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Articles

Conceptions and practices on Worker Health for professionals of the Expanded Core for Family Health and Primary Care

Concepções e práticas sobre a Saúde do Trabalhador para profissionais do Núcleo Ampliado de Saúde da Família e Atenção Básica (resumo: p. 15)

Concepciones y prácticas sobre la Salud del Trabajador para profesionales del Núcleo Ampliado de Salud de la Familia y Atención Básica (resumen: p. 15)

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Abstract

The study aimed to understand the meanings attributed to Worker's Health (WH) by health professionals of the Expanded Core for Family Health and Primary Care (Nasf-AB in the Portuguese acronym), as well as its consequences in the production of care in PHC. Interviews with 13 professionals from different areas were analyzed based on Discourse Analysis. Meanings of work as a generator of diseases and those related to the Social Determinants of Health (SDH) emerged. Through the actions of Nasf-AB on work/worker, it was possible to see how this team works as a filter of the tensions produced by users, family health teams and management. The discourse of work as a producer of diseases is still predominant; however, the perception of work as SDH produces openings for these professionals to act in the expanded clinic as reference technicians in WH.

Keywords: Occupational health. Primary health care. Health personnel. Qualitative research. Discourse.

Introduction

In Brazil, the Surveillance of Worker's Health (VISAT) has been an integral part of the Brazilian National Health System (SUS) since its creation in the 1990s. It is responsible for guaranteeing assistance, surveillance, information, research, and popular participation of workers throughout the national territory[1]. Since then, the field of Workers' Health (WH) has experienced improvements and expansions, such as the creation of the National Network for Integral Care of Workers' Health (RENAST) in 2002, and the publication of the National Policy for Workers' Health (PNSTT) in 2012[2].

The PNSTT, in particular, considers the transversality of the WH field and the view of work as a Social Determinant of Health (SDH). Among its strategies, the PNSTT points to the importance of care for users-workers in the sphere of Primary Health Care (PHC), given its proximity to the territories where individuals live and work, representing their first contact with health services and allowing a longitudinal follow-up. Thus, it organizes and coordinates the flows throughout the health network, something that favors the attention and management of care to the working population in SUS[2].

Additionally, the Expanded Core for Family Health and Primary Care (Nasf-AB), established in 2008, aims to expand the resolutive capacity of PHC in the country through technical-pedagogical and clinical-support offered by a team of specialists to PHC generalist teams[3]. Thus, the Family Health Teams (FHT) supported by Nasf-AB should be prepared to recognize their work as part of SDH and include this knowledge in the development of promotion, protection, surveillance, care, and rehabilitation actions of the user-worker in the area covered by the teams of the Family Health Strategy (FHS)[4].

However, despite being immersed in complex relations of work-health-disease and environment in the territories where they work, PHC teams have difficulties that put boundaries to their practices focused on WH. Among them we. Should highlight: the teams' work overload, the turnover and fragility and/or precariousness of the links in the work contracts, the preponderance of local political interests over the real health needs of the population, the fragility of RENAST, the prioritization of other programs, the professional inexperience associated with the lack of recognition of the problems arising from the work-health-disease relationship, and, above all, the deficiency in training and technical support in WH[4-6].

Nasf-AB, as a strategic supporter of FHS, is responsible for providing clinical, health, and educational support in WH[4]. However, studies show that the support of Nasf-AB towards FHS, either does not cover the WH or does not happen with the expected frequency, revealing an incipient performance of Nasf-AB on issues related to WH[7,8].

If, on the one hand, the diversity of areas of knowledge of the professional categories encompassed by the Nasf-AB foster the interprofessional elaboration of actions aimed at workers in PHC territories[9], on the other hand, the different conceptions and meanings that each professional attributes to WH can be barriers to the articulation and growth of these actions[10,11].

Considering that WH in this context is recent as a health policy and, consequently, its actions may also be unknown by health professionals, the following question is raised: what are the meanings and senses produced by the discourses of Nasf-AB professionals about their conceptions and practices of WH in PHC? It is also known that these elements can help in the development of planning and training strategies that allow the effectiveness of comprehensive care to the user-worker in PHC territories. In view of this, this study aimed to understand the meanings attributed to WH by health professionals of Nasf-AB, as well as its developments in the production of care in PHC.

