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Nurses' working environment in primary care: perceptions and repercussions on professional practice

Ambiente de trabalho de enfermeiros na atenção primária: percepções e repercussões na prática profissional

Entorno laboral de los enfermeros en la atención primaria: percepciones y repercusiones en la práctica profesional

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ABSTRACT

Objective: To understand the perceptions of primary health care nurses about their work environment and its repercussions on professional practice.

Method: An exploratory-descriptive qualitative study conducted between September and October 2024 with 16 primary health care nurses in Manaus. Data were collected through semi-structured interviews and subjected to Reflective Thematic Analysis, supported by Atlas.ti® software and grounded in the conceptual framework of Healthy Work Environment.
Results: The analysis identified five thematic axes: work environment and its conditions, which includes overload, inadequate infrastructure, and risks; dynamics of interpersonal relationships, covering leadership, conflicts, and communication; motivation and job satisfaction, encompassing recognition, purpose, and autonomy; worker health and well-being, which highlighted the absence of institutional policies and insufficient training regarding needs; and perception and experience of a healthy environment, including physical structure, organizational bonding, and psychosocial factors.
Final considerations: For a healthy environment, primary care nurses need organizational support and professional recognition. Although autonomy is limited by barriers, factors such as team collaboration and recognition mitigate the effects of work overload and poor infrastructure. Local actions such as safety protocols, psychosocial support, and reorganization of schedules stand out as strategies to strengthen the work environment.
Descriptors: Nurses; Primary Health Care; Work; Motivation; Interpersonal Relations.

RESUMO
Objetivo: Compreender as percepções dos enfermeiros da Atenção Primária à Saúde sobre o ambiente de trabalho e suas repercussões na prática profissional.
Método: Estudo qualitativo exploratório-descritivo, realizado entre setembro-outubro de 2024 com 16 enfermeiros da Atenção Primária à Saúde de Manaus. Os dados foram coletados por meio de entrevistas semiestruturadas e submetidos à Análise Temática Reflexiva, com apoio do software Atlas.ti® e sustentada pelo referencial conceitual de Ambiente de Trabalho Saudável.
Resultados: A análise identificou cinco eixos temáticos: ambiente de trabalho e suas condições, que inclui sobrecarga, infraestrutura inadequada e riscos; dinâmica das relações interpessoais, abrangendo liderança, conflitos e comunicação; motivação e satisfação profissional, envolvendo reconhecimento, propósito e autonomia; saúde do trabalhador e bem-estar, que destacou a ausência de políticas institucionais e capacitação insuficiente frente às necessidades; e percepção e vivência de um ambiente saudável, incluindo estrutura física, vínculo organizacional e fatores psicossociais.
Considerações Finais: Para um ambiente saudável, enfermeiros da Atenção Primária necessitam de suporte organizacional e valorização. Apesar da autonomia ser limitada por barreiras, fatores como colaboração da equipe e reconhecimento atenuam os efeitos da sobrecarga e da infraestrutura precária. Destacam-se ações locais como protocolos de segurança, apoio psicossocial e reorganização de agendas para fortalecer o ambiente laboral.
Descritores: Enfermeiros; Atenção Primária à Saúde; Trabalho; Motivação; Relações Interpessoais.

RESUMEN
Objetivo: Comprender las percepciones de los enfermeros de Atención Primaria de Salud sobre el entorno laboral y sus repercusiones en la práctica profesional.
Método: Estudio cualitativo exploratorio-descriptivo, realizado entre septiembre y octubre de 2024 con 16 enfermeros de Atención Primaria de Salud de Manas. Los datos se recopilaron mediante entrevistas semiestructuradas y se sometieron a un análisis temático reflexivo, con

el apoyo del software Atlas.ti® y respaldado por el marco conceptual del Entorno Laboral Saludable.
Resultados: El análisis identificó cinco ejes temáticos: el entorno laboral y sus condiciones, que incluye la sobrecarga, la infraestructura inadecuada y los riesgos; la dinámica de las relaciones interpersonales, que abarca el liderazgo, los conflictos y la comunicación; motivación y satisfacción profesional, que abarca el reconocimiento, el propósito y la autonomía; salud y bienestar del trabajador, que destacó la ausencia de políticas institucionales y la insuficiente capacitación frente a las necesidades; y percepción y experiencia de un entorno saludable, que incluye la estructura física, el vínculo organizacional y los factores psicosociales.
Consideraciones finales: Para lograr un entorno saludable, los enfermeros de atención primaria necesitan apoyo organizativo y reconocimiento. Aunque la autonomía se ve limitada por diversas barreras, factores como la colaboración del equipo y el reconocimiento atenúan los efectos de la sobrecarga y la precaria infraestructura. Destacan las medidas locales, como los protocolos de seguridad, el apoyo psicosocial y la reorganización de las agendas para fortalecer el entorno laboral.
Descriptores: Enfermeros; Atención Primaria de Salud; Trabajo; Motivación; Relaciones Interpersonales.

INTRODUCTION

The healthcare work environment constitutes an ecosystem that encompasses physical, social, emotional, and technical dimensions, with repercussions on the quality of care and the well-being of professionals[1]. In recent decades, this understanding has moved beyond a purely structural focus to incorporate organizational, relational, and subjective aspects that continuously interact with working conditions. This conceptual expansion shifts the focus to the dynamics of work in healthcare and to the factors that influence team performance, worker experience, and the repercussions on patient care[2].

