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Original Article

Prevalence of anxiety and depression in Brazilian Primary Health Care workers[1]

Prevalência de ansiedade e depressão em trabalhadores da Atenção Primária à Saúde

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Abstract

Introduction: The update of the National Primary Health Care in 2017 brought important setbacks to the Brazilian health system, hindering professional performance and favoring the psychological illness of workers. **Objective:** To evaluate the prevalence of anxiety and depression in primary health care workers. **Method:** This is a cross-sectional study conducted in 2017 in a large city in the interior of the state of São Paulo. We evaluated 173 professionals from Primary Health Care teams, using a questionnaire with sociodemographic and professional variables; the Beck Anxiety Inventory (BAI); and the Beck Depression Inventory (BDI-II). **Results:** Anxiety was present in 45.3% of the professionals, with 25.0% having mild anxiety, 9.9% having moderate anxiety, and 10.5% having severe anxiety. Depression was present in 41.0% of professionals, 28.9% with mild depression, and 12.1% with moderate depression. There was a higher prevalence of anxiety (17.3%) and depression (28.3%) among community health workers and a lower prevalence of anxiety (1.2%) and depression (0.6%) among doctors. **Conclusion:** There is a high prevalence of anxiety and depression in Primary Health Care professionals, especially in community health workers. Municipal managers should implement measures to care for workers' health, as well as ensure favorable working conditions, to prevent the professionals from becoming ill.

Keywords: Occupational Health, Mental Health, Health Personnel, Primary Health Care.

[1]This is an article resulting from the master's thesis entitled "Anxiety, depression, and engagement in Primary Health Care professionals", defended in November 2020, in the Postgraduate Program in Nursing at the Federal University of Rio Grande, under the guidance of Prof. Dr. Luciano Garcia Lourenção. As it is research involving human beings, the study was submitted to the Research Ethics Committee (CEP-FAMERP/SP) and approved with a favorable opinion for its realization, Opinion number 1,776,737 of October 17, 2016.

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Resumo

Introdução: A atualização da Política Nacional de Atenção Básica em Saúde, em 2017, trouxe importantes retrocessos para o sistema de saúde brasileiro, dificultando a atuação profissional e favorecendo o adoecimento psíquico dos trabalhadores. **Objetivo:** Avaliar a prevalência de ansiedade e depressão em trabalhadores da atenção primária à saúde. **Método:** Estudo transversal, realizado em 2017, em um município de grande porte do interior paulista. Foram avaliados 173 profissionais das equipes da Atenção Primária à Saúde, utilizando um questionário com variáveis sociodemográficas e profissionais; o Inventário de Ansiedade de Beck (BAI); e o Inventário de Depressão de Beck (BDI-II). **Resultados:** A ansiedade esteve presente em 45,3% dos profissionais, sendo 25,0% com ansiedade leve, 9,9% com ansiedade moderada e 10,5% com ansiedade grave. A depressão esteve presente 41,0% dos profissionais, sendo 28,9% com depressão leve e 12,1% com depressão moderada. Houve maior prevalência de ansiedade (17,3%) e de depressão (28,3%) entre Agentes Comunitários de Saúde e menor prevalência de ansiedade (1,2%) e de depressão (0,6%) entre médicos. **Conclusão:** Há uma prevalência elevada de ansiedade e depressão em profissionais da Atenção Primária em Saúde, especialmente em agentes comunitários de saúde. Os gestores municipais devem implementar medidas de atenção à saúde dos trabalhadores, bem como garantir condições de trabalho favoráveis, para evitar o adoecimento dos profissionais.

Palavras-chave: Saúde do Trabalhador, Saúde Mental, Pessoal de Saúde, Atenção Básica à Saúde.

Introduction

In Brazil, the Family Health Strategy (*Estratégia Saúde da Família* - ESF) is considered a priority care model at the primary level of the Unified Health System (*Sistema Único de Saúde* - SUS), which comprises Primary Health Care (PHC) or Primary Care (PC) services. The ESF originated in 1994, with the Family Health Program (*Programa Saúde da Família* - PSF), successor to the National Program of Community Health Workers (*Programa Nacional de Agentes Comunitários de Saúde* - PACS), implemented in 1991. The first teams were implemented in the northeast region of Brazil, and from 1996 onwards, the ESF gained strength, causing significant changes in the work process in health and health care (Lourenção & Soler, 2004; Guedes et al., 2011).