Methods

This is an exploratory qualitative study[12], in which the theoretical and methodological perspective adopted was the French Discourse Analysis, since it relied on what was said in the discourse to understand how the meaning of words is historically constructed and expresses ideological positions, working the relationship language-discourse-ideology[13].

The research setting consisted of three municipalities in the 9th Health Region of the state of Paraíba, in which 13 health professionals had been part of the Nasf-AB Teams (EqNasf-AB) for more than a year and did not hold positions such as management, leadership, or trust. The sample size was defined by the criteria of theoretical saturation[14].

Data collection occurred between November 2018 and February 2019, through the semistructured interview technique[15], based on a pre-structured script and audio recordings, later transcribed to digital media. The transcribed fragments of the speeches were identified by the initials according to the professional category and followed by cardinal numbers according to the interview order.

Data were analyzed by applying three heuristic questions proposed by Souza[16]: "1) What is the concept-analysis present in the text? 2) How does the text construct the concept-analysis? 3) To which discourse belongs the concept-analysis constructed in the way the text constructs?" (p. 21).

First, floating reading of the material was conducted, and then analytical reading with application of the first heuristic question. This was followed by the second question, which generated the constitutive meanings of the concept-analysis and, finally, by the third question, which made it possible to understand the meanings that this concept brings to local practices.

The meanings that comprised these constructs emerged from the textual marks: paraphrase (what is maintained); polysemy (displacement); metaphor (transference); relation of saying and not saying (silence); and modalizations (softening). Furthermore, the conditions of production that represent the context of elaboration of the speeches[13].

The research was cleared by the Research Ethics Committee, according to the consolidated opinion no. 2.677.650. The participants were informed that there would

be measures to protect their identity, in order to reduce the risks of non-anonymity (retaliation, persecution), and that the material collected would be used exclusively for research purposes.

Results

Conditions of Production

The 13 health professionals represented five Nasf-AB teams (EqNasf-AB) of the 9th Health Region of the state of Paraíba, whose categories reflected the local health need[17]: social worker; physical therapist; speech therapist; nutritionist; and psychologist. Seven were female and six were male, with a minimum age of 25 and a maximum age of 58.

The time since graduation ranged from two to 31 years, and nine participants had graduated from private institutions. Regarding post-graduation, six had it in areas related to public health; five in areas related to clinical specialties; three in areas related to public management; one in areas associated with law; four in mental health; and one in teaching.

Regarding the time of work in Nasf-AB, there was a variation of one year and eight months to approximately seven years during the data collection period. However, in relation to previous occupational experiences, there were works in the fields of commerce and services, such as sales, teaching, and public sector (social assistance, mental health, and health surveillance); and in industries.

Regarding the loco-regional characteristics where the speeches were produced, the Nasf-AB workers recognize themselves as follows: "[...] we work in the *Sertão Paraibano*" (Fi1). This fragment expresses other speeches that denote the identification of the worker with this scenario. It is argued here that the place from which the subjects speak is constitutive of what they say[13]. So, it is a region of the Caatinga biome, with semi-arid climate, little rainfall, vegetation with few leaves and adapted to dry periods. This image is associated with a poor and dry place, whose local productive activities are characterized by the use of manual labor for the production of goods and services, as well as for the reproduction of life[18].

The landscape can influence the way discourses are produced, since discourse is not only what is said, but the relationship with the context of its elaboration, producing meanings. Thus, the conditions of production can have a strict meaning, related to the aspects of speech enunciation, or a broad meaning, based on socio-historical and ideological aspects[13].

Thus, the analyzed speeches generated the concept-analysis "Worker's Health", which was built based on two meanings: 1) the work-health-disease relationship, and 2) which worker?

The work-health-disease relationship

Work as a generator of illnesses and accidents

In search of understanding the meanings attributed to work by Nasf-AB professionals, it was observed that the textual marks built the concept-analysis evidencing work as a "generator of illnesses":

> [...] [workers] adopt... habits, wrong postures, work with loads, exacerbated weights, which develop a series of osteo-muscular complications. (Fi1)

> the issue of work overload [...] this ends up affecting, whether it wants to or not, health, right? [...] this process of worker's illness. (As2)

> in the workplace, we also notice in relation to other diseases [...] overweight [...] muscular distention. (Nu1)

The injuries whose causal link is probably linked to gestural movement, which, for being badly executed, is expressed in the words: "wrong", "exacerbated", "overload", "too much", "extensive". In this way, the meanings of the speeches are based on the aspects that highlight the work due to the conditions under which it is performed and as a cause of diseases.