This configuration, however, manifests unevenly in different professional realities. The context experienced by nurses presents disparities between countries and regions, influenced by socioeconomic conditions and specific public policies. In consolidated healthcare systems, adequate infrastructure, competitive salaries, and professional appreciation are observed; conversely, in less favored contexts, overcrowding, resource scarcity, and exhausting work shifts prevail[3]. In Brazil, this panorama is heterogeneous: reference institutions offer better conditions, while other units face a shortage of professionals, precarious infrastructure and excessive care demand, especially in the most vulnerable regions[4].

In the context of Primary Health Care (PHC), the challenges are intensified by the nature of the work, which requires greater interaction with the community and a longitudinal approach to patients. Recent studies show that most PHC nurses work in adverse conditions,

marked by work overload, insufficient material and human resources, and limited institutional support. These conditions compromise the physical and mental health of professionals, reduce the effectiveness of prevention and health promotion actions and negatively impact health indicators[5].

According to the World Health Organization (WHO), a Healthy Work Environment (HWE) is one that actively promotes the physical, mental and social well-being of workers, ensuring safe, dignified and motivating conditions. This concept transcends the mere absence of risks, involving the creation of a space that fosters comprehensive health, productivity, and satisfaction, through organizational practices aimed at reducing stress, preventing overload, and stimulating professional development. This framework integrates four dimensions — physical environment, psychosocial environment, personal health resources, and community involvement, which are articulated to a central component: ethics and values[6]. Although this conceptual framework dialogues with advances produced since the 1980s, such as the studies of Laurell and Noriega on workloads and the contributions of the psychodynamics of work, due to its global character requires critical and contextualized appropriations. From this perspective, the group of researchers associated with the present study proposed a conceptual expansion supported by two interconnected dimensions: the objective and the subjective[7-8].

The objective dimension includes components of Praxis, such as situational factors of real work (workforce, workloads, and material, human, and structural conditions), components of work organization (coordination, planning, leadership, and evaluation of personnel, technologies, and structures). The subjective dimension integrates the singular affective component (moral agency, motivation, recognition, and job satisfaction) and the ethical climate component. At the interface between both dimensions is the worker's health, understood as a result from the interaction between objective conditions and subjective experiences in daily professional life[7].

A central contribution of this approach lies in conceiving a healthy work environment as one that is favorable to care, promotes values, is ethically and aesthetically expressive, and is subjectively empowering, enabling professionals to realize, in their work practice, the values that underpin their profession and their moral choices, while mediating and promoting the expression of themselves as ethical subjects[7,9].

In line with this perspective, the concept of Positive Practice Environment (PPE) is a proposition of the International Council of Nurses, referring to contexts that strengthen professionals' commitment to the organization and the profession, enhance team well-being, and improve continuity, quality of care, and institutional outcomes. This concept has

informed several international studies, including the development of assessment instruments[10].

Despite these conceptual advances, recent transformations in health systems have been reshaping nurses' daily work. The growth of precarious employment, contractual flexibility, and work intensification due to administrative reforms and new management arrangements, especially after changes in funding, have altered the organization and dynamics of work[11].

These conditions become even more evident given the scarcity of region-specific analyses, particularly in the Northern Region of Brazil, where socioeconomic, logistical, and geographic factors decisively impact the configuration of work in health. These factors interfere with the distribution of resources, care organization, demand intensity, and the nurses' experiences in PHC[12]. In contexts of lower economic development, fragile employment relationships, high workload, and greater emotional strain are more frequent, with direct repercussions on organizational climate, motivation, safety of care, and the construction of healthy work environments[4,5,11].

Given this scenario, it becomes relevant to develop investigations that consider the particularities of work environments in PHC, considering their regional and contextual diversities, with a view to strengthening the work environment of nurses working in the Unified Health System (*Sistema Único de Saúde* - SUS). This study aims to understand the perceptions of PHC nurses about the work environment and its repercussions on professional practice.

METHOD

Exploratory-descriptive study, with a qualitative approach, conducted using the WHO's HWE conceptual framework, articulated with authors who expand this concept in the field of nursing[6-7]. The research report was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ).

The study was conducted in the health sector of the municipality of Manaus, capital of the state of Amazonas. The provision of primary healthcare services is the responsibility of the Municipal Health Department (*Secretaria Municipal de Saúde* - SEMSA), which is administratively organized into five Health Districts (DISA): North, East, West, South and Rural. The municipality has 288 Basic Health Units (BHU).

A total of working in the municipal primary health care network of Manaus participated in the study. Participants were selected by convenience sampling, including professionals from all Health Districts. Inclusion criteria comprised nurses with at least three

months of experience in the health unit. This period was considered adequate to allow integration into the service, familiarity with the work process, organizational demands, and established interpersonal relationships. Exclusion criteria included nurses who held exclusively management positions in the BHU, since the analytical focus of the study concerned professionals directly involved in care delivery and in the daily routine of PHC, whose experience allows a more faithful understanding of the repercussions of the work environment on professional practice.

Although the municipality has many nurses, the inclusion did not seek numerical representativeness, but rather a diversity of experiences capable of supporting the qualitative analysis. The number of participants was defined throughout the data collection and analysis process, being maintained when data saturation and inductive thematic analysis were reached, that is, when the interviews began to repeat patterns of meaning, without the introduction of new elements relevant to the analytical construction and confirmed during coding in the data analysis[13]. Even in the stages preceding the actual analysis (transcription and familiarization), theoretical recurrence was observed after the 14th interview, and two subsequent interviews were conducted for greater certainty. In the analytical process, from the 13th coded interview onwards, it was confirmed that no new codes and categories emerged, to consolidate the patterns already identified and achieve two types of saturation (inductive thematic and data), in two moments (collection and analysis), according to the adopted framework[13].

