

# Quality of life at work: speech of professionals of the Family Health Strategy

*Qualidade de vida no trabalho: discurso dos profissionais da Estratégia Saúde da Família*  
*Calidad de vida en el trabajo: el discurso de los profesionales en Estrategia Salud de la Familia*

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## ABSTRACT

**Objective:** To understand the meanings that health professionals of the Family Health Strategy attribute to quality of life in the workplace. **Method:** This is a qualitative, descriptive study with a qualitative-quantitative approach, performed with 123 health professionals. Data were collected between July and September 2014 and subsequently exposed to descriptive analysis and the Collective Subject Discourse (CSD) analysis method, with the aid of the QualiQuantsoft® software. **Results:** The meanings given to quality of life in the workplace include both subjective aspects and those associated with work conditions and interpersonal relationships. Issues related to work conditions were the most relevant, totaling 121 key expressions, followed by interpersonal relationships in the workplace with 72 expressions. **Conclusions:** Professionals provide subjective meanings and objectives to the quality of life in the workplace, apart from recognizing the interference that this has on user health care.

**Keywords:** Quality of life; Work; Health Personnel; Family Health Strategy.

## RESUMO

**Objetivo:** Compreender os significados que os profissionais de saúde da Estratégia Saúde da Família (ESF) atribuem à qualidade de vida no trabalho. **Métodos:** Pesquisa qualitativa, descritiva. Realizada nas Unidades de ESF, com 123 profissionais de saúde. Os dados foram coletados entre julho e setembro de 2014. O material resultante das entrevistas foi exposto à análise do Discurso do Sujeito Coletivo, com o auxílio do software QualiQuantsoft®. **Resultados:** Os significados conferidos a qualidade de vida no trabalho, perpassam tanto pelos aspectos subjetivos, como também pelos quesitos das condições de trabalho e dos relacionamentos interpessoais. Com 121 expressões-chave, as questões das condições de trabalho foram as mais expressivas, seguida pelas relações interpessoais no trabalho, com 72 expressões-chave. **Conclusão:** Os profissionais conferem significados subjetivos e objetivos à qualidade de vida no trabalho, além de reconhecerem a interferência dessa temática para a melhoria da assistência ao usuário.

**Palavras-chave:** Qualidade de vida; Trabalho; Profissional de Saúde; Estratégia Saúde da Família.

## RESUMEN

**Objetivos:** Comprender los significados que los profesionales de la Estrategia Salud de la Familia (ESF) atribuyen a la calidad de vida en el trabajo. **Método:** Investigación cualitativa, descriptiva, con abordaje cualicuantitativa, realizada en Unidades de ESF, con 123 profesionales de salud. Los datos fueron colectados entre Julio y Septiembre de 2014. El material resultante fue expuesto al método de Análisis del Discurso del Sujeto Colectivo, con auxilio del software QualiQuantsoft®. **Resultados:** Los significados conferidos a la calidad de vida en el trabajo emergen desde los aspectos subjetivos, como en quesitos de las condiciones laborales y relaciones interpersonales. Con 121 expresiones-clave, las cuestiones referentes a condiciones de trabajo fueron las más expresivas, seguida por las relaciones interpersonales, con 72 expresiones-clave. **Conclusión:** Los profesionales confieren significados subjetivos y objetivos a la calidad de vida en el trabajo, además de reconocieren la interferencia del tema en la mejora de la asistencia al usuario.

**Palabras clave:** Calidad de vida; Trabajo; Personal de salud; Estrategia de Salud Familiar.

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Submitted on 07/31/2015.

Accepted on 11/08/2015.

DOI: 10.5935/1414-8145.20150072

## INTRODUCTION

This study was part of a wide project that investigated the work and quality of life of ESF professionals in such city, following different research approaches: an analytical quantitative study and a qualitative descriptive study based on collective subject discourse (CSD).

Working with health has its particularities, thus it can be regarded as living work being performed. It has a relational origin, in which what is produced arises from the relationship between producers and consumers. In health, users incorporate the role of consumers whereas health professionals are the producers<sup>1</sup>.

The current scenario in which health work is performed results from successive social and political changes. The 8<sup>th</sup> Brazilian Health Conference should be mentioned, as it contributed to the preparation of the Health Section from the Federal Constitution of 1988 and of the *Sistema Único de Saúde* (SUS - Unified Health System)<sup>2</sup>.

