



# Work context and pleasure-suffering in primary health care during the COVID-19 pandemic<sup>a</sup>

*Contexto de trabalho e prazer-sofrimento na atenção primária à saúde durante a pandemia da COVID-19*

*Contexto de trabajo y placer-sufrimiento en la atención primaria de salud durante la pandemia de COVID-19*

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## ABSTRACT

**Objective:** to analyze the work context and the pleasure and suffering relations among Primary Health Care professionals during the 2019 Coronavirus pandemic. **Method:** mixed-method study conducted with 52 health teams from September 2021 to February 2022. A total of 224 professionals participated in the quantitative stage and 20 in the qualitative stage. Quantitative data were submitted to analytical statistics, and qualitative data to Thematic Content Analysis. **Results:** scales indicated a critical evaluation of organization (mean  $3.45 \pm 0.71$ ) and working conditions ( $3.22 \pm 1.02$ ), as well as professional burnout ( $3.29 \pm 1.71$ ), and lack of recognition ( $2.33 \pm 1.69$ ); freedom of expression was satisfactory ( $4.30 \pm 1.37$ ). Professionals with chronic diseases showed higher levels of burnout ( $p \leq 0.001$ ) and lower fulfillment/greater lack of recognition ( $p \leq 0.002$ ); longer professional experience was associated with fulfillment and freedom of expression ( $p \leq 0.002$ ), but also with burnout ( $p \leq 0.004$ ). Qualitatively, suffering due to uncertainties, readaptations, and fear stood out; pleasure was derived from vaccination and recognition. **Conclusion and implications for the practice:** The pandemic changed working conditions and organization, with subjective suffering predominating, mediated by labor obstacles, while pleasure acted as resistance. Investment in infrastructure, professional appreciation, and occupational health policies within Primary Health Care is urgently needed.

**Keywords:** Coronavirus; Nursing; Occupational Health; Primary Health Care; Working Conditions.

## RESUMO

**Objetivo:** analisar o contexto de trabalho e as relações de prazer e sofrimento de profissionais da Atenção Primária à Saúde na pandemia do Coronavírus de 2019. **Método:** estudo de método misto, realizado com 52 equipes de saúde no período de setembro de 2021 a fevereiro de 2022. Participaram 224 profissionais na etapa quantitativa e 20 na qualitativa. Os dados quantitativos foram submetidos à análise estatística analítica, e os qualitativos, à Análise Temática de Conteúdo. **Resultados:** as escalas indicaram avaliação crítica da organização (média  $3,45 \pm 0,71$ ) e das condições de trabalho ( $3,22 \pm 1,02$ ), bem como esgotamento profissional ( $3,29 \pm 1,71$ ) e falta de reconhecimento ( $2,33 \pm 1,69$ ); a liberdade de expressão foi satisfatória ( $4,30 \pm 1,37$ ). Profissionais com doença crônica apresentaram maior esgotamento ( $p < 0,001$ ) e menor realização/falta de reconhecimento ( $p \leq 0,002$ ); maior tempo de experiência associou-se à realização e liberdade de expressão ( $p \leq 0,002$ ), mas também ao esgotamento ( $p = 0,004$ ). Na etapa qualitativa, destacou-se sofrimento por incertezas, readaptações e medo; prazer por vacinação e reconhecimento. **Conclusão e implicações para a prática:** a pandemia alterou as condições e a organização do trabalho, predominando sofrimento subjetivo mediado por obstáculos laborais, com prazer como resistência. Urge investir em infraestrutura, valorização profissional e políticas de saúde do trabalhador na Atenção Primária à Saúde.

**Palavras-chave:** Ambiente de Trabalho; Atenção Primária à Saúde; Coronavírus; Enfermagem; Saúde do Trabalhador.

## RESUMEN

**Objetivo:** analizar el contexto laboral y las relaciones de placer y sufrimiento de los profesionales de la Atención Primaria de Salud durante la pandemia de Coronavirus de 2019. **Método:** estudio de método mixto, realizado con 52 equipos de salud entre septiembre de 2021 y febrero de 2022. Participaron 224 profesionales en la etapa cuantitativa y 20 en la cualitativa. Los datos cuantitativos fueron sometidos a estadística analítica y los cualitativos a análisis temático de contenido. **Resultados:** las escalas indicaron una evaluación crítica para la organización (media  $3,45 \pm 0,71$ ) y las condiciones de trabajo ( $3,22 \pm 1,02$ ), el agotamiento profesional ( $3,29 \pm 1,71$ ) y la falta de reconocimiento ( $2,33 \pm 1,69$ ); la libertad de expresión fue satisfactoria ( $4,30 \pm 1,37$ ). Los profesionales con enfermedades crónicas presentaron mayor agotamiento ( $p \leq 0,001$ ) y menor realización/falta de reconocimiento ( $p \leq 0,002$ ); el mayor tiempo de experiencia se asoció con la realización y la libertad de expresión ( $p \leq 0,002$ ), pero también con el agotamiento ( $p \leq 0,004$ ). Cualitativamente, se destacó el sufrimiento por incertidumbres, readaptaciones y miedo; el placer provino de la vacunación y el reconocimiento. **Conclusión e implicaciones para la práctica:** la pandemia alteró las condiciones y la organización del trabajo, predominando el sufrimiento subjetivo mediado por obstáculos laborales, con el placer como resistencia. Es urgente invertir en infraestructura, valoración profesional y políticas de salud del trabajador en la Atención Primaria de Salud (APS).

