ORIGINAL ARTICLE

Community Health Agents and their experiences of pleasure and distress at work: a qualitative study

AGENTES COMUNITÁRIOS DE SAÚDE E AS VIVÊNCIAS DE PRAZER – SOFRIMENTO NO TRABALHO: ESTUDO QUALITATIVO

AGENTES COMUNITARIOS DE SALUD Y LAS EXPERIENCIAS DE PLACER-SUFRIMIENTO EN EL TRABAJO: ESTUDIO CUALITATIVO

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ABSTRACT

The objective of this study was to identify the situations that cause pleasure or distress at work among the Community Health Agents (CHA) in a city in Rio Grande do Sul state/Brazil. A qualitative study was performed with 24 agents as the participants. Data collection took place in 2009 through the use of focal groups, using the thematic analysis technique. The situations causing pleasure at work were: being recognized, solving problems, working with peers and being creative. Situations causing distress were: deficiencies in the health service; lack of knowledge regarding their roles; lack of recognition; the stress of teamwork; the obligation of living and working in the same area; daily living and becoming involved with the social problems of the community; and being exposed to violence, which resulted in fear. It was verified that there is a need for adopting interventions with a view to promoting better working conditions, professional satisfaction and the health of community agents.

DESCRIPTORS

Community Health Aides
Family Health Program
Working conditions
Occupational health
Health personnel

RESUMO

Este estudo objetivou identificar as situações geradoras de prazer - sofrimento no trabalho dos Agentes Comunitários de Saúde (ACS) de um município do Rio Grande do Sul/Brasil. Foi realizada uma pesquisa de abordagem qualitativa, com participação de 24 agentes. A coleta dos dados ocorreu em 2009, por meio do grupo focal, empregando-se a técnica da análise temática. As situações geradoras de prazer no trabalho foram: ser reconhecido, ser resolutivo, trabalhar junto aos pares e usar a criatividade. As situações geradoras de sofrimento foram: deficiências nos serviços de saúde; desconhecimento das funções; falta de reconhecimento; o sofrimento de trabalhar em equipe; a obrigatoriedade de morar e trabalhar no mesmo local; convivência e envolvimento com os problemas sociais da comunidade e a exposição à violência, resultando em medo. Evidenciou-se a necessidade de adoção de medidas interventivas com vistas a promover melhores condições de trabalho, satisfação profissional e saúde aos agentes comunitários.

DESCRITORES

Auxiliares de Saúde Comunitária
Programa Saúde da Família
Condições de trabalho
Saúde do trabalhador
Pessoal de saúde

RESUMEN

Se objetivó identificar situaciones generadoras de placer-sufrimiento en el trabajo de Agentes Comunitarios de Salud (ACS) de municipio de Rio Grande do Sul/Brasil. Se efectuó investigación cualitativa con participación de 24 agentes. Datos colectados en 2009 mediante grupo focal, empleándose análisis temático. Las situaciones generadoras de placer en el trabajo fueron: ser reconocido, ser resolutivo, trabajar junto a los pares y utilizar la creatividad. Las situaciones generadoras de sufrimiento fueron: deficiencias de los servicios de salud, desconocimiento de las funciones, falta de reconocimiento, sufrimiento al trabajar en equipo, obligatoriedad de residir y trabajar en el mismo lugar, convivencia y grado de envolvimiento con los problemas sociales comunitarios y exposición a la violencia derivado en miedo. Se evidenció la necesidad de adopción de medidas de intervención, apuntando a promover mejores condiciones de trabajo, satisfacción profesional y salud para los agentes comunitarios.

DESCRIPTORES

Auxiliares de Salud Comunitária
Programa de Salud Familiar
Condiciones de trabajo
Salud laboral
Personal de salud

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INTRODUCTION

The 1988 Constitution, also known as the Citizen Constitution, defines health as a right of the citizen and a duty of the State and, to guarantee this constitutional right, the Unified Health System (SUS) was created. Law 8080/90, also called the Organic Law of Health, which rules on the establishment of the SUS, also determines on the execution of occupational health actions, which includes workers' health promotion and protection[1].

