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Weaknesses and strategies to strengthen Occupational Health actions in Primary Health Care: perceptions of health workers

Fragilidades e estratégias para fortalecimento das ações em Saúde do Trabalhador na Atenção Primária à Saúde: percepções de trabalhadores de saúde

Abstract

Objective: To identify weaknesses and strategies to strengthen worker's health actions in Primary Health Care (PHC) based on the knowledge and perceptions of health professionals. **Methods:** This qualitative descriptive exploratory research was conducted in a city in the state of São Paulo, Brazil, between July and August 2020. Seventeen health professionals linked to three PHC units participated. The theoretical saturation criterion was observed for the composition of the convenience sample. The data were analyzed according to content thematic analysis. **Results:** As weaknesses, participants had difficulty in recognizing PHC users as workers, showing little familiarity with worker's health line of care, disarticulation of different points in the network, and limited performance of the Workers' Health Reference Centers (Cerest – *Centros de Referência em Saúde do Trabalhador*). They pointed out strategies for strengthening such as: knowledge and recognition of Cerest as a supporter of activities in health services, strengthening of intersectoral articulation for workers' health surveillance, health education actions, and PHC structure for worker access. **Conclusion**: The identified weaknesses and strategies point to the need for investment in the revitalization of the Cerest, articulation of the care network, and training professionals, focused on matrix support and the assumptions of workers' health surveillance.

Keywords: Occupational Health; Primary Health Care; Surveillance of the Workers Health; Occupational Health Policy; Health Services.

Resumo

Objetivo: Identificar fragilidades e estratégias para fortalecimento das ações em Saúde do Trabalhador (ST) na Atenção Primária à Saúde (APS), a partir dos conhecimentos e percepções de trabalhadores de saúde. **Métodos:** Pesquisa qualitativa, descritiva-exploratória, realizada em um município paulista, em julho e agosto de 2020. Participaram 17 profissionais de saúde, vinculados a três unidades da APS. Foi observado o critério de saturação teórica para composição da amostra por conveniência. Os dados foram analisados segundo a análise temática de conteúdo. **Resultados:** Como fragilidades, os participantes tiveram dificuldade em reconhecer os usuários da APS como trabalhadores, houve pouca familiaridade com a linha de cuidado em ST, desarticulação nos diferentes pontos da rede e atuação limitada dos Centros de Referência em Saúde do Trabalhador (Cerest). Apontaram como estratégias para fortalecimento: (re)conhecimento do Cerest como apoiador das atividades nos serviços de saúde, fortalecimento da articulação intrasetorial para a Vigilância em Saúde do Trabalhador, das ações de educação em saúde e da estrutura da APS para o acesso do trabalhador. **Conclusão**: As fragilidades e estratégias identificadas apontam para a necessidade de investimentos para a revitalização dos Cerest, articulação da rede de atenção e formação dos profissionais, direcionada ao matriciamento e aos pressupostos da vigilância.

Palavras-chave: Saúde do Trabalhador; Atenção Primária à Saúde; Vigilância em Saúde do Trabalhador; Política de Saúde do Trabalhador; Serviços de Saúde.

Introduction

The object of this study was Occupational Health (OH) in the context of Primary Health Care (PHC), based on national policies aimed at OH in the the Brazilian Unified Health System (Sistema Único de Saúde [SUS]) and the theoretical framework of Social Determinants of Health[1], which considers living conditions, work, employment/unemployment, and factors related to the work environment in the health-disease process of individuals.

PHC teams play an essential role in consolidating Workers' Health Surveillance, since the particularities of the work process and territorial insertion make it possible to understand the relationships between users' living, health and working conditions, and how these impact on the health-disease process, and it is their responsibility to establish any relationship between the diagnosis and the user's current or previous work activity[2]. This presupposes recognizing and investigating the impact of work activity on workers' health.

The National Network for Comprehensive Occupational Health Care (Renast) was a milestone for structuring OH actions in the SUS through the Workers' Health Reference Centers (Cerest – Centros de Referência em Saúde do Trabalhador) with a focus on Workers' Health Surveillance[3]. The organization of actions based on PHC has also been considered essential for the implementation of the National Occupational Health Policy (PNSTT)[4] and for the consolidation of Renast, as it is closer to the context of users and makes it possible to know, identify and propose interventions based on the needs of territories and users[5].

