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HEALTHY WORK ENVIRONMENT IN PRIMARY HEALTH CARE: INTEGRATIVE LITERATURE REVIEW

AMBIENTE DE TRABALHO SAUDÁVEL NA ATENÇÃO PRIMÁRIA À SAÚDE: REVISÃO INTEGRATIVA DA LITERATURA

AMBIENTE DE TRABAJO SALUDABLE EN ATENCIÓN PRIMARIA: REVISIÓN BIBLIOGRÁFICA INTEGRADORA

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Objective: to identify, in the scientific production, constituent elements of a healthy work environment in Primary Health Care for workers' health. Method: integrative literature review, conducted from June to August 2019, according to a search protocol built with eligibility parameters for the definition of a sample of 35 studies, to answer the guiding question: Which elements of the work environment in primary care refer to workers' health? Results: the analysis resulted in the elaboration of categories about illness and stress as repercussions of the subjective experience of work and the protective alternatives, education and transformation of work environments. Conclusion: in the scientific production studied, the constituent elements of a healthy work environment in Primary Health Care, related to workers' health, are generators of illness and stress and are in constant association with the context of this level of care, with the political management and the health work process, and with subjective experiences at work.

Descriptors: Working Environment. Occupational Health. Primary Health Care. Public Health. Occupational Health Nursing.

Objetivo: identificar, na produção científica, elementos constituintes do ambiente de trabalho saudável na Atenção Primária à Saúde para a saúde dos trabalhadores. Método: revisão integrativa da literatura, realizada no período de junho a agosto de 2019, conforme protocolo de busca construído com parâmetros de elegibilidade para a definição de uma amostra de 35 estudos, para responder à questão norteadora: Quais elementos constituintes do ambiente de trabalho na atenção primária referem-se à saúde dos trabalhadores? Resultados: a análise resultou na elaboração das categorias acerca do adoecimento e do estresse como repercussões da vivência subjetiva do trabalho

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e das alternativas protetivas, de educação e de transformação dos ambientes de trabalho. Conclusão: na produção científica estudada, os elementos constituintes do ambiente de trabalho saudável na Atenção Primária à Saúde, relacionados à saúde dos trabalhadores, são geradores de adoecimento e estresse e estão em constante associação ao contexto desse nível de atenção, à gestão política e do processo de trabalho na saúde e às vivências subjetivas no trabalho.

Descritores: Ambiente de trabalho. Saúde do trabalhador. Atenção Primária à Saúde. Saúde pública. Enfermagem do Trabalho.

Objetivo: identificar, en la producción científica, los elementos constitutivos de un ambiente de trabajo saludable en Atención Primaria de la Salud para la salud de los trabajadores. Método: revisión bibliográfica integradora, realizada de junio a agosto de 2019, según un protocolo de búsqueda construido con parámetros de elegibilidad para la definición de una muestra de 35 estudios, para responder a la pregunta guía: ¿Qué elementos constitutivos del ambiente de trabajo en atención primaria hacen referencia a la salud de los trabajadores? Resultados: el análisis dio lugar a la elaboración de categorías sobre la enfermedad y el estrés como repercusiones de la experiencia subjetiva del trabajo y las alternativas de protección, educación y transformación de los ambientes de trabajo. Conclusión: en la producción científica estudiada, los elementos constitutivos del ambiente de trabajo saludable en la Atención Primaria de Salud, relacionados con la salud de los trabajadores, son generadores de enfermedad y estrés y están en constante asociación con el contexto de este nivel de atención, la gestión política y el proceso de trabajo en salud y las experiencias subjetivas en el trabajo.

Descriptores: Ambiente de Trabajo. Salud Laboral. Atención Primaria de Salud. Salud Pública. Enfermería del Trabajo.

Introduction

It is understood as a healthy work environment the one in which all workers collaborate collectively, in a process of continuous improvement in the protection and promotion of safety, health, and well-being of all, with the support of management. This definition, developed by the World Health Organization (WHO) in consultation with different organizations, by including psychosocial factors and health practices, reveals a growing concern with work environments because of their breadth and their relation to health promotion[1].

