Healthcare workers' experiences during the COVID-19 pandemic in Argentina: A syndemic approach to hospitals

ANAHI SY

Abstract The SARS-CoV-2 pandemic put into evidence the need to think in syndemic terms, as all health issues co-exists with environmental, social, economic and political factors that exacerbate any epidemic. In this work we propose the concept of "syndemic" to analyze what happened in public hospitals of Argentina, from a socio-epidemiological perspective. In methodological terms, semi-structured interviews with workers were carried out in two stages: at the start of the pandemic in Argentina, via WhatsApp and through virtual meeting platforms. The content analysis of the narratives makes it possible to identify how health workers, in many situations, are the architects of problem-solving strategies that emerge during the pandemic: managing shortages (of supplies, for example) and providing care – even at risk to their own health. We also identified deliberative spaces of "dialogue-work" among workers (meetings, crisis committees, union activities), recognized as environments of support, care and/or self-care during the pandemic. In these spaces some challenges facing the health sector must be seen syndemically. We conclude by analyzing the potential of applying the concept of syndemic to public health problems and policies in hospital institutions from a socio-epidemiological perspective, highlighting the transformative process of workers to attend to emergency situations. These dimensions are crucial in developing health policies in synch with other processes of socio-epidemiological change, which occur both within hospitals and within the population that uses public health services.

Keywords hospital; syndemic; COVID-19 pandemic; healthcare workers; socio-epidemiology

Introduction

The declaration of the coronavirus pandemic has highlighted that any approach aiming to understand and address health-disease processes at the population level, recognize environmental risks, and promote more balanced and sustainable ecosystems must necessarily begin with considering the interactions of humans with other living things and the shared environment they inhabit (Walsh *et al*. 2020; Rock *et al*. 2009).

Chabrol and Kehr (2020) propose that COVID-19 emerged at a time when, in Southern European countries such as France and Spain, important social movements in defense of public health were under way; the pandemic interrupted mass-mobilization while also fueling continued reflection on the gradual degradation of working conditions and quality of care in public hospitals due to under-staffing and under-financing. In Argentina, a similar process was unfolding, evidenced from previous years, for example, by the downgrading of the Ministry of Health to a department, resulting in a reduction in personnel and funding, with the consequent degradation in working conditions and salaries (Sy *et al.* 2021).

In Latin American countries, COVID-19 pandemic overlaps with endemic diseases (tuberculosis, Chagas, dengue, hepatitis, and HIV, among others, called "neglected diseases"), seasonal diseases (such as the flu and other respiratory diseases) and diseases that have acquired an epidemic or pandemic status (obesity, diabetes, and hypertension, among others). The situation is potentiated not just fear of contagion, but also actual experiences of stigmatization, racism, gender inequalities, inequalities in the access to information, exposure to different types of violence, the availability of social protection policies and programs as well as access to health care, among others (Fronteira *et al.* 2021).

Ethnographic studies evidence that hospitals are not closed, total institutions but are continu-

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ations and condensations of society at large. Van der Geest and Finkler (2004) contrast new hospital ethnography with earlier functionalist models. They state that life in the hospital should not be regarded in contrast with life outside the hospital. Street and Cleman (2012) highlight the hospital is not an island and cite recent articles have emphasized the permeability of the hospital: the movement of patients, staff, and visitors in and out of the institution and the social relationships, inequalities, and cultural values that they carry with them (e.g., Mooney & Reinarz 2009; Quirk; Lelliott & Seale 2006). Moreover, it is argued that those social and cultural continuities are not merely external impingements on biomedicine. Biomedical practices and diagnostic styles are themselves adapted to the social and cultural conditions of the country in which a hospital is located (e.g., Finkler 2004; Gibson 2004; see also Berg & Mol 1998). While the COVID-19 pandemic has rendered the image of hospitals as solutions for health problems even more powerful and unquestioned, it has also shown the fragility, overwhelmedness and chronic strain of these institutions, aggravated by decades of outsourcing and austerity policies that have left many of them drained of personnel, maintenance and means.

In Latin America, and specifically in Argentina, ethnographic studies (Crojetovic 2010; García *et al*. 2017; Sy *et al.*, 2021; Moglia & Sy 2022 and 2023) illustrate the permeable character of hospital practices in contexts of scarce resources and extraordinary demand. These studies highlight how the subjectivity, creativity, and agency of workers shape processes of care and attention, as well as communication and interpersonal relationships.

