandemic exacerbated job precariousness and the mental health of professionals due to high demand, scarcity of Personal Protective Equipment (PPE), and uncertainties about disease management. Violence in work territories and insufficient resource management were identified as aggravating factors for working conditions and the mental health of Primary Healthcare workers.

KEYWORDS: Healthcare Workers. Primary Health Care. COVID-19.

**RESUMO**

O estudo buscou compreender as repercussões psicossociais do contexto da sindemia em trabalhadores da Atenção Primária à Saúde, no período da pandemia por COVID-19 e da pandemia de desregulamentações do trabalho. A pesquisa qualitativa explorou as repercussões psicossociais da sindemia sobre os trabalhadores da Atenção Primária à Saúde em Fortaleza, Ceará. Utilizou-se da Análise de Discurso para analisar os relatos de 21 trabalhadores de três Unidades de Atenção Primária, destacando os riscos de violência urbana e os efeitos biológicos e psicossociais da sindemia. Os resultados indicaram que, no período, exacerbou-se a precarização do trabalho e agravou-se a saúde mental dos profissionais, devido à escassez de Equipamentos de Proteção Individual (EPI) e incertezas sobre o trabalho e o manejo da doença. A violência nos territórios e a gestão insuficiente de recursos foram apontadas como agravantes das condições laborais e da saúde mental dos trabalhadores da Atenção Primária à Saúde.

PALAVRAS-CHAVE: Trabalhadores da Saúde. Atenção Primária à Saúde. COVID-19.

## INTRODUCTION

The great viral pandemic of the globalized world has been overcome, mainly in countries with universal public health systems, which have been more successful in this regard when associated with a scenario of political hegemony of democratic governments[1]. However, this process has had a number of repercussions, including the lives of Primary Health Care (PHC) workers.

In Brazil, the existence of the Unified Health System (*Sistema Único de Saúde – SUS*) has led to a significant critical reflection on the challenges faced by Primary Health Care (PHC) in relations of the demands imposed by COVID-19. This situation required the guarantee of qualified investments and the training of professionals, considering the specificities of the work carried out by the Family Health Strategy (*Estratégia Saúde da Família – ESF*)[2].

During the COVID-19 pandemic, PHC in Latin America has had its capacity being underestimated, especially when compared to the practices in other countries. Even so, many initiatives focused on territories and communities tried to integrate Health Surveillance with promotion, prevention and care, despite partial implementation and insecure work contracts. The need to construct new meanings and practices for a more comprehensive PHC system was perceived, which could contribute to the recovery of the balance between society and the environment. Considering this, PHC needed to be rethought, based on the healthcare network's care systems and their importance in the face of the pandemic[3].

The impacts mentioned happened in a complex sociopolitical context, marked by a political scenario unfavorable to the SUS, such as the reformulation of the National Primary Health Care Policy (*Politica Nacional de Atenção Básica da Saúde – PNAB*). The reforms relativized universal coverage and comprehensive care, limiting access to services and changing financing to a model based on care and procedures, instead of comprehensive care[4]. In addition, the reorganization of the ESF teams in a minimal format weakened the work process, prioritizing a curative, medicalizing and productivist logic, typical of Capitalism, especially in its neoliberal aspect[5].

This work illustrates the concept of syndemic, in the sense of the indeterminacy of pandemics, in the technical epidemiological dimension and in the creation of a risk map that could cover two pandemics: COVID-19 and the precariousness of the SUS. One can mask, reveal or reinforce the other, manifesting itself in six axes of conflict: diffuse fear, awareness of the probability of death, loss of agency, embarrassment of forced coexistence, interruption of sociability practices and political-ideological contradiction over explanations and solutions[1].

In this way, it is possible to identify the repercussions of this syndemic, which continues to this day, in processes that have weakened the lives and mental health of workers: the spread of

SARS-CoV-2, the death of peers and family members, social isolation, illness due to the burnout caused by the high demand for care and the weakening of their own working conditions[6].

The present study sought to understand the perceived risks and their psychosocial repercussions in the context of the COVID-19/Precariousness of the SUS syndemic, among PHC workers.