**Palabras clave:** Atención Primaria de Salud; Condiciones de Trabajo; Coronavirus; Enfermería; Salud Laboral.

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## INTRODUCTION

The Coronavirus Disease 2019 (COVID-19) pandemic brought several challenges to health services, which faced adaptations in work organization.<sup>1,2</sup> Among these adaptations, measures aimed at reducing inequalities in access to health services, minimizing the risk of infection, and protecting the safety of health professionals stood out.<sup>3-5</sup>

To reduce inequalities in coping with the COVID-19 pandemic, the scenario of Primary Health Care (PHC) is highlighted, as it plays an important role in health protection, prevention, and disease control through early diagnosis, treatment, follow-up, and individual and family monitoring.<sup>6</sup> Furthermore, PHC is established as the gateway to the health system, through care coordination and the organization of actions aimed at reducing social inequities in access and improving the quality of health services for the population, requiring intensive professional performance in contexts of high vulnerability.<sup>7,8</sup>

During work activities throughout the COVID-19 pandemic, health professionals who developed care activities involving physical contact constituted a group with high exposure to contamination. This reality generated fears of infection and transmission to family members, work overload, stress, lack of Personal Protective Equipment (PPE), long working hours, and physical and emotional exhaustion, negatively impacting professionals' health.<sup>9</sup>

According to Dejours,<sup>10</sup> in Work Psychodynamics, disruptive events such as the pandemic may destabilize workers' psychological balance, intensifying suffering when work conditions and organization prevent the mobilization of collective defensive strategies.

It is known that even before the challenges posed by the COVID-19 pandemic, PHC faced inadequacies in the physical spaces of health units, shortages of equipment, materials, and human resources, which were reflected in work conditions and organization.<sup>11</sup> Publications on the work context of health professionals during the COVID-19 pandemic show that most studies focused on professionals working in hospital environments.<sup>12-14</sup> However, although there are studies on PHC performance during the pandemic,<sup>15,16</sup> investigations still predominantly occur in hospital settings, with less attention given to subjective repercussions and to the experiences of pleasure and suffering lived by PHC professionals in their daily work context.

Workers' health is understood as resulting from working conditions, material resources, infrastructure, workload, and work organization, such as task division, processes, hierarchical and social relations, mediated by the subjective experience of pleasure and suffering.<sup>10</sup> Pleasure arises from recognition, identification with the task, and the possibility of creative fulfillment; suffering emerges from feelings of powerlessness, frustration, and the conflict between prescribed and real work.<sup>10</sup> Some studies<sup>17,18</sup> indicated that these relationships may have been intensified in PHC during the pandemic.

Thus, understanding the work context and the relationships of pleasure and suffering among PHC professionals during the pandemic supports managerial interventions and workers' health policies, contributing to the quality of care and the protection of the workforce. Therefore, this study's objective is to analyze the work context and the relationships of pleasure and suffering among PHC professionals during the COVID-19 pandemic.

## METHOD

This is a mixed-methods study with a concurrent triangulation strategy.<sup>19</sup> In this study, a mixed-methods design with quantitative predominance (QUAN-qual) was chosen because the objectives required both quantifying the extent and intensity of experiences of pleasure and suffering at work and an in-depth understanding of the contexts and processes that mediated them. The quantitative phase enabled measurement of the work context and indicators of pleasure-suffering broadly within the studied population, identifying statistical patterns and associations. The qualitative phase complemented this view by exploring professionals' perceptions, experiences, and meanings attributed to the work changes imposed by the pandemic, enriching the interpretation of numerical data.<sup>20</sup>

The quantitative phase used a cross-sectional and analytical design, and the qualitative phase was descriptive, with a methodological orientation based on Thematic Content Analysis.<sup>21</sup> This study was guided by the Mixed Methods Appraisal Tool (MMAT), used to strengthen the methodological rigor of mixed-methods studies.<sup>22</sup>

The study setting was a municipality in the interior of the state of Rio Grande do Sul (RS), Brazil, served in PHC by 52 health teams, including 29 Primary Care Teams (PCT) and 23 Family Health Strategy (FHS) teams. The research was conducted from September 2021 to February 2022.

The study population consisted of the 52 PHC health teams, totaling 295 PHC professionals, including physicians, Nursing staff, oral health teams, and Community Health Workers (CHW).

In the "QUAN" phase, all PHC professionals who had worked for at least six months in coping with the COVID-19 pandemic, in accordance with the minimum time required for applying the Work Context and Pleasure-Suffering Indicators scales that compose the Work Inventory and Disease Risk (*Inventário de Trabalho e Risco de Adoecimento* - ITRA), were invited via institutional email. Those who agreed to participate were approached in person to complete the electronic form.

Among these respondents, a sample was included in the "qual" phase, selected through stratified random sampling proportional to professional categories (physicians, nurses, Nursing technicians, CHW, dentists, and oral health assistants), based on a list provided by the Municipal Health Department. Proportionality followed the real population distribution (e.g., a higher number of CHW and nurses). Those on vacation, sick leave, or any type of leave during the data collection period were excluded.

The sample for the “QUAN” phase consisted of all professionals who completed the electronic form (n=224). In the “qual” phase, 20 PHC professionals were randomly selected, and the final number (n=20) was reassessed and confirmed by the theoretical saturation criterion, achieved when new interviews no longer added significant elements to the emerging analytical categories.

Sociodemographic data were collected through dichotomous categorical variables, such as sex and marital status, and numerical variables, such as age, number of children, education level, weekly workload, and length of experience in the health field and in the health unit; work-related data consisted of polytomous categorical variables, such as professional category, and dichotomous variables, such as supervisory or coordination roles.

Lifestyle and health data related to the pandemic were obtained through dichotomous categorical variables, whereas ordinal qualitative variables, such as alcohol consumption and physical activity practice, were assessed using a seven-point Likert scale (never “1” to always “7”), and “diet” was evaluated using a five-point Likert scale (very poor “1” to excellent “5”).

