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ORIGINAL ARTICLE

Workplace violence amidst the COVID-19 pandemic in primary care in Ceará

Violência laboral em meio à pandemia da covid-19 na atenção primária no Ceará

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ABSTRACT This study aimed to analyze the prevalence, types, victims, and perpetrators of workplace violence during the COVID-19 pandemic in a municipality in the northwest region of Ceará. This is a descriptive, quantitative study conducted in 22 health centers, with the participation of 125 workers from the Family Health Strategy. The Survey Questionnaire Workplace Violence in the Health Sector was used to collect data. It was found that 49% of the professionals interviewed suffered some type of workplace violence during the period. The feminization of work was observed, with 89% of women reporting experiences of violence. Verbal aggression was the most frequent type, followed by a double burden of psychological violence: verbal aggression and mutual moral harassment. Situations of sexual harassment and physical violence were also reported on a smaller scale. The main perpetrators were the patients themselves and co-workers. The results reveal the severity of violence in healthcare work in contexts of health crises and highlight the predominance of verbal violence and overlapping forms of aggression. This reinforces the need for preventive and protective actions, especially in addressing gender-based violence, in accordance with International Labour Organization guidelines.

KEYWORDS Occupacional health. Workplace violence. SARS-CoV-2. Family Health Strategy. Primary Health Care.

RESUMO *Objetivou-se analisar a prevalência, os tipos, os sujeitos vitimados e os autores das situações de violência laboral durante a pandemia da covid-19 em um município da região noroeste do Ceará. Trata-se de uma pesquisa descritiva, de abordagem quantitativa, realizada em 22 centros de saúde, com a participação de 125 trabalhadores da Estratégia Saúde da Família. Para a coleta de dados, utilizou-se o instrumento Survey Questionnaire Workplace Violence in the Health Sector. Constatou-se que 49% dos profissionais entrevistados sofreram algum tipo de violência laboral no período. Observou-se a feminilização do trabalho, com 89% das mulheres relatando experiências de violência. A agressão verbal foi o tipo mais frequente, seguida por dupla carga de violência psicológica: a agressão verbal e o assédio moral de forma mútua. Também foram relatadas, em menor escala, situações de assédio sexual e violência física. Os principais perpetradores foram os próprios pacientes e colegas de trabalho. Os resultados revelam a gravidade da violência no trabalho em saúde em contextos de crise sanitária e destacam a predominância da violência verbal e de formas sobrepostas de agressão. Reforça-se a necessidade de ações preventivas e protetivas, especialmente no enfrentamento da violência de gênero, conforme diretrizes da Organização Internacional do Trabalho.*

PALAVRAS-CHAVE *Saúde do trabalhador. Violência no trabalho. Sars-CoV-2. Estratégia Saúde da Família. Atenção Primária à Saúde.*

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Introduction

Workplace violence is a highly complex and widespread phenomenon that has attracted increasing attention, especially in the health field[1]. The definition proposed by the International Labor Organization (ILO) in 2003[2] characterizes workplace violence as situations in which workers face abuse, threats, or aggression related to their work, including during commuting, and that compromise their safety, well-being, or health. Although this definition represents an important conceptual framework, it is essential to recognize its limitations given the breadth and diversity of manifestations of violence observed in contemporary workplaces[3].

The concept of violence can be broadened by adopting Johan Galtung's theoretical perspective, expressed in the so-called 'Theory of the Triangle of Violence' or 'Violence Triangle'. This theory proposes the existence of three interconnected and mutually reinforcing dimensions of violence. The first is direct violence, which manifests itself through physical or verbal actions that cause immediate harm to individuals or groups, such as assaults, insults, or harassment. The second is structural violence, associated with systems, institutions, and social structures that produce and reproduce inequalities and injustices, such as the lack of equitable access to health services or gender disparities. The third dimension is cultural violence, related to values, norms, beliefs, and symbolic representations that legitimize and naturalize inequalities, such as discriminatory stereotypes and deep-rooted prejudices[4].

In this context, this study seeks to contribute to the elucidation of the problem by comparing its results with similar international research, thus broadening the understanding of the phenomenon of workplace violence in diverse contexts.

It is essential to emphasize that the three layers of violence are interconnected and exert mutual influence, forming a persistent cycle that can be difficult to break. Direct violence can arise from unjust cultural structures and norms, while structural and cultural violence, in turn, contribute to the maintenance of direct violence by creating conditions that favor its occurrence and naturalization.