Participants were invited through an invitation letter sent via WhatsApp®, using contacts provided by the directors of the units and district managers after direct approach. Participant selection considered proportionality among districts and units, according to availability and institutional access. Data were collected by the principal researcher (a master's student in Nursing), who has prior experience in qualitative research methods and received training from the academic advisor and coordinator of the macroproject that integrates studies on the topic. Neither researcher had any institutional ties with the informants or conflicts of interest.

After professionals' acceptance, interviews were scheduled via WhatsApp®, according to participants' availability, ensuring that they were conducted at times that did not interfere with their work activities. Data collection took place between September and October 2024, through semi-structured interviews, conducted individually, in a private place located in the study setting.

During data collection, the study objectives were presented to participants, and the Informed Consent Form (ICF) was provided. There were no refusals or withdrawals. Afterwards, two instruments were presented: one aimed at characterizing the socioprofessional profile and another corresponding to the semi-structured interview guide, composed of six questions developed considering the HWE conceptual framework. These questions explored the assessment of the current environment, the essential elements for a healthy environment, strengths and weaknesses, difficulties and factors of motivation and demotivation, the perception of safety and the fulfillment of the worker's health needs, as well as possibilities or viable measures for improving the work environment. The interview script was previously tested with a nurse working in PHC, in a meeting held via Google Meet®, with the aim of evaluating the clarity, relevance, and ability of the questions to facilitate the highlight of elements related to the work environment and professional perspectives. This procedure allowed for minor adjustments in format, wording, and ordering of the topics.

The interviews were digitally recorded (audio), with an average duration of 20 minutes, and subsequently transcribed in full using the Google Docs® tool, without the need for repetition. The transcripts were imported into the Atlas.ti® software (version 8.0, Qualitative Research and Solutions, 2021) to assist in data analysis. Understanding of the material was guided by the precepts of Reflexive Thematic Analysis (RTA), and its interpretation was based on the framework of a healthy work environment. RTA is a way of organizing qualitative data, seeking to understand, in addition to individual themes, the relationship between them and how they are constructed through dialogue, being an iterative method, allowing transitions between stages for a deeper understanding of the data[14].

The RTA was conducted following the six phases proposed by Braun and Clarke[14]. initially, familiarization with the empirical material occurred during the transcription process and through repeated reading of the interviews, with initial notes, reflections, and analytical impressions recorded in the memo field of the Atlas.ti® software. In the second phase, initial coding was performed through the identification and extraction of meaningful elements related to the research problem. This process was supported by the HWE conceptual framework, which guided the identification, naming, and organization of analytical codes. This stage resulted in 19 codes and 200 coded excerpts. In the third phase, codes were organized and grouped based on semantic and conceptual convergence, generating six provisional themes. The fourth phase involved reviewing these themes in relation to the codes and the entire dataset, leading to the restructuring of some categories and refinement of thematic boundaries. In the fifth phase, themes were defined and named, culminating in five

final themes that express the analytical scope of the study, with their construction and delimitation guided by the HWE concept. The final phase consisted of producing the report presented in the results section, articulating interview excerpts, reflexive interpretation, and dialogue with the literature, supported by the theoretical framework to aid understanding and discussion of the findings. Additionally, other themes emerged during the research and were explored by the authors in a different analytical scope within a mixed-methods study.

As part of qualitative reflexivity, rigor and credibility were ensured through careful attention to the following aspects: documentation of the rationale underlying procedural and interpretative decisions to ensure analytical consistency; and confirmability, through monitoring potential researcher bias, beginning with transcription by the same researcher who conducted the interviews, and confirmation of coding and categorization by three researchers (triangulation and auditing, including review of the reflexive diary). Qualitative validity was achieved at the level of descriptive validity (faithfulness of representation through investigator triangulation, transparency, and respect for participants' expressions, as evidenced in the presentation of results with original excerpts in all categories) and interpretive validity, through low-inference description to accurately preserve participants' subjective perspectives, even when this required more detailed description and extensive use of quotations[16].

All ethical principles related to research involving human beings were respected, in compliance with the provisions of the Brazilian National Health Council Resolution No. 466/2012. Authorization to conduct the study was obtained from the Municipal Health Department of Manaus, and approval was granted by the Research Ethics Committee of the *Universidade Federal de Santa Catarina* under opinion No. 6.735.782 and CAAE: 77073224.4.0000.0121. All participants provided informed consent by signing the Informed Consent Form. To ensure anonymity, participants' statements are identified by the letter N (nurse), followed by a number corresponding to the order in which they were interviewed (1-16).

RESULTS

The study involved 16 participants, with a predominantly female profile (93.75%), and ages concentrated above 45 years (43.75%). Most professionals were married (37.5%), had 11–20 years since graduation (37.5%), and held a specialization degree (87.5%). Regarding employment type, temporary contracts predominated (62.5%). The most common salary range was 5 to 6 minimum wages (56.25%), and the prevailing weekly workload was 40

hours (81.25%). Most professionals were part of the Family Health team (FHT) (81.25%) (Table 1).