For quantitative data collection, a form developed by the authors was used, containing sociodemographic, work-related, pandemic-related, and health questions, as well as two subscales of the ITRA, an instrument composed of four subscales that allow evaluation of the dimensions of the relationship between work and risk of illness in terms of representation of the work context, demands (physical, cognitive, and affective), experiences, and damages.<sup>23</sup> For this study, the Work Context Assessment Scale (WCAS) and the Pleasure and Suffering Indicators at Work Scale (PSIWS) were used due to their theoretical alignment with the research objectives, which focused on the articulation between objective dimensions (work conditions and organization) and subjective dimensions (pleasure-suffering), according to Work Psychodynamics. The other subscales (human cost and damages) were excluded to maintain analytical focus and avoid instrument overload.

The WCAS consists of three factors: work organization, working conditions, and socio-professional relationships. It is a five-point scale, where 1 = never, 2 = rarely, 3 = sometimes, 4 = frequently, and 5 = always. In the work context, risks of illness are classified as: (1) above 3.7 = negative, severe evaluation; (2) between 2.3 and 2.69 = moderate, critical evaluation; (3) below 2.29 = positive, satisfactory evaluation.<sup>23</sup>

The PSIWS consists of four factors, two evaluating experiences of pleasure at work (professional fulfillment and freedom of expression) and two evaluating experiences of suffering (professional burnout and lack of recognition). It is a seven-point scale, where 0 = none, 1 = once, 3 = three times, 4 = four times, 5 = five times, and 6 = six or more times.

For the analysis of pleasure factors, positive items, the specification, qualification, and frequency with which the experience is lived were considered, and disease risk at work were classified into three levels with individual standard deviations,

as follows: (1) above 4 = more positive, satisfactory evaluation; (2) between 3.9 and 2.1 = moderate, critical evaluation; (3) below 2.0 = rarely, severe evaluation. For suffering factors, negative items, the analysis was performed at the following levels: (1) above four = more negative, severe evaluation; (2) between 3.9 and 2.1 = moderate, critical evaluation; (3) below 2.0 = less negative, satisfactory evaluation.<sup>23</sup>

In the “qual” phase, the interview script was developed by the study authors based on the research question and consisted of nine questions addressing daily work during the COVID-19 pandemic, teamwork organization, risks of illness, and impacts on health.

Quantitative data collection was conducted in person by two previously trained Nursing students, using a tablet provided by the researcher to access the data collection instruments via an electronic form (Google Forms). The qualitative phase was conducted by the first author of this article, in person at the workplace, as previously arranged with participants. The locations ensured safety, comfort, and privacy for researchers and participants. Interviews lasted approximately 30 minutes, were audio recorded using digital recorders after participants' authorization, and fully transcribed in Microsoft Word 2010.

Data from the “QUAN” phase were coded and transferred to Microsoft Excel and analyzed using the Statistical Package for the Social Sciences (SPSS), version 20.0. Continuous variables were described using measures of central tendency and dispersion: mean and standard deviation. The Shapiro-Wilk normality test was performed to verify variable distribution; Chi-square or Fisher's exact test, according to cell frequency, was used for associations between categorical variables; and the Mann-Whitney test was used for asymmetric continuous variables. Pearson bivariate correlations were performed for symmetric variables and Spearman correlations for asymmetric variables. Differences with two-tailed “p” values lower than 0.05 or with a 95% Confidence Interval (CI) were considered statistically significant. Cronbach's Alpha Coefficient was applied to verify the reliability of the ITRA subscales.

In the “qual” phase, the data were transcribed and subjected to Thematic Content Analysis, which occurs in three stages: pre-analysis; material exploration; and data interpretation.<sup>20</sup> In pre-analysis, floating reading and identification of material relevant to the study objective were performed. During material exploration, statements were coded and semantic content organized into analytical categories. Finally, in data interpretation, theorization and discussion of results were conducted in light of Work Psychodynamics and other studies published in the scientific literature.

Data integration occurred concurrently, using the complementarity technique: quantitative results, such as high suffering scores or negative evaluations of the work context, guided the qualitative exploration of specific themes, while qualitative narratives illustrated and explained the statistical patterns found, allowing mutual confirmation, such as the statistical association between working conditions and burnout, corroborated by statements about fear and insecurity.

This integration was organized through a joint display, which facilitated combined visualization and the generation of meta-inferences.<sup>24,25</sup>

Ethical principles were respected according to Resolution No. 466/12 and Resolution No. 510/16 of the Brazilian National Health Council (CNS). The Free and Informed Consent Term (FICT) was obtained, informing about both phases, and sent together with the online form. In the interviews, the names of health professionals were replaced by the acronyms PHY for physicians, NUR for nurses, TEC NUR for Nursing technicians, and CHW for Community Health Workers, followed by a numerical order representing the sequence of interviews. The study was approved by the National Research Ethics Commission (CONEP) on July 15, 2021.

## RESULTS

The “QUAN” phase consisted of 224 professionals, including 34 (15.2%) physicians, 45 (20.1%) nurses, 16 (7.1%) dentists, 44 (19.7%) Nursing technicians/assistants, 79 (35.3%) CHW, and six (2.7%) dental office assistants/attendants. There was a predominance of females (81.2%), with a mean age of 43.84 (±10.41), self-reported White race/color (83.5%), and 158 (70.5%) were married or had a partner. Regarding participants’ health, 125 (55.8%) used continuous medications, and 101 (45.1%) reported living with some disease. Concerning work-related data, 178 (79.5%) did not have another employment relationship, and 39 (17.44%) held coordination/supervision roles.

Table 1 presents the mean, standard deviation, minimum, maximum, Cronbach’s Alpha, and risk classification of the factors from the Work Context Assessment Scale and the Pleasure and Suffering Indicators at Work Scale. All domains of the WCAS and PSIWS scales were classified as critical, except for freedom of expression (satisfactory), indicating negative repercussions of the pandemic both in objective dimensions (working conditions and organization) and subjective dimensions (pleasure-suffering).

Table 2 presents the factors of the work context scale and the pleasure and suffering indicators at work scale according to the sociodemographic and work-related variables of PHC professionals.