The SUS is structured in organizational and doctrinal principles, which is aimed, among other purposes, at promoting the replacement of the Flexnerian health care model, centered on procedures, for another based on health promotion, protection, recovery and rehabilitation actions<sup>3</sup>.

The *Programa Saúde da Família* (PSF - Family Health Program) was created in 1994 to foster this change in health care models and SUS consolidation, with the purpose of achieving a model founded on comprehensive individual, family and collective health care, thus giving a new direction to health practices<sup>4</sup>. Due to its innovative characteristics and coverage, in 1998, the PSF began to be understood and known as *Estratégia Saúde da Família* (ESF - Family Health Strategy)<sup>5</sup>.

In this transition, reflections and actions related to the process of humanization of health care practices must be contextualized. The Brazilian Ministry of Health, through the *Política Nacional de Humanização* (PNH - National Humanization Policy), recommends actions to all participants in the health production process: users, managers and workers<sup>6</sup>.

Of all principles regulating the PNH, the following ones are emphasized as they support the changes required for workers: the strengthening of team work, commitment to equality of relationships, and recognition of health professionals<sup>6</sup>.

A study performed in Brazil with 797 Primary Health Care workers identified that, when dissatisfied with their work, they were more likely to evaluate their quality of life negatively in the physical, psychological and social dimensions. Moreover, those who perceived their own health to be affected considered their quality of life to be negative in these dimensions<sup>7</sup>.

Understood as a health determinant, as health does not mean the absence of diseases exclusively<sup>8</sup>, work is an aspect that has an influence on individuals' quality of life, as it involves an increase in working hours, number of jobs and increasing job market requirements<sup>9</sup>.

In view of what has been described, contextualizing Quality of Life in the Workplace (QLW) becomes relevant. The literature shows no consensus about its definition. However, there was

agreement on the fact that QVT is closely associated with work humanization, an instrument that guarantees the well-being and participation of professionals in the workplace<sup>10</sup>.

Family health work is comprised by complex relationships, due to the need for a bond, not only with users, but also with their families and the social environment in which they live. There is yet much to be researched to understand this new type of work process, given its insufficient time of existence.

Aiming to contribute to studies on QLW and to help the process of consolidation of the National Humanization Policy with regard to workers, the present study included the following guiding questions: What meanings do ESF health professionals attribute to quality of life in the workplace? In their perception, what factors can influence quality of life in the workplace?

Thus, the present study aimed to understand the meanings that ESF health professionals attribute to quality of life in the workplace.

## METHODS

A qualitative and descriptive study was performed with community health agents, dental assistants, dentists, nurses, physicians and nursing assistants/technicians working for the Family Health Strategy of a medium-sized city. During data collection, this city included 50 ESF teams, of which 46 were located in its urban area and four in its rural area, totaling a population of 531 professionals.

The sampling selection process for the analytical quantitative study obtained a total of 342 interview attempts. Thus, this study adopting the CSD used a complementary sample, i.e. participants were individuals not selected for the analytical quantitative study, resulting in a total of 189 professionals. This decision was based on the fact that the entire population was allowed to participate in the study, in addition to preventing responses from being biased, as the professionals interviewed had not been previously approached with questions related to the same theme.

A total of 123 interviews were obtained between July and September 2014, considering refusals, work leaves and vacations of professionals. The interview guidelines were developed by the author and comprised of two parts: the first part included data on professionals' identification and the second one included questions about their perception of QLW and the factors that influence it.

Individual interviews were set up and subsequently performed. Authors participated in these interviews, supported by five previously trained interviewers. The place of interview varied according to the availability of participants and infrastructure provided by the health units. Data were recorded on audio and fully transcribed in a computer subsequently. Participants were identified by a sequence of numbers to guarantee their anonymity.

Data were submitted to exploratory analysis through simple frequencies and position measurements (mean). The empirical material resulting from the transcription of interviews followed

the CSD analysis method, which consists in a qualitative data tabulation and organization technique developed by Lefreve and Lefreve in the 1990s<sup>11</sup>. This material was read thoroughly, seeking to extract relevant contents from each response, key expressions and their corresponding key ideas. "Key expression" is a term that designates the fragments and passages obtained from the material collected. They are selected by researchers and represent the essence of interviewees' responses. Each homogeneous set of key expressions is given a linguistic expression or denomination that shows the meaning found in the responses analyzed in a concise and synthetic way, which is designated as "key ideas". A group of similar key ideas was named a "category"<sup>11</sup>.