## METHOD

This is a qualitative investigation, with an exploratory and critical-reflexive dimension, based in the theoretical-methodological framework of Discourse Analysis[7,8]. It was analyzed the discourse of PHC workers at the VI Regional Health Coordination Office (*Coordenação Regional de Saúde – CRSVI*) in Fortaleza, Ceará, Brazil, given the psychosocial impacts on their personal and professional lives, driven by the syndemic during the COVID-19 pandemic.

The scenario was chosen because it is the most populated region of Fortaleza, Ceará, which includes the Messejana and Jangurussu neighborhoods, in which the highest number of COVID-19 cases were recorded (n = 3,579), according to the 22nd Epidemiological Week[9] of 2020.

The study was carried out from December 2021 to March 2022, in three Primary Health Care Units, involving 21 interviewed workers who were part of the total research population, including: six Community Health Agents (*Agentes Comunitários de Saúde – ACS*) and three Endemic Disease Control Agents (*Agentes de Combate a Endemias – ACE*) at UAPS-01; six ACS and one manager at UAPS-02; one physician, two nurses, and three nursing technicians at UAPS-03. In the human resources configuration of Primary Health Care in Fortaleza, Ceará, Brazil, there is a job known as Intermediate Level Management (*Direção de Nível Intermediário – DNI*), which is usually held by professionals in the ACS role, working in collaboration with local managers. These professionals also participated in this study, representing this category.

Regarding the participants' profile, the predominant age group was 22 to 30 years old (43%), with the majority being female (86%), and the largest representation being from ACS: nursing technicians, nurses, and physicians, with an average length of service ranging from 2 to 5 years.

This population includes high school, technical, or graduated level workers, who had been working at the UAPS for least six months and agreed to take part of the study, forming a significant intentional sample. For data collection, the Focus Group technique was used in both in-person and remote formats, due to health requirements regarding distancing rules imposed by the COVID-19 pandemic and its repercussions in each unit.

Three meetings with the Focus Group occurred[10], one in person and two remote, made up

of 5 to 12 participants. One group session was conducted in each unit: UAPS-01 (in-person); UAPS-02 and UAPS-03 (remote). The dynamics for the operationalization of the Groups followed these criteria:

a) Initial contact with the CRSVI of Fortaleza to present the research proposal and its objectives, receiving the proper authorization;

b) Direct invitation to workers at UAPS-01, 02, and 03 who met the inclusion criteria, with support from local management, aiming to coordinate the release of research participants to join the study, in a room previously available at the UAPS;

c) Execution of the Focus Groups, guided by a semi-structured interview script to encourage discussion, with questions organized in a logical sequence of discursive complexity;

d) The Groups were guided by the main researcher, ensuring ethical and coherent facilitation of participants, through the promotion of a safe, respectful, and sanitary environment, and using moderation techniques aimed at keeping focus on the problematizing questions;

e) The sessions were recorded by audio and video. Notes were taken in a Diary, where the researcher’s direct experience with the subjects was documented.

The participants' statements were fully transcribed, generating the textual corpus required for Discourse Analysis (DA). As a theoretical-methodological tool, DA tries to understand language as the production of meaning, a symbolic work in the field of human relations. This study is part of social activity and includes issues of subjective/singular life, made up of individuals and their histories[7].

To carry out the analysis, the three steps suggested by Eni Orlandi[7] for understanding the process of meaning production through discourse were followed:
1 – Linguistic Surface, which involves analyzing the materiality of the text and identifying its discursive elements; 2 – Discursive Object, which aims to understand how the text/discourse is situated within a specific social and political context, marked by discursive formations; 3 – Discursive Process, which examines how discourse contributes to the reproduction or transformation of power relations in society, through the meaning of what is said and unsaid, reflecting the ideological formations of the discourse.

The research was approved by the Research Ethics Committee (*Comitê de Ética em Pesquisa – CEP*) of the Universidade Estadual do Ceará – UECE (opinion n.º 5.136.506; CAAE n.º 51758721.3.0000.5534). In accordance with Resolution no. 466, confidentiality of information was kept through codes composed of the occupation acronym along with the Focus Groups from which the categories emerged[11].

## RESULTS AND DISCUSSION

### Risks related to urban violence within the Primary Health Care work área

The work in PHC is based on acting in the territory, understanding that it is there that people's lives, health and illness unfold. In many of these territories, violence appears as an everyday element, in its many forms of expressions. This category will address the participants' speeches about risks related to violence in the PHC work territory.