In the “qual” stage, 20 health professionals were interviewed, including three physicians, four nurses, three Nursing technicians, and ten CHWs. From the analysis of these interviews, four categories emerged: (1) Uncertainties of the COVID-19 pandemic in the PHC context; (2) (Re)adaptations in working conditions and organization in PHC in response to COVID-19; (3) Experiences of pleasure and suffering in PHC work during the COVID-19 pandemic; and (4) Impact on professionals’ health in the face of COVID-19.

In the category “Uncertainties of the COVID-19 pandemic in the PHC context”, professionals reported insecurity, fear, and a lack of initial preparedness due to the novelty of the virus and the absence of clear protocols, which contributed to subjective suffering.

*At the beginning, we felt very lost, in the sense that there was guidance coming all the time, every day there were new updates on management, on how to deal with cases, what to do, whether to refer to the emergency department or not. (PHY 5)*

*At the beginning, there was a lack of knowledge, we didn’t have much organization regarding PCR collection, right? And where we could refer the users. (NUR 14)*

*The problem with the pandemic is that it created a lot of doubts among people, and for us, health professionals too, there came a time when we didn’t even know what we were supposed to do anymore. (CHW 7)*

In the category “(Re)adaptations in working conditions and organization in PHC in response to COVID-19”, professionals highlighted changes in care processes, redistribution of tasks, suspension of routine activities, prioritization of COVID-19 care, and structural inadequacies, including improvised spaces and lack of isolation rooms.

*With the pandemic, the appointments were stopped, right? At the beginning, there was no way to continue, everything had to be reserved for the virus. (CHW 15)*

**Table 1.** Mean, Standard Deviation, Minimum, Maximum, Cronbach’s Alpha, and Risk Classification of the factors of the Work Context Assessment Scale and the Pleasure and Suffering Indicators at Work Scale. Porto Alegre (RS), Brazil, 2024.

Scale	Factors	Mean± SD	Minimum	Maximum	Cronbach’s alpha	Risk classification
WCAS	Work organization	3.45±0.71	1.45	5.00	0.87	Critical
	Socioprofessional relationships	2.5±0.92	1.00	5.00	0.91	Critical
	Working conditions	3.22±1.02	1.00	5.00	0.93	Critical
PSIWS	Professional fulfillment	3.96±1.41	0.33	6.00	0.92	Critical
	Freedom of expression	4.30±1.37	0.00	6.00	0.90	Satisfactory
	Professional burnout	3.29±1.71	0.00	6.00	0.92	Critical
	Lack of recognition	2.33±1.69	0.00	6.00	0.92	Critical

**Table 2.** Assessment of Work Context and Indicators of Pleasure and Suffering at Work according to the sociodemographic and work-related variables of PHC health professionals during the COVID-19 pandemic. Porto Alegre (RS), Brazil. 2024.

Scales	WCAS				PSIWS		
Factors	Work Organization	Socioprofessional relationships	Working Conditions	Professional Fulfillment	Freedom of Expression	Professional Burnout	Lack of Recognition
Variables	Mean± SD	Mean± SD	Mean± SD	Mean± SD	Mean± SD	Mean± SD	Mean± SD
	P	P	P	P	P	P	P
<b>Sex</b>	3.48±0.68	2.51±0.92	3.25±1.03	3.96±1.34	4.31±1.30	3.42±1.71	2.41±1.71
Female	3.30±0.77	2.49±0.88	3.07±0.97	3.99±1.70	4.28±1.63	2.73±1.62	2.00±1.59
Male	0.15	0.90	0.31	0.88	0.91	0.01	0.16
<b>Age *</b>	-0.17	-0.13	-0.11	0.11	0.05	-0.10	0.08
	0.11	0.57	0.86	0.84	0.45	0.12	0.21
<b>Skin color</b>							
White	3.40±0.69	2.52±0.90	3.15±1.01	4.01±1.38	4.30±1.38	3.28±1.72	2.31±1.70
Black/Mixed-race/	3.66±0.73	2.43±0.98	3.54±1.00	3.75±1.56	4.32±1.33	3.33±1.69	2.44±1.64
Another	0.04	0.58	0.37	0.30	0.95	0.88	0.66
	0.01	0.07	0.04	-0.00	0.06	-0.01	0.05
<b>Sleep hours*</b>	0.86	0.27	0.54	0.97	0.31	0.81	0.42
<b>Marital status</b>	3.50±0.60	2.71±0.88	3.34±0.99	3.84±1.40	4.01±1.42	3.64±1.60	2.88±1.66
Single	3.42±0.74	2.42±0.92	3.16±1.03	4.01±1.41	4.43±1.33	3.15±1.74	2.11±1.66
Married	0.45	0.31	0.23	0.40	0.03	0.05	0.001
<b>Number of children*</b>	-0.11	-0.24	-0.13	-0.04	0.10	0.04	-0.04
	0.84	0.001	0.04	0.51	0.10	0.54	0.80
<b>Continuous medication</b>	3.46±0.69	2.64±0.98	3.29±1.08	4.02±1.39	4.33±1.34	3.28±1.69	2.27±1.81
No	3.43±0.71	2.40±0.85	3.16±0.97	3.59±1.54	4.09±1.59	3.32±1.93	2.59±1.45
Yes	0.77	0.05	0.32	0.14	0.40	0.92	0.16
<b>Lives with a disease</b>	3.41±0.70	2.57±0.95	3.23±1.08	4.19±1.34	4.39±1.22	2.74±1.56	1.90±1.48
No	3.49±0.71	2.42±0.87	3.20±0.95	3.78±1.44	4.23±1.47	3.73±1.70	2.68±1.77
Yes	0.36	0.22	0.83	0.02	0.39	0.001	0.001
<b>Education level*</b>	-0.05	0.00	-0.07	0.05	-0.05	-0.07	-0.03
	0.37	0.91	0.29	0.46	0.40	0.29	0.56
<b>Professional category</b>							
Physician	3.15±0.70	2.38±0.92	2.91±1.02	4.50±1.31	4.28±1.65	3.01±1.92	1.91±1.75
Nurse	3.81±0.49	2.76±0.86	3.37±1.08	3.98±1.20	4.26±1.14	3.38±1.48	2.56±1.59
Dentist	3.06±0.84	2.63±0.97	2.82±1.13	3.86±1.73	4.12±1.80	2.43±1.84	2.05±1.93
Nursing Technician/ Nursing Assistant	3.34±0.65	2.40±0.90	3.16±1.05	4.36±1.32	4.64±1.37	3.08±1.75	2.05±1.74
Agents/ Care Assistant	3.52±0.69	2.42±0.89	3.37±0.85	3.46±1.44	4.18±1.29	3.75±1.62	2.69±1.62
CHW	3.21±1.01	2.81±1.37	3.18±1.67	4.77±0.31	4.47±0.64	2.14±1.14	1.16±0.82
Dental Office Assistant/ Dental Office Attendant	0.001	0.29	0.13	0.001	0.59	0.01	0.05
<b>Time of experience in the health area*</b>	-0.08	-0.10	-0.09	0.16	0.14	-0.13	-0.09
	0.20	0.11	0.19	0.01	0.02	0.04	0.16
<b>Time of experience in the health unit*</b>	0.14	0.08	0.19	0.001	0.04	0.15	0.09
	0.02	0.26	0.01	0.99	0.54	0.03	0.17
<b>Weekly workload*</b>	0.06	0.001	-0.05	-0.03	-0.04	0.09	0.04
	0.37	0.85	0.42	0.62	0.55	0.19	0.52
<b>Coordination/ supervisory position</b>	3.43±0.71	2.54±0.97	3.27±1.04	3.91±1.41	4.26±1.38	3.32±1.74	2.34±1.68
No	3.52±0.68	2.35±0.56	2.94±0.88	4.22±1.37	4.50±1.29	3.15±1.57	2.32±1.75
Yes	0.44	0.23	0.06	0.21	0.32	0.55	0.96
<b>Work in another service</b>	3.49±0.70	2.52±0.93	3.28±1.01	3.92±1.41	4.27±1.38	3.30±1.67	2.35±1.65
No	3.26±0.69	2.44±0.84	2.97±1.04	4.15±1.41	4.45±1.32	3.27±1.88	2.27±1.86
Yes	0.05	0.61	0.06	0.32	0.43	0.90	0.79
<b>Alcohol use*</b>	-0.02	-0.01	-0.01	-0.11	-0.09	-0.03	0.03
	0.75	0.87	0.82	0.07	0.16	0.58	0.62
<b>Nutritional assessment*</b>	-0.10	-0.05	-0.05	0.15	0.13	-0.14	-0.20
	0.11	0.37	0.44	0.02	0.04	0.03	0.001
<b>Days of physical activity*</b>	-0.04	-0.05	-0.10	-0.06	-0.11	-0.05	-0.05
	0.47	0.42	0.12	0.37	0.09	0.42	0.41