The WHO itself emphasizes the need for research and studies within the professional practice environment in health institutions, given the perception of the existing gap[2]. In Primary Health Care (PHC), as well as in the different levels of care, it is considered the fact that the integral elements of the work environment offer risks both to the safety of the public and its workers. The set of these elements, as well as the links they establish between each other, can be a tool for analysis and interpretation of the conditions and qualities of these environments.

Whether through instruments for evaluating the work environment, or through studies with different methodological approaches on the theme, the contributions can imply in actions directed to the worker. The scientific productions give visibility to the working conditions that have repercussions on the worker's health, and the analyses, potentially, unveil macro and micro labor scenarios[3].

In Primary Care, it can be listed some factors that interfere with the worker's health, related to the excessive and complex workloads and to the working conditions that cause physical and emotional illness[4-5]. PHC, the first level of contact of people with the Health Systems, in most cases of demands in this area, is the entrance door and organizer of flows and counterflows between all points of the health care network[6]. After 30 years of the implementation of the Brazilian Unified Health System (SUS), discussing the healthy work environment in the Brazilian Primary Care inserts this context in the global agendas on worker's health, situating its own historical and cultural limits.

The concept of healthy work environment implied in the context of PHC enabled the design of the guiding question of this research: "Which constituent elements of the work

environment in Primary Care refer to workers' health?" The objective was to identify, in the scientific production, constituent elements of the work environment in Primary Care for the workers' health.

Method

This is a bibliographical study of the type Integrative Literature Review in which the process of analysis and categorization was carefully organized in six phases[7]: phase 1 - establishing the research question; phase 2 - searching the literature in the databases; phase 3 - categorizing the studies; phase 4 - evaluating the studies included in the review; phase 5 - interpreting the results; and phase 6 - synthesizing the knowledge.

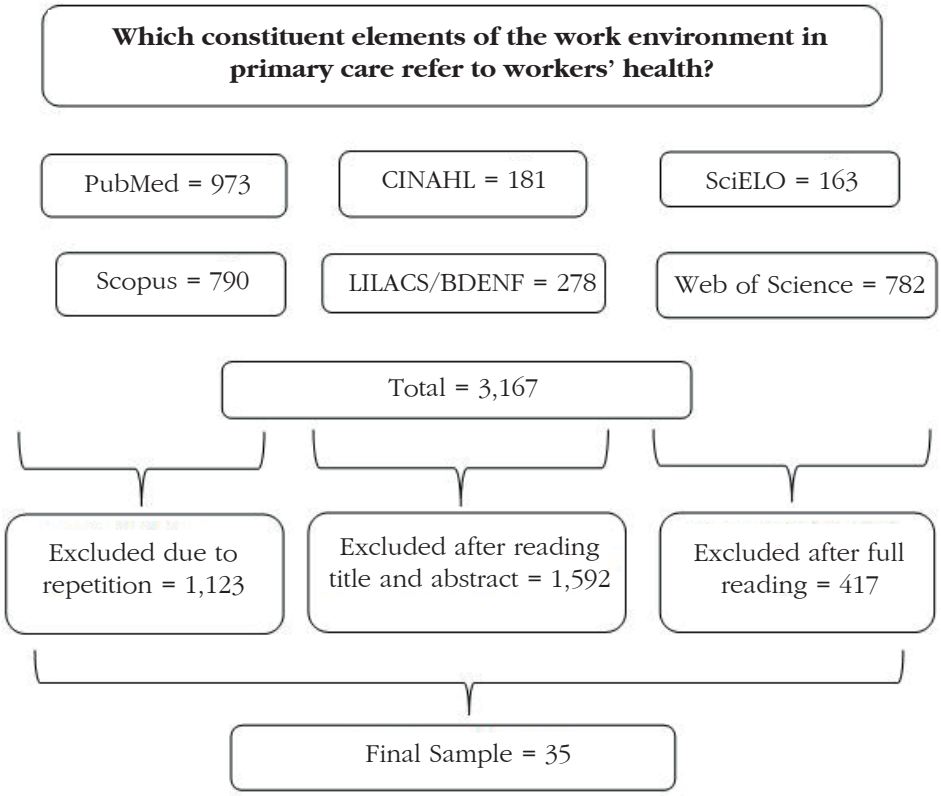
The literature review protocol was developed in the period from June to August 2019 with the guiding question: Which constituent elements of the work environment in Primary Care refer to workers' health? The temporal delimitation was set between 2010 and April 2019. The type of publication was article. The strategies of combining 109 alternative and synonymous search terms related to the Health Sciences Descriptors (DeCS) referred to four themes: Work environments, Primary Health Care, Factors associated with the environment, and worker's health. The languages English, Spanish, and Portuguese were established. The databases consulted were: Publisher Medline (PubMed), Cumulative Index to Nursing & Allied Health Literature (CINAHL), Scientific Electronic Library Online (SciELO), Sci Verse Scopus (Elsevier), Web of Science (WoS), Latin American and Caribbean Literature on Health Sciences (LILACS) and the *Base de Dados de Enfermagem* (BDENF).