The role of health workers, especially in PHC, in defining strategies and actions to strengthen OH is crucial; to this end, they need to develop general and specific skills during their initial and continuing training. This includes: providing comprehensive care, understanding the social determinants of health, recognizing the relationship between health-disease conditions and work, establishing a causal link between illness and work, planning and implementing actions on health promotion and protection measures, work and social security referrals, and notification in health information systems[6]. Moreover, health professionals need to be satisfied with their work in order to guarantee a quality service, since dissatisfaction can affect the quality of the service provided[7].

A study carried out in Minas Gerais shows that PHC workers sometimes even recognize the causal link between work and illness, but don't refer the user to Cerest due to the difficulty in recognizing the networks of care for OH, the relationship between OH and PHC, and the flow of information/notification[8,9].

Although PHC is recognized by professionals[10] and it is important to develop professional skills to work in PHC, not as a specialty, but as part of the comprehensive health care proposed by the SUS[6], there are still shortcomings and fragmentation that negatively affect occupational health care[8,9]. With this in mind, the aim of this study was to identify weaknesses and strategies for strengthening OH actions in PHC, based on the knowledge and perceptions of health workers.

Method

Type of study

Descriptive-exploratory, qualitative research that followed the Consolidated Criteria For Reporting Qualitative Research (COREQ)[11].

Location, population, and sample

The study was carried out in a municipality in the state of São Paulo, which had 22 Family Health Units (USF) and 12 Basic Health Units (UBS). At the time, the municipality didn't have a PHC technical reference organized into

a nucleus, coordination, management or program, as recommended by Resolution 603/2018[12]. Matrix support for PHC teams was provided by a regional Cerest located in another municipality and some Workers' Health Surveillance-directed actions were carried out by the municipal epidemiological surveillance services - such as compulsory notification and notification of accidents at work via the Notifiable Diseases Information System (Sinan) - and by health surveillance , such as inspections of workplaces.

For the random selection of participants, the 34 units were placed in an Excel® spreadsheet, organized according to the region they covered (to obtain research data from different regions), listed, and separated between UBS and USF, in order to ensure the participation of professionals who worked in both models of unit. The draw was made using Excel®'s "random between (x,y)" function.

It was decided to start data collection at the first UBS drawn, alternating with the next USF and so on. The unit was contacted by telephone to present the project and invite them to take part in the research. After accepting, the unit provided a date and time for the collection, as well as the interview format (face-to-face or virtual). The target audience was health professionals working in municipal PHC, and the convenience sample was made up from the selected units.

Data collection

The data were collected in July and August 2020 through individual face-to-face and virtual interviews, lasting approximately ten minutes each, carried out by the nursing student and main author of this article, who was previously trained for this purpose. The interviews were guided by a script of semi-structured questions, containing questions for sociodemographic characterization (gender, age, occupation/profession, length of professional training, length of time working in PHC, and length of time working in the unit) and eight open questions: (1) How do you see OH in the SUS? (2) How do you understand the role of your health unit in relation to OH? (3) What activities are carried out in your unit aimed at OH? (4) How does communication and the flow of information work between your unit and other points/services in the municipal and regional network in the OH area? (5) Have you received any training in the OH area? (6) What difficulties do you see in relation to OH? (7) What strategies do you consider important for strengthening OH in PHC? (8) Would you like to add any more information?

All the health professionals present at the time of data collection were invited and there were no refusals. The script was validated in a pilot test in an unselected unit before data collection began, with a nurse, a community health agent (CHA), and a dentist chosen at random. After analyzing the data, it was necessary to readjust some of the questions, as the interviewees had difficulties understanding them.

The face-to-face interviews were carried out in the unit itself, in a private room, respecting the health standards for the prevention of COVID-19. The virtual interviews were carried out via the Google Meet® platform, observing the guidelines for research in virtual environments of the National Research Ethics Council (Conep).

The interviews were digitally recorded, transcribed, stored, and archived on an individual, password-protected computer. After manual transcription in a Word® document, the videos and audio were destroyed. First names and other words that could identify the workplace, professionals, or users were excluded in order to guarantee anonymity. The transcripts were organized numerically according to the order in which the interviews took place (P1, P2, P3... Pn) and identified according to work unit with the letters "U" for UBS professionals and "E" for USF professionals.

In qualitative research, priority is given to the quality of the information obtained and not the quantity of interviewees; therefore, the focus was on the dimension of the question linked to the profile of the group and their representativeness as social actors. Data collection was completed when the information provided by the participants was able to represent the whole category[13]. To do this, the data was collected and analyzed simultaneously, so that saturation could be seen[14] and it was possible to point out thematic convergences.