**Note:** Asymmetric distribution of continuous variables was considered, and the Mann-Whitney test was applied. However, for presentation purposes, means and standard deviations were included in the table to facilitate the interpretation of the findings. \* Spearman correlations.

*Our unit couldn't handle the number of consultations, we tried to keep chronic patient visits by phone to reduce people coming into the unit, but we had to focus on COVID-19. (NUR 20)*

*To set up the COVID room, we had to close the dressing room during the morning shift, because that space was also used for it. (TECH NUR 10)*

In the category “Experiences of pleasure and suffering in PHC work during the COVID-19 pandemic”, reports of pleasure were related to professional fulfillment, recognition, and actions such as vaccination, contrasting with suffering associated with losses and direct contact with the disease.

*I felt pleasure being here, working as a nurse during the pandemic, pleasure in doing my job. (NUR 13)*

*One of the pleasures was when vaccination started, the vaccination campaigns, right? Seeing people grateful and getting vaccinated; at the beginning, how many photos we took of older adults, right? (CHW 15)*

*At least being there to talk and comfort that person, because sometimes what people need after a COVID diagnosis isn't medication, but a word of comfort. (PHY 16)*

In the category “Impact on professionals' health in the face of COVID-19”, symptoms of stress, anxiety, emotional burnout, fear of infecting family members, and overload were highlighted, including narratives of initial insecurity relocated here due to their stronger association with subjective suffering and professional exhaustion.

*I got sick during this pandemic, and it wasn't COVID, it was mental, it was a lot of stress. (CHW 2)*

*For me, it was very hard to work during those two years, I got to the point of having crying spells, I started using medication to control these feelings, and I needed psychiatric treatment for my anxiety. (CHW 3)*

*It was also wearing us down at the beginning, and it still has effects today, because people are more impatient with our work, and we also feel overloaded with all this information. (PHY 5)*

Another aspect that became evident in the interviews was the work overload in PHC during the COVID-19 pandemic.

*Working during the pandemic was extremely exhausting, we had no right to seniority leave, no vacation, nothing. In fact, we had no rights at all. (CHW 2)*

*I think all health professionals felt overloaded, there's no way they wouldn't have. (TECH NUR 19)*

The results' integrated analysis shows that the pandemic simultaneously modified working conditions (precarious infrastructure, physical risks) and work organization (pressure for results, task redistribution), directly affecting the subjective experience of pleasure (fulfillment, recognition) and suffering (exhaustion, fear, insecurity).

Figure 1 presents the integration of the “QUAN” and “qual” results, combined through data connection, regarding how PHC professionals faced the COVID-19 pandemic.

## **DISCUSSION**

This study highlighted the negative impact of COVID-19 on the work context and its repercussions on the suffering of professionals working during the pandemic, evidenced by critical classifications in the applied scales, associated with reports of uncertainties, the need for work readaptations, emotional burnout, stress, overload, insecurity, and fear.