Our hypothesis is that in the hospital space, during the pandemic, there is a synergistic interaction between pre-existing precarious working conditions and emergent problems, such as physical and mental exhaustion, promoting the development of new forms of working and new capacities that are unpredictable in the context of uncertainty.

In this sense, we revisit the concept of syndemic, introduced by the anthropologist Merrill Singer in 1990 to talk about the HIV/AIDS epidemic. He proposed understanding the synergistic interaction of health problems that coexist with environmental, social, economic and political factors that exacerbate any epidemic (Singer 1996).

This biocultural synthesis involves: 1) the intertwinement with the most important health problems at the local level; 2) the way in which individuals and their community understand health-disease; 3) the intervening social, political and economic dimensions, as well as the environmental conditions that can contribute to health or to the development of disease. This dialectical proposal drives the concept of syndemic (Singer 1996 and 2003).

More recently Singer and colleagues (2003) have broadened this concept to analyze its application to public health programs and policies. This entails a syndemic orientation to the prevention of as well as to the health problems associated with an epidemic, considering these connections when developing health policies in tune with other processes of social change so as to generate the conditions necessary for collective health. The concept of syndemic challenges the way disease has traditionally been conceptualized and defined, as a differentiated, discrete and disjunctive entity that exists (in theory) separate from other diseases and the social groups and contexts in which they are found (Singer & Clair 2003).

Such an expansion of the concept posits the existence of "community health" for both social scientists and those who develop policies. In this sense the concept operates as a theory that would make it possible to predict how to intervene effectively to mitigate risks to public health (Tsai *et al.* 2017).

This syndemic model shares fundamental premises with the field of public health and with collective health in particular. Such premises have been described in detail – with greater emphasis in one dimension or another – from the schools of thought of Latin American Social Medicine (Laurell 1986), critical epidemiology (Breilh 1995 and 1997), also Collective Health; ethnoepidemiology (Almeida Filho 1992, 1993, 2000 and 2020) and socio-epidemiology or sociocultural epidemiology (Menéndez 1990, 1992, 2008 and 2009; Haro 2010; Hersch-Martínez & Haro 2007; Hersch-Martínez 2013; Sy 2017).

In very general terms, what can be highlighted in any of these schools of thought is the need to consider any health problem (whether or not it is

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epidemic) in the socio-cultural, political and economic context in which it occurs, understanding that the problem at the same time emerges from these conditions, which in turn also impact the persistence, chronicity or the possibility of caring for health effectively. Disease is not conceived of as an individual but rather as a collective, social, or community problem (the terminology varies by author).

In seeking to replace the term pandemic for that of syndemic, emphasis is placed on that broader view; these concepts and perspectives acquire new value in light of the present pandemic.

Analyzing the present situation as a syndemic – much in the same way as analyzing it from a socio-epidemiological perspective – means thinking beyond the SARS-CoV-2 virus, incorporating an analysis of the global problem of social inequalities and living conditions, that is, how the population lives, falls ill and dies, in addition to considering the synergy resulting from the interaction between COVID-19 and other epidemic or endemic diseases.

This pandemic has irreversibly deteriorated the health of many sectors of the population, even those who have not contracted COVID-19; the increase in unemployment and poverty, the mental health crises and emergencies or the worsening of previously existing chronic diseases are some examples, among others.

Recent research developed in Latin America also makes use of the concept of syndemic; Almeida-Filho highlights a proliferation of concepts such as syndemic, infodemic, pandemic, to propose the need to develop a "pandemiology" (2021: 18). Mastrangelo *et al.* (2022) signal that in Argentina, COVID-19 emerged in a syndemic manner with infectious and chronic diseases as well as those associated with poverty (dengue, tuberculosis and measles). They suggest that this multi-morbidity is simultaneous, consecutive, and preexisting in the marginalized neighborhoods with a high index of unmet basic needs in which the authors' research takes place. In this sense, the April 2022 editorial of *Cadernos de Saúde Pública* criticizes the thesis that this is a "democratic disease," highlighting that all epidemics are at the same time biological, social and historical phenomena that express themselves unequally in the population, seen in the inequities in the risk of infection, illness or death, as well as the possibility of accessing care. In this context, as it is now known, the COVID-19 morbidity and mortality burden falls principally upon the poorest, revealing and deepening the enormous social inequalities in health already existing in Brazil (Werneck 2022) and also in other countries. Werneck (2022) therefore calls for the incorporation of the concepts of syndemic and intersectionality in epidemiological studies, citing the work of Horta *et al.* (2022), who, in the same issue of the journal, demonstrate the lack of access to health care during the first months of the pandemic in the most disadvantaged groups of the population, which makes it possible to foresee the impact in chronic diseases the care of which was postponed. In Argentina, the work of Remorini *et al.* (2021) makes reference to the local expressions of the syndemic; they posit it in relation to the impact on and implementation of responses in the everyday work of health services, from the perspective of applied anthropology. Unlike these works, our study proposes that the syndemic does not "act upon" or "express itself in" but rather is a constitutive part of what occurs in hospitals and among its workers. Here we propose to explore from a socio-epidemiological perspective the syndemic of the COVID-19 in health institutions, particularly public hospitals.