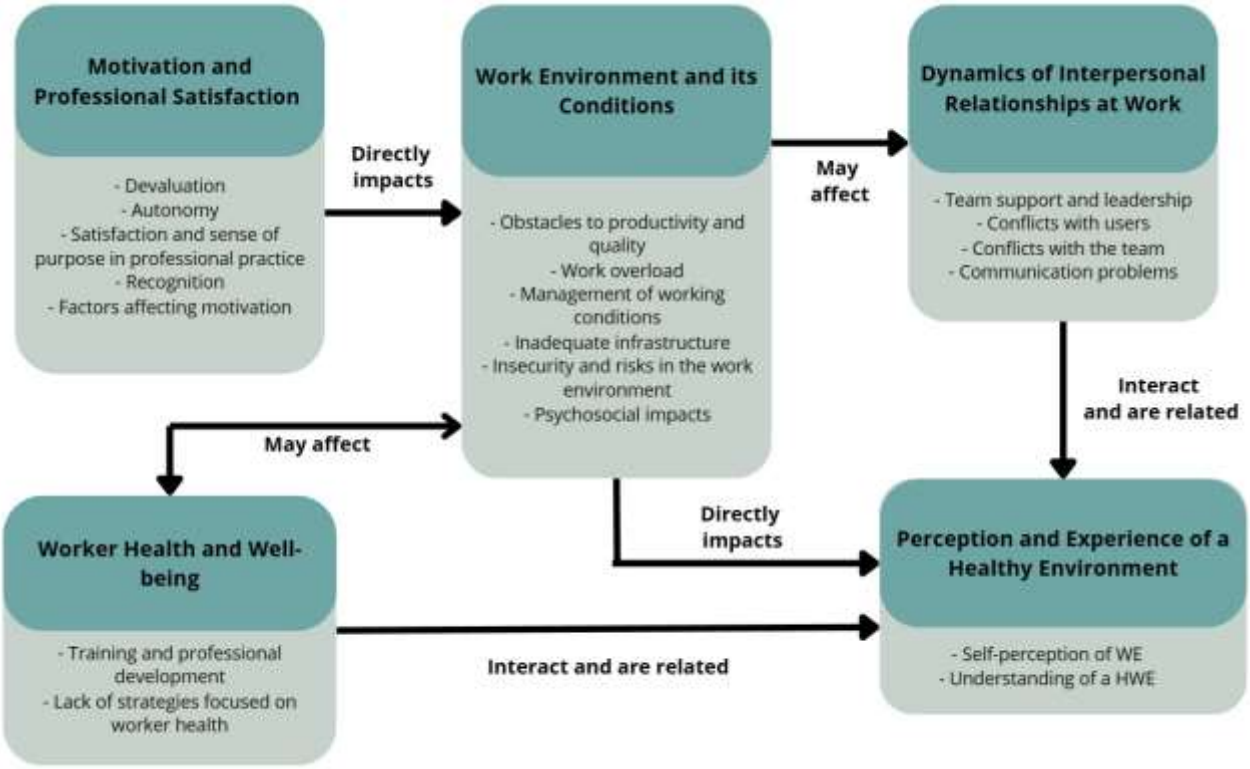
Table 1- Socioprofessional profile of nurses, Manaus, Amazonas, Brazil, 2024.

Variables	Definition	N	Percentage
Sex	Female	15	93.75%
	Male	1	6.25%
Age	26-35 years	4	25%
	36-45 years	4	25%
	Over 45 years	7	43.75%
Marital Status	Married	6	37.50%
	Stable union	2	12.50%
	Divorced	4	25%
	Single	4	25%
Time since graduation	1-10 years	5	31.25%
	11-20 years	6	37.50%
	Over 20 years	5	31.25%
Postgraduate studies	Specialization	14	87.50%
	Residency	2	12.50%
Type of contract	Temporary	10	62.50%
	Civil servant	6	37.50%
Salary range	3 to 4 minimum wages	3	18.75%
	5 to 6 minimum wages	9	56.25%
	7 to 8 minimum wages	4	25%
Time working in PHC	1-5 years	8	50%
	6-10 years	2	12.50%
	11-15 years	1	6.25%
	16-20 years	5	31.25%
Time in current institution	Less than 1 year	1	6.25%
	1-10 years	13	81.25%
	11-20 years	3	18.75%
	Over 20 years	1	6.25%
Weekly workload	20 hours	1	6.25%
	30 hours	2	12.50%

	40 hours	13	81.25%
Type of team	Primary Health Care Team (PHT)	3	18.75%
	Family Health Team (FHT)	13	81.25%

The study analysis identified five central themes reflecting professionals' perceptions of their work environment and the factors influencing their health and well-being, directly integrating with the components that affect or support professional practice. These themes represent the main concerns, strengths, and challenges faced by nurses and, through the themes, they interconnect and correlate, reflecting the complexity and interdependence of the factors that influence the work environment and professional practice in PHC (Figure 1).

Figure 1- Work environment of PHC nurses in Manaus and its multiple connections, Amazonas, Brazil, 2024



Source: Prepared by the authors, 2025.

Work Environment and its Conditions

The perception of the work environment is highlighted in the statements as an inherent aspect for the professional performance of nurses in PHC. Participants mentioned inadequate infrastructure, such as the lack of a permanent room for patient care and the poor maintenance of certain areas. Furthermore, the work overload due to parallel functions and the high patient demand represent barriers to the exercise of their duties.