When addressing the phenomenon of workplace violence in Family Health Centers (CSF) in Ceará during the COVID-19 pandemic, caused by the SARS-CoV-2 virus, it was essential to consider the broader perspective of workplace violence presented by Galtung[4]. In addition to identifying incidents of direct violence, it is crucial to examine the organizational, political, and cultural structures that may be contributing to such violent acts. Only by comprehensively understanding violence and its various layers can effective prevention and intervention strategies be developed.

In Primary Health Care (PHC) services, with CSFs being one of the main health facilities supporting this policy network, professionals play an essential role, grounded in the concept of community-based, longitudinal, comprehensive, universal, and equitable care. Similarly, in the provision of primary care to the population, workplace violence emerges as a concerning and challenging issue[5] that can affect not only work processes but also the organization of the work culture, leading to mental illness among healthcare workers.

The arrival of the COVID-19 pandemic significantly worsened the challenges faced by healthcare workers, further worsening working conditions, increasing work overload, a lack of adequate resources, and concerns about their own health and safety. This adverse context may have contributed to the increase in episodes of violence in PHC during the health crisis[6,7]. Several studies have documented the high prevalence of workplace violence in healthcare settings worldwide, highlighting the urgent need to address this phenomenon in a coordinated and systematic manner[8-15].

Given this context, it became essential to conduct a detailed analysis of workplace violence in CSFs located in the interior of the

state of Ceará during the COVID-19 pandemic. Thus, the objective of this research was to analyze the prevalence, types, main victims, and perpetrators of workplace violence situations that occurred during the pandemic in a municipality in the northwestern region of Ceará.

Material and methods

This is a descriptive, quantitative study conducted between March and May 2021 in a municipality located in the northwestern region of the state of Ceará. The research is an excerpt from a study developed within the scope of the Master's Degree in Family Health at the Federal University of Ceará (UFC), entitled 'Workplace Violence in Family Health Centers and its Interfaces with Work Conditions and Organization'. To meet the specific objectives of this excerpt, a targeted analysis of the variables contained in the original instrument was conducted, selecting those related to the prevalence, types, victims, and perpetrators of workplace violence.

The municipality has 36 CSFs, distributed across 22 units in the urban area and 14 in peripheral districts, covering a contingent of 1,312 health professionals, as well as 64 Family Health teams. To establish sampling parameters, the study was restricted to CSFs located in the urban area, in the municipal headquarters, due to the health risks arising from the COVID-19 pandemic. Furthermore, selection for the data collection instrument was limited to three specific professional categories: physicians, nurses, and nursing technicians/auxiliaries, resulting in a potential sample of 184 participants.

A non-probabilistic convenience sample was used, based on the feasibility of accessing professionals during the pandemic and the operational constraints of the period. These three categories were included because they are the professionals most exposed to violence within the units. Community Health Agents (CHAs) were not included because they predominantly work externally, with distinct work dynamics. This would require specific instruments and approaches, a possibility to be considered in future studies.

Study sampling was determined using the finite population formula.

Finite population formula

$$\frac{n = ZGC^2 \times P \times Q \times N}{e^2 \times (N-1) + ZGC^2 \times P \times Q}$$

legend:

N = population: 184

n = sample value

ZGC = 1.96

P = prevalence – 50%

In this context, 67.93% of the target population was included, equivalent to 125 workers, distributed among 41 nurses, 26 physicians, and 58 nursing technicians/auxiliaries. These participants were selected based on the following inclusion criteria: a) having worked at the CSF for a minimum of 12 months; and b) having voluntarily agreed to participate in the study by signing the Free and Informed Consent Form (ICF). Professionals who were absent during data collection due to sick leave, vacation, or otherwise not meeting the aforementioned criteria were excluded from the analysis.

Data were collected using the Survey Questionnaire Workplace Violence in the Health Sector, proposed by the World Health Organization (WHO), the ILO, the International Public Services and the International Council of Nurses (ICN)[16], translated and adapted into Portuguese[17]. The questionnaire's questions on workplace violence remained unchanged, consisting of 18 questions on physical violence and 13 questions on types of psychological violence (verbal aggression, bullying/bullying, sexual harassment, and racial discrimination).

During the data collection period, the research environment was under alert due to the increased risk of transmission and

contamination by the novel coronavirus (SARS-CoV-2), the agent that transmits COVID-19. Therefore, it was decided to fully transcribe and administer the Survey Questionnaire Workplace Violence in the Health Sector[16,17] through an online form in Google Docs. Initially, the target population was invited to participate in the survey via phone calls, WhatsApp messages, and emails provided by the Municipal Health Department.