In this sense, we propose the syndemic involves health institutions, where the uncertainty, new work protocols, and physical and mental exhaustion of the workers interact synergistically with the prior working conditions (work precarity, supply shortages, among others), requiring the development of new forms of working and new capacities, necessary in contexts of uncertainty. Simultaneously, this situation has demanded new strategies of government, in which the epidemiological data is insufficient to understand and address the problem. The circulation of people can be measured, permitting an understanding of the increase or decrease in the number of new cases and deaths, but it has been seen that there is no measure that works to intervene in human behavior. Although it is true that the circulation of a virus can be limited with vaccinations, this pandemic involves much more than a virus; it has involved living conditions, the way in which people live and die – having irreversibly deteriorated the health of many population groups – and it has challenged

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the forms of work and the work capacities of the health sector as well as demanded of the State in general new government strategies [Sy *et al.* 2021].

Although the virus does not seem will stop circulating, the challenge of intervening in this new socio-epidemiological reality that the pandemic has produced will remain.

Our proposal is to discuss a little-examined and little-visualized dimension of the syndemic that unfolds within the health institutions. We base our work in the narratives of health workers in hospitals of the southern area of the metropolitan region of Buenos Aires, where the majority of hospitals in the metropolitan area are located, as well as where indicators related to health, overcrowding, poverty and violence are most concerning.

THEORETICAL-METHODOLOGICAL FRAMEWORK

Although it is possible to think that "globalization" has tended to homogenize health problems and populations, and indeed the COVID-19 epidemic has acquired worldwide dimensions in epidemiological terms, the way in which the disease affects populations is not homogenous; the social and cultural inequalities that characterize Latin American countries represent a limit to statistical standardization or generalization. As is proposed with the concept of syndemic, an epidemic health problem does not have its origin in the risk behaviors of people and social collectives in a way isolated from their living conditions, their access to health care and their ability to meet basic needs such as food, work or housing, among others. This category also allows us to reflect upon the differences and inequalities that preexist the COVID-19 pandemic and their differential impact by gender, age, ethnicity or social class, among other dimensions.

Latin America is characterized by its diversity and its ethnic, racial, economic and environmental inequalities, among others, which coexist and overlap in ways that can be more or less contradictory. In these contexts the pandemic also presents consequences that cannot be described, much less addressed, exclusively from a modern epidemiology point of view.

The socio-epidemiological approach developed in this work has its precedents in Latin American authors such as Menéndez (2008 & 2009), Sy (2017 & 2018) and Sy *et al.* (2021), seeking to overcome the biological and positivist biomedical bias that characterizes a large part of modern epidemiological research in order to examine this pandemic not explicitly intending to do so "in syndemic terms" per se. Doing so entails an openness to ethnographic-type research to examine unexplored issues and model new scientific objects in the field of collective health, recognizing the socio-historical character of the discipline of epidemiology itself. It also requires the construction of models of interpretation of health-disease processes[1] in modern societies capable of integrating both perspectives through the application of methodological strategies that competently combine quantitative and qualitative approaches in a single ethno-epidemiological strategy. One of the central premises is that health-disease phenomena are social processes and, understood as such, are also historical, complex, fragmented, conflictive, dependent, ambiguous and uncertain (Almeida Filho 1992; 2000). Whith "Socio-epidemiology" or "socio/ethno-epidemiology" we highlight the need to integrate the methods, techniques and theory of medical anthropology, ethnography and epidemiology (Hersch Martínez & Haro 2007; Menéndez 2008, 2009; Álvarez 2008; Haro 2010; Hersch Martinez 2013). This perspective does not just seek to change the statistical representation of a phenomenon but rather to obtain a conceptual development that makes it possible to understand the historical and social base of the unequal distribution of health in human populations. Thus, socio-epidemiology is a discipline whose ultimate purpose is to transform concrete health realities. From the perspective of Latin American socio-epidemiology, the subject is considered not only the unit of description and analysis, or as is traditionally considered, "the object of study," but also is included as a transformative agent that produces and not just reproduces the social structure and meanings (Menéndez 2009).