The speech of Nasf-AB professionals also revealed meanings about the work-health-disease relationship in the normalizing/auditing perspective of the work environment:

> [...] in ((certain city)) even happened an accident due to lack of equipment, who was working in construction and then hit a wire and the man died [...]. (Fo1)

> here is a small town, they do construction, they don't use é... protection, work accidents always happen [...] As here there is nothing é... inspection, there is nothing [...]. (Nu2)

> in our region we have many people that depend on work, like farmers, others in construction services, that don't really have the proper regulation, nor the use of PPE, and don't really have the proper monitoring. (Fi1)

The use of the words "materials," "equipment," "investment," "protector," and "PPEs" refer to the use of Personal Protective Equipment (PPEs), which are brought up by the subjects with negative intonations, that is, highlighting their lack. The words "supervision", "regulation", "monitoring", and "support" referred to a specialized rearguard in occupational health and safety to ensure the proper supervision in these environments. Such measures are necessary for the prevention of accidents related to the work environment. It can be seen, then, that this is a discourse that sees the work as "accident generator" and that needs punctual interventions on the most evident health risks.

The condition of where they speak from is brought up in these speeches reinforcing that, because they are small municipalities at a distance from the capital, work accidents occur due to an omission to the health of these workers, as denounced by Nasf-AB professionals. By the "not said", it is possible to infer that these subjects reveal that, in other places, this can be minimized by the possibility of having an effective and specialized rearguard supervising the work environments.

Work as a Social Determinant of Health

In the speeches, meanings of recognition of work as a SDH were produced:

> [...] before we used to, when we talked about health, we had an idea that health was the total absence of disease, right? And... through the studies, the information, the access, there is a lot of knowledge, we see that it is not only that! It is not only the absence of disease that characterizes health, right? It's a whole context, right? [...] that favors well-being, in this professional's relationship with work, and sometimes there is a process of vulnerability that interferes in this process of health and disease [...]. (Ps3)

> [...] the issue of work, and... and that is directly linked to the way, for example, the way you work, "or do not work", will imply [...] in your health status, it may even imply some, some diseases too [...]. (As1)

Subject Ps3 denotes that the work-health-disease relationship is marked by the biologist discursive memory and by the notion of health, captained by the World Health Organization. Such conceptions were used here not only to conceptualize health, because it is paraphrased that health "is not just that!", it depends on a "context" and work is brought to compose this relationship, in some situations as a generator of well-being (health) and in others as a source of vulnerability (disease). Moreover, when subject As1 says the "way you work, or 'don't work'", it shows that it is not only the fact of working that implies the health-disease process, but also that of not working, since other determinants can interfere in this process arising from the fact of not having a job.

The conditions of production "training" and "professional experience", here, expose meanings, since social workers and some psychologists ended up producing a discourse with this broader view on the health-disease process. The other professions still maintain the discourse with an emphasis on the cause-effect within the perspective of the clinic, of mechanicism, and of getting sick.

Which worker?

Workers in the territory: about seeing and not being able to see

The subjects point out the recognition of workers in health care, through the textual marks:

> In this issue of worker's health. [...] in the commerce there, with the teachers and with the health workers themselves, in primary care. (Fi4).

> [...] this one who spoke was a bricklayer, and he said he had to go up and down and ((sigh)) on the one hand he felt tired because of smoking, and if he stopped smoking, he would be afraid of getting fat, and to go up and down the stairs? (Nu2)

> [...] we are assisting several workers, from several companies, who come from abroad, from... people who are travelers, who work... selling from door to door, so our relationship with these people is very wide. (Ps3)

> The demands that come to me, that most people, unfortunately, are those that 'don't have a job' right?! (As1)

In the speeches, workers from several segments are mentioned: "farmer", "bricklayer", "teacher", "health professional", "public servant", "merchant", "street vendor", "self-employed", besides the subject "without work". From this angle, work is pointed as a producer of demands for the Nasf-AB, exemplified in occupations that represent the formal and informal sectors of the economy, as well as those who do not have a job.