The outcome of CSD techniques is the creation of a synthesis speech, written in the first person singular, of similar findings that belong to the same key idea. As a research method, the CSD enabled the nature of contradictions and similarities among the perceptions of social agents or collective subjects to be retrieved from the social context studied<sup>11</sup>.

The QualiQuantsoft® software was used to analyze data. All participants signed an informed consent form. This research project was approved by the Research Ethics Committee of a federal university, under protocol number 673850.

## RESULTS AND DISCUSSION

Of all 123 (100%) professional interviewed, 114 (92.68%) were females and nine (7.32%) were males. Mean age was 40.41 years (53.66%), ranging from 22 to 68 years. In terms of professional category, participants were distributed as follows: 66 community health agents (53.66%), ten dental assistants (8.13%), nine dentists (7.32%), 12 nurses (9.76%), 12 physicians (9.76%) and 14 nursing assistants/technicians (11.38%). Mean length of time working for the ESF was 6.39 years, varying from one month to 225 months (18 years and nine months).

Meta-categories and categories arose from the analysis process, as shown in Figure 1. Aiming to reveal the categories, Figure 2 shows the sharing of key ideas obtained from the discourses of all 123 participants. It is important to remember that each interviewee may have contributed to more than one key idea when the CSD was prepared.

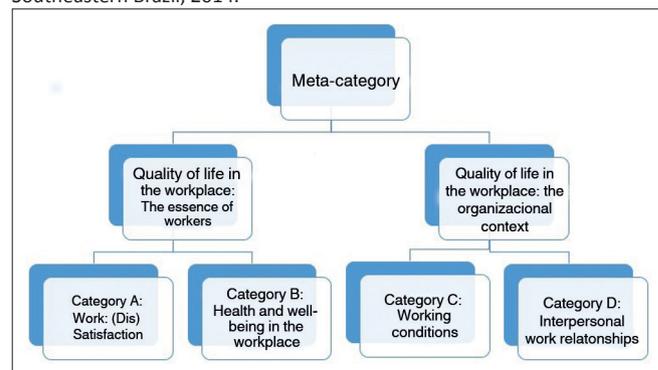
### Meta-category - Quality of life in the workplace: The essence of workers

This meta-category shows the subjective aspects found in the perception of QLW.

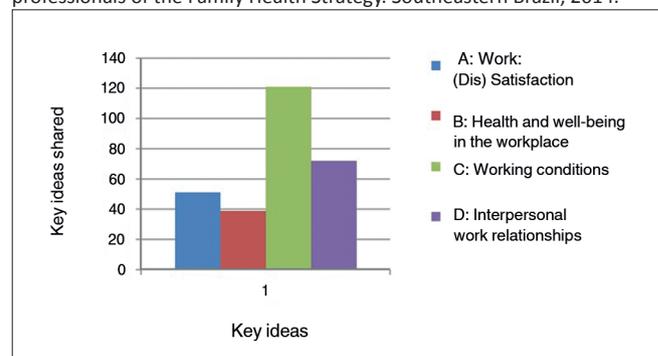
#### Category A: Work: (Dis) Satisfaction

The criteria used to include key expressions and ideas in this category were the responses of professionals describing the fact that they like, feel love for and find fulfillment in their profession, in addition to having feelings of satisfaction and dissatisfaction with their work.

**Figure 1.** Analysis plan with meta-categories and thematic categories. Southeastern Brazil, 2014.



**Figure 2.** Proportions of key ideas shared, regarding the following questions: "Quality of life in the workplace: what does this mean to you?" and "What influences your quality of life in the workplace?" in the discourses of professionals of the Family Health Strategy. Southeastern Brazil, 2014.



*To me, quality of life in the workplace is when we feel satisfied with what we do, it's the level of satisfaction with what I chose to do in my life, my self-realization. I have to be happy about my work and to like my profession. I usually say that when we like what we do and have willpower and love for our profession, we do it well and we receive a good pay. But we see many things, many problems that we can't resolve. This makes us feel bad and hopeless, like we could and should do more. We feel frustrated and when you work dissatisfied, you get sick (04-06-09-10-18-19-33-49-52-59-67-68-73-86-89-91-92-95-97-102-103-106-109-114-115-127-129-132-134-165-166-168-169-170-172-174-179-183-223-210-217-226).*

"To like what one does" was pointed out as the main reason for satisfaction with work among primary health care professionals. This affinity for one's profession has a positive effect on workers<sup>12</sup>. The importance of professionals identifying with their work should be emphasized, even in difficult and complicated situations<sup>13</sup>.