The challenges of addressing issues related to the mental health of workers were already presented at the beginning of the Focus Groups. When explaining the theme and objective of the research, 'psychosocial aspects in workers during the COVID-19 pandemic', the following statement emerged:

> "[...] We are adults, we understand. There is no way for us to leave anymore. There is no way for us to leave anymore, we have already committed ourselves, so let's get down to business, because, well... it's not possible." ACS1

This speech appeared during the initial explanation, given by the facilitator group in relation to research addressing and the psychosocial dimension of work. Thus, the interviewees associated the discussion only with mental health/illness issues, creating a stigma in dealing with the topic.

The workers reflected uncertainties and difficulties in exposing psychosocial demands that impact their daily practice. Their reaction to the proposed topic resonates with previous stigmas in the field of mental health, which was clear in the verbal and non-verbal language and in what was said and unsaid by the group participants, both in person and in the hybrid/remote mode.

After the initial presentation, the discussion in the groups was focused on the guiding questions of the study. The ethical explanation and the clarification regarding the study's contribution to the population helped to mitigate possible miscommunication or doubts about the research. Urban violence was one of the key issues mentioned by participants as a risk factor in the health work process in PHC. The following speech explains the scenario faced by workers:

> "Regarding violence, our unit is located in a community that is very complicated at the moment. There have always been these confrontations for a long time. The risk we face is very high. There is almost no security, there are only security guards, who are not even armed. The risk is constant, on all sides." ACS2

Regarding violence portrayed by the workers as a risk, it is important to highlight that the services provided by PHC teams require work activities to be effectively carried out and decentralized within the users' own territory, with grater proximity to homes and social spaces of the community, which may lead to increased exposure to urban violence[12].

Urban violence is defined as a complex phenomenon that affects various dimensions of

contemporary society. It is essential to understand that it encompasses cultural and educational values, personal and national economic instability, injustices and social inequalities, and legal impunity. Moreover, it can be stated: “These aspects refer to a macropolitical context that is reproduced in the workplace, including the service sector”[13].

The perception of risk related to violence mentioned by the survey participants refers to urban violence, characterized by situations involving gunfire exchanges, conflicts with the police, among others. This type of violence occurs in the place where PHC professionals operate[14] and thus presents obstacles to the maintenance of health care practices.

The consequences of working in areas dominated by urban violence can be explored in two main dimensions: the limitations on care practices and the psychosocial harm to the professionals involved. From the discussions in the focus groups, it is evident that the participants placed greater emphasis on the second dimension.

Concerning the psychosocial effects experienced, the damage caused by these working conditions to the health of the professionals includes psychological effects such as fear, insecurity, and anxiety, which affect their job satisfaction and motivation[12] and may lead to the development of a defensive strategy of passivity[15].

The psychosocial impacts of working under such conditions are mentioned by the participants:

> “If you talk about mental health, we were running away in fear of gangs (and we still are (ACS 2)) and gunshots, then COVID arrived... then you mix the two things, and what about our mental health? The pressure (...).” ACS1

> “We have to live with this exposure, with the risk of violence and we have this concern for our family, our mental health is going crazy.” ACS4

The reality of urban violence is evident in many Brazilian metropolises, and Fortaleza-CE is no exception. Statistics from the Department of Public Security and Social Defense (*Secretaria da Segurança Pública e Defesa Social – SSPDS*)[16] on intentional lethal and violent crimes reported an increase in cases during the pandemic period, rising from 660 victims in 2019 to 1,250 victims in 2020. There was also a change in the profile of crimes in the region, which occurred more frequently within households, possibly as a result of changes in social dynamics due to the due to the need for isolation as a measure to control COVID-19[17].

Looking at the scenario of public policies, there has been a gradual breakdown of assistance to the population and a lack of responsibility on the part of the state in relation to constitutionally guaranteed social rights. This context contributes to increased social and health inequities.