Data analysis

The data was analyzed using Thematic Content Analysis[15], which involves three stages: (a) pre-analysis - a complete reading of all the interviews; (b) exploration of the material - highlighting important points made by the participants and identifying categories of analysis; and (c) treatment of the results - condensing the issues raised by the participants and choosing representative statements. Two categories emerged from the analysis[15]: (1) Weaknesses in OH care in the HCN (Health Care Network) and (2) Strategies for strengthening OH in the HCN. Three codes were identified for the first category (lack of knowledge of the HCN flow for OH; intra- and intersectoral disarticulation; and health service structure) and four for the second (recognition of Cerest as a supporter; health education actions; PHC coordination for OH; and PHC structure for worker access). The data was discussed in the light of national policies and the theoretical framework adopted[1].

Ethical aspects

This study was approved by the Ethics Committee of the Federal University of São Carlos, under opinions No. 3.827.030 (issued on February 7, 2020), No. 4.149.846 (amendment approved on July 12, 2020), and CAAE 23210819.0.0000.5504. All participants signed the Informed Consent Form (ICF) and all ethical aspects of research with human beings were respected.

Results and Discussion

Seventeen health professionals from two UBS and one USF took part in the study, including nursing assistants (n = 5), nurses (n = 3), community health agents (n = 3), physicians (n = 3), nursing technicians (n = 2), and oral health assistants (n = 1). Most of the participants were female (n = 14), with an average age of 39 years, an average length of professional training of ten years, an average length of time working in PHC of seven years and an average length of time working in the unit of three years and six months.

Weaknesses in OH care in the HCN

The participants showed a limited understanding of OH as a public policy and found it difficult to recognize the user as a worker, in addition to attributing OH care exclusively to companies, making it clear that there is a limitation in considering work as a Social Determinant of Health[1]. In addition, although professionals see workers of different profiles daily, they are unable to recognize the influences of work on the main complaint that motivated the search for the health service, such as stress, depression, and cardiovascular problems[16].

When they were questioned about OH actions in the SUS, they showed a lack of knowledge about the organization of Renast, as well as the existence of Cerest, aspects that compromise actions in this line of care. The municipality studied belongs to a Cerest which is based in another city, which can be a hindrance to technical support for the units it covers. The literature[17] points out that health secretaries in the regions where Cerests are based find it difficult to understand the regional nature of this entity, which may partly explain the low level of activity of these centers in other cities.

Both UBS and USF professionals reported a lack of actions aimed at workers, indicating that employers are responsible for developing these actions - which shows a lack of knowledge about public policies aimed at OH:

> *I see as little as possible, there are very few actions* [...] *they're very specific, okay?* (P7U)

> *I think* [occupational health actions] *it would have to be in the company where they work, right? It should start there, because most of their problems start at work, I think it should be there* (P5U).

By referring responsibility to the company, the interviewees reveal that they are unaware of the important role of PHC (and their own role) in the effective inclusion of occupational health actions in the SUS. Because it is close to where people live and work, PHC has the potential to recognize the relationship between the disease and work, to identify informal workers and the various forms of insertion into the job market (a consequence of productive restructuring) and the situations of risk to health as a result of the work situation[17]. It is worth noting that companies have responsibilities in the field of occupational health, but PHC is the protagonist of actions to protect and promote workers' health[4]. However, in relation to these actions:

> *It falls far short of what we could offer. Yeah, we don't have a leg, okay? We're so plastered with doctor-consultation, doctor-consultation, and procedures that we can't do any extra-field work, you know? So, we're very stuck here because our internal demand is so bureaucratic* (P7U).

> *Hm, we need to improve a lot. We need to improve primary care a lot* [...] *it needs to be more active, it's a bit passive, you know? It's waiting for the worker to arrive, but they arrive sick, right?* [...] *it's totally uncharacteristic, because there's no prevention of anything* (P13U).

Even 30 years after the creation of the SUS and the model of comprehensive health care, prevention activities are still incipient, and physician-centered care with a focus on the disease persists. A historical overview of occupational health in the SUS highlighted that even today, the same challenges as years ago still exist, even after some progress in the area, due to the invisibility of the worker-user to health teams and, consequently, the health-disease-work process is not an object of action[17].