Discourses revealed that professionals like the work they perform. However, when encountering difficulties, such as the inability to resolve user problems, they express their disappointment, frustration and dissatisfaction.

It can be observed that the discourse from these professionals is in agreement with the results found in the literature, where community health agents state they are the solution to people's problems, the main reason for job satisfaction. This is because frustration affects professionals when work does not achieve the expected results<sup>14</sup>.

### **Category B: Health and well-being in the workplace**

The key expressions and ideas in this category allude to the health of professionals, their well-being in the workplace and the events that interfere with this peaceful state.

*To me, quality of life means to feel well, to be happy to work. It's connected to our well-being and it involves our self-esteem and health in general: physical, mental and emotional. It's when you feel pleasure leaving your home to go to work. It's when your job doesn't harm your health, your well-being. We listen to the problems of others and see the situations that make people sick, so we end up carrying this load a bit, we get stressed, then we go home and want to forget about these problems, but we can't, we keep thinking about them (02-05-08-11-14-15-16-22-32-49-56-57-58-59-60-91-98-100-113-115-123-139-153-177-178-188-224-06-44-48-226-95-149-153).*

The term "well-being in the workplace" has been used to indicate the subjective effects of QLW, those that refer to the consequences of labor conditions for the attitudes, feelings and behavior of workers<sup>15</sup>.

The present study sought to understand the concepts and experiences of nurses regarding quality of life and QLW in primary health care, showing their speech, which focuses on feeling well in the workplace and being physically and psychologically healthy<sup>16</sup>.

Discourse reveals that well-being means to be healthy in general - physically, mentally and emotionally. This concept is in accordance with what the World Health Organization (WHO) proposes to define as health: not the inexistence of disease, but rather that which encompasses the biological, psychological, social and spiritual aspects<sup>17</sup>.

Work is capable of having repercussions on global health, apart from physical and emotional health. This occurrence is mentioned in the discourse of participants in this study<sup>18</sup>.

### **Meta-category - Quality of life in the workplace: the organizational context**

This meta-category shows professionals' point of view about external factors, those involving the responsibility of institutions and the network of relationships established in the workplace.

### **Category C: Working conditions**

This category includes key expressions and ideas related to work conditions.

*To me, quality of life in the workplace is all that is involved with the development of our work, it includes many things. It's a matter of environment, adequate physical space and material resources that are provided to our work, it's whether you have work conditions or not. There are human resources, whether sufficient or not, apart from the daily stress, work routine, working hours, safety and receiving a good pay. So, we must have good work conditions, we should have everything to perform our jobs fairly with respect and all that is required (01-02-03-04-07-09-11-15-16-20-23-27-31-32-39-43-49-52-55-59-60-63-68-70-71-72-78-82-83-85-86-87-89-90-92-97-98-99-100-106-108-109-113-114-115-119-123-127-129-130-131-139-140-142-149-158-167-168-169-170-171-172-173-174-183-184-188-189-196-197-209-217-219-222-223-224-225).*

Insufficient or inadequate work conditions hinder or even prevent the purposes of Family Health Care to be achieved, such as health comprehensiveness and promotion. Thus, there is a direct proportion between work conditions and QLW<sup>19</sup>.

Concomitantly with the increase in user demand for health services, professionals have to deal with the difficulties that hinder or prevent care from being provided. The performance of work under such conditions, in addition to restricting activities, can both explain why professionals become ill and compromise the quality of health care provided<sup>20</sup>.

Additionally, participants also mentioned working hours as a factor that affects quality of life in the workplace. They stated that eight-hour shifts are too long and should be reduced to six hours. This corroborates with the literature, which shows that professionals were willing to work fewer hours, indicating that this change would result in better quality of life in the workplace<sup>21</sup>.

"Safety" was a term mentioned by interviewees to allude to physical safety and describe a stable employment status. With regard to physical safety, they emphasized that health units are located in environments with high crime rates and that they are exposed to high-risk situations when visiting homes.