The option for the year 2010, as the initial date of the research, is due to the release of the conceptual framework relating to workers' health, published by the WHO, which considers a global action plan with objectives to promote and protect worker health in the workplace[1].

For source management, Mendeley software was used. To avoid interpretation bias, two reviewers carried out the selection and categorization of results simultaneously and independently. Both followed the review protocol, with thorough and exhaustive reading of titles, abstracts, and full texts. A third reviewer participated in the discussion regarding the resolution of doubts and/or disagreements. The initial sample enabled the removal of repeated studies. After reading the titles and abstracts, some studies were excluded due to content incompatibility with the objectives of this review. In the stage of reading the studies in their totality, new exclusions were made, because it was found that some did not answer the guiding question.

A Microsoft Excel® spreadsheet was prepared, containing the following information: author(s), year of publication, language, country of origin, journal of publication, study design, main topic of the article. The content of the articles was entered into the Atlas.ti 7.5.18 software for the organization of information, with identification of codes corresponding to the constituent elements of the healthy work environment in primary health care and grouped later, by thematic similarity, for the delineation of categories. Figure 1 illustrates the process of selection and definition of the samples.

Figure 1 – Search process and sample definition for the Integrative Literature Review



Source: Created by the authors.

Results

Of the 35 articles that composed the sample of this study, the largest number of publications occurred in the period from 2013 to 2015 (51.4%), followed by 2016 to 2018 (31.4%). The articles were published in English (51.4%), Brazilian Portuguese (45.7%), and Spanish (2.9%). Studies using quantitative methods (63%) were the leaders, followed by qualitative methods (34.2%); with a minimum share of mixed methods (2.8%). The studies included in the present review are presented according to: author(s), language of publication and country of origin; journal and year of publication; and topic of interest for the review (Table 1).

Table 1 – Sample articles according to language of publication, method, and year of publication. Florianópolis, Santa Catarina, Brazil – 2010-2019 (N=35)

Variables	n	%
Language of publication		
English	18	51.4
Spanish	1	2.9
Portuguese	16	45.7
Method		
Quantitative	22	63
Qualitative	12	34.2
Mixte	1	2.8
Year of Publication		
2010-2012	5	14.3
2013-2015	18	51.4
2016-2018	11	31.4
2019	1	2.9

Source: Created by the authors.

The results were grouped and discussed in two categories: 1 - Illness and stress as repercussions of the subjective experience of work; and 2 - Protective alternatives, education and transformation of work environments.

Chart 1 presents the articles in the sample, separated by author and year of publication, focus of interest, and analysis categories.

Chart 1 – Sample articles according to author(s) and year of publication, focus of interest and classification by category(ies) of analysis

(continued)