Precarious working conditions, such as inadequate infrastructure, improvised spaces, lack of equipment, and changes in work organization, including task redistribution, suspension of routine activities, and pressure for results, contributed to subjective suffering, according to the Psychodynamics of Work,<sup>10</sup> in which obstacles to work performance generate feelings of helplessness, frustration, and defensive strategies that, when unsuccessful, lead to burnout.<sup>26-28</sup>

However, sources of pleasure also emerged, with satisfactory levels in items such as pride, professional fulfillment, identification with tasks, and personal gratification. These findings, corroborated by qualitative reports about vaccination, user recognition, and the possibility of offering comfort, illustrated the concept of pleasure as arising from symbolic recognition, creative mobilization, and perceived social contribution, even in adverse contexts.<sup>10</sup>

In light of the Psychodynamics of Work, precarious working conditions, such as uncomfortable environments and insufficient equipment, generated suffering by confronting prescribed work with real work, hindering the proper execution of tasks, and fostering feelings of inadequacy. Changes in work organization, such as excessive pace, pressure for results, and hierarchical redistribution of tasks, intensified role conflict and ambiguity, contributing to stress and emotional burnout.<sup>10,26-29</sup>

The precarious infrastructure of health units was already a frequent issue in the PHC professionals' routine. However, the COVID-19 pandemic worsened this reality, with the reorganization of schedules to prioritize respiratory symptoms and the improvisation of spaces, such as outdoor areas and the use of inadequate rooms. Brazilian studies conducted in similar settings<sup>30,31</sup> also evidenced structural inadequacy, overcrowding, and difficulties in separating patient flows, contrasting with more favorable experiences in municipalities with greater support.<sup>32,33</sup>

It was observed that the COVID-19 pandemic caused significant changes in physical infrastructure conditions, material resources, and work organization, including processes of territorialization, longitudinality, and care coordination among PHC professionals. Previously, units were based on these principles,<sup>34</sup> however, the pandemic required adaptations that weakened infrastructure,



increased fear and insecurity, but maintained the concern to promote care centered on users' needs despite the challenges.

Based on the study results, precarious working conditions negatively influenced professional satisfaction, generating feelings of inadequacy in meeting respiratory care demands and reducing previously fulfilling activities. Difficulties in allocating suspected users and performing tests in appropriate settings reinforced the need for investment policies in PHC, which has historically received fewer resources than the hospital sector.<sup>35</sup>

In the Psychodynamics of Work, suffering results from unpredictable situations that prevent collective mobilization and generate emotional exhaustion.<sup>10</sup> The pandemic reality caused suffering among participants, including fear of family contamination, social isolation, and loss of users, findings similar to international studies that associated fear, anxiety, and depression with occupational exposure.<sup>36-38</sup>

On the other hand, pleasure was related to gratification from positive outcomes, such as vaccination campaigns and user recognition, strengthening professional identity.<sup>10,39,40</sup> This symbolic reward acted as a strategy of resistance to suffering, highlighting the importance of valuing PHC during health crises.

The identified weaknesses reinforced the need to strengthen PHC through financial investment, professional qualification, and adequate infrastructure, especially in the post-pandemic context and in the persistent conditions related to COVID-19.

## CONCLUSION AND IMPLICATIONS FOR PRACTICE

In summary, in light of the Psychodynamics of Work, the results revealed that the COVID-19 pandemic simultaneously modified precarious infrastructure conditions, physical risks, and the organization of work, such as task redistribution and pressure for results in PHC, directly impacting professionals' subjective experience. These objective dimensions mediated pleasure and suffering: work-related obstacles generated suffering, with predominance of burnout, fear, and insecurity, while sources of recognition and creative fulfillment, such as care actions and vaccination, fostered pleasure as a strategy of resistance and preservation of mental health.

The practical and managerial implications were clear: it became urgent to strengthen worker health policies in PHC, with investments in adequate infrastructure, reduction of organizational overload, psychological support programs, and professional appreciation, with symbolic and material recognition. Such measures not only mitigated suffering but also promoted pleasure at work, contributing to workforce sustainability, to the quality of care in the SUS, and to preparedness for future health crises.

As limitations, the cross-sectional design was highlighted, which prevented longitudinal analysis of pleasure-suffering trajectories and the establishment of temporal causality, in addition to possible influences of uncontrolled external factors. Furthermore, data collection conducted during the pandemic was affected by logistical difficulties, absences, and the emotional context of participants, potentially influencing response rates and the depth of narratives.

For future research, longitudinal studies were suggested to follow the resilience and post-pandemic recovery of PHC professionals, exploring interventions based on the Psychodynamics of Work aimed at collectively promoting pleasure at work and preventing illness. This study reinforces the need for a holistic approach that integrates the objective and subjective dimensions of work, aiming to protect professionals' health and ensure the effectiveness of the health system.

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## DATA AVAILABILITY RESEARCH

The contents underlying the research text are included in the article.

## CONFLICT OF INTEREST

There is no conflict of interest.