ESF professionals establish close connections with the population, apart from routinely experiencing social and family disruptions. As a result, they mentioned the presence of urban violence, fear and lack of safety when performing work activities in the outskirts of the city<sup>22</sup>.

Furthermore, participants reported their desire to work without feeling concerned about service contracts. Employment relationships in health performed through unregulated contracts for limited times, outsourcing and under-hiring have significantly increased among local governments. This practice corroborates with the loss of labor regulations in the modern world<sup>23</sup>.

The discourses of professionals point to salaries as a condition that influences quality of life in the workplace. The question of income is approached in two different ways and participants reported that their pay does not have to be great, as long as it is compatible with the functions performed. On

the other hand, they also mentioned the need for better income distribution, as there is significant inequality among the salaries paid to ESF professionals.

### Category D: Interpersonal work relationships

This category shows key expressions and ideas about interpersonal work relationships. Researchers decided to divide this category into three distinct discourses, as participants indicated that ESF relationships occur between professional/professionals; professionals/users; and professionals/managers. A total of 72 key ideas arose from the interviews.

*I understand that quality of life in the workplace is when you can relate well to those working with you, when you have good relationships in the work environment... It's so unpleasant to be at a place without harmony, because we have to work many hours, we spend the whole day here and if we don't have a good relationship with our colleagues and the team is not working together, this makes you tired, disappointed and stressed out and it creates an unbearable environment. There is too much talking here and this is stressful, there are many who are sent away from their work due to gossip and those meddling with your life [...] (01-02-09-18-19-23-27-33-39-48-67-70-82-85-88-89-90-95-97-102-113-119-123-138-144-150-151-153-158-169-173-178-179-189-198-225).*

Interpersonal relationships and the interaction through dialogue, based on friendship and participation in the family health teams, promote cooperative and humane work<sup>24</sup>. Interviewees also mentioned respect and good humor to achieve a harmonious workplace. Team work is a required factor to obtain a suitable quality of life at work<sup>16</sup>.

The community health agents interviewed in a certain study considered the relationships formed in the team to be essential to perform their work well, especially with regard to the resolution of community problems<sup>9</sup>. Their discourse expresses such idea when it is stated that all professionals should be united to perform well, aiming to provide better care to users. This is because the ESF can only become real through the integration of the work performed by its several professionals.

According to participants in this study, the relationship between the population of health service users and professionals is among the interpersonal causes that interfere with quality of life in the workplace, its relevance being pointed out as follows:

*[...] I think quality of life in the workplace involves the relationships with the community. It means to get along with users, to receive residents well and to be welcomed by the population. However, there is a lack of humanization among people, they don't respect*

*patients anymore, they are needy when they get here and the professionals themselves are impolite. Another problem is when resources are lacking and you have to deal with a patient, deal with them and they argue with you and don't understand what we're going through here due to this lack of materials and broken equipment. Patients don't want to know about this, they simply want to arrive and receive care, they don't understand that it's not that we don't want to provide care, it's because we don't have the materials and then they fight and argue with us. Users come here, offend us and even call the ombudsman [...] (01-02-09-18-19-23-27-33-39-48-67-70-82-85-88-89-90-95-97-102-113-119-123-138-144-150-151-153-158-169-173-178-179-189-198-225).*

In the ESF context, the relationship between professionals and users is complex and it involves ethical questions. This relationship is not limited to healing practices, because social actors also meet during health education activities. The ethical aspects present in the relationships established by the ESF show interconnections with society, families and the health team itself<sup>25</sup>.

The existence of an effective relationship between professionals and users has positive effects for both of them<sup>25</sup>. Users' dissatisfaction with the services provided results in dissatisfaction among workers themselves<sup>12</sup>.

Their discourse exemplifies this situation, as professionals reported the lack of adequate conditions to perform work with quality and resolvability is a factor that causes tension in the relationship with users. Through their discourse, it could be observed that participants believe that users do not understand the actual limited conditions under which work is performed, preventing them from understanding that health services are not conducted due to lack of conditions. This situation upsets the relationship between health professionals and the community.