Author and year of publication	Focus of interest	Categories of analysis
Peralta N, Godoi Vasconcelos AG, Griep RH, Miller L. 2012[8]	Work Ability Index (WAI) in Primary Health Care.	1, 2
Halcomb E, Ashley C. 2016[9]	Nursing workforce, satisfaction and strategies for their retention in the environment.	1
Abbas MAF, Fiala LA, Rahman AGA, Fahim ARE. 2010[10]	Violence against health care workers in the workplace.	1
Pinto ACS, Almeida MI, Pinheiro PNC. 2011[11]	Vaccination status of professionals in Primary Health Care and vulnerability to biological risks.	1
Dias MDA. 2013[12]	The integrality of care in Worker's Health and the expansion of actions to Primary Health Care.	1
Bertussi VC, Junqueira MABB, Giuliani CD, Calçado RM, Miranda FJS, Santos MA, et al. 2018[13]	Association between psychoactive substance use and depression, stress and anxiety among nursing professionals in Primary Health Care.	1
González Jara MA, Mora Hidalgo A, Avalos Gulin JC, Albiach ML, Ortiz LM, Monserrat PT, et al. 2013[14]	Exposure of glutaraldehyde chemical compounds in Primary Health Care.	1
Siegrist J, Shackelton R, Link C, Marceau L, Knesebeck O, Mckinlay J. 2010[15]	Levels of work-related stress among Primary Health Care professionals in different health care systems.	1
Oliveira LP, Camargo FC, Iwamoto HH. 2013[16]	Violence in the daily work of Family Health teams.	1, 2
Gómez-Gascón T, Martín-Fernández J, Gálvez-Herrer M, Tapias-Merino E, Beamud-Lagos M, Mingote-Adán JC, et al. 2013[17]	Burnout syndrome and organizational alternatives for prevention.	2
Costa PCC, Francischetti-Garcia APRF, Pellegrino-Toledo VP. 2016[18]	Expectations of Brazilians nurses regarding the reception performed by them at the Primary Health Care.	1
Hongxia Guo RN, Chunping Ni RN, Changqing Liu RN, Jiping Li BN, Suzhen Liu MSN. 2019[19]	Stress and perceived influences among nurses in community care.	1
Silva MO, Peixoto DA, Nóbrega TBT. 2013[20]	Nursing perceptions of accident and health conditions in primary care.	1
Cipriano FG, Ferreira LP, Servilha EAM, Marsiglia RMG. 2013[21]	Voice disorder and work routine of Community Health Agents in the work environment and work organization.	1
Silveira SLM, Câmara SG, Amazarray MR. 2014[22]	Prevalence and predictors of Burnout Syndrome among workers.	1
Scherer MDA, Oliveira CI, Carvalho WMES, Costa MP. 2016[23]	Disconnect between work and training and the education tool via specialization.	1
Silva SCPS, Nunes MAP, Santana VR, Reis FP, Machado Neto J, Lima SO. 2015[24]	Prevalence and factors associated with Burnout Syndrome in Primary Health Care professionals.	1, 2

Chart 1 – Sample articles according to author(s) and year of publication, focus of interest and classification by category(ies) of analysis (conclusion)

Author and year of publication	Focus of interest	Categories of analysis
Speroni KS, Fruet IMA, Dalmolin GL, Lima SBS. 2016[25]	Perceptions and motivations of Community Health Agents about their actions in the work process.	1
Pegoraro PBB, Schaefer R, Zoboli ELCP. 2017[26]	Identification, management, and prevention of psychic and moral exhaustion in primary care workers.	1, 2
Costa FM, Martins AMEBL, Lima CA, Rodrigues QF, Santos KKF, Ferreira RC. 2017[27]	Hepatitis B vaccination among primary care workers.	1
Zhang M, Yang R, Wang W, Gillespie J, Clarke S, Yan F. 2016[28]	Job satisfaction of community health workers and reforms in Primary Health Care in China.	1
Nehmy RMQ, Dias EC. 2010[29]	Reflection on the changes in the world of work, reorganization of the Brazilian Unified Health System, and the practice of professionals in primary care.	1
Maun A, Nilsson K, Furaker C, Thorn J. 2013[30]	Health system transition and the perceived impact on work by health center managers.	1
Bhatnagar A, Gupta S, Alonge O, George AS. 2017[31]	Individual and organizational factors, their interactions and effects on motivation in primary care, such as financial incentives.	2
Fisekovic Kremic MB, Terzic-Supic ZJ, Santric-Milicevic MM, Trajkovic GZ. 2017[32]	Verbal and psychological workplace violence in Primary Health Care.	2
Rule J, Dunston R, Solomon N. 2016[33]	Educational methodology with workers and changes and new neanings in Primary Health Care in Australia.	2
Silva CCS, Rodrigues LMC, Silva VKBA, Silva ACO, Silva VLA, Martins MO. 2013[34]	Accidents and working conditions in the Family Health Strategy in the perception of nursing professionals.	2
Pessoa VM, Rigotto RM, Arruda CAM, Machado MFAS, Machado MMT, Bezerra MGV. 2013[35]	Economic development and implications for work, the environment, and workers' health.	2
Costa JO, Sousa MNA, Feitosa ANA, Feitosa MO, Assis EV, Custódio PP. 2013[36]	Strategies adopted by the personnel department team to minimize conflicts between workers in basic health units.	2
Carreiro GSP, Ferreira Filha MO, Lazarte R, Silva AO, Dias MD. 2013[37]	Mental and psychic disorders in Family Health Strategy workers.	2
Duffrin C, Diaz S, Cashion M, Watson R, Cummings D, Jackson N. 2014[38]	Factors influencing health workforce development in rural settings.	2
Ojakaa D, Olango S, Jarvis J. 2014[39]	Health conditions and performance of the health workforce.	2
Rao KD, Ryan M, Shroff Z, Vujicic M, Ramani S, Berman P. 2013[40]	Rural recruitment strategies in primary care.	2
Cahú GRP, Costa SFG, Costa ICP, Batista PSS, Batista JBV. 2014[41]	Moral harassment experienced by nurses in the work environment.	2
Holmes ES, Santos SR, Farias JA, Costa MBS. 2014[42]	Burnout Syndrome and quality of life of nurses in Primary Health Care.	2