According to data from the Primary Health Care Secretariat of the Ministry of Health, in July 2020, Brazil had more than 43,300 registered Family Health teams, responsible for the health care of 63.74% of the Brazilian population, that is, 133,955,548 Brazilians. The largest coverage by the ESF is found in the Northeast (82.28% coverage by 16,250 teams), Midwest (67.61% coverage by 3,412 teams), and North (64.67% coverage by 3,783 teams) (Brasil, 2020).

Despite the advances brought by the expansion and consolidation of the ESF, especially with the publication of the National Policy on Primary Care (PNAB), in 2006, the update of the PNAB, carried out in 2017, brought important setbacks for the

health system, such as the reduction of the funding for the ESF, suppression of the priority of the ESF as a care model in PHC, and consolidation of incomplete teams, with only one Community Health Agent (CHW) (Brasil, 2006, 2017). These changes weaken the effectiveness of this care model and compromise the resolution of the SUS (Brasil, 2017; Giovanella et al., 2020).

However, changes in working conditions are followed, reflected by fragile bonds, low pay, incomplete teams, and work overload which, combined with the precarious infrastructure of the Health Units and the lack of supplies and equipment, favor wear and tear and physical and mental illness of PHC workers, which can make them dissatisfied, unproductive or ill, developing pathologies such as anxiety and depression (Araújo et al., 2016; Carvalho et al., 2016; Garcia Junior et al., 2018; Morosini et al., 2018; Cordioli et al., 2019; Giovanella et al., 2020).

Although there are no comprehensive epidemiological studies that determine the magnitude of these diseases in the Brazilian population, we estimate that anxiety disorders affect 9.3% and depression 15.5% of Brazilians, making them an important public health problem (World Health Organization, 2017; Brasil, 2019; Sampaio et al., 2020).

When it affects workers, these diseases can cause damage, such as intense suffering, work dysfunction, difficulty in performing daily activities, damage to social, family, and occupational interaction. In the case of PHC workers, there may be damage to the health system and impacts on the health care of SUS users (Fernandes & Marziale, 2014; World Health Organization, 2017; Sampaio et al., 2020; Santana et al., 2020).

Brazilian studies show a prevalence of 30.0% to 50.0% of anxiety and 25.0% to 30.5% of depression in health professionals, showing that this is an important public health problem (Rotta et al., 2016; Gonsalez et al., 2017; Lourenção et al., 2017; Garcia Junior et al., 2018; Lourenção, 2018; Moura et al., 2018; Sampaio et al., 2020). These studies also point out that factors such as pressure in the work environment, unregulated sleep, gender, and marital status are associated with the development of anxiety, while the work sector, type of bond, position, age, and color are associated with the development of depression.

In this context, it is important to know the psycho-emotional conditions of workers in PHC services to establish health care actions and policies for workers that improve working conditions and eliminate risk factors for mental illness, reducing anxiety and preventing depression among professionals from the Family Health teams.

Based on the above, this study aimed to verify the prevalence of anxiety and depression in primary health care workers.

Method

This is a quantitative, cross-sectional study carried out in a large city in the interior of the state of São Paulo, in 2017.

We included all professionals of the minimum ESF teams (doctors, nurses, nursing assistants/technicians, and community health workers) working in 15 PHC Units in the city during the study period, totaling 340 professionals. The sample was defined by convenience and consisted of 173 professionals who responded to the instruments, 22 doctors, 28 nurses, 38 nursing assistants/technicians, and 85 community health workers. We excluded from the

study the professionals who were on vacation during the period of data collection and/or away from professional activities for any other reason.

For data collection, we used three self-administered instruments: one elaborated by the researchers, containing sociodemographic and professional questions of the workers; the Beck Anxiety Scale or Beck Anxiety Inventory (BAI) (Karino & Laros, 2014); and the Beck Depression Scale or Beck Depression Inventory (BDI-II) (Gomes-Oliveira et al., 2012).