Regarding the National Primary Care Policy (*Política Nacional de Atenção Básica – PNAB*), setbacks place the Family Health Strategy (*Estratégia Saúde da Família – ESF*) at risk, weakening the multiprofessional, comprehensive, collective, and universal perspective of health

care, as can be seen in the changes in funding for the Family Health Support Center (*Núcleo de Apoio à Saúde da Família – NASF*)[18]. As for mental health, the dispute over models of care is intensifying, as reflected in the increase in funding for hospital-based care, particularly for therapeutic communities, neglecting territorial services within the Psychosocial Care Network (Rede de Atenção Psicossocial – RAPS)[19].

In the case of Community Health Agents (*Agentes Comunitários de Saúde – ACS*), a factor that adds complexity to the issue is their frequent condition of dual affiliation: they are professionals who provide services and residents of the region. In this sense, they are often immersed in the dynamics and internal rules of the community, which may serve as a protective factor due to the expertise and bonds established within the population, but at the same time increases their exposure to the risk of violence[15].

When addressing violence, PHC workers, including ACS, adopt the position of external agents to the community, creating, discursively, a distinction between “us” and “them,” which plays a role in the reproduction of ideological conceptions, preventing a deeper understanding of the phenomenon of violence[20].

In a syndemic scenario, where the COVID-19 coexists with the neoliberal pandemic of labor deregulation[1] and other vulnerabilities that reinforce social inequalities and the precarization of work, the impacts on the working conditions and health of PHC workers are not always clearly understood by them.

Through this analysis, social demands emerge, discursively expressed in a complex way, as the topic itself requires. Issues related to urban violence and its repercussions on fieldwork/in-territory/community practices were emphasized, especially in a context intensified by the COVID-19 pandemic.

## Biological and Psychosocial Risks of Work in Primary Health Care in a Syndemic Context

This section seeks to understand and discuss how the unknown tends to make PHC workers sick, due to contamination and fear of contagion by COVID-19. The COVID-19 pandemic has brought fears about the new, the unsaid and the misunderstanding in the workplace. All of this in the face of weaknesses in educational processes for prevention, protection and promotion, and occupational safety, in a complex and contradictory political context and denialist discourses.

The study "Psychosocial Risks and COVID-19: the rebirth of health and safety at work"[21] shows that the COVID-19 pandemic has increased biological and psychosocial risks in the workplace, especially in PHC.

Biological risks are derived from disease-causing agents, according to Regulatory Standard-32 (NR 32)[22], such as genetically modified or non-genetically modified microorganisms;

cell cultures; parasites; toxins and prions. Psychosocial risks are correlated with the work environment, labor management, and psychological and social factors that exist in this context, which can contribute to or even trigger physical and mental illness in workers[23].

It was possible to observe, through the analysis of the discourse and the notes, that the rapid evolution of knowledge about the virus and prevention measures resulted in frequent changes in guidelines and recommendations, leading to inconsistent and contradictory messages, at times conflicting.

The pressure to keep the continuity of care, combined with the lack of PPE and communication failures, contributed to the increase in psychosocial risks. The workers reported feelings of vulnerability and insecurity, reflecting the urgent need for improvements in educational processes and worker health policies to face the challenges imposed by the pandemic. The Focus Group technique imposed on the collective a consensus that was usual for the moment they were living.

This discussion presents statements from the focus group consisting of speeches by workers linked to UAPS, under the management of a Social Organization. The concerns arising from possible occupational risks related to work in PHC during the COVID-19 pandemic are reported:

> “We get sick physically and mentally [...] we are exposed to the virus, to catch the virus, we have to wear PPE, in that madness, it was really something atypical and it was very exhausting, from Sunday to Sunday, without rest. It really was exhausting.” MED1
>
> “We all got sick [...] COVID-19 itself, professionals got it more than once [...] Nurse confirms absences due to COVID-19”. ENF2

Absolute and relative frequencies of work-related COVID-19 notifications were recorded in the Notifiable Diseases Information System (Sistema de Informação de Agravos de Notificação – Sinan) between 2020 and 2021 in Brazil. According to Vieira and collaborators[24], the data showed that 65.1% were women, 42.1% were Black or Brown, 37.1% had completed high school, 28.4% lived in the Northeast region, 32.8% were between 30 and 39 years old and 36.2% of the cases, a Work Accident Report (Comunicação de Acidente de Trabalho – CAT) was not issued. The most affected group, accounting for 21.91% of the cases, were mid-level technicians.