After expressing interest in contributing to the study, the informed consent form was sent by email for review and possible clarification of any questions. All informed consent forms were printed in duplicate and signed in person, following established security recommendations. Finally, the Survey Questionnaire on Workplace Violence in the Health Sector[16,17] was sent by email, completed, and validated by the research participants.

The study's quantitative data were coded and transposed into Microsoft Windows Excel®. Analysis was performed using the Statistical Package for the Social Sciences (SPSS) software, version 18.0. Categorical (qualitative) variables were described using absolute and relative frequencies, while quantitative (continuous and scalar) variables were described using measures of central tendency and dispersion: mean, standard deviation, median, and interquartile ranges.

This study followed the ethical and legal precepts established by the 1964 Declaration of Helsinki, revised during the 64th General Assembly in Fortaleza, Brazil, in 2013, as well as Resolution No. 466/2012 of the National Health Council (CNS) and the standards of the National Commission for Research Ethics[18], being submitted to the Scientific Commission of the Municipal Health Department and, subsequently, to the Research Ethics Committee No. 0052/2020 through the Plataforma Brasil, being approved under No. 4,633,244 (CAAE: 39139720.7.0000.5053). It should be noted that there was no financial support of any kind.

Results and discussion

Prevalence of workplace violence in Family Health Centers and its relationship with the COVID-19 pandemic scenario

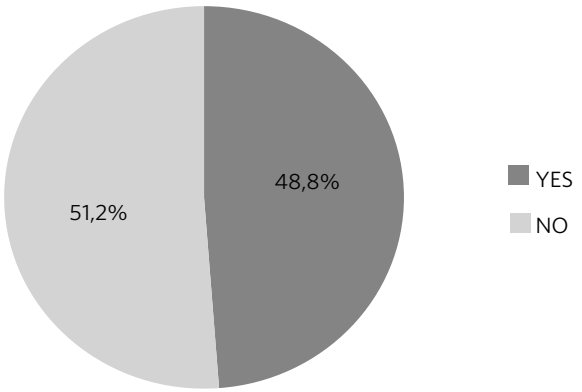
The sample was composed mostly of women (90.4%), with a predominance of the 31-45 age group (70.4%). Regarding education, 53.6% of the participants had completed higher education, while 44% had completed high school. The majority of the sample identified themselves as brown (83.4%) and single (54.4%). Regarding monthly income, 52.8% of the professionals reported receiving more than two minimum wages. Regarding occupation, 46.4% were nursing technicians, 32.8% were nurses, and 20.8% were doctors.

The results of the investigation revealed a significant prevalence of workplace violence in the CSFs in the municipality investigated. According to *graph 1*, 49% of the sample reported exposure to workplace violence in the last 12 months. This scenario is analogous to studies conducted in PHC settings in Rio Grande do Sul[14] and Fortaleza, Ceará state[19], in which a representative number of respondents reported having experienced some episode of violence. This pattern was also observed in PHC settings in the cities of Sarajevo Canton, Bosnia and Herzegovina[20].

The incidence of workplace violence in the investigated CSFs was higher than the results found in Bangladesh, Asia[21]. However, the findings of this study contrast with data from a study conducted with PHC professionals in Spain, where over 90% of the sample reported having been exposed to some type of violence in the workplace[22].

These results highlight the need for actions and policies aimed at preventing and combating workplace violence in PHC, both locally and internationally. It is essential to promote a safe and healthy work environment for healthcare professionals, ensuring their biopsychosocial integrity, and guaranteeing quality patient care.

Graph 1. Distribution of workers subjected and not subjected to workplace violence in the last 12 months in Family Health Centers in a municipality in the northwest region of the state of Ceará, Brazil, 2025



Source: Own elaboration.

The analysis of the relationship between the COVID-19 pandemic and the panorama of workplace violence in the CSFs of the city studied is significantly relevant, considering the context of a health crisis that has exacerbated structural inequalities and directly impacted working conditions. This scenario is corroborated by another study[6] that found that many attacks were motivated by fear of virus transmission, misinformation, or dissatisfaction among patients and families. Both studies showed that the pandemic intensified psychosocial risk factors at work, such as stress, work overload, and precarious working relationships, contributing to the trivialization and naturalization of violence against healthcare professionals.