In 1997, the Brazilian Ministry of Health (MS) issues the first Basic Operational Standard of the SUS/NOB-97. This document redefines the SUS management model, representing a possibility to make comprehensive health care feasible. Actions include the Family Health Program (FHP) and the Community Health Agent Program (CHAP), as strategies to put in practice the changes in the health care model[2].

These programs acknowledge Community Health Agents' (CHA) contribution to the reorientation of the care model, highlighting the following functions: accomplishment of disease prevention and health promotion through health education actions, developed at home and in the community[3].

Among the innovative elements the FHP introduces, the inclusion of Community Health Agents into the health team stands out, who play a strategic role in the consolidation of the SUS, as they facilitate the population's access to health actions and services and represent the link between the teams and the community[4].

The work dynamics of Community Health Agents is complex and displays different particularities, which is enhanced by the fact that these workers experience the reality of the neighborhood they live and work in. One important factor to be highlighted is that their training, on the other hand, is based on biomedical reference frameworks, which turns them into bearers of multiple contradictions[5].

The space where the Community Health Agents live is the same space they act in; people in their social reality are the same people who direct their care actions and, thus, in their daily life, these workers experience actions permeated by a set of feelings that vary between omnipotence and frustration[6], which can translate into feelings of pleasure and suffering at work.

Hence, work and the relations it originates are never a space of subjective or social reality, as the individual's confrontation with external challenges can trigger suffering and disease or constitute a source of pleasure and psychosocial development[7].

Suffering happens when there is a lack of intermediation between the worker's expectations and the reality the organization of work imposes. Suffering plays a fundamental role that articulates health and disease at the same time. The healthy implies coping with impositions and pressure at work, which cause psychological instability, while the pathological is related with flaws in the ways of coping with reality and is established when the desire to produce defeats the workers' desire[8].

Besides the (re)signification of suffering, pleasure at work occurs when workers are allowed to develop individual potentials, through freedom of creation and expression, enhancing cognitive-technical bonds that result in their activities, promoting workers' satisfaction[9].

Community Health Agents play a fundamental role in the current primary health care model in Brazil, in complex work context, entailing particularities and a range of situations, which justifies research on issues related to these workers' health.

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Besides, the motivations to accomplish this study comprise concerns deriving from one of the authors' experiences as a nurse in a Community Health Agent Program (CHAP) team and readings and reflections in the Research and Study Group "Work, Health, Education and Nursing", particularly in the research line "Occupational Health" at *Universidade Federal de Santa Maria* (UFSM)/RS/Brazil, which aims to investigate, among other themes, pleasure-suffering at work.

This study aimed to identify situations that produce pleasure and suffering in the work of Community Health Agents in a city in the State of Rio Grande do Sul/ Brazil.

METHOD

In this qualitative study, the focus group technique was used to collect data from Community Health Agents (CHA) in a city in the State of Rio Grande do Sul/Brazil.

In the city under analysis, the Community Health Agents' work started in 1996 with CHAP teams, and was expanded until 2003, when they were absorbed by the Family Health Strategy (FHS) teams. Today, there are 16 FHS teams in the city, as well as four CHAP teams; each FHS team includes six Community Health Agents and, in each CHAP team, there are 12 agents.

The study population consisted of 96 Community Health Agents who were active in the FHS teams and 48 CHAP team members in the city, totaling 144 subjects.

The focus group technique consists in obtaining data based on meetings with a group of people who represent the study object[10]. To compose the focus group, one Com-

munity Health Agent from each FHS team and two from each CHAP team were drafted, totaling 24 Community Health Agents, who were divided in two groups. The study inclusion criterion was to work as an agent in the city for at least one year. Agents who did not comply with this criterion were excluded, as well as agents who were absent from work, on any kind of leave or who had not completed 12 months of work at the time of data collection.

Three meetings were held with each group, that is, three with the CHAP agents and three with the FHS agents. There was no need for further meetings or group participants, in view of the study objectives and data exhaustion.