The BAI measures the intensity of anxiety symptoms, based on 21 questions about how the person has been feeling in the last week. Answers to the questions are expressed at four levels (absence; mild; moderate; severe). This scale has high internal consistency (Cronbach's alpha = 0.92) and test-retest reliability for 1 week, r (81) = 0.75 (Cunha, 2001; Karino & Laros, 2014).

The BDI-II measures the intensity of depression, through 21 questions that address various items related to depressive symptoms such as hopelessness, irritability, and cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and decrease of libido. The scale was validated in Brazil, proving to be reliable and valid for measuring depressive symptoms in the Brazilian population. It had an internal consistency of 0.93, concurrent validity (correlation of 0.63-0.93 with scales applied simultaneously), and acceptable severity predictive capacity (more than 65% correct classification of depressed individuals) (Cunha, 2001; Gomes -Oliveira et al., 2012).

Data collection was scheduled with the nurses of the health units and carried out during the team meeting, at which time the researchers explained the objectives and invited the professionals to participate in the study, signing the Informed Consent Form. Then, the researchers delivered the questionnaires to the professionals and explained how to answer the different questions (open or closed). The answered instruments were placed in a brown envelope, without identification, to preserve the professionals' identity.

The application of BAI and BDI followed the recommendations of the Beck Scales Manual (Gomes-Oliveira et al., 2012). After reading the instructions to the study participants and guidance on the responses on a Likert-type scale, the test protocol for responses was delivered. The correction was carried out together with a psychologist from the research group and the classification of the professionals' levels of anxiety and depression followed the recommendations of the Beck Scales Manual (Cunha, 2001).

We used sociodemographic data to characterize the study population. Depression anxiety levels were categorized into the absence of depression/anxiety, mild depression/anxiety, moderate depression/anxiety, and severe depression/anxiety (Cunha, 2001).

The comparison of depression anxiety levels with the sociodemographic and professional characteristics of the workers was performed using the chi-square test, considering a significance level of 5% ($p \leq 0.05$).

The study was approved by the Research Ethics Committee of the institution, under Opinion No. 1,776,737, of October 17, 2016.

Results

The study included 173 professionals, 22 (12.7%) doctors, 28 (16.2%) nurses, 38 (22.0%) nursing assistants/technicians and 85 (49.1%) community health workers. There was a prevalence of female professionals [147 - 85.1%], higher education [77 - 44.5%], married [104 - 60.1%], aged from 21 to 35 years [77–44.5%], with a family income of two to five minimum wages [111–64.2%]. Sixty-two (35.8%) professionals said they had a chronic disease.

We highlight that 114 (66.7%) said they were satisfied with their profession; however, 107 (61.8%) already stated that they had already thought about giving up the profession.

The average time of work in PHC was four years and one month [CI 95%: four years to five years and two months], with 64 (37.0%) professionals having between two and five years of work and 58 (30.5%), up to two years of experience in PHC.

Figure 1 shows that 78 (45.3%) professionals presented some degree of anxiety and 71 (41.0%) some degree of depression.