Some of the difficulties presented by the participants in this study had already been mentioned in the literature[5,8,9,17]. This fact highlights the still-challenging scenario for changing praxis, although efforts have been made to identify competencies and strategies for emancipatory training of these professionals[6,18]. This points to the importance of making Permanent Health Education, an instrument for strengthening the SUS, a possible practice in the realities of work, with a view to overcoming everyday problems and transforming the work process[19].

The speeches highlighted the lack of intra-sectoral coordination; the lack of knowledge of the flow of care for workers within the HCN; the problems in the structure of health services within PHC; the absence of extended opening hours to welcome workers; and the insufficient number of professionals to carry out actions aimed at OH.

> *This connection is missing. We always joke that we, in the Primary Care network, live in a reality where each place is in a different canoe. So, for example, we're in a canoe, then regulation is in a canoe, the hospital is in a canoe, and we can't connect, you know? You're kind of jumping from branch to branch, you can't get a network to connect "oh, I'll call here, then I'll call the hospital" and we can. Wow, it's really difficult* (P13U).

The lack of knowledge about the organization of the HCN and the lack of communication between the services demonstrate the lack of preparation in providing care to workers. Lack of knowledge of the flows[8] and the absence of information exchange between units[20,21] make it difficult to direct workers in health care and to develop projects and actions in OH[21].

Regarding the relationship between health units and other points in the HCN for worker care, there is a lack of intra-sectoral coordination, due to little dialog or even lack of knowledge of care and referral flows. The participants reported that when there is a specific demand, such as an accident at work, they make telephone or electronic contact with a specific general healthcare unit, which is responsible for providing support and continuity in monitoring the worker within the SUS. It can be seen that although there is a flow, it is not formally structured in the health service in the municipality, which hampers the effectiveness of the work carried out, makes the environment confusing and weakens relationships[22]. This may reflect the lack of a municipal policy on OH and of health promotion and disease prevention activities[23].

About the notification instruments that cover occupational health issues, such as Sinan and the Occupational Accident Assistance Report (RAAT), only one participant mentioned knowing about the notification instruments,

but did not understand how to proceed with directing the worker, showing little affinity with this important workers' health surveillance documentation. Despite the growing participation of different sectors in OH policies, there are still few proposals on how to make this practice effective among managers and workers in the field[24]. Thus, it is clear that the actions proposed by the PNSTT have been poorly developed in the municipality studied[23], and that the concept of workers' health surveillance as a tool for articulating intra- and intersectoral health knowledge and practices[24] has not yet been consolidated.

Challenges in communicating with employers were also an aspect mentioned by the participants, highlighting the lack of sensitivity and trust on the part of employers towards sick workers.

> *Unfortunately, I don't think companies are prepared for this, right? To really understand the worker, right?* (P17E).

> *There have been companies that have contacted me to question the sick leave, and I said "no, the patient is away for so many days because* [...]*". Because some companies see employees as a number, right? It's minus one. So they don't even care if the guy is really ill or not. And the guy really had a problem, and I said "no, he's off work and it's for an indefinite period and until he gets better, he won't come back to work". There's also this, there are companies that want to push workers to the limit, you know, and workers, afraid of losing their jobs, sometimes work sick and so on* (P13U).

It's important for PHC teams to know the working population in their territory and try to coordinate with the different bodies involved in workers' health surveillance, especially Cerest, to promote educational actions aimed at employers and the workers themselves, to facilitate care for workers. This is because, at the time of the study, the municipality did not have a structured OH team, as proposed by Ordinance No. 603/2018[12].

It is also worth noting, according to the aforementioned Ordinance[12], that the promotion, surveillance, and assistance actions for occupational health, considering the different levels of complexity, must have the PHC as the coordinating center and be coordinated via Cerest. However, the regional Cerest is responsible for 24 municipalities and, due to the overload of demands, is unable to carry out effective actions with and in all the municipalities it covers. A study carried out in the same region pointed out that there is a mismatch between Cerest's infrastructure and the demands, and that it operates more in the host municipality[10].

With the current national context of productive restructuring or "euphemism for the precariousness and intensification of work" and the flexibilization of work relations, there is an increasing need for surveillance actions to make the relations of this world of work visible[25].

Another challenge encountered by the participants was the lack of feedback on notifications of accidents at work or illnesses made by PHC professionals, demonstrating the need felt by the team to know the outcomes of the notifications made.