## REFERENCES

1. Pan American Health Organization. Time is of the essence – Countries of the Americas must act now to slow the spread of COVID-19 [Internet]. Washington: PAHO; 2020 [cited 2025 Sep 6]. Available from: [https://www.paho.org/hq/index.php?option=com\\_content&view=article&id=15762:time-is-of-the-essence-countries-of-the-americas-must-act-now-to-slow-the-spread-of-covid-19&Itemid=1926&lang=en](https://www.paho.org/hq/index.php?option=com_content&view=article&id=15762:time-is-of-the-essence-countries-of-the-americas-must-act-now-to-slow-the-spread-of-covid-19&Itemid=1926&lang=en)
2. World Health Organization. Coronavirus disease 2019 (COVID-19) [Internet]. Geneva: WHO; 2020 [cited 2025 Sep 6]. (Situation Report; 68). Available from: [https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200328-sitrep-68-covid-19.pdf?sfvrsn=384bc74c\\_8\\_CDC](https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200328-sitrep-68-covid-19.pdf?sfvrsn=384bc74c_8_CDC)
3. Rafael RMR, Neto M, Carvalho MMB, David HMSL, Acioli S, Faria MGA. Epidemiology, public policies and Covid-19 pandemics in Brazil: what can we expect? *Rev Enferm UERJ*. 2020;28:e49570. <http://doi.org/10.12957/reuerj.2020.49570>.
4. Ruiz-Fernández MD, Ortega-Galán AM, Fernández-Sola C, Hernández-Padilha JM, Granero-Molina J, Ramos-Pichardo JD. Occupational Factors Associated with Health-Related Quality of Life in Nursing Professionals: A Multi-Centre Study. *Int J Environ Res Public Health*. 2020;17(3):982-975. <http://doi.org/10.3390/ijerph17030982>. PMID:32033257.
5. World Health Organization. WHO calls for healthy, safe and decent working conditions for all health workers, amidst COVID-19 pandemic [Internet]. Geneva: WHO; 2020 [cited 2025 Sep 6]. Available from: <https://www.who.int/news/item/28-04-2020-who-calls-for-healthy-safe-and-decent-working-conditions-for-all-health-workers-amidst-covid-19-pandemic>
6. Quites HFO, Silva TC, Viegas SMF, Gontijo TL, Oliveira VC, Guimarães EAA. Coping strategies in Primary Health Care in the COVID-19 pandemic in Minas Gerais, Brazil. *Saúde Debate*. 2023;47(139):818-29. <http://doi.org/10.1590/0103-1104202313907>.
7. Portaria nº 2.436 de 21 de setembro de 2017 (BR). Aprova a Política Nacional de Atenção Básica. *Diário Oficial da União* [Internet], Brasília (DF), 21 set 2017 [cited 2025 Dec 6]. Available from: [https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436\\_22\\_09\\_2017.html](https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html)
8. Nedel FB. Enfrentando a COVID-19: APS forte agora mais que nunca! *APS em Revista*. 2020;2(1):11-6. <http://doi.org/10.14295/aps.v2i1.68>.