*[...] I understand that being well received by the department of health and managers contributes to quality of life in the workplace, because managers don't usually try to know the needs of professionals, we are often isolated and out of touch. We keep receiving orders and we have the impression that these people don't have a clear idea of what happens here. They worry much more about users than professionals. But if professionals don't have a good quality of life, how about users, who are the purpose of all this? So managers don't usually help us and we feel very undervalued professionally speaking (01-02-09-18-19-23-27-33-39-48-67-70-82-85-88-89-90-95-97-102-113-119-123-138-144-150-151-153-158-169-173-178-179-189-198-225).*

Manager support is a key aspect to perform health sector tasks, a fact that enables professionals to feel satisfied. The lack of an effective relationship between professionals and managers leads to frustration, as managers demand results without knowing whether there are conditions to develop what is being requested<sup>23</sup>.

Managers' lack of feedback on the results achieved in the services is an obstacle they encounter when participating in decision-making processes, apart from affecting the relationship of cooperation between managers and workers<sup>20</sup>.

## FINAL CONSIDERATIONS

Based on the findings of this study, it is possible to consider that the meanings attributed to quality of life in the workplace by ESF health professionals include both subjective aspects, such as feeling satisfied with one's profession and enjoying one's job, and work condition aspects and those associated with professional relationships.

It should be emphasized that the social representation that was most frequently reported in the situation studied was perception of quality of life in the workplace related to the organizational context. With 121 key expressions, the questions about work conditions were the most significant, followed by interpersonal relationships in the workplace with 72 key expressions.

This result shows that institutions need to assess the work conditions they are providing, as investments aimed at improving quality of life in the workplace will reflect on health care and user satisfaction, apart from reducing absenteeism, work-related accidents and other events.

Finally, one of the limitations of this study was the fact that interviews were conducted in the workplaces, as this is known to be a factor that may inhibit professionals from discussing controversial themes. Another limitation was that the population was restricted to one city exclusively, so that generalizations about the results could not be made.

## ACKNOWLEDGEMENT

To *Fundação de Amparo à Pesquisa do Estado de Minas Gerais* (FAPEMIG - Minas Gerais State Research Support Foundation) for the financial support.