Source: Created by the authors.

The categories are concurrent, but complementary. Initially, this may sound like a contradiction, but the studies revealed work environments in Primary Care that promote illness and stress, however, they pointed out coping strategies.

1 – Illness and stress as repercussions of the subjective experience of work

The studies presented factors that preceded, generated or even accelerated the physical and psychological/mental illness of PHC workers. Psychic problems and mental disorders were indicated as predominant among health professionals, due to factors such as high management demands[8-9]. Among these workers, depression and anxiety were among the psychiatric disorders related to working conditions characterized by overload, exhausting routines, and permeated by conflicting and illness-promoting interpersonal relationships[10-14].

The proximity of PHC workers to the social reality of the territories, coupled with the scarcity of resources to provide effective care and offer comprehensive health care, produced a feeling of powerlessness. In addition, subjective interactions in these scenarios could become sources of psychic illness[15]. Studies have observed that health care workers who worked in direct user assistance were more likely to demonstrate negative psychiatric symptoms[14,16]. The management of services and health policies were also confrontations that caused illness and stress, either related to situations of lack of managerial action, or by oppressive hierarchical attitudes[17].

Unfavorable economic conditions and exposure to risks were also configured as limiting and stress-generating factors for PHC workers[18-19]. The lack of knowledge about diseases and the lack of attention to risk situations were also elements of an unhealthy environment. Despite being health workers, they were not immune to these aspects[20-21]. There were obstacles and gaps that jeopardized effective individual worker protection[22]. The alarming data was due to the high degree of ignorance of the workers themselves about the notification of cases of accidents in the environment[23], besides the precariousness of the occupational assistance coverage for these workers[24].

Another aspect of the work processes impaired by management referred to the high turnover rate of professionals. A study identified the incidence of Burnout among physicians related to this context[24]. The challenge redoubles when such professionals are endowed with defense mechanisms that mask, under an apparent normality, a latent process of suffering or psychic disorder[25].

The negative effects of the work processes in unhealthy environments were trigger points for the appearance of symptomatic manifestations of workers, revealing illness and stress. Studies have shown a significant increase in these pictures[13-14].

In the public sector, Nursing is configured as a stressful profession[19], with an excess of activities performed, a reduced number of professionals, relationship difficulties among the team, reduced salaries, double or triple shifts, and several work bonds, among other aspects[26].

Occupational health among PHC workers was also identified as negligent in a study conducted in the municipality of Montes Claros (MG), which indicated the need to incorporate measures to protect workers' health in the services, besides recommending that the determinations of health protocols be followed[27].

Among the difficulties that permeated the professional environment of these workers, a study[22] highlighted the following: emotional distress due to living with sick people, family conflicts, personal fragilities; risk situations, including death, physical aggression and violence; lack of recognition and shortage of human resources. The main physical complaints resulting from stress were: headaches, hypertension, anxiety, lower back problems, besides the development of other chronic diseases[22]. The fact is that health professionals were sick, mostly incapacitated for the function they performed[28]. Staying at work was justified by the need for

employment, besides the personal satisfaction of working in the chosen profession; this condition, in itself, was a generator of illness and stress[29].