However, other marks construct that the user-worker is still invisible in the eyes of Nasf-AB professionals, as the subjects report not receiving demands from WH, while citing cases already attended:

> [...] she reports to me that she doesn't like the work, she is not satisfied at work, but it is logical that it is not the work that is the condition for her to have gained, [...] but that it is the work that is the condition for triggering in the health, as occurs perhaps in an unhealthy environment is mold, that is, physical, chemical, microbiological conditions, I never attended. (Nu2)

> It is not that we do not receive it, right? It's like this, maybe we even get it, but [...] the professional that makes the referral can't identify that that... that disease is related to the patient's work, right? (Fi2)

Thus, there is a discursive dichotomy, in which the subjects assist workers, but cannot identify them as WH, exactly because this demand comes to Nasf-AB with other specifications: "stress", "depression", "stroke", "overweight" and not "work-related disease" or "in the work environment".

The kind of care provided to workers by Nasf-AB: an assistance-specialized care

Since the speech of Nasf-AB professionals is dichotomous, textual marks construct how this care is offered to workers when the demand is identified as WH:

> [...] we identify [...] what profession he really has, so we can see if there is a correlation with the condition he presents, from then on [...] he will be oriented beforehand to the removal, or reduction of these activities, or correction of postural habits, or finally, it is... so that he does not need to abandon this post, this work. (Fi1)

> when there is a demand, which is very rare to be diagnosed, which is usually work-related disease, we go and give orientation at home. (Fi2)

> [...] I do anamnesis, evaluation and treatment, CLINICAL, and see if he is being followed up by other professionals, if not, I also make the referral! (Fo1)

It is evident that Nasf-AB professionals, in caring for the worker, perform care activities (outpatient and home care), educational activities and intra/intersectoral referrals. However, even though some activities are developed in a shared way among the professionals of EqNasf-AB, an emphasis is given to the individual work performed by the specialists that make up the teams, showing fragmentation in the work process.

Due to the focus on the specialty of Nasf-AB health professionals, hegemonically, care activities, especially rehabilitation activities, are overlapped with health promotion and prevention. When a more integral view of the work is identified, it has to do with a discourse production that goes through the purposes of academic training and previous professional experience with emphasis on the social, as observed in the speech of subject Ps3:

> [...] we went to care for her, she had suicidal ideation, right? So, it was a big concern, we did all the monitoring, [...] besides CAPS [Psychosocial Care Center] we referred her to some courses that the city also offers, sewing course, and we also referred her to a painting course, and today [...] this person is already ordering products, right? (Ps3)

Thus, the meanings produced in the discourse above are of the offer of integral care to the user-worker who didn't have a job, whose occupation gave a new meaning to himself, impacting positively on his state of health and well-being.

The silences in the speech of Nasf-AB also speak volumes about this care offered. Firstly, the integration between Nasf-AB and FHS in the development of WH actions is silenced, in which we see a wall between teams that, through some gaps, allows an exchange about WH, especially when it comes to the health demand of the workers of the FHS itself. Secondly, aspects concerning VISAT are silenced, testifying possible absence of knowledge or effective action of it in this territory.

The Nasf-AB worker

By assuming the position of workers, NASF-AB professionals revealed that they are also subject to health problems, just like others:

> In NASF [...] we go through stressful situations at work, [...] and it can even trigger some kind of disorder or some kind of disease. (Ps1)
>
> how can I take care of other people's health if I'm not taking care of mine? (As1)
>
> [the State] Gives conditions, more conditions for the health worker, to take care of the worker out there, but also conditions for the health caregivers themselves, to be taken care of. (As2)

The Nasf-AB worker reactivates the issue of technical back-up for workers in this health region, with emphasis on their work context. In the speech of subject As2, there is a responsibility imposed on the State for the support for Nasf-AB professionals to develop actions in WH. At the same time, means must be provided so that this health worker is also the target of WH actions: "the care of the caregiver" (As2).

Discussion

The speeches regarding WH in this study revealed the hegemony of the idea of work as a generator of diseases and accidents, which may hinder the adoption of other actions in terms of WH. However, in a marginal way, it is also possible to notice the emergence of the notion of work within the context of SDH, still influenced by the specificity of the core training of some professionals of Nasf-AB more linked to the humanities and social sciences. It was also pointed out, in the discourse on the workers, that the professionals of Nasf-AB, on the one hand, recognize themselves as workers of the territory and perceive the insufficiency of assistance to deal with the problems of WH, and, on the other, denounce the pressure to provide assistance and complain about the lack of technical support and supervision, which would enhance the actions of WH promotion and surveillance in the PHC territory.