The literature highlights[6] the clear burdens placed on and on health systems during the pandemic and presents evidence of the inadequacy of PHC in the face of new demands. This scenario has led to waves of violence against health workers not only in the investigated CSFs but also around the world[3,4], including in the Middle East[23], Pakistan[24], Spain[25], and Latin American countries such as Mexico[26], Brazil[6,7], and Peru[27].

The worsening of the Brazilian pandemic situation has positioned the country as the epicenter of COVID-19 in South America and placed it second in the world in number of cases[28]. This panorama may be linked to the combination of political counter-reforms, constant attacks and dismantling of the Unified Health System (SUS), the exhaustion of strategies to contain health crises, and neoliberal responses to urgent demands[29]. This resulted in an intense process of precariousness exacerbated by the implementation of Constitutional Amendment No. 95 (EC 95/2016), which embargoed investments in essential public sectors, such as health, for two decades[25]. Furthermore, the scrapping, underfunding and lack of government priority in managing the health crisis, especially during a government in times of pandemic, contributed to further aggravating the situation[29,30].

During the pandemic, working conditions were exacerbated, especially due to the stance adopted by the highest executive authority, the President of the Republic, who disastrously chose to adopt a denialist approach regarding the severity of the novel coronavirus. This manifested itself in downplaying the seriousness of the pandemic, encouraging the population to disregard isolation measures and basic precautions, such as wearing masks, and recommending the use of medications with no proven efficacy in preventing and treating the disease[30].

Based on this observation, Brazilian authors have highlighted the importance of PHC in

managing the COVID-19 overload curves. During the three waves of the pandemic, PHC was the main gateway to health services within the SUS (Unified Health System), playing a fundamental role in containing the overload of the health system, providing effective care for cases of this disease and promoting continuous and comprehensive care for patients with other health conditions. This was possible through the effective use of the Health Care Network (RAS) as a primary strategy.

In addition to the overload on health systems, the relationship between the overwhelming spread of COVID-19 cases and the triggering of a wave of violence against health professionals[26] has generated more than 600 cases of violence, intimidation and/or stigmatization against health professionals in more than 40 countries[24].

The findings are extensive and shed light on the problem, highlighting the incidence of violence in health services in Peru, where the majority of physicians involved in patient care during the COVID-19 pandemic were exposed to violent acts[25]. Similarly, in Brazil, a study of health professionals from all five regions of the country revealed that almost half of the workers reported having suffered occupational violence during the COVID-19 pandemic[32].

PHC professionals in the city of Murcia, Spain[25], experienced similar outcomes, in which some conflicts and/or episodes of violence arose due to demands for transformation and/or adaptation during and after the COVID-19 pandemic. In general, interviewees expressed the perception of inadequate adaptation of PHC, resulting in insufficient attention, which, in turn, contributed to incidents such as assaults[24].

These consequences directly and indirectly impact the work of multidisciplinary healthcare teams. This results in health problems and harm that affect the biopsychosocial dimensions of these professionals, thus reverberating in the reduction of the workforce, illness and/or burnout of the team, compromising the quality of care offered to those who use health services, in addition to generating additional costs for the health network[32].

Professionals exposed to workplace violence in Family Health Centers: breakdown by sex, gender, and professional category

The female presence at work is evident in this study, since 90.4% of the sample identified as women. These results corroborate the predominant profile of professionals working in the health sectors both nationally20 and internationally[23].

Women have historically been associated with the role of caregivers, predominating in caregiving activities both within the family and in professions such as nursing and social work. During the COVID-19 pandemic, they have been largely on the front lines of caring for sick and elderly individuals, both inside and outside institutions – and they continue to assume, exclusively or predominantly, responsibility for caring for families[33].

This panorama raised questions about the intersections between gender, work and violence, given that this research demonstrated that almost all (f = 89%) of the workers reported experiences of one or more types of violence in the last 12 months prior to the study, including physical, verbal, emotional/psychological, sexual violence and/or moral harassment.

Gender-based violence represents a specific form of violence that disproportionately impacts women and people who identify with gender minorities. This form of violence, highlighted in the results of this study, is based on social norms, unequal power structures, and power imbalances between men and women. In the context of CSFs, gender-based violence can take various forms, including sexual harassment, gender-based bullying, and gender discrimination. Similar results were found in studies conducted in Europe[20] and Brazil[34], which associated workplace violence with gender issues. This issue has been analyzed by

the ILO, resulting in the creation and promotion of Recommendation No. 206/2019, which emphasizes the importance of implementing more inclusive, integrated, and gender-sensitive approaches to violence and harassment in the world of work[35].