The increased hours at work and the decreased time for personal and family life generated conflicts of roles and responsibilities between personal and work life. This imbalance was related to the increase of mental problems in these workers[30].

2 – Protective alternatives, education and transformation of work environments

To face situations that generate illness and stress or, in general, to promote a healthy work environment in PHC, studies have evidenced continuing education and permanent education. Spaces for education, listening and support to the worker, specifically focused on behavioral and emotional aspects, have become indispensable in the world of work[9,31]. The Brazilian Policy for Worker's Health (PNSTT) is a legal instrument that represents a potential guarantee of a healthy work environment, despite the limits of its concretization in the PHC[32].

At the individual level, studies pointed to the worker's own actions on the environment, to produce positive effects for their health, providing improvements for themselves, with internal organization, planning with goals and time division, besides flexibility in problem solving. Actions of the worker about themself based on individual practices were also reported, such as physical exercises, good nutrition, leisure, relaxation, and therapeutic support[26,33].

The knowledge factor was reported as fundamental for the prevention of diseases. Professionals with a higher education level were better able to face the ills caused by conflicts in the work environment[16,34-35]. The physical and psychic risks in the work environment could be properly understood and worked on as an object of dialogue and intervention via multiprofessional, interdisciplinary and intersectoral actions in the health area, with the primary objective of changing the work processes[8,17]. Learning alternatives should be built and supported in the group experience, including the approach to the health of the professionals themselves and the understanding about the worker's health[36-37]. Thus, educational actions should be directed to the improvement of knowledge and self-care practices, interfering in the motivation for the work process[24].

In various contexts, although the vulnerability of PHC workers to violence was known, little had been invested to reduce and address this problem; horizontal relations between workers and users of primary care could be reflected in better quality of care[38-39].

The measures to protect the health worker permeated several factors, such as: physical and mental health and social protection, permanent and continuing education activities, breaks during the workday, conflict management, improvement of environmental working conditions, better use of health technologies, appreciation of worker participation and humanization actions/projects, and psychological counselling[26,40].

Among examples of protective intervention were reported actions of food and nutritional (re)education to sedentary professionals[39], and also strategies focused on biosafety and immunization[35,42].

Discussion

Among the studies that addressed the relation between illness and stress with the work environment, the most notable were those that dealt with the importance of psychological illness, sometimes related to factors of work organization, especially conflicts in hierarchical relationships in the work environment. Psychic problems are part of the PHC worker's routine and are fed by feelings of incapacity, impotence and lack of resources. The results of the studies indicated worrying rates of this type of illness and insufficient interventions in the short or medium term. According to the Pan American Health Organization (PAHO), mental disorders had an increase of 15% between 2005 and 2015, and will be the main cause of work disability in the coming years[43-44].

It is understood that the commitment of the workers with their functions and objectives lead to excessive concerns and illness, without material compensations that are compatible with gains, remuneration, job plans, and careers. These situations, coupled with times of economic crisis and unemployment, exacerbate anxiety and require living with burnout and mental health exhaustion.

Among the psychological conditions, the Burnout syndrome has been reported in studies with different healthcare professionals. Its relation with turnover in the services warrants reflection on this context, whether by personal initiatives or by service management. In the Brazilian PHC, the turnover of professionals has been high, and the reasons vary according to the region, the structure of the service network and the type of contract, among other explanations[45-46].

The biggest challenge for coping with mental and psychological suffering lies in the early detection of the presence of suffering (stress, anxiety, depression, exhaustion, Burnout, among others), before long-lasting consequences set in, including demobilization, disbelief, and resistance to change/innovation in the work process[24].

It is evident that stress in the PHC work environment is a complex phenomenon, which results in stress for the worker and affects the loss of quality of care and the professional's illness.

From the perspective of ethics, Brazilian research on the moral distress process highlights its multi-causality, due to obstacles and constraints present in work environments, which prevent workers from acting according to their moral judgment, altering their self-perception and their own ethical-moral experience[47-48].