During the first meeting with each group, the Informed Consent Term was distributed and the aims, justification and benefits of the research were presented, in compliance with the premises of Resolution 196/96 on research involving human beings[11]. During subsequent meetings, the following themes were addressed: situations that produce pleasure and suffering in the work of the Community Health Agents.

Data were collected between March and April 2009 and the average duration of meetings was 90 minutes. Besides the research subjects, the researcher responsible for conducting the themes also participated, as well as an observer who helped to register events, observing participants' non-verbal language and other manifestations.

The meetings were recorded with the participants' consent and data were transcribed in a word processor. Afterwards, the interviews were subject to exhaustive reading, in search of evidence to better understand the contents.

For data analysis, thematic content analysis was applied, which comprises three phases: ordering, classification and final analysis[12]. Data analysis was based on two categories: *situations generating pleasure and situations generating suffering in the Community Health Agents' work.*

As specific meetings were held with the CHAP and FHS agents, data were analyzed separately but the results found in both groups are similar, which justifies their grouping.

The project received approval from the Institutional Review Board at *Universidade Federal de Santa Maria* (UFSM), under protocol (CAAE) number 0304.0.243.000-08.

Due to the data collection technique applied, the Community Health Agents could not be individualized. Thus, the researchers decided to present their discourse in italics, highlighting that all group members participated.

RESULTS AND DISCUSSION

The 24 Community Health Agents who participated in the study are female. The predominant age range is between 31 and 40 years. The majority is married (66%) and has finished secondary education (75%). Concerning the time of work (65%), most of them have been professionally active for between one and five years, similar to other study findings[5].

The above description points towards a population of female workers, with education levels higher than what is required for their job, and have life and work experience as agents, a fact that can influence the diversity and intensity of their experiences of pleasure-suffering at work.

In the first category, the agents appointed *situations that generate pleasure at work* related to the possibility of being acknowledged, being able to solve problems, working with peers and using one's creativity at work.

The Community Health Agents manifested experiences of pleasure, in view of the community's acknowledgement and users' manifestations of affection, kindness and gratitude for the work performed, according to the fragments below:

> (...) the hugs we get, the children call us aunty, the elderly are normally affectionate to us and we like it.

Acknowledgement is the valuation process of the efforts made and the suffering invested in the accomplishment of the work. The experience of pleasure and self-accomplishment result from the possibility to construct the subject's identity[8].

Studies involving Community Health Agents from Vitória/ES[13] and the interior of São Paulo State[6] evidenced that they experienced gratification for their work, in view of the community's acknowledgement, in accordance with the present research data.

The Community Health Agents related *Problem-solving ability* with the possibility of solving the users' problems and findings that the work performed is leading to better health conditions for the community. The following fragments exemplify this situation of pleasure in the agents' work:

> I feel very satisfied, when I'm able to solve the user's problem.

This data is in line with the results of a study[7] among Community Health Agents, in which pleasure at work was related with the possibility of solving the users' problems and helping the families. This problem-solving ability can also be associated with the privileged access to medical professionals, which grants them status in the community they live in[6-7].

Problem-solving ability remits to the possibility of materializing work, that is, the workers is able to give meaning to the effort made to accomplish the task, which can positively influence the self-esteem, satisfaction and professional identity of the workers inserted in this job context.

Another situation that generated pleasure at work was the possibility to **work with peers.** The Community Health Agents reported that they like to work in partnership with other agents, as they share work-related difficulties and offer mutual help. Below are some fragments:

> It gives you pleasure to work, when there's a partnership among the CHA, we are able to solve more things together.

> When we get help from college CHAs, when we are able to relate well.

In a report about health promotion workshops in a group of Community Health Agents, mutual help among the agents represents important evidence, which remits to these workers' close relation[14] and to the present study results.

The Community Health Agent uses the term "partnership" to indicate a horizontal relation, in which there is freedom to talk about the problems in daily work and to elaborate strategies to solve them. It is noteworthy that, when they talk about pleasure at work, the agents in this research cite their peers instead of the team, which may suggest that, in the relation with the entire team, they are unable to experience the same degree of freedom to reflect, organize and talk about their work or, also, that the relation among different health professionals is vertically organized.