These perspectives are closely related to North American Critical Medical Anthropology (they share a Marxist legacy). A recent criticism of the concept of syndemic, published in *Social Science and Medicine,* signals the absence of references to intersectionality (Sangaramoorthy & Ben-

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ton 2021). The response posits that syndemic theory stems from Critical Medical Anthropology (Bulled & Singer y Ostrach 2022). In 1995, Singer had already clearly stated that from this perspective: 1) health is profoundly political; 2) the mission of the theory is emancipatory and aims not just to understand but also to change the patterns of oppression and exploitation that occur with respect to health; 3) a commitment to change is established as a fundamental aspect of the discipline (Singer 1995). These assertions are very familiar in the field of collective health as a whole, and in the field of sociocultural epidemiology in particular.

It is from this theoretical-methodological approach that we propose situating this study in hospitals so as to analyze the syndemic reality they experience in the context of the coronavirus pandemic.

The area of study is the southern region of the Metropolitan Area (MA) of the province of Buenos Aires. According to the 2010 census, the population of the province of Buenos Aires is 15,625,084 inhabitants, 9,916,715 of which correspond to the MA (INDEC 2012). The southern region of the MA has the highest population density, with 3,747,486 inhabitants. According to INDEC data (2021), in the second semester of 2020, 40.9% of homes in the *partidos* [jurisdictions unique to the province of Buenos Aires, similar to counties] of Greater Buenos Aires were at poverty level and 4.5% were considered to be indigent[2]. This region concentrates the largest number of Zonal and Interzonal General Hospitals in the province, a total of 20.[3]

The sample of people interviewed was made up of general hospital workers (of zonal or interzonal hospitals) from the southern area of the MA. The selection criteria for interviewees was: a) that their workplace (at least one, in the event of more than one job) be one of the aforementioned general hospitals; b) that they worked at the institution (whether prior to or at the time of the interview) during the period of the coronavirus pandemic. These sampling criteria ensure achieving the greatest possible diversity of workers, not just professionals but also technical and administrative staff.

In this sense, in a first exploratory stage, carried out between May and August 2020, contact with the workers was established via WhatsApp in order for them to narrate their experiences. A message was sent through institutional networks inviting workers to participate in the research, offering information about the study objectives and the ethical precautions that would be taken. When a worker responded with interest in participating, we provided them with greater detail through a WhatsApp audio message or a personal call. These first contacts also referred us to others who might be interested in participating (reaching a total of 41 workers; 34 female and 7 male). In the second stage of the study, occurring between May and November 2021, a total of 38 semi-structured interviews were carried out (24 female and 14 male), mostly via Zoom, GoogleMeet or Jitsi, although some were in-person. Staff of different areas such as cleaning, administration, medical care, mental health, social work, nursing, biochemistry and security were interviewed in order to reveal the views and experiences of different social actors involved in the hospital during the pandemic, as is proposed by socio-epidemiology.

The processing of the whatsApp audio and the interviews recorded included a full transcription of the audio and content analysis of the narratives. Initially, a comprehensive and thorough reading of the transcribed text was carried out, oriented at obtaining an overall view of the full set of narratives obtained and the elaboration of categories and theoretical concepts, as well as an explanation of the preliminary presumptions orienting the analysis. Next, certain descriptions and inferences were elaborated and definitive emergent categories were constructed in articulation with the data and theoretical categories.

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It is also connected to an international network of research teams examining the experiences of health workers during the COVID-19 pandemic in 22 countries. This network is coordinated by the Rapid Research Evaluation and Appraisal Lab (RREAL) at the University College of London in the United Kingdom.

The data was obtained in accordance with the ethical precautions established by the Argentine

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Ministry of Health in the document "Guía para Investigaciones con Seres Humanos" (Res. MSAL 1480/2011). The overall project encompassing this study was approved by the Research Ethics Committee of the Juan H. Jara National Institute of Epidemiology (Record N°059/2016, FOLIO 107. Comittee of Human Research Minutes N°2, 09/02/2016, Code SY 01/2020).