9. Pfefferbaum B, North CS. Mental health and the covid-19 pandemic. *N Engl J Med.* 2020;383(6):510-2. <http://doi.org/10.1056/NEJMp2008017>. PMID:32283003.
10. Dejours CA. Loucura do trabalho: estudo de psicopatologia do trabalho. 6. ed. São Paulo: Cortez – Oboré; 2015.
11. Medeiros PA, Silva LC, Amarante IM, Cardoso VG, Mensch KM, Naman M et al. Health status of primary healthcare professionals from Santa Maria, RS, Brazil. *RBCS.* 2016;20(2):115-22. <http://doi.org/10.4034/RBCS.2016.20.02.04>.
12. Jaarsma T, van der Wal M, Hinterbuchner L, Köberich S, Lie I, Strömberg A. Flexibility and safety in times of coronavirus disease 2019 (COVID-19): Implications for nurses and allied professionals in cardiology. *Eur J Cardiovasc Nurs.* 2020;19(6):462-464. <http://doi.org/10.1177/1474515120921027>. PMID:32323572.
13. Xiang YT, Yang Y, Li W, Zhang L, Zhang Q, Cheung T et al. Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. *Lancet Psychiatry.* 2020;7(3):228-229. [http://doi.org/10.1016/S2215-0366\(20\)30046-8](http://doi.org/10.1016/S2215-0366(20)30046-8). PMID:32032543.
14. Xiao X, Zhu X, Fu S, Hu Y, Li X, Xiao J. Psychological impact of healthcare workers in China during COVID-19 pneumonia epidemic: a multi-center cross-sectional survey investigation. *J Affect Disord.* 2020;274:405-410. <http://doi.org/10.1016/j.jad.2020.05.081>. PMID:32663970.
15. Fernandes MNS, Boufleuer E, Finckler PVPR, Trindade LL, Tavares JP, Pai DD. Implications of the COVID-19 pandemic on Primary Health Care: an integrative review. *Rev Eletr Enferm.* 2022;24:e70085. <http://doi.org/10.5216/ree.v24.70085>.
16. Oliveira FES, Trezena S, Dias VO, Martelli H Jr, Martelli DRB. Common mental disorders in Primary Health Care professionals during the COVID-19 pandemic period. *Epidemiol Serv Saude.* 2023;32(1):e2022432. <http://doi.org/10.1590/s2237-96222023000100012>. PMID:37283353.
17. Baptista PCP, Lourenção DCA, Silva-Junior JS, Cunha AA, Gallasch CH. Distress and pleasure indicators in health care workers on the COVID-19 front line. *Rev Lat Am Enfermagem.* 2022;30:e3555. <http://doi.org/10.1590/1518-8345.5707.3519>. PMID:35476012.
18. Lima CCM, Fernandes TF, Barbosa MS, Rossi-Barbosa LAR, Pinho L, Caldeira AP. Analysis of indicators of pleasure and suffering at work associated with anxiety and depression among community health agents. *J Bras Psiquiatr.* 2023;72(2):80-09. <http://doi.org/10.1590/0047-208500000047>.
19. Creswell JW, Clark VLP. Pesquisa de métodos mistos. 2. ed. Porto Alegre: Penso; 2013.
20. Creswell JW, Creswell JD. Projeto de Pesquisa: métodos qualitativo, quantitativo e misto. 5. ed. Porto Alegre: Penso; 2021.
21. Minayo CS. Pesquisa Social. Teoria, método e criatividade. 29. ed. Petrópolis: Vozes; 2010.
22. Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M et al. Mixed methods appraisal tool (MMAT) Version 2018: user guide [Internet]. Montreal: University McGill; 2018 [cited 2025 Sep 6]. Available from: [http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/attach/127916259/mmat\\_2018\\_criteria-manual\\_2018-08-01\\_eng.pdf](http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/attach/127916259/mmat_2018_criteria-manual_2018-08-01_eng.pdf)
23. Mendes AM, Ferreira MC. Inventário sobre o trabalho e riscos de adoecimento – ITRA: instrumento auxiliar de diagnóstico. In: Mendes AM, editor. Psicodinâmica do trabalho: teoria, método e pesquisas. São Paulo: Casa do Psicólogo; 2007. p. 111-26.
24. Guetterman TC, Fetters MD, Creswell JW. Integrating quantitative and qualitative results in health science mixed methods research through joint displays. *Ann Fam Med.* 2015;13(6):554-61. <http://doi.org/10.1370/afm.1865>. PMID:26553895.
25. Fetters MD, Curry LA, Creswell JW. Achieving integration in mixed methods designs—principles and practices. *Health Serv Res.* 2013;48(6 Pt 2):2134-56. <http://doi.org/10.1111/1475-6773.12117>. PMID:24279835.
26. Monteiro WF, Ferreira DS, Lima KJV, Tavares IC, Ramos FRS. The organization of healthcare work in the light of ergology: experiences in the COVID-19 pandemic. *Rev Esc Enferm USP.* 2023;57:e20220261. <http://doi.org/10.1590/1980-220x-reeusp-2022-0261pt>. PMID:37130425.
27. Pereira D, Leitão J, Ramos L. Burnout and quality of work life among municipal workers: do motivating and economic factors play a mediating role? *Int J Environ Res Public Health.* 2022;19(20):13035. <http://doi.org/10.3390/ijerph192013035>. PMID:36293606.
28. Betancourt-Sánchez LC, Ochoa-Gelvez EO, Velásquez-Bernal CC, Rozo-Silva YA, Quiroga-Vargas DA. Occupational health in the framework of the COVID-19 pandemic: a scoping review. *Rev Salud Publica.* 2020;22(3):381-388. <http://doi.org/10.15446/rsap.v22n3.87238>. PMID:36753167.
29. Silva BRG, Corrêa APV, Uehara SCSA. Primary health care organization in the Covid-19 pandemic: scoping review. *Rev Saude Publica.* 2022;56:94. <http://doi.org/10.11606/s1518-8787.2022056004374>. PMID:36383807.
30. Fernandez MV, Castro DM, Fernandes LMM, Alves IC. Reorganizar para avançar: a experiência da Atenção Primária à Saúde de Nova Lima/MG no enfrentamento da pandemia da COVID-19. *APS Rev.* 2020;2(2):114-21. <http://doi.org/10.14295/aps.v2i2.84>.
31. Murakami MN, Araújo FJ, Marques CP. The reorganization and performance of Primary Health Care in the context of the COVID-19 pandemic: a narrative review. *Braz J Develop.* 2022;8(2):12232-51. <http://doi.org/10.34117/bjdv8n2-252>.
32. Silveira JPM, Zonta R. Experiência de reorganização da APS para o enfrentamento da COVID-19 em Florianópolis. *APS Rev.* 2020;2(2):91-6. <http://doi.org/10.14295/aps.v2i2.122>.
33. Guimaraes FG, Carvalho TML, Bernardes RM, Pinto JM. A organização da Atenção Primária à Saúde de Belo Horizonte no enfrentamento da pandemia Covid-19. *APS Rev.* 2020;2(2):74-82. <http://doi.org/10.14295/aps.v2i2.128>.
34. Maciel FBM, Santos HLPC, Carneiro RAS, Souza EA, Prado NMBL, Teixeira CFS. Community health workers: reflections on the health work process in Covid-19 pandemic times. *Cien Saude Colet.* 2020;25 (suppl. 2):4185-95. <http://doi.org/10.1590/1413-812320202510.2.28102020>. PMID:33027355.
35. Afonso MVG, Pereira CEA, Silva WB, Silva MVS. The role of Social Determinants of Health and Primary Health Care in controlling COVID-19 in Belém. *Physis.* 2021;31(02):e310207. <http://doi.org/10.1590/s0103-73312021310207>.
36. Fernandez M, Carvalho W, Borges V, Klitzke D, Tasca R. A Atenção Primária à Saúde e o enfrentamento à pandemia da COVID-19: um mapeamento das experiências brasileiras por meio da Iniciativa APS Forte. *APS Rev.* 2021;3(3):224-3. <http://doi.org/10.14295/aps.v3i3.216>.
37. Sarti TD, Lazarini WS, Fontenelle LF, Almeida APSC. What is the role of Primary Health Care in the COVID-19 pandemic? *Epidemiol Serv Saude.* 2020;29(2):e2020166. <http://doi.org/10.5123/S1679-49742020000200024>. PMID:32348404.
38. Souza NVDO, Carvalho EC, Soares SSS, Varella TCMYML, Pereira SRM, Andrade KBS. Nursing work in the COVID-19 pandemic and repercussions on workers' mental health. *Rev Gaúcha Enferm.* 2021;42(spe):e20200225. <http://doi.org/10.1590/1983-1447.2021.20200225>. PMID:33566891.
39. Luz EMF, Munhoz OL, Morais BX, Greco PBT, Camponogara S, Magnago TSBS. Repercussions of covid-19 in the mental health of nursing workers. *Rev Enferm Cent O Min.* 2020;10:81. <http://doi.org/10.19175/recom.v10i0.3824>.
40. Queiroz AM, Sousa AR, Moreira WC, Nóbrega MPSS, Santos MB, Barbosa LJV et al. The novel COVID-19: impacts on nursing professionals' mental health? *Acta Paul Enferm.* 2021;34:91. <http://doi.org/10.37689/acta-ape/2021AO02523>.

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## Work context and pleasure-suffering in PHC

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