In 2020, the states with the highest number of work-related COVID-19 notifications recorded in Sinan were Rio Grande do Sul (6,612 cases), Rio de Janeiro (4,833 cases), and Ceará (4,718 cases). In 2021, the situation showed relative improvement for the state of Ceará, with 2,591 cases, placing it sixth among the federal units, behind Rio de Janeiro (6,346 cases), Rio Grande do Sul (5,566 cases), Santa Catarina (5,277 cases), São Paulo (3,347 cases), and Bahia (3,153 cases)[24].

The evidence[24] also brings the risk posed by the type of work environment as a means of transmission for the SARS-CoV-2 virus. It therefore requires greater monitoring on the part of the

government in order to promote further investigation into the different degrees of occupational vulnerability, so that protective measures can be implemented as part of occupational safety efforts, aiming to reduce exposure, contamination, and transmission of the virus.

In this context, a scoping review study[25] identified an increase in the number of workers affected by COVID-19, with nursing professionals, aged between 20 and 43 years, being the most impacted among health sector workers providing care.

It was observed that the conditions for illness are strongly correlated with the conditions for the professional practice of workers, an aspect intrinsic to health management and work conditions, as reflected in the lines below:

> “Regarding PPE [...] the health system was not prepared, it was a new disease. And they really failed, the management, the city government in a way, but then everything got sorted out and it worked out, let's say it was under control in Fortaleza, thanks to the work of the health agent, of the whole team, right?! Doctors, nurses. We didn't stop working.” ACS4
>
> “There was too much exposure. There was no way to defend ourselves, there were no tests to do, it was just the guidance and medications that we didn't know would work the way we wanted, it was up to us, luck and God.” ACS5
>
> “In the beginning it was difficult [...] it was only after the Union got involved, after we complained a lot, that things improved in relation to PPE.” ACS6

The statements from participants in groups ACS04, ACS05, and ACS06 reflect the severity of the COVID-19 emergency, during which management, Primary Health Care (PHC) services, and health workers were unprepared to face a crisis of this kind, especially due to its unusual nature. Vulnerability quickly affected the frontline workers, who found themselves alone amid the chaos that unfolded in a work environment without even the minimal conditions for care provision.

The challenges imposed by the context included a lack of knowledge on how to manage care, resulting from the deficiency of the educational processes experienced. Humanity was racing against time to discover ways to manage the disease in order to control its spread. Furthermore, even when protective measures—such as the use of personal protective equipment (PPE)—were known, there were significant challenges in acquiring and supplying them in sufficient quantity and with suitable quality. This amplified the impact of psychosocial risks, including fear, anxiety, and the exhaustion of health professionals, caused by uncertainty, lack of resources, and constant pressure to manage the viral pandemic in an extraordinarily harmful environment for occupational safety.

This was a complex, multifaceted context of causality that led to the illness of many health workers who, nonetheless, remained on the front lines of the fight against COVID-19. Although the study did not aim to quantify the number of SUS users treated by the PHC units, it is known that the demand was extremely high. This was one of the contributing factors to the nationwide

shortage of PPE[26].

The increase in the number of patients and the scarcity of PPE created a favorable environment for infection and viral spread among health workers[25]. In this context, many professionals were required to maintain a high workload, often taking on additional hours due to a shortage of human resources, thereby contributing to physical, mental, and professional exhaustion.

Another critical factor that affected occupational health and safety in the face of biological and psychosocial conditions was COVID-19 denialism—a political-ideological issue that caused serious confusion and directly impacted both the physical and mental health of workers. These professionals felt unprotected in the face of anti-vaccine discourse and non-compliance with public health guidelines, such as hygiene protocols, barrier methods like mask-wearing, and the practice of social distancing:

> “A person who has a little more knowledge influences others ‘this vaccine kills, this vaccine is killing’ [...] the contamination itself is very high [but some of the deaths are said to be due to the vaccine]” ACS3

> “Within the community, very few people wear masks (...) the neighbors are sick, most of them get sick.” ACS6

ACS03's statement is sometimes misleading, as it relates the individuals who spread fake news as individuals who have superior knowledge, when they may simply have a higher social status, such as members of Congress or Internet influencers. It is necessary to problematize and reflect on this statement, in order to understand how subjectivity incorporates and reproduces what is old and new in mass communication, naively or cynically articulating contradictory facts without any logical or scientific proof.