## REFERENCES

1. Franco TB, Merhy EE. Cartografias do Trabalho e Cuidado em Saúde. *Revista Tempus Actas de Saúde Coletiva*. 2012; 6(2):151-63.
2. Conselho Nacional de Secretários de Saúde (BR). *Legislação Estruturante do SUS*. Brasília (DF): Conselho Nacional de Secretários de Saúde; 2011.
3. Scherer MDA, Marino SRA, Ramos FRS. Rupturas e resoluções no modelo de atenção à saúde: reflexões sobre a estratégia saúde da família com base nas categorias kuhnianasInterface: Comunicação, Saúde, Educação 2005;16(9):53-66.
4. Seclen J, Fernandes AS. Experiências e desafios da atenção básica e saúde familiar: caso Brasil. In: *Organização Pan-Americana da Saúde - OPAS, Organização Mundial da Saúde - OMS, Ministério da Saúde (BR). Projeto de Desenvolvimento de Sistemas e Serviços de Saúde*. Brasília (DF): Organização Pan-Americana da Saúde; 2004.p.1-122.
5. Silva-roosli ACB, Athayde MG. Trabalho e Psicodinâmica do Reconhecimento no Cotidiano da Estratégia Saúde da Família. In: Assunção AÁ; Brito J. *Trabalhar na Saúde: experiências cotidianas e desafios para a gestão do trabalho e do emprego*. 22ª ed. Rio de Janeiro: FIOCRUZ; 2011. cap. 3, p. 29-37.
6. Ministério da Saúde (BR). *Política Nacional de Humanização: a humanização como eixo norteador das práticas de atenção e gestão em todas as instâncias do SUS*. Brasília (DF): Secretaria-Executiva. Núcleo Técnico da Política Nacional de Humanização; 2004.
7. Teles MAB, Barbosa MR, Vargas AMD, Gomes VE, e Ferreira EF, de Barros Lima AME et al. Psychosocial work conditions and quality of life among primary health care employees: a cross sectional study. *Health Qual Life Outcomes*. 2014;12(1):1-12.
8. Lei n.º 8.080, de 19 de setembro de 1990 (BR). Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União, Brasília (DF)*, 19 set 1990: Seção 1:1.
9. Araújo GA, Soares MJGOI, Henriques MERM. Qualidade de vida: percepção de enfermeiros numa abordagem qualitativa. *Rev Eletr Enf*. 2009;11(3):635-41.
10. Sant'anna AS, Kilimnik ZM, Moraes LFR. Antecedentes, origens e evolução do movimento em torno da Qualidade de Vida no Trabalho. In: Sant'anna AS; Kilimnik ZM, org. *Qualidade de vida no trabalho: abordagens e fundamentos*. 3ª ed. Rio de Janeiro: Elsevier; 2011. Cap.1, p. 3-30.
11. Lefevre F, Levefre AM. *Pesquisa de Representação Social: Um enfoque qualiquantitativo*. 2ª ed. Brasília (DF): Liber Livro Editora; 2012. 224 p.
12. Lima CA, Oliveira APS, Macedo BF, Dias OV, Costa SM. Relação profissional-usuário de saúde da família: perspectiva da bioética contratualista. *Rev. Bioét*. 2014 Jan./Apr. 22(1):152-60.
13. Leite DF, Nascimento DDG, Oliveira, MAC. Qualidade de vida no trabalho de profissionais do NASF no município de São Paulo. *Physis (Rio de Janeiro): Revista de saúde coletiva*. 2014; 24(2):507-25.
14. Brand CI, Antunes RM, Fontana RT. Satisfações e insatisfações no trabalho do agente comunitário de saúde. *Cogitare enferm*. 2010 Jan./Mar.;15(1):40-7.
15. Silva CA, Ferreira MC. Dimensões e indicadores da qualidade de vida e do bem-estar no trabalho. *Psicol*. 2013 July/Sep.;29(3):331-9.
16. Daubermann DC, Tonete VLP. Qualidade de vida no trabalho do enfermeiro da Atenção Básica à Saúde. *Acta Paul. Enferm* 2012; 25(2):277-83.
17. Lima CA, Oliveira APS, Macedo BF, Dias OV, Costa SM. Relação profissional-usuário de saúde da família: perspectiva da bioética contratualista. *Rev. Bioét*. 2014 Jan./Abr. 22(1):152-60
18. Martellet EC, Motta RF, Carpes AD. A saúde mental dos profissionais de saúde e o programa de educação pelo trabalho. *Trab. Educ. Saúde*. 2014 Set./Dez.; 12(3):637-54.
19. Bertocini JH, Pires DEP, Scherer MDA. Condições de Trabalho e renormalizações nas atividades das enfermeiras na saúde da família. *Trab. Educ. Saúde*. 2011 Jan./Abr.; 9(1):157-73.
20. Assunção AÁ, Jackson Filho JM. Transformações do Trabalho no Setor Saúde e Condições para Cuidar. In: Assunção AÁ. Brito J. *Trabalhar na Saúde: experiências cotidianas e desafios para a gestão do trabalho e do emprego*. 22ª ed. Rio de Janeiro: FIOCRUZ; 2011. cap. 2, p. 45-66.
21. Leite DF, Nascimento DDG, Oliveira MAC. Qualidade de vida no trabalho de profissionais do NASF no município de São Paulo. *Revista de Saúde Coletiva*. 2014;24(2):507-25.

22. Fernandes JS, Miranzi SSC, Iwamoto HH, Tavares DMS, Santos CBD. A relação dos aspectos profissionais na qualidade de vida dos enfermeiros das equipes Saúde da Família. Rev. Esc. Enferm. USP. 2012 Apr.; 46(2):404-12
23. Assunção AÁ. Condições de Trabalho e Saúde dos Trabalhadores da Saúde. In: Gomez CM, Machado JMH, Pena PGL. Saúde do Trabalhador na Sociedade Brasileira Contemporânea. Rio de Janeiro. Fiocruz; 2011. cap.21, p. 453-478.
24. Azambuja EP, Fernandes GFM, Kerber NPC, Silveira RS, Silva Alcione L, Gonçalves LHT et al. Significado do trabalho no processo de viver de trabalhadoras de um programa de saúde da família. Texto Contexto Enferm. 2007 Jan./Mar.; 16(1):71-9;
25. Lima L, Pires DEP, Forte ECN & Medeiros F. Job satisfaction and dissatisfaction of primary health care professionals. Esc. Anna Nery. 2014 Jan./Mar.; 18(1):17-24.

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Note: This article was extracted from the Master's dissertation presented to the Postgraduate Program in Health Care of the Universidade Federal do Triângulo Mineiro in 2014.