> *We don't get a feedback on these notifications, you see. And since we don't have this feedback from these notifications, there's no way to work with statistics, there's no way to prepare or plan. When you work with Epidemiological Surveillance in the sense that you have to have the numbers and work on your actions based on those numbers, today we don't have them, we work blindly, right, in the municipality. There's no feedback on our actions, you know? How many notifications were recorded in 2019? Which institutions had the most notifications? What were the main damages? We don't have any of that, you know?"* (P1U).

Epidemiological data is important for establishing and directing health care actions[20]; however, the inefficiency of data management hinders the planning and prioritization of interventions and discourages health services from making new notifications, since there is no feedback from epidemiological surveillance, workers' health surveillance, or Cerest itself to the teams. A recent study shows that the municipality has been making progress in this context, aiming to draw up an epidemiological profile of workers, despite underreporting[23]. However, health professionals, health service managers, students, workers, and representative bodies (trade unions and

companies) see the fragility of the epidemiological information generated by underreporting as a limiting factor in strengthening occupational health actions in the municipality[10].

The limited opening hours of health units (from 7am to 5pm) was pointed out as a hindrance to workers' access to PHC services. Some participants reported that, for a while, some units were open at night to provide specific services to workers, but currently there are no PHC units with extended opening hours. The fact that the units are open during business hours makes it difficult for workers to access them, as they must be absent from work and submit a medical certificate to the company.

> *These extended hours were at least offered to those who really worked and needed them and didn't want to give a sick note because not everyone who wants to come for a routine appointment wants to give a note, right? If you look at it, if you think about it, a sick note is for someone who can't work that day, but a consultation that is scheduled, programmed, there would be no need, right?* (P17E).

The restriction on the opening hours of health units is a problem for the development of OH actions, since the period of service conflicts with the working hours of the vast majority of workers. It can also make it difficult to offer specific activities to this population, since some participants reported that the units have group activities, but none specifically for workers.

The participants considered the lack of health professionals to be a challenge for the development of OH actions, but also criticized the lack of initiative on the part of the teams and the absence of training actions in this field, a finding similar to that of a study carried out in the PHC of a municipality in Ceará[9].

> *We have a very limited number of staff here* [...] *so there's no way to sit down, discuss, work something out. So, if we had more people, we'd have more time, more people available, and I also think a little bit of goodwill, right? Because, in general, I don't see any interest among the workers here in doing this* (P4U).

> *It's the continuing education here that is sorely lacking in health. I don't know about abroad, but here there's no rhythm to continuing education, which is necessary, right?* (P4U).

The undersizing of PHC teams and the organization of health work can overload professionals, an aspect that is closely related to professional dissatisfaction[7], demotivation, and the possibility of illness[26], which can compromise the work process and other life activities. Managers' lack of knowledge about these problems hinders progress on the worker issue.

The majority of interviewees reported that there were no specific educational activities for occupational health care, as found in other studies[8,9] which may make it difficult to understand the user as a worker, showing that PHC's role in the development of OH in the SUS is still timid[27].

Strategies for strengthening OH care

As a strategy for strengthening OH in PHC, the participants valued health care networks; they recognized the need for Cerest to act as a supporter in the actions to be developed in health services to promote intra-sectoral coordination; they reinforced the need to develop continuing education actions and to (re)organize PHC for worker access

> *Few countries have these networks, right? I think it's very good, it should be more valued, much more valued by public bodies* (P8U).

> *From my point of view, I think it should be a little more flexible,* [that specialized OH services] *participate more here, work more in the field rather than just there* (P7U).

At the same time as the participants valued the organization of the health system into networks, they demonstrated a low level of knowledge about Renast, which is one of the major challenges to be overcome in order to incorporate the fabric that supports each network into their daily work in an articulated and stitched manner. The PNSTT[4] ratifies the importance of intra- and intersectoral communication for promoting networking, one of the obstacles to providing care to workers.

The lack of awareness of the existence of Cerest, which has technical staff specialized in OH for matrix support, indicates the urgent need to strengthen communication and dissemination between the different points that make up Renast, which would help to strengthen workers' health surveillance. An important means of change in the OH area is the matrix support provided by Cerest to other non-specialized health services, aimed at improving the quality of workers' health care in PHC and enabling networking[5]. The relationship between matrix support workers and matrix support workers benefits both parties[8] because, in addition to the personal and institutional gains, it enables work to be carried out in a more autonomous way and with increased knowledge in the area, since the matrix support worker is not obliged to know everything but must know the whole OH field[28].