Results

> "We went to work because it was our job and we'd chosen it before the pandemic, but nobody wanted to be a hero, ok? We all had to do it because it was our job."

The people interviewed organized their narratives according to their lived experiences, shared among those who work in hospitals and health centers but not always coinciding with the "official" narratives, such as the organization of data into epidemiological weeks or according to stages (from 1 to 5, in which different activities were allowed). During this time of epidemiological emergency, in which we were in contact with different hospital workers from the Greater Buenos Aires area, we could identify experiences that situate those who work in the health field in a unique framework of space and time. We organize our results based on this temporality narrated to us by those at the center of this work.

Not seeing the forest for the virus

The start of 2020 attracted our attention towards a virus moving in an unpredictable way, giving rise to the idea of it "escaping from a laboratory" in China, although finally its zoonotic origin was established (Reyes *et al.* 2021).

On January 12, 2020, Chinese scientists made public the genome of the new coronavirus, the cause of a new human disease: COVID-19 (WHO 2020b).

Rapidly we found ourselves living in a reality that felt part science fiction movie and part apocalyptic catastrophe. There was a proliferation of images from China that at the time seemed farfetched – people with plastic bottles covering their whole faces or with surgical suits fumigating streets or involved in violent confrontations in incomprehensible situations.

On March 2, 2020, the first case of coronavirus was confirmed in Argentina and on March 7 the first death was reported in Latin America. On March 11 the World Health Organization (WHO) granted pandemic status to the expansion of SARS-CoV-2, highlighting the speed of the virus's spread and the passivity of the governments worldwide (OMS 2020). At the same time it was highlighted that COVID was not just a crisis in the area of public health but affecting society as a whole, and governments were urged to take measures oriented at the prevention of infection and minimize the virus's impact. On March 12, 2020, the Argentine government signed the Decreto de Necesidad y Urgencia (Declaration of Emergency) that established a health emergency, enabling the Ministry of Health to adopt the necessary public health measures to avoid propagation of the virus. As a corollary, on March 19, 2020, Preventative and Obligatory Social Isolation was declared. Only those known as "essential workers" had permission to circulate. In general, health workers were considered "essential," although not all of them; there were primary health care centers closed at the start of the pandemic and hospital services that were "put on pause," workers without protocols to follow, with uncertainty about the obligation of going to work (or not) and in what way, to do what, how to reach patients and users that needed them urgently, for psych treatments or for dental emergencies or for medication for a chronic illness.

> "This issue that during the pandemic there aren't other illnesss, no? Because there are people who need continuity in their treatment, these situations of risk that haven't been easy in mental health."

The quotation emphasize the fact that lot of people does not receive care for chronic or emergent health problems except for COVID-19. In this context "new" care strategies were developed, certain territory-based practices appeared, in the home of the users themselves or via telephone.

Another important issue was the shrinking of the staff in the health system in general, because people went on leave or because they were part of the population defined as "at risk."

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In the institutions, rotating work shifts were established so as to reduce the exposure of the whole staff at the same time. These shifts meant more hours in the day but fewer overall days, thereby guaranteeing coverage and, in the event that isolation was necessary, a smaller group of people who would be required to isolate.

A critical example at the start of the pandemic was availability the personal protective equipment (PPE), in addition to the discussions about its utility as a type of protection from or prevention of infection, and about who should use it and when. This situation stirred old rivalries among professionals: At the beginning, the infectious diseases specialists fought everyone to not use a mask, they wanted to work in the emergency room without a mask themserlves. There was a big crisis between the staff and the infectious diseases specialists, everyone brought their own mask. They say: "At first everything was very tense".

In some cases, during this first period, access to equipment occurred through donations or the direct purchase of the workers themselves.

We have to get through the winter

These issues highlighted at the start of the pandemic were accented and others were added in the winter, during what was known as the "first wave." Regarding this situation, one worker explains:

> "We had to buy our clothes, we had to deal with the bad pay. The work isn't worse than before the pandemic, the risk is greater than before, and people are worse to the health staff, they're more violent, more toxic".

Although the shortages of supplies as well as the situations of violence towards the staff or the low salaries are problems that pre-exist the pandemic, they became more visible and magnified especially when there was a sharp increase in the number of cases, intensifying unease and discomfort. While violence was recognized as pre-existing, it reemerged in this context, especially visible to those in charge of hospital security. A health care worker ironically says:

> "In March of this year, a person came in, I was covering the emergency room. And a guy came in who wanted to be seen right away, but I explained that the protocol was that he had to go through triage to get his temperature taken (...) And the man spit green mucus in my face. And when I told my boss what had happened he said 'well, it's part of the job'. The supervisor higher up told me 'ok, but let it go, it's over now'."