Researchers[36,37] note that gender disparities tend to disappear when considering violence issues as a whole. However, when analyzing a specific type of violence, such as sexual harassment, women emerge as the main victims[36,37].

Women working in CSFs face additional challenges arising from structural gender inequalities present in society. This includes the perpetuation of gender stereotypes, the undervaluation of women's work, and the lack of opportunities for leadership and professional advancement. These factors can increase women's vulnerability to violence in the workplace, further exacerbating the situation during the pandemic.

The primary characteristics for analyzing gender-related workplace violence are intrinsically related to the feminization of health professionals, the devaluation of Nursing – the majority category in the health area – and the socio-historical factors that associate women with a position of submission and fragility, in addition to assigning them the role of integral caregivers[38,39].

It is noteworthy that, even amid struggles for gender equality, women continue to face violent acts simply because they are female[36]. This places them in a submissive position in the face of the domination and authoritarianism prevalent in more masculinized work environments, establishing asymmetrical power relations in the context of health services[39].

Therefore, it is essential to adopt a comprehensive and integrated approach to understanding violence, considering its multiple dimensions and its interaction with the social determinants of health. Beyond the layers of violence already discussed, the need to recognize gender-based violence as a central and structuring component of this phenomenon is highlighted.

Based on these concepts, work-related violence emerges as a significant concern, profoundly affecting many health professionals, with a particular impact on women and nursing staff. Unfortunately, these professionals face a dual threat: gender-based violence and workplace violence. This phenomenon once again reflects the machismo rooted in Brazilian society, a reality that frequently manifests itself in the context of health[40].

The double burden of violence in PHC is amply evidenced in this research, as shown in *graph 2*, which shows that 80.3% of professionals exposed to workplace violence were nursing professionals, a result of the sum of nursing technicians (39.3%) and nurses (41%). A study conducted with nursing staff in high-risk reception centers in the state of Rio Grande do Norte highlighted the frequency of violent acts directed at these professionals, especially because they are the first to interact with clients, families, and communities, and are often considered the primary representatives or intermediaries of the health service in the public eye[38].

One study also highlighted a new morphology of the 'sociosexual and racial division of labor', in which white female workers suffer more than white men. Black female workers are even more penalized than white women. The intensification of female labor may further exacerbate this inequality[41].

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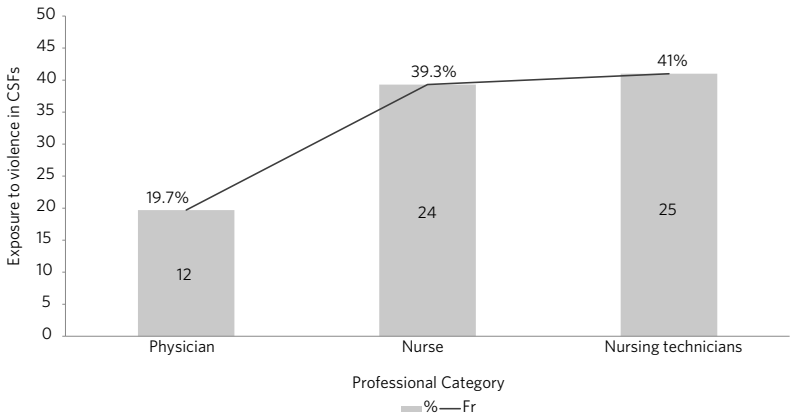
Graph 2. Distribution of professionals (n = 61) who were victims of aggression in Family Health Centers, according to occupational category, in a municipality in the northwest region of the state of Ceará, Brazil, 2025



Source: Own elaboration.

Workplace violence directed at nursing staff is a complex and multifaceted issue that cannot be examined in isolation. It is intrinsically linked to the organization of society and the unequal distribution of opportunities among different social groups and professional categories. Therefore, it is necessary to consider the gender issues that permeate society and how these factors reflect on relationships and work dynamics.

The motivations and evidence that triggered acts of violence against healthcare professionals – regardless of professional category, especially those working in PHC – were associated with multiple interconnected factors. Among these are: the spread of conspiracy theories; distrust and insecurity toward healthcare workers; high demand from users; long wait times; misinformation and fear regarding COVID-19; as well as the need for personnel (with teams significantly understaffed), as well as supplies and equipment, including medications, personal protective equipment, and respirators for the high demands of specialized services. These elements, combined with external structural factors such as the lack of public safety and the increase in violence in society, contribute to an even more vulnerable work environment for PHC professionals.