In addition to intra-sectoral coordination, strengthening Renast presupposes building links with the community and acting on emerging problems in the area. Mapping health risks related to work requires the adoption and monitoring of epidemiological indicators that show trends and priorities for action. To do this, it is necessary to study the relationship between risks and illnesses, a move that requires, in addition to matrix support, the strengthening of information systems and continuing education.

> *It's training for all the professionals at the basic units or USFs and also better dissemination of the findings, of the forms* [...] *The forms are reported, and we send them to* [epidemiological] *surveillance, right?* (P1U).

> *The main strategy is to improve communication itself. I think communication and making it* [discussions about OH] *more routine, becoming part of our daily lives, without us having to look for it, it's already there, you know?* (P7U).

> *So, I think that perhaps some informative material could be sent via email or WhatsApp or even in physical form so that professionals are aware of the existence of programs and which patients would be assigned to these programs, and even so that we could better guide the population* (P2U).

The interviewees pointed out the importance of strengthening coordination with epidemiological surveillance to disseminate the data, as a subsidy for targeting actions, revealing the challenge and the need for cross-sector actions in the SUS network[27]. They also highlighted the need to train PHC teams and disseminate information material on OH to workers and users, initiatives that could be led by Cerest and would be important tools for improving workers' health surveillance[17].

Training network professionals to improve workers' health surveillance can arouse greater interest among health professionals in the subject[27]. To do this, it is essential that managers are familiar with the OH line of care in order to promote professional training strategies. In this sense, teaching-service integration can be an important ally, by providing spaces for exchange and learning, favoring the collective construction of knowledge[29].

The participants also proposed extending the opening hours of the PHC units to favor access by the worker-user.

> *Firstly, the issue of opening hours: I think there could be at least one unit in each sector of the city that goes until at least six o'clock in the afternoon* (P3U)

> *Look, I think it would be interesting if evening hours were brought back, right?* (P17E).

The units' opening hours compromise access to health services for those who work during the day and at weekends. Offering alternative opening hours expands the possibilities for workers to access the health system[9], a strategy that should be adopted by municipal management, in an orderly plan that includes different opening hours and units, to reach the entire working population and without increasing the teams' working hours.

Social distancing and the rearrangement of the way health units operate as a result of the COVID-19 pandemic have led to alternatives being put in place for the general population.

> *We're having the experience of telecare now, right? Because of the pandemic, we're not making as many visits anymore, so it's been good that there are people that I sometimes don't, most of the time I don't meet at home, but I end up being able to talk on my cell phone, so this experience is also interesting from that point of view, that we can at least get a little bit closer to this patient. I think that's interesting too* (P16E).

In addition to extending the opening hours of PHC units, telecare could be an important strategy inherited from the pandemic for providing care to workers, since it doesn't impact on the costs of hiring staff or infrastructure. This and other strategies should be analyzed and implemented by health managers to strengthen workers' health surveillance and the field of OH at the municipal level, which are so necessary for health promotion and comprehensive care.

Final considerations

This study made it possible to understand the knowledge and perspectives of health workers and identified both weaknesses and strategies for strengthening OH actions in municipal PHC.

Even more than 20 years after the creation of Renast, some weaknesses still persist, such as the lack of knowledge about public OH policies and the difficulty health professionals have in viewing PHC users as workers, showing little familiarity with this line of care and with the organization of the HCN in the municipality. Based on the findings, it can be said that the logic of the biological model still persists, centered on disease and with few health promotion and disease prevention actions in PHC, as well as the challenges in understanding the social determinants of health in the process of workers becoming ill. Other weaknesses pointed out by the participants are related to the lack of coordination at the different points in the network, the limited role of Cerest, and communication failures which contribute to the weakening of this line of care.

Despite the weaknesses highlighted, the participants pointed out some concrete strategies for strengthening OH in the municipality, such as getting to know/acknowledging Cerest as a supporter of activities in health services, strengthening intra-sectoral coordination (especially with Cerest and epidemiological surveillance); developing educational activities with PHC workers and users on issues related to OH; identifying the epidemiological profile of workers, based on notification forms; structuring PHC by extending the opening hours of the units.