The predominant influence of assistance care in the speeches of Nasf-AB professionals here is explained, in part, by three distinct forces that affect and shape their practices in terms of: 1) the force of individual user demand, primarily seeking clinical and rehabilitative assistance; 2) the strength of the eSF, which does not share with Nasf-AB the provision of care to user-workers, but requires from these professionals clinical and specialized approaches; and 3) the force of management, which does not provide means for the specialized care network to strengthen and fulfill its role, allowing the development of WH actions in PHC.

Regarding the meanings produced about work and workers, the discourses are based on two Health Care Models: Biopsychosocial and Biomedical. While the first one is concerned with identifying factors that lead people to get sick, as determinants in which one can intervene with health promotion and prevention, the second one still shares the mechanistic view of the human being, focused on the disease/injury with specific interventions[19].

Considering the role of Nasf-AB in the transformation of health practices in PHC in order to cause changes in the health care model[20,21], the conceptions about work-

health-disease identified in the discourse of professionals are pointed out as barriers to the performance of their activities[22,23]. Still, it is necessary that Nasf-AB professionals recognize themselves as agents of this process, i.e., professionals capable of reflecting on their professional identities to review the limits and possibilities of their practices[24].

In the constitution of the professional identity of the "Nasf-AB worker", it is possible to notice that the influences of their own training and professional experience, as well as the work context, imply in the way health professionals talk about WH in PHC.

With respect to education and experience, the discourse brought them as the guiding axis of the conceptions attributed to the work within the work-health-disease triad that also impact the development of the Nasf-AB practice - for some, focused on fragmented care (biomedical), and for others, on integral care (biopsychosocial)[6].

Regarding the work context, it was observed in the discourse of the subjects the notion of territory, because they highlighted the peculiarities of the world of work in the scenario where they perform their work activities, pointing it as a generator of illnesses and accidents that require from Nasf-AB specialized timely interventions, predominantly clinical-assistance, and that the lack of technical-pedagogical support does not allow the expansion of these options[4,11]. With this, the Nasf-AB professionals have trouble to see the "workers" as "users" of the health service, being assisted from several other perspectives and invisible as workers[5,10]. Thus, the work performed at Nasf-AB tends to value more the heterogeneous multiprofessional action, focused on the specific fields of different professions, to the detriment of interprofessional collaboration, which values the proactive integration between knowledge and practices of each nucleus for decision making, in order to overcome a fragmented action[25].

Resistance to the interprofessional proposal in health care is strongly linked to positivist and biocentric traditions and the disciplinary knowledge-power relationship that locks up knowledge in compartments aimed at training specialists[26]. Moreover, when analyzing the configurations of Nasf-AB teams and their performance, Nascimento *et al*.[21] recognized three types of EqNasf-AB based on the matrix support as a work methodology recommended by the Ministry of Health: care-curative EqNasf - represents only an access to the specialist professional nuclei; semi-matrix EqNasf - prioritizes individual activities over joint ones; and matrix EqNasf - approaches the proposal of matrix support to the FHS.

From this perspective, the tensions established on the Nasf-AB in the study scenario bring it closer to the semi-matrix EqNasf-AB configuration, because, even if other actions are developed, the focus of the work falls on the individual care-specialized[21] practice, encouraged and charged by a management that does not offer mechanisms and back-up for the necessary inspection and surveillance; FHS teams that refer and require from Nasf-AB the clinical-specialized actions; and, finally, users who are encouraged to seek at Nasf-AB the specialist that looks for their disease/injury. In this way, they put the Nasf-AB in place of specialized care that is precarious in many Brazilian municipalities[20,27].

Such practices encourage the hegemony of curativism and consumption of products, procedures, and services, and resist the health surveillance model. Therefore, actions that resize the relationship with the FHS regarding WH and the role of VISAT

are silenced by Nasf-AB. After all, being a "Nasf-AB worker" in a small town in the Sertão Paraibano means, ultimately, being a specialist only, because it seems unfeasible to take actions aimed at promotion and surveillance, since these require a technical-pedagogical backstop that is not available and a way of doing that contradicts the interests of the micropowers constituted in the territories.