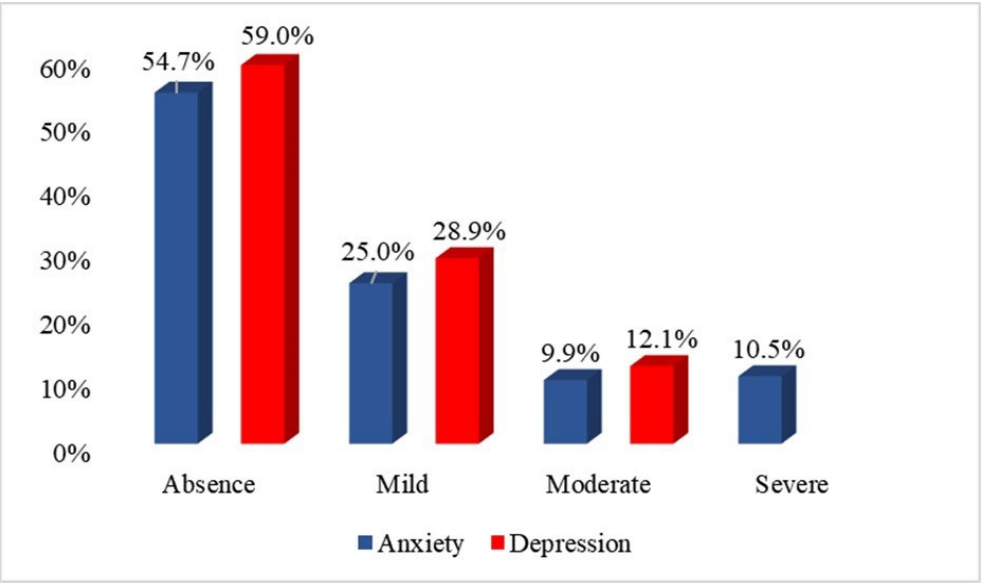

Figure 1. Distribution of the percentage of PHC professionals, according to the degree of anxiety and depression (n=173).

Table 1 shows that there was a statistically significant difference in levels of anxiety between the different professional categories (p=0.006), education (p=0.008), satisfaction with the profession (p=0.000), and have thought or not about giving up the profession (p=0.001). Regarding professional categories, there was a higher prevalence of anxiety among Community Health Workers – 54.2% had some level of anxiety. Doctors were the professionals with the lowest occurrence of anxiety – 10.5% of these professionals had some level of anxiety. Also, higher percentages of anxiety were observed among professionals with elementary education (24.2%), who were not satisfied with their profession (23.8%), and who had already thought about giving up the profession (35.2%).

Table 1. Distribution of anxiety levels of PHC professionals, according to sociodemographic and professional variables (n=173).

	Absence n (%)	Mild n (%)	Moderate n (%)	Severe n (%)	p-value
Professional category					
Doctor	17 (10.3)	2 (1.2)	-	-	**0.006**
Nurse	18 (10.9)	4 (2.4)	4 (2.4)	-	
Nursing Assistant/Technician	17 (10.3)	14 (8.5)	3 (1.8)	3 (1.8)	
Community Health Agent	38 (23.0)	22 (3.3)	9 (5.5)	14 (8.5)	
Gender					
Male	16 (9.7)	5 (3.0)	-	1 (0.6)	0.180
Female	74 (44.8)	37 (22.4)	16 (9.7)	16 (9.7)	
Education level					
Elementary School	35 (21.2)	21 (12.7)	8 (4.8)	11 (6.7)	**0.008**
High school	5 (3.0)	8 (4.8)	3 (1.8)	-	
Higher education	50 (30.3)	12 (7.3)	5 (3.0)	5 (3.0)	
Age group					
21 to 35 years old	39 (23.6)	17 (10.3)	7 (4.2)	10 (6.1)	0.353
36 to 50 years old	38 (23.0)	15 (9.1)	4 (2.4)	6 (3.6)	
51 to 65 years old	9 (5.5)	9 (5.5)	3 (1.8)	1 (0.6)	
Marital status					
Married	55 (33.3)	21 (12.7)	13 (7.9)	10 (6.1)	0.660
Single	27 (16.4)	15 (9.1)	3 (1.8)	5 (3.0)	
Separate	6 (3.6)	4 (2.4)	-	2 (1.2)	
Widow	2 (1.2)	2 (1.2)	-	-	
Family Income (minimum wages)					
Up to 1	4 (2.4)	2 (1.2)	1 (0.6)	1 (0.6)	0.449
2 to 5	52 (31.5)	32 (19.4)	10 (6.1)	15 (91)	
6 to 10	18 (10.9)	4 (2.4)	2 (1.2)	1 (0.6)	
More than 10	15 (9.1)	3 (1.8)	3 (1.8)	-	
Chronic disease					
Yes	24 (14.5)	19 (11.5)	6 (3.6)	9 (5.5)	0.068
No	66 (40.0)	23 (13.9)	10 (6.1)	8 (4.8)	
Time of service at the ESF					
0 to 2 years	37 (22.4)	9 (5.5)	5 (3.0)	5 (3.0)	0.684
> 2 and ≤ 5 years	28 (17.0)	19 (11.5)	6 (3.6)	7 (4.2)	
> 5 and ≤ 10 years	11 (6.7)	8 (4.8)	3 (1.8)	1 (0.6)	
> 10 years	12 (7.3)	5 (3.0)	2 (1.2)	4 (2.4)	
Satisfied with the profession/occupation					
Yes	73 (44.2)	25 (15.2)	4 (2.4)	7 (4.2)	**0.000**
No	17 (10.3)	17 (10.3)	12 (7.3)	9 (5.5)	
Already thinking about giving up the profession/occupation					
Yes	43 (26.1)	30 (18.2)	13 (7.9)	15 (9.1)	**0.001**
No	47 (28.5)	12 (7.3)	3 (1.8)	2 (1.2)	