The limitation of this study is that the data was not interpreted in the light of the different professional categories, which could have highlighted the different levels of knowledge among team members. However, it does advance knowledge in identifying that, even after the publication of OH policies at the national level, investments are still needed in different ways to consolidate and strengthen them at the municipal level, especially aimed at training PHC team professionals to understand, plan, and develop OH actions and programs. Investments are also needed to revitalize Cerest and train professionals in matrix support and strategies of workers' health surveillance.

It is hoped that the findings of this research will stimulate new studies aimed at investigating concrete actions that strengthen OH care from a municipal perspective, as well as exploring the organization of this line of care in health care networks.

References

1. Dalhlgren G, Whitehead M. Policies and strategies to promote social equity in health. Stockholm: Institute for Future Studies; 1991[cited 2023 Set 1]. Available from: https://www.researchgate.net/publication/5095964_Policies_and_strategies_to_promote_social_equity_in_health_Background_document_to_WHO_-_Strategy_paper_for_Europe
2. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Secretaria de Vigilância em Saúde. Saúde do trabalhador e da trabalhadora. Brasília, DF: Ministério da Saúde; 2018. (Cadernos de Atenção Básica, n. 41).

3. Ministério da Saúde (BR). Portaria no 2.728, de 11 de novembro de 2009. Dispõe sobre a Rede Nacional de Atenção Integral à Saúde do Trabalhador (RENAST) e dá outras providências. Brasília, DF: Ministério da Saúde; 2009[cited 2023 Apr 22]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2009/prt2728_11_11_2009.html

4. Ministério da Saúde (BR). Portaria nº 1.823 de 23 de agosto de 2012. Institui a Política Nacional de Saúde do Trabalhador e da Trabalhadora. Brasília, DF: Ministério da Saúde; 2012[cited 2023 Jan 25]. Available from: http://bibliotecadigital.economia.gov.br/handle/123456789/980

5. Lazarino MS, Silva TL, Dias EC. Apoio matricial como estratégia para o fortalecimento da saúde do trabalhador na atenção básica. Rev Bras Saude Ocup. 2019;44:e23. https://doi.org/10.1590/2317-6369000009318

6. Geraldi L, Miranda FM, Silva JA, Appenzeller S, Mininel VA. Competências profissionais para a atenção à saúde do trabalhador. Rev Bras Educ Med. 2022;46(2):e071. https://doi.org/10.1590/1981-5271v46.2-20210469

7. Silva FL, Lorenzi LJ, Bisetto LA, Belo LF, Gomes GAO, Mininel VA. Satisfação no trabalho de trabalhadores da Atenção Primária à Saúde: um estudo exploratório. REME - Rev Min Enferm. 2022; 26:e-1471. https://doi.org/10.35699/2316-9389.2022.37894

8. Souza Neto F, Bezerra OM. A saúde do trabalhador na Atenção Primária à Saúde: vivências em uma Unidade Básica de Saúde em Belo Horizonte, Minas Gerais. Rev APS. 2022;25 Supl 2:201-18. https://doi.org/10.34019/1809-8363.2022.v25.35043

9. Gonçalves AB, Cidade EC, Araujo AC. Saúde do trabalhador na Atenção Básica: (des)conhecimento, fragilidades e potencialidades segundo profissionais da Atenção Básica no município de Iguatu/CE. Conjecturas. 2022;22(2):1051-73. https://www.researchgate.net/publication/359492367_Saude_do_Trabalhador_na_Atencao_Basica_desconhecimento_fragilidades_e_potencialidades_segundo_profissionais_da_Atencao_Basica_no_municipio_de_IguatuCE

10. Cavinatto TJ, Santos LL, Moriguchi CS, Silva MF, Camarotto JA, Mininel VA. Fortalecimento da Rede Nacional de Atenção Integral à Saúde do Trabalhador pela mobilização social: relato de experiência. Rev Bras Saude Ocup. 2024;49:e1. https://doi.org/10.1590/2317-6369/04022pt2024v49e1

11. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007 Dec;19(6):349-57. https://doi.org/10.1093/intqhc/mzm042

12. Ministério da Saúde (BR). Conselho Nacional de Saúde. Resolução nº 603, de 8 de novembro de 2018. Brasília, DF: Ministério da Saúde; 2018 [cited 2023 Apr 1]. Available from: https://www.gov.br/conselho-nacional-de-saude/pt-br/acesso-a-informacao/legislacao/resolucoes/2018/resolucao-no-603.pdf/view

13. Minayo MCS. Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. Rev Pesq Qualitativa. 2017 abr; 5(7):1-12.

14. Fontanella BJ, Luchesi BM, Saidel MG, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad Saude Publica. 2011 Feb;27(2):388-94. https://doi.org/10.1590/S0102-311X2011000200020

15. Minayo MC. Desafio do conhecimento: pesquisa qualitativa em saúde. 14a ed. São Paulo: Hucitec; 2014. O desafio do conhecimento: pesquisa qualitativa em saúde; p. 208-9.