Given this complexity, the implementation of comprehensive public policies capable of comprehensively addressing the multiple dimensions of workplace violence in healthcare is essential, with the goal of ensuring the safety, dignity, and well-being of healthcare professionals[7,9].

Revealing the types of workplace violence and their perpetrators in Family Health Centers in Ceará

In the practical context of PHC, understanding the phenomenon of violence is fundamental and challenging due to its multidimensional nature, which involves several causes and determining factors[42]. It is essential to recognize that violence is one of the social determinants of health, which affects the population's access to care services, requiring a broad reflection on the reality of the affected communities, valuing their resilience and life potential[42].

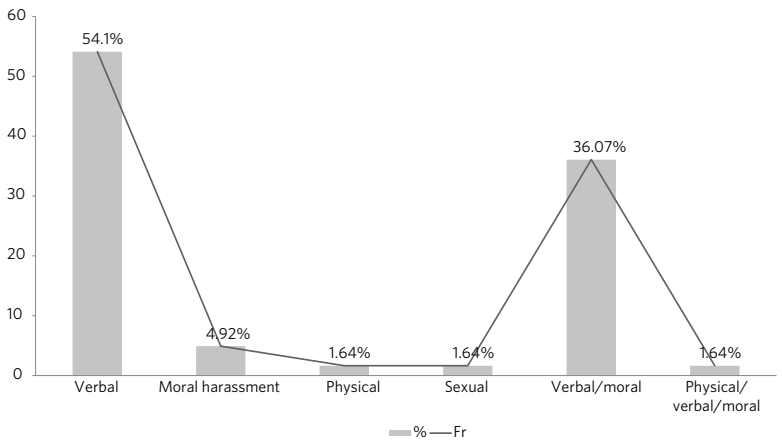
The strain on healthcare systems, including PHC, due to the global COVID-19 pandemic has resulted in an increase in cases of violence against Family Health Strategy workers[43,44].

These incidents highlight not only the structural weaknesses of health systems in the face of external events, such as pandemics and catastrophes, but also reveal the historical precariousness of working conditions, wages, and employment, the neglect of which contributes to profound and persistent impacts

on the safety and biopsychosocial well-being of health professionals.

Based on this scenario, this study revealed that psychological violence was the most prevalent, with the subtype being verbal aggression (f = 54.1%), as shown in *graph 3*, followed by the double burden of psychological violence: verbal aggression and mutual bullying (f = 36.1%) and bullying (f = 4.9%). These forms of violence can be categorized as direct, symbolic, structural, and psychological[3,4], depending on their manifestation.

Graph 3. Distribution of types of workplace violence in Family Health Centers, in a municipality in the northwestern region of the state of Ceará, Brazil, 2025



Source: Own elaboration.

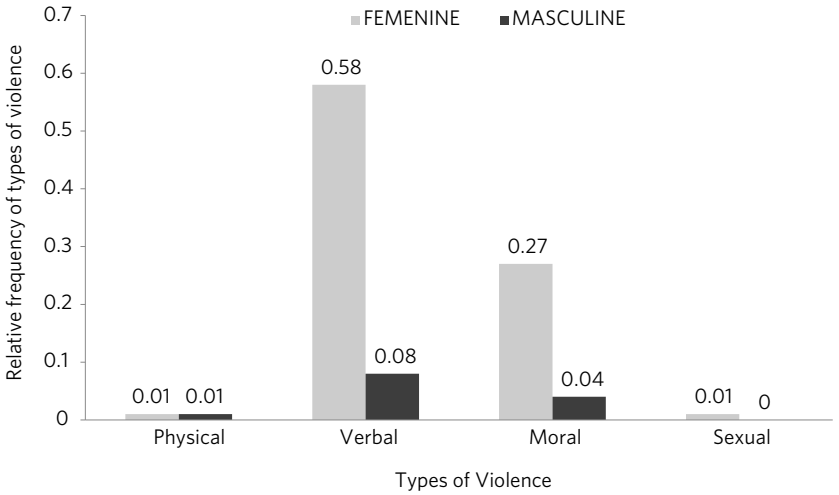
One form of violence that is often underestimated but has a significant impact on professionals' mental health is verbal aggression, which manifests itself in practice as low social approval. National and international literature reveals that verbal aggression is the most frequently cited form of violence by PHC professionals, ranging from disdainful attitudes, inappropriate treatment, insults, disregard, arrogance, rudeness, or disrespectful communication[38,39].