Besides the psychic aspect, the worker also gets physically ill. Chronic illnesses are frequently manifested by health care workers. Chronic health conditions are silently integrated into everyday work and manifest themselves in a significant number of workers who suffer from heart, circulatory, and/or respiratory problems[49]. It is understood that this is not to fragment psychic and physical illnesses, but to express a warning about the cyclical interrelation between these two effects of unhealthy environments on the health of the worker.

Most of the studies analyzed express the increase in education and the overwhelming participation of the female gender in the healthcare labor market. Although stress is not exclusive to any profession, the work of nursing is emphasized, due to the excess of activities[42], to which can be added the accumulation of functions, the double journey for nurses-women-mothers. The Brazilian scenario, by sustaining a strong patriarchal and macho culture, penalizes women with an overload of multiple tasks and responsibilities, which is still reproduced by the women themselves, who are reluctant to give up the control of raising children, maintaining the inequality in the division of tasks[50].

If, on the one hand, the realities still expose work environments permeated by conflicts that predispose to illness and stress, on the other hand, there are coping strategies or strategies to mitigate the negative effects. They are collective or individual alternatives of the worker's own initiative, which seeks to overcome difficulties and promote self-care. It is considered, after the analysis of the studies in this review, that the actions are still punctual and limited. The comprehensiveness and amplitude of coping strategies should involve the collective of PHC workers and be continuously promoted.

It is understood that actions to promote healthy work environments cannot be dissociated from concrete working conditions and worker participation, nor can they consider only demands for productivity and the achievement of metrics, but they must include the well-being, protection, safety, and promotion of worker health.

Regarding the control of work-related diseases, a study identifies serious problems, including the underreporting of acute and chronic cases, still influenced by prejudice, ignorance, and insecurity about rights. The greatest evidence, in this dimension of health care for workers, is the recognition of the importance of information and access to resources and mechanisms for the prevention of diseases, ways to work better and

manage interpersonal relationships, conflicts, and difficulties in the work environment. It is clear, in the worker's health surveillance actions, the guarantee of participation of workers' representatives and surveillance technical advisors in the work environments, besides the establishment of health promotion strategies, through negotiation with workers for participation[51].

When talking about protective measures for workers in PHC, it is important to consider the complexity of the territories; therefore, it is necessary to integrate other sectors, such as public security, organization of workers and education, especially because it covers issues related to social vulnerabilities[49-50]. This integration of instances, according to the guidelines for surveillance of workers' health in the SUS, includes matrix support and solidarity and complementary actions between regions, states, and municipalities, to strengthen actions in the care networks, health promotion, and education in health[51-52].

The limitations of this study are due to the strategies implemented in the search, according to the inclusion and exclusion criteria, a fact that limits it to a sample of a reality given by the own parameters of this review.

Conclusion

The review allowed the conclusion that the constituent elements of a healthy work environment in PHC, related to workers' health, are generators of illness and stress and are in constant association with the context of this level of care, with the political management of the work process in health and with subjective experiences at work.

The findings of this research can contribute to improvements in health care for PHC workers, especially with regard to people management. Based on the premise that the collaboration between research, teaching, and management, under scientific foundations in the area of Nursing, occurs as a provocation for the medium and long-term transformation of these health environments, the result can also have repercussions on improvements in assistance to users.

Faced with challenging situations for the constitution of healthy work environments, the workers envision strategies to face the limits, for collective and individual protection. Knowledge as a product of educational initiatives seems to be the key to the transforming mobilization of environments. However, the process is complex, requires dialogue among all actors, intersectoriality, and consolidation of public policies for workers' health.

Collaborations:

1 – conception, design, analysis and interpretation of data: Lenna Eloisa Madureira Pereira, Flavia Regina Souza Ramos and Paola da Silva Diaz;

2 – article writing and relevant critical review of the intellectual content: Lenna Eloisa Madureira Pereira, Flavia Regina Souza Ramos and Laura Cavalcanti de Farias Brehmer;

3 – final approval of the version to be published: Lenna Eloisa Madureira Pereira, Flavia Regina Souza Ramos, Laura Cavalcanti de Farias Brehmer and Paola da Silva Diaz.

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