The Community Health Agents mentioned the pleasure to *use one's creativity at work,* manifested through the freedom of expression, as a situation that generates pleasure at work, especially when they make personal efforts to organize and accomplish community integration activities, according to the following fragments:

> When we get resources for the parties. We do that through garage sales, risottos and sale of recyclable materials.

> At the party of the hypertensive patients, we make hot-dogs, sew group identification vests, accompany them, participate in the party, cheer for the queen of our group and even dance.

Work allows workers to develop their potential through freedom of expression and use of creativity, which remits to satisfaction and awareness about their role in the organization they work for and the society they are inserted in[9].

These study results ratify Dejours' premise that pleasure is a consequence of the organization of jointly developed work, including respect for each human being and his/her particular characteristics[15].

In the category *situations generating suffering at work,* the agents mentioned health service deficiencies, lack of knowledge on Community Health Agents' functions, lack of acknowledgement, suffering for working in a team, obligation to live and work at the same place, contact and involvement with the community's social problems and exposure to violence and the fear deriving from this process.

Health service deficiencies are factors that cause suffering in the agents' work, mentioning situations like the services' lack of problem-solving ability, constant changes in health team members and discontinuity of projects. The following fragments clarify this issue:

> The Basic Health Unit does not see them (the users), they come onto us to require care and we can't do anything.

> When the supervisor changes, the team loses its structure (...) everyone things (s)he has to be in command. And the interesting thing is that they only remember to command the CHAs.

> Each day someone comes to see us, full of good intentions, to develop something in the community, then they leave and we are threatened, because what they promised does not happen.

The weaknesses in the health service tend to affect the lack of problem-solving ability for community problems, which causes additional suffering to the Community Health Agents, due to the close relation that is constantly established and to the bond constructed with the community, so that they feel responsible for the families[7].

The political-administrative discontinuity causes ruptures due to staff rotation and weakens bonds with the community, which negatively influences the teams' work process[16] as, besides compromising the quality of care delivery, it causes suffering to the workers involved.

Concerning project discontinuity, the Community Health Agents investigated in this study reported that they are called upon to participate in academic, social, educational projects, among others. They become co-responsible before the community. When the projects do not work out or end, the agent, who stands closest to the community, has to explain all of the reasons why that situation happened. This finding relates to a source of suffering that is hardly explored in other studies. It refers to the accountability users attribute to agents, as they see them as responsible for the health actions and, in addition, for governments and civil society's actions.

The *suffering generated by lack of knowledge on the Community Health Agent's functions* was also reported during the research. In that sense, the agents mentioned that the community and the health team are unfamiliar with their functions, which implies a task burden and negatively affects their professional acknowledgement. The following fragments exemplify this situation:

(...) I am charged for things that aren't even CHAs' function.

We have a lot to do: on the one hand the users' increasing charges and, on the other, the health team that is always inventing more things to do.

This findings remits to the results of a research[17] that mentions the fact that the population is unfamiliar with the FHS' care logic or, also, that the Community Health Agents' service supply is not organized so as to change the care model, which puts a strain on the agents, in view of their difficult and complex task of explaining to users what the FHS is and, consequently, their functions as agents.

Today, a large group of health workers in SUS services remain unfamiliar with the range and depth of the actions Community Health Agents perform[6], in line with the present study results, as part of the agents reveal that conventional health units predominate over FHS units.

During the focus groups, the Community Health Agents reported on different situations of suffering related to lack of acknowledgement for their work. This derives from the feeling that the efforts the agents make in daily work are not acknowledged, and also from the strictness and untruthfulness of users' criticism against the agents' work:

You do ten things right, and one thing you don't manage, it gets a lot of criticism.

I feel hurt, when the users come to the center and say that it has been two or three months that you don't visit them, while you were there a week earlier.

When their demands are not responded, the population does not recognize the quality of the Community Health Agents' actions, nor the efforts made to accomplish them and expresses charges for effective and problem-solving actions, intensified by the users' constant contact with the agents[7].