16. Barbosa AM, Neves R F, Martiniano CS, Brito GE, Lima MA. Concepções e práticas sobre a Saúde do Trabalhador para profissionais do Núcleo Ampliado de Saúde da Família e Atenção Básica. Interface (Botucatu). 2023;27:e220533. https://doi.org/10.1590/interface.220533

17. Mendes JM, Wünsch DS, Machado FS, Martins J, Giongo CR. Saúde do trabalhador: desafios na efetivação do direito à saúde. Argumentum. 2015;7(2):194. https://doi.org/10.18315/argumentum.v7i2.10349

18. Trapé CA, Narciso KR, Cordeiro L, Gaiotto EM. Estratégias de fortalecimento de saúde do trabalhador e da trabalhadora: a experiência de uma unidade básica de saúde. BIS. Boletim Do Instituto De Saúde. 2023;24(2):145-56. https://doi.org/10.52753/bis.v24i2.40174

19. Zinn GR, Lecca CG, Mira VL, Santos PT, Silva EM. Educação permanente em saúde como prática possível: uma experiência na atenção primária. Cienc Cuid Saude. 2022;21:e59584. https://doi.org/10.4025/ciencuidsaude.v21i0.59584

20. Cardoso LS, Cezar-Vaz MR. Elementos del proceso de comunicación em el trabajo de la red de salud del trabajador. Index Enferm. 2018 oct-dic;27(4):196-200.

21. Barros JO, Daldon MT, Rocha TO, Sznelwar LI, Lancman S. Intersetorialidade em saúde e trabalho no contexto atual brasileiro: utopia da realidade? Interface (Maynooth). 2020;24:1-14. https://doi.org/10.1590/interface.190303

22. Silva RD, Fonseca BM. A vigilância nos ambientes e processos de trabalho em Palmas – Tocantins: diagnóstico situacional e contribuições ao setor. Tempus Actas Saude Colet. 2018;11(2):199. https://doi.org/10.18569/tempus.v11i2.2236

23. Silva MF, Mieiro DB, Camarotto JA, Takahashi MA, Mininel VA. Vigilância em Saúde do Trabalhador na perspectiva de gestores e tomadores de decisão. Rev Bras Saude Ocup. 2023;48:e1. https://doi.org/10.1590/2317-6369/05221pt2023v48e1

24. Lancman S, Daldon MT, Jardim TA, Rocha TO, Barros JO. Workers' health intersectoriality: Old questions, new perspectives? Cienc Saude Colet. 2020; 25(10):4033-4044. https://doi.org/10.1590/1413-812320202510.27572018

25. Vasconcellos LC. Vigilância em saúde do trabalhador: decálogo para uma tomada de posição. Rev Bras Saude Ocup. '2018;43 suppl 1:1-9. https://doi.org/10.1590/2317-6369000029517

26. Faria MG, Silveira EA, Cabral GR, Silva RO, Daher DV, David HM. Saúde do trabalhador no contexto da estratégia de saúde da família: revisão integrativa de literatura. Esc Anna Nery Rev Enferm. 2020; 24(4):1-10. https://doi.org/10.1590/2177-9465-EAN-2020-0027

27. Camara EA, Belo MS, Peres F. Desafios e oportunidades para a formação em Saúde do Trabalhador na Atenção Básica à Saúde: subsídios para estratégias de intervenção. Rev Bras Saude Ocup. 2020;45:e10. https://doi.org/10.1590/2317-6369000009418

28. Navarro AP, Signorelli MC, Albuquerque GS. Apoio matricial na saúde do trabalhador no Paraná: potencialidades e desafios. Rev Bras Saude Ocup. 2020;45:1-9. https://doi.org/10.1590/2317-6369000002618

29. Ferreira L, Barbosa JS, Esposti CD, Cruz MM. Educação permanente em saúde na atenção primária: uma revisão integrativa da literatura. Saude Debate. 2019;43(120):223-39. https://doi.org/10.1590/0103-1104201912017

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