A study[45] reveals that more socially accepted professionals deal with less stress and psychological demands at work, while those with low social approval face greater stress, psychological demands, and a higher incidence of work-related violence. Therefore, it is essential to address both structural violence and its various manifestations in the workplace, such as verbal aggression and bullying, to promote healthier and more equitable work environments for all employees[45].

Regarding physical violence, the study revealed that two nursing technicians (f = 1.6%) were victims, as shown in *graph 3*. Nursing technicians can be targets of physical violence because they work in triage and reception areas in healthcare facilities[34,38]. The increase in incidents of violence can be attributed to the stressful environment generated by the COVID-19 pandemic, as documented in various sources[8,27]. This phenomenon is especially observed among professionals who perform triage due to distrust, misinformation, belief in conspiracy theories, fear of the disease, and overcrowding[27,30].

Graph 3 shows the absence of reports of violence due to racial discrimination in this study, a subtype of psychological violence – unlike previous studies in Brazil[28] that identified incidents of harassment and/or racial discrimination among PHC professionals.

Graph 4. Association between forms of violence and the gender of workers at Family Health Centers in a municipality in the northwestern region of the state of Ceará, Brazil, 2025



Source: Own elaboration.

Graph 4 examines the relationship between the types of violence and the participants' gender. Verbal violence was most common against female workers (f = 58%), followed by moral violence (f = 27%). These findings are consistent with previous studies conducted in Caxias, Maranhão[39], Italy[37], and Europe[21].

The responses analyzed revealed a similarity in exposure to physical violence, as both sexes were affected in both incidents (*graph 4*). This finding contrasts with the findings of Magnavita and Heponiemi[37], who found that male workers were slightly more exposed to physical aggression.

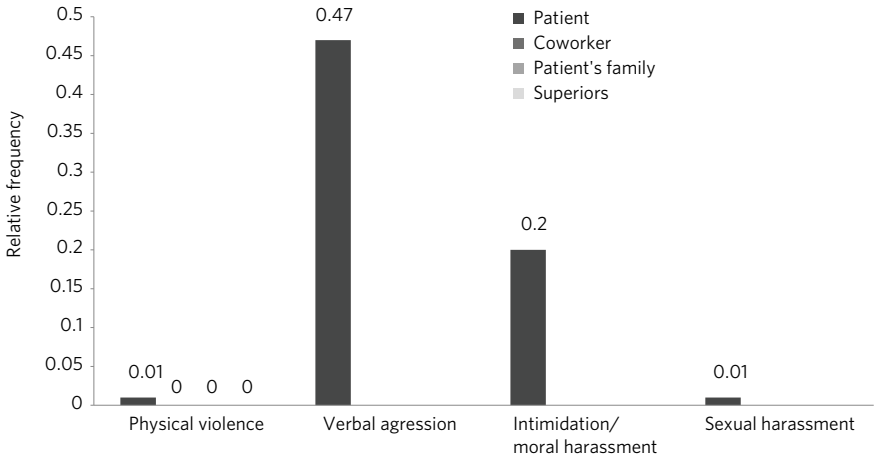
A low prevalence of sexual harassment was observed in this study, with one reported case (f = 1%) directed at a nurse. It is important to note that female professionals are frequently targets of this type of violence[36,37]. This situation represents a double threat in the nursing team's work context, given gender-based violence and the nature of the profession[39,40].

Regarding the magnitude of this phenomenon, even when the numbers are relatively small, its relevance becomes alarming given the possibility of underreporting or bias in the approach to these cases[20]. Contrary to the findings of this study, a significant incidence of sexual harassment directed at nursing staff was observed in the city of Riyadh, Saudi Arabia[36].

This phenomenon of sexual harassment manifests itself through common forms of violence, such as derogatory jokes and comments related to sex, as well as offensive body postures[36]. The main perpetrators of sexual harassment cited were coworkers, followed by superiors and, to a lesser extent, healthcare service users and their companions or family members[36].

In this study, when investigating the main perpetrators/aggressors (*graph 5*) of violent acts in CSFs, users emerged as the most frequent (f = 69%). These results are consistent with similar studies in southern Brazil, Jordan, Spain, Italy, and Asia[22,23,37,39,40]. These studies also highlighted the prevalence of non-physical violence, with most cases attributed to patients.