> *Regarding the physical structure, I find it very inadequate, because we have two nurses in a single room, so many times we are in situations, for example, one attending prenatal care and the other doing COVID testing in the same room.* (N12)

> *I think we need more rooms. For example, I am here now and my colleague, who is the afternoon-shift nurse, has arrived. When he comes in and starts providing care from that time on, I can no longer see patients, because there is no room available*. (N4)

> *We had a problem because the teams were moved downstairs* […] *they were taken out of here precisely so that their room could be turned into a consultation room. And downstairs we had a series of problems with water infiltration, mold, and humidity*. (N1)

> [...] *Today a nurse works in the administrative area, provides patient care, works as a psychologist, works in the storeroom, as HR* [human resources], *does everything. So, my biggest difficulty is an overload of duties that is not appropriate for a nurse, and they have to do it for the BHU to function, in addition to the large number of users to attend to.* (N3)

Within this theme, the narratives showed that the psycho-emotional impacts experienced by Primary Health Care nurses are deeply linked to workplace conditions, highlighting emotional overload, stress, and the lack of adequate support to deal with these demands. Professionals reported the need to extend working hours and take on additional tasks due to colleagues' illness, which leads to physical and mental exhaustion. The pressure for productivity is pointed out as a demotivating and contributing factor to illness, leading to feelings of discouragement.

> *Uncertain schedules and having to extend them, how does that work? Sometimes we have to do extra work to be able to cover, to help colleagues too, many of whom also get ill, even due to stress, and sometimes we have to double the workload a little, and I'm the one who ends up with impaired mental health*. (N11)

> *This issue of management pressure and lack of understanding sometimes overwhelms us a lot* [...] *I attend to many users a day, I don't think there's a professional here who sees as much as I do. But I work, like, based on production* [actions and services performed]. *Production is more important than the colleague who's on the other end, or the user. That's a bit demotivating, I personally have already experienced burnout because of this excess.* (N12)

Workplace insecurity is highlighted by nurses as a constant source of fear and vulnerability, stemming from the lack of effective physical and material protection measures. Professionals report the absence of armed security guards, non-functioning cameras or cameras with blind spots, and units located in high-risk areas, which amplifies the sense of unprotection. Even when present, security personnel primarily focus on protecting property rather than people, leaving workers unsupported in conflict situations. This set of

vulnerabilities generates a widespread feeling of insecurity, affecting both the physical well-being and mental health of nurses, who remain exposed to risks without adequate institutional support.

> *Zero protection. Our BHU is in a very dangerous area. We are surrounded by drug trafficking, so we have no security. We have been robbed several times. So, I don't feel safe at all, including with the patients themselves.* (N9)

> *But the issue that could be improved is also installing cameras, which we don't have here, and there have been many cases where even the nurse's cell phone was stolen in the room, there aren't cameras in the hallway either. There's even a security guard here, but he's not here for the staff, for the people, only for the property*. (N12)

Dynamics of Interpersonal Relationships at Work

Interpersonal relationships are fundamental to the harmonious functioning of the work environment in PHC, involving interactions among colleagues, managers, and patients that rely on communication, collaboration, and proper conflict management. Reports indicate that disagreements are frequent and directly affect workplace dynamics, emerging from differences of opinion, competition for recognition, and communication failures. The lack of prior notice regarding absences also exacerbates tensions, creating additional workload for the present staff and contributing to feelings of frustration and burnout in daily team routines.

> *Sometimes I notice that there are some conflicts with colleagues from nursing and reception. There are situations where communication doesn't flow as it should, which ends up causing friction. There's a nursing colleague who loves to be absent, and sometimes I take care of his patients, I get tired and he doesn't inform anyone, it's frustrating* (N6)

> *I don't know if you've heard of "Previne Brasil." We have three strategies* [teams] *here. So some colleagues want to compete and always be in first place. And sometimes that gets in the way, it's demotivating, you know? Because, like, we try to do all the work correctly, inform the other team from a strategy that worked, but they don't tell us anything.* (N8)

Although the above reports present communication problems and conflicts, there are statements of support and collaboration among professionals. Trust, leadership support, and the ability to work as a team are positive aspects that contribute to a more harmonious and productive environment. Nurses seek to resolve these conflicts through meetings, such as weekly discussion circles, where they try to align expectations and find collective solutions to conflicts.

> *And to show that we need that sector, that we trust that collaborator, that the manager is important for the unit and that we need committed people to reach our goal. So, to reach our goal, it doesn't depend only on me as a nurse or a doctor, no. It depends on the team.* (N5)

> *So, there is the work schedule, there is a conversation, there are meetings, both as a team and separately by area, and then we bring everyone together, see the difficulties, see what we can improve in internal conflicts to deliver the best result.* (N3)

Conflicts with patients stand out due to the vulnerability of professionals in tense or aggressive situations. Reports of threats and shouting mainly arise from patients arriving dissatisfied or impatient. Although professionals try to resolve these situations peacefully, the narratives consistently indicate a need for more robust internal policies to protect the team and ensure a safe and respectful work environment.