These narratives reveal how violent situations are naturalized within the institutions and those who suffer them are revictimized. In this case the security staff, in the context of the pandemic, were doubly exposed: to violence but also to infection as the result of interactions of this type with those in need of hospital care.

In this context there were also those who took leave or quit for health or personal reasons, leaving their job in the hospital: With the increase in demand, scarcity was once again magnified:

> "In nursing human resources have been historically scarce. These are problems from even before I started working at the hospital (...) this goes beyond the pandemic".

Another preexisting issue that worsened during the pandemic is the lack of space and cleanliness in the hospitals:

> "In the middle of a COVID outbreak in our service (residency) we had to fight for them to clean our bathroom, they hadn't come to clean the area where we sleep for three months".

New demands also appeared: "the emergency room became an intensive care unit and we aren't intensivists." Old rivalries reemerged, connected to institutionalized inequalities among doctors and nurses, linked to professional and gender hierarchies that preexist the pandemic: It's disproportionate, you know, it's always been like that and it'll continue to be like that, it's like machismo, ok? There's a huge difference between men and women, here there's a huge difference between doctors and nurses. Here we're still in the stone ages, they think we're errand boys, "bring the bedpan," "change the diaper." This got worse in the pandemic [...] the nursing profession grew a lot during the pandemic [...] but there's no recognition of that.

Low salaries and multiple jobs are also a pre-pandemic epidemic:

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> "And don't get me started on what salaries we make, it's so little, we doctors earn a little more but this nurse who is vital, who is ... nothing would work without her (...) has to have two jobs, so they come, that is, they work 12 hours a day and get here totally exhausted".

A health care worker ironically says

> "Don't congratulate me so much, just pay me what I'm worth; I'm just saying, just a minor little detail [ironic tone]".

The adjustment variable in these situations in the body itself, the health of the workers. In the case of women, many are also heads of households depending entirely on their salary and domestic labor for the reproduction of the domestic life in their homes:

> "You start rethinking a bunch of things, I've always had two jobs, and that's when I started rethinking things and saying 'Is all of this worth it?' At the end of the day, if something happens to me, my kids will be left all alone."

The simultaneity of problems at an institutional level, reflected in the narratives, reaches the subjective, individual dimension:

> "After a long shift, when it was a hard shift, you come back to your house and feel empty, you feel like you gave it your all and you've earned your rest, but you also feel like you don't have anything, like your life doesn't belong to you, you feel like you came home to your house and suddenly your life is nothing...you were 32 hours at the hospital and you get home at 5 in the afternoon and you don't have the energy to do anything, it's so hard, and of course there's the contact with death, the contact with people dying."

Workers situate their hope in the immediate future. "It's winter now, we have to get through the winter [...] we hope that the spring comes soon". The major expectation was around the vaccination to change the situation.

The second wave

During the second wave these problems worsened and magnified, the lack of roms and workers fatigue and exhaustion were increased; "I had to sedate four patients on the same night because there was no room in critical care".

Workers, and especially the area of social work, recognize problems have to do more with the precarization of the lives of people, they stopped seeing and stopped accompanying "even if it's not something COVID related, or it is but in a more complicated way".

As is evident in the quote, workers recognize that COVID acts syndemically on populations, even when they don't give it that name, they recognize the worsening of the clinical state of chronic diseases and the deterioration of living conditions as a determinant of health-disease.

There is unease expressed in the narratives resulting from the unique circumstances in synergistic interaction with pre-existing issues. This synergy among epidemics at the population level also manifests itself at the hospital level, among its workers: they spoke of episodes of COVID-19 infection, hypertension, rashes, headaches, panic attacks, extreme anxiety, fear, stiffness, and worsening of the state of chronic diseases, as well as "sadness, deep sadness" throughout this period.

In search of the next horizon

In the same way that problems that magnify and worsen during the pandemic can be identified, there are also relational dimensions that intervene synergistically in supporting health workers. In this sense, the place of the "team" in moments of anxiety or despair is valued; the team is the space in which "paralysis" is prevented and a response to the "fear" and "paranoia" emerging in these circumstances is given, especially in solitary moments.