With regards to VISAT, it is still necessary to highlight that the IV National Conference on Workers' Health, held in 2014, pointed to the regionalization of WH actions[28]. However, there are no Workers' Health Reference Centers (CEREST) in the 9th Health Regional of the state of Paraíba, and the region is covered by the Macro-regional CEREST, located more than 150km away and responsible for about 88 municipalities. Thus, the Nasf-AB professionals were silent and, at the same time, denounced the lack of technical support from CEREST for not existing or being able to provide the necessary support for Nasf-AB professionals to perform the WH actions in their territories, highlighting the difficulties of implementing the RENAST in small municipalities.

New paths, however, are pointed out in this study, since the speech of identification with the territory places these professionals as potential reference workers for the strengthening of VISAT in PHC, showing that the Nasf-AB can contribute to the completeness of care provided to workers, as long as they have the adequate conditions and receive training to act[4]. For this, it is necessary to invest in the qualification of these professionals for technical support in WH, in interprofessional work and in Permanent Education in Health.

Final considerations

The speech of Nasf-AB professionals pointed to an understanding of WH that considers work as a producer of diseases and that demands specialized clinical and care interventions from the EqNasf-AB, pointing to the supremacy of the biomedical model in the conceptions and care practices in these PHC territories. However, by recognizing themselves as workers, considering the SDH and yearning for changes, the Nasf-AB workers showed that, on a daily basis, they experience WH and can think about themselves as a reference professional in places where the CEREST has operational difficulty in being present, provided they have a technical-pedagogical support to help them expand their work.

By seeing the user-workers and their demands, but not approaching them as such, it may be revealed the abyss between PHC, specialized care, and VISAT. The vacuum left by the last two in the municipalities of the 9th Health Region of the state of Paraíba reveals the effort that must be made in the structuring of the health network so that in fact the provision of care in WH follows the PNSTT guidelines. In that way we do not have to wait a few more decades to see the care to the Brazilian worker materialize, as we have waited for the guidelines for WH in PHC since the 1st National Conference of Worker's Health (1986) until the publication of PNSTT (2012).

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Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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Resumo

O estudo objetivou compreender os significados atribuídos à saúde do trabalhador (ST) pelos profissionais de saúde do Núcleo Ampliado de Saúde da Família e Atenção Básica (Nasf-AB), bem como seus desdobramentos na produção de cuidados na Atenção Primária à Saúde. Entrevistas feitas com 13 profissionais de diferentes áreas, que foram exploradas com base na Análise do Discurso. Emergiram sentidos do trabalho como gerador de agravos e aqueles relacionados com os Determinantes Sociais de Saúde (DSS). Por intermédio das ações do Nasf-AB sobre o trabalho/trabalhador, foi possível visualizar o quanto essa equipe funciona como filtro das tensões produzidas por usuários, equipes de saúde da família e gestão. O discurso do trabalho como produtor de agravos ainda é predominante; contudo, a percepção do trabalho como DSS produz aberturas para que esses profissionais possam agir na clínica ampliada como técnicos de referência em ST.

Palavras-chave: Vigilância em saúde do trabalhador. Atenção Primária à Saúde. Profissional de saúde. Pesquisa qualitativa. Discurso.

Resumen

El objetivo del estudio fue comprender los significados atribuidos a la Salud del Trabajador (ST) por parte de los profesionales de la salud del Núcleo Ampliado de Salud de la Familia y Atención Básica (Nasf-AB), así como sus desdoblamientos en la producción de cuidados en la Atención Primaria de la Salud. Se analizaron entrevistas realizadas con 13 profesionales de diferentes áreas, con base en el Análisis del Discurso. Surgieron sentidos del trabajo como generador de agravios y aquellos relacionados con los Determinantes Sociales de Salud (DSS). Por medio de las acciones del Nasf-AB sobre el trabajo/trabajador, fue posible ver hasta qué punto ese equipo funciona como filtro de las tensiones producidas por usuarios, equipos de salud de la familia y gestión. El discurso del trabajo como productor de agravio todavía es predominante; no obstante, la percepción del trabajo como DSS produce aperturas para que esos profesionales puedan actuar en la clínica ampliada como técnicos de referencia en ST.

Palabras clave: Vigilancia en salud del trabajador. Atención Primaria de la Salud. Profesional de Salud. Encuesta cualitativa. Discurso.