Regarding depression, there was a statistically significant difference in the levels found between the different professional categories (p=0.001), age group (p=0.001), presence or not

of chronic disease (p=0.015), satisfaction with the profession (p= 0.000), and having thought or not about giving up the profession (p=0.002), as shown in Table 2. Regarding the professional categories, there was a higher prevalence of depression among Community Health Workers - 56.6% of the professionals presented some level of depression. Doctors were the professionals with the lowest occurrence of depression, with 5.2% of these professionals having some level of depression. Even higher percentages of depression were observed among professionals aged 21 to 35 years (21.1%), who did not have a chronic disease (22.3%), who were not satisfied with their profession (21.1%), and who have already thought about giving up the profession (31.3%).

Table 2. Distribution of depression levels of PHC professionals, according to sociodemographic and professional variables (n=173).

	Absence n (%)	Mild n (%)	Moderate n (%)	p-value
Professional category				
Doctor	18 (10.8)	1 (0.6)	-	**0.001**
Nurse	18 (10.8)	8 (4.8)	1 (0.6)	
Nursing Assistant/Technician	25 (15.1)	8 (4.8)	4 (2.4)	
Community Health Agent	36 (21.7)	32 (19.3)	15 (9.0)	
Gender				
Male	15 (9.0)	6 (3.6)	1 (0.6)	0.440
Female	82 (49.4)	43 (25.9)	19 (11.4)	
Education level				
Elementary School	31 (18.7)	32 (19.3)	12 (7.2)	0.260
High school	12 (7.2)	3 (1.8)	1 (0.6)	
Higher education	54 (32.5)	12 (7.2)	7 (4.2)	
Age group				
21 to 35 years old	39 (23.5)	23 (13.9)	12 (7.2)	**0.001**
36 to 50 years old	43 (25.9)	18 (10.8)	2 (1.2)	
51 to 65 years old	11 (6.6)	6 (3.6)	5 (3.0)	
66 years old or more	1 (0.6)	1 (0.6)		
Marital status				
Married	59 (35.5)	28 (16.9)	12 (7.2)	0.763
Single	30 (18.1)	16 (9.6)	5 (3.0)	
Separate	5 (3.0)	4 (2.4)	3 (1.8)	
Widow	3 (1.8)	1 (0.6)	-	
Family Income (minimum wages)				
Up to 1	4 (2.4)	2 (1.2)	2 (1.2)	0.067
2 to 5	54 (32.5)	39 (23.5)	16 (9.6)	
6 to 10	19 (11.4)	5 (3.0)	1 (0.6)	
Moe than 10	18 (10.8)	3 (1.8)	1 (0.6)	
Chronic disease				
Yes	26 (15.7)	25 (15.1)	7 (4.2)	**0.015**
No	71 (42.8)	24 (14.5)	13 (7.8)	
Time of service at the ESF				
0 to 2 years	39 (23.5)	11 (6.6)	6 (3.6)	0.315
> 2 and ≤ 5 years	29 (17.5)	25 (15.1)	7 (4.2)	
> 5 and ≤ 10 years	14 (8.4)	6 (3.6)	3 (1.8)	
> 10 years	13 (7.8)	7 (4.2)	3 (1.8)	
Satisfied with the profession/occupation				
Yes	77 (46.4)	25 (15.1)	8 (4.8)	**0.000**
No	20 (12.0)	24 (14.5)	11 (6.6)	
Already thinking about giving up the profession/occupation				
Yes	49 (29.5)	34 (20.5)	18 (10.8)	**0.002**
No	48 (28.9)	15 (9.0)	2 (1.2)	