> "The pandemic put on the table some issues that I understand are like a certainty in our work logic, that is, we couldn't have gone through this pandemic without all the teamwork we'd been carrying out beforehand [...] it somehow puts into evidence that you have to plan things, you have to work in teams, [...] nothing new, right? But I think it really imposed itself strongly".

Unions, crisis committees and team meetings were spaces of support for workers during the crisis, with them stating "we couldn't have tolerated it any other way." Although we asked about spaces

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of emotional or psychological support formally offered during the pandemic, the institutional proposals did not go beyond the institution's own area of psychology, that is, seeing one's own colleagues, with the intimidating situation that this generated. There were also individual responses to start therapy or pharmacological treatment, with personalized therapeutic accompaniment.

A horizon of hope with the vaccines can be detected. Hospitals have now become spaces in which the workers feel "safer than outside." There's a certain stability and predictability of PPE, protocols and protection measures.

Although workers seek a future horizon in which "a return to normalcy" is possible, the transition to the post-pandemic requires certain considerations in the sense that there is no returning to a previous state but rather a continuity toward a new socio-epidemiological reality. From this place it is necessary to consider and re-consider the reality of those who today provide care with respect to who they were two years ago. A return to a previous state is implausible, no one comes back unchanged from situations like those experienced in the pandemic; even continuing like nothing had happened would be disruptive, because the circumstances have changed.

The workers discern consequences of the syndemic in the future, in particular in the socio-epidemiological profiles of those who seek care in the public health sector. The secondary effects of sequelae of COVID will have to be cared for, as well as the health situations that were postponed during the pandemic:

> "A lot of surgeries are being reprogrammed and that's wrong. It's wrong at the level of the patient's health, but at the level of the health system there's no alternative: I don't have beds in the care units, I can't make them up, so I can't operate."

There are cases of scheduled operations and other situations more connected to chronic diseases, the treatments of which were interrupted or discontinued, with a corresponding worsening of the clinical picture.

These issues present a novel scenario in public health, a new socio-epidemiological reality with some conclusions that require consideration:

> "The lessons aren't for each health service, they're for the health system [...]. It doesn't work, you have the public system, the social security system and the private system, with zero coordination, zero. So the public system ends up absorbing everything that the private and social security systems can't or don't want to absorb in the pandemic [...]. The country's health system needs to be reformed because like this it works badly, no, it works terribly. And there's no awareness in the population that it's not working."

This narrative expresses the need to establish deep transformations. Talk to "zero coordination" refers to the fragmentation of the health system in Argentina composed by public, social security and private parts. Although it is true, as Franco and Merhy (2017) explain, the work processes in health materialize in the actors – individual and collective – that produce them, we should not lose sight of the local scenarios in which those processes take place. The pandemic generated a new situation at the macro level that had unique expressions in hospitals, contributing to the visibilization of certain problems and highlighting some social actors while invisibilizing others. In this sense, our work did not limit itself to exclusively interviewing workers that directly treated COVID cases, but rather, in accordance with our theoretical framework, posits the necessity of dialoging with all hospital workers situated in their unique work scenarios. This allows us to see that the distribution and concentration of processes affecting health are not the same for all the personnel, with differences produced in relation to, for example, gender, hierarchy and labor inequalities existing within the institutions.

DISCUSSION AND FINAL CONSIDERATIONS

From the syndemics framework, it becomes clear that during the pandemic, hospitals faced a convergence of existing issues such as endemic and epidemic diseases and social demands with newly emerging or situational problems and challenges, all arising from the necessity to respond to the health emergency. The pandemic established new, centralized forms of organization, norms and management decisions that came into tension with the limits of autonomy of workers to produce health, with impacts that could have been

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reflected in their work with users and in their relationship with colleagues or other hospital workers. Those interviewed narrated that their everyday work was carried out in a context of scarcity of PPE, human resources and infrastructure, which demands constant readjustment and adaptation between the ideal and the possible.

These transformations show that their everyday work also affects the health of hospital workers. An often invisibilized or naturalized dimension in the narratives of these workers is that beyond the exposure to COVID infection, a number of new situations of violence, tension and stress appear in hospitals; a closeness to death is developed in a way that, according to the interviewees' narratives, they had never experienced before.

In this sense, granting descriptive and analytic priority to the different experiences and perspectives of those who work in the health field though their own narratives allows for a comprehension of certain dimensions that contribute to fragilizing and violating the health of the workers themselves, connected not only to the unexpected events of the pandemic that we are analyzing (as it is unfolding), but also to pre-existing problems that become magnified during the epidemiological emergency: working multiple jobs, low salaries and the inadequate infrastructure of the hospital are recurring topics. These dimensions highlight the syndemic character that the pandemic acquires within health institutions, in this case hospitals.