> *Of course, we've also been threatened by a patient who came seeking the service, but there was no way to attend them, it was completely full; we could only do reception. But we are very vulnerable because if a conflict arises here, we are in the middle of it. Someone needs to organize this so we can feel safe*. (N2)

> *Like, some users are more impatient; sometimes a situation occurs where they leave dissatisfied, shouting.* (N4)

> *There's always someone who gets upset. There's always a patient who wants to hit the girls up front. There's always a patient whose appointment is scheduled, but they miss it and want to be seen on the day that's convenient for them*. (N13)

Motivation and Professional Satisfaction

In the Motivation and Professional Satisfaction domain, the reports highlight autonomy as a central factor for motivating PHC nurses. The freedom to make decisions, implement protocols, and manage teams is perceived as rewarding. Participants report feeling comfortable proposing strategies and conducting their activities in accordance with the guidelines of the Ministry of Health, which strengthens their confidence and engagement. Professionals emphasize the importance of a collaborative work environment, in which peer support and close management contribute to job satisfaction.

> *I feel very comfortable in my work environment, I have full autonomy to develop my work process, put forward my ideas, and implement my strategies to deliver quality work.* (N2)

> *For sure, I would say that what motivates me is the atmosphere among colleagues. Like, we really support each other. There's that team spirit, you know?* […] *Management also tries to stay close and listen to us* (N15)

Recognition emerges as a symbolic element for professional satisfaction. Statements of patients and managers who value the work performed reinforce a sense of purpose, motivation, and recognition. Community-based actions with positive feedback from users are seen as gratifying moments that reaffirm the importance of nurses' work in PHC.

> *We celebrated with them and did an action there. And we assisted 690 people. It's very gratifying when a user comes to you and says, "Nurse, thank you very much." Or "Nurse, today you really outdid yourself." That gives me purpose. (*N8)

> *They say, 'Look, I want to come back here just with you. I want to come here* [...] *I took two buses to get here, but I come because I was treated here.' The other day, a lady came here to say that in the exam collection room, the scheduling room, the woman called me princess. I already won my day today. So, that's satisfying. The manager finds out and comes to congratulate us.* (N7)

However, there are factors that affect motivation, including a range of structural and organizational challenges. The lack of adequate space for specific activities is mentioned as an obstacle that limits nurses' practice and affects motivation. The lack of materials and resources, combined with work overload and lack of time to adequately care for users, also contributes to demotivation.

> *What demotivates me is that we don't have an environment to develop our community lectures. We don't have space. I don't even suggest alternatives, because management doesn't accept them.* (N2)

> *And what really demotivates me sometimes is not having enough materials to do good work, to provide good care, not having qualified staff, not having a bit more time because of so many programs you have to work with, you end up falling short by reducing the time with the user, and that's very bad.* (N3)

> *What demotivates us is when a professional is absent. We have a shortage of professionals* […] *they arrive late or don't inform us, we can't plan ourselves, and it affects work organization* (N11)

In the thematic set, devaluation also emerges as a concerning factor that negatively impacts engagement and satisfaction among PHC professionals. The lack of recognition, both financially and for the work performed, is identified as one of the main sources of demotivation. Professionals report that even when they dedicate themselves intensely and achieve significant results, recognition is scarce or nonexistent, especially when minor shortcomings are overemphasized at the expense of their efforts.

> *This makes me very demotivated. And the lack of recognition. We are not recognized. You can do 99%, but if on a given day you do 1% less in something, you are worthless. Furthermore, our salaries do not represent all our work here* [BHU] (N4)

> *The biggest issue, I think, is the lack of recognition. We give our all, go beyond what we can, and it seems that no one values it, neither with thanks nor with rewards* [financial]. (N16)

Worker Health and Well-being

Regarding the lack of institutional strategies for worker health, a clear shortage of policies and programs aimed at the well-being and mental health of PHC nurses was evident. Workers highlighted the absence of regular initiatives for institutional support, psychological assistance, or emotional follow-up that could help them cope with daily pressures and challenges. It was noted that the only available alternatives are the use of the municipal health insurance plan or receiving care internally as users, which does not address the need for structured and preventive support.

> *There is no strategy. There has been no training or internal sector that supports worker health. It may exist, but it has never been presented to me* (N3)

> *We don't have any permanent program related to worker health. Unfortunately, it ends up being something very subjective* […] *the worker at the unit has two options: either they join the municipal health insurance plan to have external support, or within the unit they become just another user who will be attended* (N10)

Regarding Training and Professional Development, they highlight that, although there are training and capacity-building initiatives offered by senior management, there is a perception that participation also depends on the engagement/willingness of each worker. Professionals mention the completion of various training sessions throughout the year, many focused on specific programs, which contributes to updating and improving technical skills, however, many still do not meet the daily needs of nurses' work.

> *Look, we have access to several training opportunities throughout the year, with specific training for each program and more general training. These opportunities are important for updating knowledge and improving our professional practice. But I feel that, in some cases, these trainings could be more aligned with our real day-to-day needs.* (N1)

> *'m new, I've been here for a year, and there have been some occasional trainings that I attended. But, honestly, few professionals go. I've never seen it full, and it's not always mandatory.* (N8)

Perception and Experience of a Healthy Environment

Statements about the Perception of the Work Environment (WE) reveal a multifaceted view of PHC professionals about their workplace. On the one hand, there is recognition of positive aspects, such as the existence of committed teams, management support, and a sense

of belonging, which contribute to collaborative work. On the other hand, significant challenges are highlighted, some already mentioned in other themes, such as overcrowding, inadequate infrastructure, and work overload, which generate physical and emotional strain. Lack of physical space, the shared rooms, and the scarcity of materials are frequently mentioned as barriers that hinder organization and efficiency in care.