The lack of a clear establishment of functions, the inexistence of a career plan and the lack of acknowledgement and valuation were appointed[14]. A study about Community Health Agents' praxis[4] evidenced that many of them considered work as something temporary and appointed the low wages, overload and devaluation of work as causes of demotivation in the profession.

These experiences of suffering are intensified to the extent that the Community Health Agents' immediate head, in this case the nurse, does not seem to check on the truthfulness of complains about the work performed, which arouses the workers' feeling of injustice and devaluation. The following fragments clarify the category:

I suffer, when the head receives complaint about my work and does not listen to what I have to say about the subject.

I don't like it when I am focused on during the monthly meeting in front of my colleagues.

Lack of confidence among FHS team members can also entail conflicts during work, causing not only punctual negative effects, but affecting the entire team's relation and the success of the work performed[18], as the Community Health Agents have important information that supports the nurse and other team members' work[19].

The agents' statements in the groups seem to diverge from the results found in one research[19] in which the nurses working in the FHS affirm that they value the agents' work, because of their direct contact with the families.

Besides feeling devalued and wronged, the Community Health Agents also discussed about the *suffering of teamwork*. They affirmed that, normally, dialogue among other team members is lacking, to allow them to express their difficulties and solve problems. Also, concerning the health team, the agents expressed that they are hierarchically treated as various team members' subordinates. The below fragment represents this category:

... the 'I-team' predominates here.

A study about teamwork among FHS nurses underlines the need to develop joint work[19], in which all professionals get involved in care at some time, depending on their competency level.

Thus, interaction about FHS and conventional health unit team members is necessary, so that they can all participate in the construction of projects, decision making and propose measures, with a view to overcoming obstacles in work practice. In that sense, the health team should acknowledge Community Health Agents as health team members who need help to filter and work with the information they have, with a view to guaranteeing professional secrecy and respect[17].

The *obligation to live and work at the same place* was another situation reported as a source of suffering in agents' work. This requirement implies privacy loss, requests from the community beyond work hours and exposure to gossip and rumors. According to the following fragments:

CHA cannot have lunch, nor sleep, during your holidays you have to get out of the community.

(...) they ask us about whether the other has HIV, cancer, if she's pregnant, if he's gonna die, if the woman suffered violence from her husband, in short, everything. There are real telltales, who get angry if you don't say anything.

The fact that they are community members and work with their neighbors can entail additional emotional exhaustion for Community Health Agents. People who live in the same neighborhood do not always have the same interests or relate well, with frequent conflicts, hostilities and disputes[20]. Therefore, one study[7] questions the agent's obligation to live in the community, alerting to the fact that this can be an additional source of psychic suffering for these workers and can become pathogenic.

Concerning gossip and rumors, one study evidences the need for Community Health Agents, during their work, to pay great attention to what they say, as it can be misunderstood or distorted[20].

Contact and emotional involvement with the community's social problems was another situation the Community Health Agents indicated as a source of suffering during the focus groups. They affirmed suffering in view of situations like: misery, prostitution, drugs use, intra-family violence, diseases and death. These situations arouse feelings of frustration and powerlessness in the agents, especially when they concern families they have affective bonds with. The following fragments illustrate this category:

> Once I got to a house and there was a lady boiling water with salt, because that was the only thing she had to give to two children.

> (...) witness prostitution due to lack of food....

> We get involved with the families, we suffer, when the person experiences problems, illnesses or when they die.

A study[7] considers the bond with the community inherent in Community Health Agents' work as a source of suffering, as being affectively and uninterruptedly involved with clients, besides witnessing the repercussions of the lack of problem-solving ability for health situations in users' lives cause suffering.

Thus, it is ratified that Community Health Agents' daily work is permeated by complex situations, including family dynamics that are hard to intervene in, violence and drugs traffic; without a social network and multidisciplinary teams to adequately respond to the emotional demand, which can contribute to the professionals' exhaustion [5].