The question remains: does the professional really believe that the information against the COVID-19 vaccine is true or is he just reproducing in an alienated way the common sense that comes from misinformation or the denial of science, behaviors commonly associated with far-right politicians?[27,28].

Pandemic denial29, in turn, is linked to scientific denial: those who deny the severity of COVID-19 often start from the denial of scientific discourses. Therefore, it is necessary to recognize pandemic denialism within a broader phenomenon. This involves unraveling its origin and its relationship with certain political and economic forces, reactionary values, and necropolitics, and also addressing the reasons behind the polarizations in populations. These are discussions in an early stage that can raise the level of understanding of denialism and its contemporary growth, aiming to confront it.

The context of the COVID-19 pandemic, which generated neglected, denied, and confronted facts, with greater or lesser effectiveness, in a social and political context constructed by masking and antagonisms, revealing potentialities and weaknesses, as proof of the resilience

of the SUS. There was a demonstration of strength, by the way in which it ensured widespread action, supplies, and human resources to confront the problem. There was a display of fragility due to the very structural conditions in which the services are provided. As we observed in the statements of groups ACS 04 and ACS 07, they all relate illness and cross-contamination to the inadequacy of UAPS, commonly characterized by small, poorly ventilated spaces, derived from residential architecture, adapted to be a health service:

> "What really hurt, I think, was the issue of space, the health center is tiny and there were a lot of people... it was difficult to separate COVID from non-COVID, everyone got COVID." ACS7
>
> "It was very difficult for us to separate COVID from non-COVID, it is very difficult for people not to get COVID, we all got COVID." ACS4

For the management and conduct of COVID-19 care, allowing people to gather in small, closed environments for long hours is truly a contradiction25. In any circumstance, when faced with infectious phenomena, the Ministry of Health recommends that workers be informed, trained, aware and mobilized for protective actions30. Workers have the right to have a safe work environment and full access to protective measures compatible with their routine activities and exceptional ones, such as those resulting from COVID-19 care.

In the context of the Focus Group, with narratives interpreted by Discourse Analysis, after being established and hierarchized, the main categories, silence and non-verbal agreement, are significant communicative elements that can provide valuable insights into the group dynamics and the participants' opinions. Although these elements do not verbally express a direct opinion, they play a crucial role in the interpretation of qualitative data. At all times, there were mimic expressions of agreement and support during the participants' speech, demonstrations of respect and implicit offers of space for others, reflexivity and cognitive processing expressed in gestures. There were also, to a lesser extent, signs of discomfort and/or disagreements in addition to verbal communication.

## FINAL CONSIDERATIONS

Based on the discursive formations, we can identify that the psychosocial impacts of work in PHC during the COVID-19 pandemic represented complex stress factors in the lives of workers. The COVID-19 pandemic and precariousness of the SUS, generated significant emotional and cognitive repercussions among PHC workers in Fortaleza, Ceará. A syndemic was characterized by the coexistence, interdetermination of COVID-19 and adverse social and work conditions, increasing the fear, insecurity and anxiety of health professionals.

The biggest challenge is in the field of managing health policies, programs, projects and services. The reorganization of ESF teams and the change in the financing model for a more

explicit and productivist focus, contributed to the precariousness of work and health services, in their daily and close meeting with the populations involved.

The study allows us to list five strategic recommendations:

• Strengthen health care management, with investment in infrastructure and supplies to ensure the adequate supply of PPE and improve the infrastructure of health units, aiming to create a safe environment for professionals and people served;

• Offer clinical-institutional supervision to services, with psychological support in a network and implementation of support projects for PHC workers, aiming to mitigate the effects of antagonistic tensions that generate discomfort and anxiety crises;

• Provide ongoing education through the development of continuous programs for health workers, focusing on the prevention of biological and psychological risks, promoting safe and efficient practices;

• Review legislation and deregulatory work practices, reducing instability, insecurity, task overload and excessive working hours, promoting a healthy balance between professional and personal life, preventing physical and mental exhaustion;

• Stimulate community relations in order to promote the integration of health professionals with the local community, building a network of mutual support and reducing the exposure to urban violence in assistance to investments in public security policy.

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