> *I assess it as an environment that presents both opportunities and challenges. On the one hand, we have a committed team, which contributes to a collaborative work climate, and we have a manager who supports us. On the other hand, we face problems such as poor infrastructure and patient overload at certain times.* (N10)

> *We face an absurd overload, especially during certain periods. There are so many people that it seems like there's no time to breathe. This is exhausting. Another thing that worries me is the physical space, the unit is too small for the number of professionals and patients we serve.* (N16)

The concept of HWE, in the perception of PHC professionals, is configured as a multidimensional construct that integrates three essential pillars: adequate physical conditions, psychosocial balance, and a health-promoting organizational structure. In addition, physical safety and availability of resources are mentioned as essential, but the human aspect is also emphasized, with a focus on humanization, freedom, empathy, and cooperation among colleagues and managers.

> *I think it's an environment where you feel safe to work, not just the physical environment, the infrastructure of the place, but a place where you can practice nursing freely, without harassment, without being coerced into doing anything you don't want to or shouldn't do.* (N1)

> *So, I understand a harmonious, humanized work environment* […] *it is a job of exchanging information, sharing what you are feeling, psychological support, good infrastructure, adequate materials, work without overload, without excessive demands.* (N3)

> *Where the Nurse can work effectively and being recognized for their work. Besides the physical environment, which is fundamental, because if it's hot, without materials, everything interferes with my care as a nurse. [...] I also think that cooperation among professionals and between the team and management is relevant for a healthy workplace.* (N12)

DISCUSSION

The socioprofessional results presented revealed a predominantly female profile, with a higher concentration of professionals aged 45 years and over, with specialization and length of professional experience between 1 and 5 years. These data are similar to those described in another study conducted in Brazil[16]. Most participants have temporary contracts, reflecting a

scenario that has become increasingly common in hiring practices across various health sectors, especially in PHC, where precarious employment relationships may negatively affect stability, the construction of a healthy work environment, continuity of care, and understanding of users' needs[11]. This characteristic, although observed in the Brazilian context, has also been evidenced in other countries, where labor flexibility processes and outsourcing directly influence the motivation and well-being of the nursing workforce in public systems[11,17].

The statements highlight structural deficiencies, such as a shortage of rooms, overcrowding and maintenance failures, which directly interfere with the organization of work and the privacy of care. These findings suggest that inadequate physical space is an operational obstacle and an element that redefines how nurses organize priorities, distribute time, and build compensation strategies in the continuity of care. In the international literature, poor physical conditions are understood as institutional stressors that tend to produce cumulative effects on nurses' health and performance, especially when they persist over time[2,5].

In this context, the need for improvisation and adaptation reveals a scenario of organizational difficulties that limit nurses' technical autonomy and pressure their ability to ensure safety and continuity of care. When articulating these findings with healthy work environment frameworks, it is observed that structural insufficiency weakens central dimensions of care, particularly those related to privacy, adequate patient flow, and the management of complex demands[6]. One study indicates that reorganizing work processes and optimizing existing spaces can mitigate these problems. However, such measures are recognized as palliative solutions, as they often generate adaptation difficulties for professionals, reinforcing the need for structural investments[18].

The structural and organizational elements previously described interact with the accumulation of tasks assigned to nurses in PHC and with the pressure to achieve institutional goals, producing psycho-emotional effects that are expressed in stress, exhaustion, and manifestations compatible with burnout. These findings reinforce the understanding that work environments marked by high demands and limited resources tend to intensify the daily tension that relates inadequate working conditions with increasing levels of psychological overload among nurses[19]. Research conducted in Portugal, Spain, and Brazil identifies that this process is associated with reduced empathy, weakened social interactions, and increased conflicts in professional and personal relationships[20]. It was observed that the overload is not restricted to the volume of activities, but is articulated with forms of work organization that

amplify the sense of individual responsibility, which helps explain the depth of the emotional effects reported.

These findings directly relate to the current evaluation and funding systems of PHC, which have reinforced the link between performance, goals and resource allocation. The pressure to meet indicators, such as monitoring chronic conditions, preventive actions and territorial registrations, falls significantly on nurses, contributing to the intensification of the workload and the perception of individual accountability for institutional goals[21].

The psycho-emotional repercussions identified are also related to the absence of minimum physical security conditions in health units. Participants reported episodes of assault, verbal aggression, and threats that generate feelings of vulnerability and fear. Studies highlight that unsafe environments tend to produce demotivation and can generate lasting psychological effects among health workers[4,22]. The interpretation of the statements suggests that recurrent insecurity reshapes how professionals perceive their daily work, giving rise to a constant state of vigilance and concern. The adoption of measures such as surveillance systems, training to manage violent situations, and strategies for organizing user flow is frequently cited as a possible way to reduce risks and strengthen the protection of nurses[22]. According to the WHO concept of HWE, the promotion of physical, mental and social well-being presupposes the existence of safe and dignified working conditions; therefore, the absence of minimum physical safety measures observed in this study compromises this principle and increases the psycho-emotional vulnerability of nurses in PHC[6].

The dynamics of interpersonal relationships also emerged as a structuring element of the nurses' experience. The reports indicated tension associated with competition for recognition, communication failures and poorly discussed hierarchies, aspects discussed in research in different international contexts that identify such factors as generating moral distress, difficulty in coordinating care and service and declines in organizational engagement[23,24]. These aspects comprise and integrate the subjective dimension of a healthy work environment, especially in the components related to interpersonal relationships, communication, cooperation, and the construction of moral agency, elements that shape how professionals attribute meaning, value, and ethical commitment to their practices in PHC[7].