PHC professionals had anxiety symptoms associated with some level of depression (54.7%). There was considerable (K=0.323) and statistically significant (p=0.000) agreement between professionals with anxiety and depression (Table 3).

Table 3. Association between anxiety and depression for PHC professionals (n=173).

Variables	Depression				Kappa	p-value
	Absence n (%)	Mild n (%)	Moderate n (%)	Total		
	Anxiety					
Absence	78 (45.3)	14 (8.1)	2 (1.2)	94 (54.7)	0.323	0.000
Mild	21 (12.2)	18 (10.5)	4 (2.3)	43 (25.0)		
Moderate	3 (1.7)	7 (4.1)	7 (4.1)	17 (9.9)		
Severe	-	10 (5.8)	8 (4.7)	18 (10.5)		
Total	102 (59.3)	49 (28.5)	21 (12.2)	172 (100.0)		

Discussion

The composition of the 15 PHC teams evaluated meets the recommendation of the National Policy for Primary Care, regarding the minimum professional composition (doctor, nurse, nursing assistant and/or technician, and community health workers) (Brasil, 2017).

In a comparison with national and international studies carried out with PHC professionals (Lourenção et al., 2012, 2019; Singh et al., 2019; Souza et al., 2019; Cordioli Junior et al., 2020; Silva et al., 2020), the profile of professionals is similar. That is, there is a predominance of females, with higher education, married, aged from 21 to 35 years old, with a family income of two to five minimum wages and up to five years of experience at PHC.

The levels of anxiety found in this study were lower than those observed in studies with nursing professionals, managers of Family Health Units, pediatric residents, and Brazilian multidisciplinary health residents (Rotta et al., 2016; Lourenção et al., 2017; Lourenção, 2018; Julio et al., 2021), showing that the evaluated PHC professionals are under less stressful working conditions, as anxiety comprises the body's response to stressful situations and generally causes symptoms such as loss of concentration, restlessness and sleep disturbances, among others (Barbosa et al., 2020).

On the other hand, the levels of depression were higher than in studies with FHS doctors and with multidisciplinary health residents (Rotta et al., 2016; Garcia Junior et al., 2018) and lower than those presented by managers of Health Units Family, pediatric residents and PHC nursing professionals (Bertussi, 2017; Lourenção et al., 2017; Lourenção, 2018; Julio et al., 2021). This difference in the level of depression of the professionals in this study is consistent with the literature, which indicates a variation of 15.4% to 40.5% in the prevalence of stress among health professionals (Corrêa & Rodrigues, 2017). It is commonly higher than the estimated prevalence of stress for the general population, which, according to the World Health Organization, is 5.8% in Brazil and 5.9% in the United States (World Health Organization, 2017). The high rates of depression among health professionals are attributed to the working conditions

of these professionals, which involve precarious physical structures, lack of materials and equipment, shortage of professionals, and work overload, in addition to the lack of social support and interpersonal support (Gontijo et al., 2020; Faria et al., 2021).

The results also showed that Community Health Workers were the professionals most affected by anxiety and depression disorders, while doctors had the lowest levels of anxiety and depression. The differences in levels of anxiety and depression between professional categories are because professionals working in PHC services are exposed to different processes and workloads for each professional category and that causes different physical and emotional strain, according to the individual capacity for resilience (Moura et al., 2018).