Among the community's social problems, *violence and fear* stand out for people living in the region, which extends to the Community Health Agents. This situation represents a source of suffering. In this perspective, many agents experience feelings of revolt against impunity, and often feel constrained for having to deliver care equally to all people in their activity area, especially to people who commit crimes and infractions. This gives rise to ethical dilemmas, which need to be discussed and problematized, so that the agents can act adequately, performing their activities in the best possible way. The following fragments exemplify this situation:

> Once, I filed a complaint about mistreatment against a child. The Tutelary Council went to the house and said I was the one who had filed the complaint. The father threatened me for a long time.

> He has already assaulted my house and the entire neighborhood, but I have to go there and even treat him well.

Exposure to violence and fear were also mentioned in the study[7], in which the community Health Agents affirmed that, in certain situations, they do not request the police or the Tutelary Council's intervention because they are thinking of their safety, as the users involved know where the agent lives with his/her family, creating a situation of fear and powerlessness, in view of the crimes verified in the community. Hence, it is evidenced that work can be dangerous, including the risk of being victims of aggression[20].

When discussing the situations that generate suffering in their work, the Community Health Agents mention their mental suffering and illness related to their job activities. The following fragment is an example:

> Our work produces mental suffering, various colleagues have already taken leave because of depression, I'm the only one in my group who has never taken antidepressants.

The use of antidepressants was appointed as a coping strategy for stressful situations at work[17]. Another study[5] evidenced the use of sedatives, tranquilizers or antidepressants in 17% of the Community Health Agents under analysis. In this sense, it is highlighted that psychic burdens exist in their work, and that it is difficult to find measures to protect these workers' health and, consequently, their self-care[20].

The Community Health Agents appointed yet another difficulty, which is the community and the health team's non-valuation of the suffering work produces, as observed in the following fragments:

> CHAs are not entitled to get ill, they think that depression is a whim.

In the post-industrial age, manifesting suffering has turned into a taboo, considered as a lack of motivation, weakness of character or emotional imbalance. Thus, suffering at work, as a factor inherent in the human condition, only gets tolerated when it is transformed into illness[21], which is a source of concern, as it furthers the establishment of chronic processes.

These research results converge with those of another study[7], in that the contact with the population, involvement with the families, entry into the homes, knowledge about demands and the impossibility of more effective actions in the health sector can generate ambiguous feelings, sometimes of pleasure, sometimes of suffering in the Community Health Agents' work.

Therefore, these feelings need to be know and (re) considered, so as to (re)signify the suffering, either by changing the causal reality or by attributing meaning to the suffering and, thus, (re)finding pleasure in work and granting well-being and health to these workers.

Thus, the importance of Community Health Agents' work for the consolidation of the SUS is reaffirmed, as well as the need for adequate training and the creation of valuation and motivational strategies for this professional practice[4].

CONCLUSION

At the end of the study, it can be affirmed that the main situations that cause pleasure for the Community Health Agents are related to the acknowledgement for the work done, problem-solving ability, work with peers, offering mutual help, and to the possibility of using creativity and freedom of expression in job activities.

The situations that generate suffering in their work are related with existing weaknesses in health services, lack of familiarity with their functions, lack of acknowledgement and difficulties to work integrated with other health team members.

The obligation to live and work in the same place entails situations that cause suffering, including privacy loss and exposure to violence and fear. Contact and involvement with the community's social problems were also appointed as situations that caused the Community Health Agents suffering.

These results show that, although they work in a complex environment with multiple functions and adverse health and social situations, the research subjects reported that they feel pleasure in many situations. Reports about their intense suffering and illness related to their work are a source of concern though.

The need is highlighted to adopt health promotion measures for Community Health Agents, with a view to minimizing and reducing the suffering that results from objective work conditions, furthering these workers' satisfaction, which is considered an intervenient factor in health. It is known that the SUS establishes occupational health actions and, therefore, it is essential for local managers to develop actions with health workers, so as to minimize unwanted effects in their lives/health.

Concerning possible study limitations, the fact is highlighted that pleasure-suffering at work is an abstract study problem that can be influenced by time, space and each worker's personal characteristics. This remits to the need to consider results in their singularity, as they picture a given city's reality.

In the teaching context, the researchers hope the present study results will contribute to raise health education institutions' awareness, at undergraduate and graduate level, regarding the need to address work and occupational health-related issues.

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