At the same time, episodes of cooperation and mutual support were described as strengthening motivation and work cohesion. The literature emphasizes that positive relationships reduce occupational stress and foster more collaborative and productive environments. Conflict mediation can stimulate shared problem-solving, although it depends on institutional practices that value communication and promote co-responsibility in care[24].

Among the aspects that shape the daily lives of nurses, perceptions related to autonomy in care and institutional recognition stand out, both of which contribute to the motivation and engagement of nurses. Reports show that the ability to make clinical and managerial decisions promotes a sense of competence and satisfaction, in line with studies that define autonomy as a structuring component of professional work[25]. The analysis indicates that this autonomy is exercised unevenly, as it depends on institutional conditions that do not always guarantee technical and management support or legitimacy to the nurse's decisions. At the same time, the perception of low valuation, whether financial or symbolic, was described as a demotivating factor, which reinforces premises of the healthy work environment framework that include adequate remuneration, participation in decisions and shared organization of the work process[6,11].

The absence of institutional strategies focused on workers' health appeared as a critical element of the nurses' experiences. The reports indicate insufficient emotional and psychological support actions, which contributes to feelings of helplessness in the face of the growing demands of PHC. Within the adopted framework, worker health constitutes one of the integrating axes of a healthy work environment, articulating objective working conditions and subjective experiences, so that the absence of institutional strategies weakens this integration and compromises the promotion of professional well-being[7].

In this sense, interventions aimed at developing socio-emotional competencies, integrative practices, and psychological support may mitigate harm to mental health and strengthen bonds and communication within teams[26]. In the present study, the recurrence of these reports suggests that the lack of support prolongs professionals' exposure to situations of strain, contributing to the worsening of symptoms such as exhaustion and demotivation. International evidence indicates that the failure to implement structured well-being programs favors the emergence of occupational illnesses, depression, absenteeism, and staff turnover in healthcare services[27,28], which reinforces the relevance of the concerns reported by the participants.

Training and professional development were cited as existing practices, although insufficient to meet nurses' everyday needs. Studies indicate that continuing education promotes technical updating and improves the quality of care[29]. However, participants reported that the initiatives offered do not keep pace with the real demands of the work process and lack regularity and alignment with care needs. National and international investigations describe similar challenges, highlighting that inconsistency and a disconnect between training content and service practices tend to limit the impact of educational

actions[30-31]. In this context, the findings suggest that the fragility of training strategies increases the perception of distance between management and the concrete demands of work, hindering the strengthening of professional competencies and team functioning.

Nurses' understanding of a healthy work environment articulated physical, organizational and relational dimensions, in line with international and national frameworks[1,5]. Participants highlighted the relevance of physical safety, infrastructure and basic resources, but also emphasized human aspects such as empathy, collaboration and recognition from colleagues and managers. Healthy environments depend on the existence of articulated teams and relationships based on mutual support, professional appreciation and material availability, elements also observed in the study with nurses in the United States[32]. hese similarities suggest that, even in distinct contexts, the construction of favorable work environments remains linked to the integration of adequate structural conditions and work practices that promote cooperation and professional recognition.

As practical contributions, the study highlights the need for investments in physical infrastructure and adequate equipment; the implementation of occupational safety policies and worker health programs; and professional valorization through the active involvement of nurses in decision-making processes. Furthermore, as it was conducted in PHC services in a capital city in Brazil's Northern Region, the study incorporates a territorial dimension by demonstrating how the socioeconomic, structural, and organizational specificities of this context influence the work environment, in accordance with the objective of understanding nurses' work experiences in the region. These measures, aligned with the local characteristics of PHC, have the potential to foster a healthier work environment and improve the quality of care within the SUS.

Regarding the study's limitations, it should be noted that it was conducted in a single municipality in the Northern Region, which restricts the diversity of possible perspectives, considering that different organizational and territorial contexts may produce distinct experiences in the PHC work environment. Furthermore, it was not possible to return the transcribed interviews to participants for verification and confirmation due to limitations in the study timeline.

FINAL CONSIDERATIONS

The research revealed that for PHC, a healthy work environment involves physical conditions, collaborative interpersonal relationships, organizational support, and professional recognition. It was observed that autonomy in decision-making is expressed primarily in care

management, in defining care priorities, in organizing patient flow, and in planning team actions, even if limited by structural barriers.

From an analytical perspective, the findings showed that infrastructural weaknesses, work overload, and physical insecurity do not operate in isolation but rather interact and amplify their effects, with repercussions on psycho-emotional well-being, teamwork, and the quality of care. This interaction between physical, organizational, and psycho-emotional factors deepens burnout and undermines nurses' work. Conversely, collaboration among colleagues, training initiatives, and managerial recognition emerge as protective elements capable of minimizing the adversities experienced.

The findings reinforce the need for managers to adopt concrete and locally applicable measures aimed at strengthening the working conditions of nurses. Among these actions stand out the implementation of minimum institutional safety protocols within health units, the creation of municipal psychosocial support programs specifically targeted at nursing professionals, and the organization of collaborative schedules that allow for a more balanced distribution of workload among nurses. The exclusive focus on nurses represents a deliberate analytical approach, consistent with the established objective. Nevertheless, it is understood that this perspective may be strengthened in future investigations that incorporate other PHC health professionals.

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