A recent work of Eduardo Menéndez (2020) posits that the fundamental space in which COVID-19 is combatted has been and continues to be that of self-care, which constitutes one of the structures that micro-groups generate in order to live and survive. Menéndez highlights that this reality remains hidden in politics and medicine, invisibilizing where the true power of containment of the pandemic lies. In our work, while our focus is on a very particular part of the population – health workers – we also could posit that an enormous power of containment, care and self-care lies in the health teams. Health care workers, in a number of situations, are architects of problem-solving strategies that emerge in the situation of the pandemic: managing scarcity (of PPE, for example) and offering care even at risk to one's own health. This is expressed in certain meanings and subjectivities shared among these workers within each institution: first, prioritize the care of the patient's health, and then one's own health or wellbeing. In relation to this dimension, different spaces of dialogue among workers (work meetings, crisis committees, union activity) are recognized as spaces of support for getting through this period of the pandemic and are valued as spaces of care or self-care.

In these deliberative dialogue-work spaces, some challenges facing the health sector (connected especially to the syndemic character of the pandemic) can also be seen, especially postponement in the care of chronic diseases, in ambulatory care, in surgical interventions and in neglected endemic health problems. The Pan-American Health Organization (2020) posits that services for the prevention and treatment of noncommunicable diseases (NCDs) have been gravely affected since the start of the COVID-19 pandemic in the region of the Americas. According to a survey carried out by the Pan-American Health Organization/World Health Organization (PAHO/WHO), since the start of the pandemic, routine health services were reorganized or suspended and many ceased to provide attention to people in treatment for diseases like cancer, cardiovascular disease and diabetes. Similarly, many health workers who usually provide this care were redirected to other areas for COVID care. Ambulatory health care services were partially or totally suspended in many countries, like Argentina. These interruptions have affected the care of people with NCDs, diabetes, hypertension, oral care and rehabilitation (PAHO 2020).

At present, health workers identify difficulties associated with this situation and, from our socio-epidemiological perspective, must appeal to their experience and knowledge of the territory to implement strategies that allow them to solve the problems that can be discerned in the present and that become important challenges for the near future.

In this way, the consideration of the syndemic within the health institutions themselves shows the complexity of dimensions that remain hidden or invisibilized from a macro perspective or from a conventional perspective of epidemiology of health systems and services. Examining the

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unique character of the worker and their work and of the teams in each institution contributes to the development of public health measures and interventions within these institutions that favor the health of their workers and of the general population, attentive to the needs felt by those who carry out their work there.

In this sense, we propose an innovative approach to syndemic by applying this concept to healthcare workers in the hospitals in which old and new problems interact synergistically. It is crucial to consider dimensions that are intrinsically connected, taking as a starting point those collective dialogue-work spaces among workers as a fundamental cohesive force for promoting any change or social transformation that materializes within the institution.

Notes

1 From Latin American theorizations health-disease process is defined as a multidimensional phenomenon that involves not only biological and clinical aspects but also social, cultural, economic, and political factors. It emphasizes how these dimensions interact and determine the health and disease of populations, highlighting social inequities and structural conditions that influence health outcomes.
2 Defined as the condition in which a person or household lacks the economic resources to cover essential basic needs for daily subsistence.
3 https://www.gba.gob.ar/saludprovincia/regiones_sanitarias

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Anahi Sy, Dr., is a Social Anthropology and health researcher. Bachelor's degree in Anthropology and a Ph.D. in Natural Sciences from the National University of La Plata (Buenos Aires, Argentina). Fellow Researcher at the Institute of Justice and Human Rights from National Council for Scientific and Technical Research (CONICET, Argentina). Professor at the Department of Community Health. National University of Lanús (UNLa). Her work focuses on health care alternatives and indigenous peoples, socio/ethno-epidemiology and mental health in psychiatric institutions and general hospitals, from an ethnographic perspective. She has worked as a consultant in UNICEF Argentina projects, in the Ministry of Health and Social Development of Argentina. Additionally, she is a member of the coordinating committee of the Argentine Network of Anthropology and Health (RedASA) and serve on the Research Ethics Committee at the University of Gran Rosario (UGR), Argentina.

ORCID: https://orcid.org/0000-0002-1281-5333

e-mail: anahisy@gmail.com

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