Graph 5. Association between types of occupational violence and their perpetrators in Family Health Centers in a municipality in the northwestern region of the state of Ceará, Brazil, 2025



Source: Own elaboration.

Coworkers were identified (*graph 5*) as perpetrators of violent acts, ranking second in the findings of this investigation (f = 19%), with verbal aggression (11%), intimidation and/or bullying (7%), and one (1%) case of physical violence. This trend was confirmed in a study of verbal aggression among healthcare professionals in CSFs in the western and far western regions of Santa Catarina, Brazil[40], as well as in the Middle East[36].

Conflict is a stressor inherent in human relationships, characterized as a dynamic and multifactorial process in which individuals or groups experience negative emotional reactions to certain situations[46].

Interprofessional relationships within the same unit are dynamic and complex, and reveal flaws in work organization, such as lack of professional recognition, conflicts in working relationships, leadership disputes, absenteeism followed by work overload, prolonged leaves, and high turnover.

The COVID-19 response has generated widespread exhaustion among healthcare workers, both healthcare professionals and invisible healthcare workers. This overload was related not only to the continued exposure to the high number of cases and deaths of patients, colleagues, and family members, but also to the profound changes the pandemic has caused to personal well-being and the dynamics of professional life[47].

Given the findings of this study, the urgent need to adopt specific preventive and protective measures aimed at tackling violence in CSFs, especially gender-based violence, both in the state of Ceará and at the national and international levels, is evident. These measures must be aligned with the guidelines of ILO Recommendation No. 206/2019[35], which guides the implementation of institutional policies aimed at eliminating harassment and gender discrimination in the workplace.

Among the priority strategies, the formulation and strengthening of internal policies that express zero tolerance for gender-based violence stand out, accompanied by the promotion of ongoing gender equality training and awareness programs aimed at all healthcare professionals. It is equally essential to establish safe, confidential, and welcoming reporting channels that offer psychological, legal, and institutional support to victims.

At the same time, public policies must consider the social determinants that sustain gender inequalities in the workplace. This implies the development of structural actions aimed at reducing wage and hierarchical

disparities, promoting equity in professional relationships, expanding opportunities for career advancement, and ensuring adequate physical and psychosocial infrastructure to address situations of violence.

Incorporating an intersectional approach, which recognizes and connects social markers of difference, especially gender, to the dynamics of workplace violence, is essential for designing more effective prevention and response strategies. Considering the significant feminization of the healthcare workforce, promoting safe, equitable, and violence-free work environments is not only an ethical and political commitment, but also an essential condition for the quality and comprehensiveness of services provided to the population.

Conclusions

The findings of this study demonstrate that workplace violence in PHC is a recurring and multifaceted phenomenon, exacerbated by structural, organizational, and sociocultural factors, especially during the COVID-19 pandemic. A significant prevalence of episodes of violence was identified, with a focus on verbal and psychological violence, primarily affecting women and nursing professionals. The lack of institutional protocols for addressing this issue, precarious working conditions, and the feminization of the workforce create a scenario of vulnerability that urgently needs to be addressed.

As a contribution to practice, the results highlight the need to formulate and implement public and institutional policies that promote safer and more equitable work environments. Priority strategies include strengthening reporting channels, supporting victims, providing ongoing training for healthcare teams on labor rights, gender equality, and violence prevention, as well as creating mechanisms for monitoring and responding quickly to situations of aggression. Such measures are fundamental for the appreciation of PHC professionals and for improving the quality of care provided to the population.

Among the study's limitations is its limited timeframe to the pandemic period, which may have amplified the perception of risk and the occurrence of episodes of violence. Furthermore, the study was conducted in a single municipality in the interior of Ceará, which limits the generalizability of the results to other contexts. Despite this, the data offer relevant insights for further research and for formulating actions aimed at protecting healthcare workers, especially in contexts marked by social and institutional vulnerabilities.

Collaborators

Olímpio ACS (0000-0002-3656-6001)* contributed to the conception, analysis, interpretation, and writing of the manuscript. Lira RCM (0000-0002-2163-4307)*, Batista MH (0000-0002-9069-678X)*, Dionisio BWR (0000-0002-0628-5807)*, Ximenes Neto FRG (0000-0002-7905-9990)*, and Sousa FWM (0000-0001-9852-6526)* contributed to the critical review of the proposal and scientific consultancy of the study. ■

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