CHW, for example, suffer an overload resulting from high work demands and mechanical, biological, physiological, and psychological workloads, which can favor mental illness, as shown by the results of this study (Lourenção et al., 2012; Faria et al., 2021). In addition, the CHWs are the professionals with the lowest level of education, with the highest prevalence of anxiety and depression, reinforcing the negative correlation between the level of education and anxiety and depression disorders (Serra-Taylor & Irizarry-Robles, 2015). Thus, we highlight that professionals with higher education tend to have a greater capacity for resilience and then, suffer less emotional distress than those with less education, which may explain the lower levels of anxiety and depression among doctors and nurses (Almeida et al., 2016; Silva et al., 2016).

The literature indicates that female and married professionals tend to have a higher prevalence of anxiety and depression due to the double workload of women, at work and home (Barros et al., 2017; Junqueira et al., 2018; Moura et al., 2018). However, our study did not find a statistically significant difference in levels of anxiety and depression between gender and marital status, a fact that may be related to the predominance of women among the professionals studied.

However, the results showed a higher prevalence of depression in young adult professionals, corroborating a study carried out with Community Health Workers in a municipality in the state of Bahia, which revealed a higher frequency of psychological disorders in women, with a stable relationship and aged under 40 years (Neves et al., 2017).

Another relevant aspect evidenced by our study concerns the statistically significant relationship between levels of anxiety and depression with the satisfaction of professionals and the desire to give up on the profession. The results showed a higher prevalence of professionals with anxiety and depression among those who reported being dissatisfied with their profession and among those who had already thought about giving up the profession. Furthermore, we found that most PHC professionals had anxiety symptoms associated with some level of depression. In this context, it is important to emphasize that the health of these professionals is closely linked to their conditions in the work area; without the necessary conditions for the performance of their function, professional wear and tear can occur. Likewise, the precariousness of the physical structure directly influences the performance of work and negatively affects the worker's emotional state. In addition, the quality of interpersonal relationships with unit managers and meeting the demands of the population also influence the psycho-emotional conditions of PHC professionals (Medeiros et al., 2015; Gonsalez et al., 2017).

Thus, the results of our study reinforce the need for municipal managers to pay attention to the presence of factors related to the work process of the PHC teams that contribute to

the illness and lack of motivation of professionals, such as precarious careers, which generate frustration with the work and feeling of devaluation; the lack of professionals on the team, which leads to overload and physical and emotional strain; disrespect by superiors and colleagues, and differentiation due to the time in the job, which generate a harmful psychosocial exposure to the worker (Lourenção et al., 2012; Medeiros et al., 2015; Ernesto et al., 2017; Cordioli et al., 2019; Giovanella et al., 2020).

Therefore, managers must guarantee support for health care actions, such as strategic planning, which guarantees the effectiveness in carrying out the tasks. After all, a work environment influenced by favorable conditions, such as adequate infrastructure, team integration, motivation, and promotion of workers' well-being, stimulates work performance and produces positive impacts, such as an increase in the level of satisfaction and work engagement of the workers. professionals (Medeiros et al., 2015; Gonsalez et al., 2017).

Although we carried out this study in only one municipality, the results provide important information about the psycho-emotional health conditions of PHC workers, showing that the work process of these professionals can predispose them to anxiety and depression.

Conclusions

This study showed that there is a high prevalence of anxiety and depression in Primary Health Care professionals. Community Health Workers had the highest levels of anxiety and depression and doctors were the professionals with the lowest level of anxiety and depression. There was a higher prevalence of professionals with anxiety and depression among those who reported being dissatisfied with their profession and among those who had already thought about giving up the profession; in addition, most professionals had anxiety symptoms associated with some level of depression.

The data indicate the importance of municipal managers implementing measures for the health care of workers, which ensure favorable working conditions, such as adequate infrastructure, team integration, motivation, and promotion of the well-being of professionals in Primary Health Care, to avoid the workers' illness and guarantee the resoluteness of the work of these professionals.

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Rayara de Souza Julio contributed to the analysis and interpretation of data and writing of the article. Luciano Garcia Lourenção and Cláudia Eli Gazetta contributed to the design of the project, analysis, and interpretation of data, and writing of the article. Stella Minasi de Oliveira and Dóris Helena Ribeiro Farias contributed to the relevant critical review of intellectual content. All authors approved the final version of the text.

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