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REAS

ORIGINAL ARTICLE

Profile and self-assessment of health among community workers in a municipality in southern Brazil

Perfil e autoavaliação de saúde de agentes comunitários em um município do sul do Brasil

Perfil y autoevaluación de la salud de los agentes comunitarios en un municipio del sur de Brasil

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Abstract

Objective: To evaluate the sociodemographic, occupational profile and self-rated health of Community Health Agents in a municipality in the southern region of Brazil. **Methods**: This was a descriptive, cross-sectional and quantitative research conducted between the months of June and December 2023, with 264 professionals working in the urban area of Ponta Grossa, Paraná. Data were analyzed using SPSS® 21 statistical software, using the chi-square test and Pearson's correlation coefficient. **Results**: The prevalence of the sample was female (100%), with a mean age of 46 years (±8.42), self-declared white (78.88%), married (49.69%) with completed secondary education (63,25%). There was a correlation between self-rated health and the following variables: diabetes mellitus (p=0.001), systemic arterial hypertension (p=0.001) and depression (p=0.017). **Conclusion**: It is concluded that the study of these workers contributes to directing support and intervention strategies for this category and, indirectly, benefits the community served.

Descriptors: Community Health Workers; Self-Assessment; Public Health.

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Resumo

Objetivo: Avaliar o perfil sociodemográfico, ocupacional e autoavaliação de saúde de Agentes Comunitários de Saúde de um município da região sul do Brasil. **Métodos**: Tratou-se de uma pesquisa descritiva, transversal e quantitativa conduzida entre os meses de junho a dezembro de 2023, junto a 264 profissionais atuantes na área urbana de Ponta Grossa, Paraná. Os dados foram analisados no software estatístico SPSS® 21, utilizando o teste qui-quadrado e o coeficiente de correlação de Pearson. **Resultados**: A prevalência da amostra foi do sexo feminino (100%), com média de idade de 46 anos (±8,42), autodeclarada branca (78,88%), casada (49,69%) com ensino médio completo (63,25%). Houve correlação da autoavaliação de saúde entre as seguintes variáveis: diabetes mellitus (p=0,001), hipertensão arterial sistêmica (p=0,001) e depressão (p=0,017). **Conclusão**: Conclui-se que o estudo desses trabalhadores contribui para direcionar estratégias de apoio e intervenção a essa categoria e, indiretamente, beneficia à comunidade atendida.

Descritores: Agentes Comunitários de Saúde; Autoavaliação; Saúde Pública.

Resumen

Objetivo: Evaluar el perfil sociodemográfico, ocupacional y la autoevaluación de salud de Agentes Comunitarios de Salud en un municipio de la región sur de Brasil. **Métodos**: Se trata de una investigación descriptiva, transversal y cuantitativa realizada entre los meses de junio y diciembre de 2023, con 264 profesionales que actúan en el área urbana de Ponta Grossa, Paraná. Los datos fueron analizados mediante el software estadístico SPSS® 21, utilizando la prueba de chi cuadrado y el coeficiente de correlación de Pearson. **Resultados**: La prevalencia de la muestra fue femenina (100%), con edad media de 46 años (±8,42), blanca autodeclarada (78,88%), casada (49,69%) con educación secundaria completa (63,25%). Hubo correlación entre la salud autovalorada y las siguientes variables: diabetes mellitus (p=0,001), hipertensión arterial sistémica (p=0,001) y depresión (p=0,017). **Conclusión**: Se concluye que el estudio de estos trabajadores contribuye a orientar estrategias de apoyo e intervención para esta categoría e, indirectamente, beneficia a la comunidad atendida.

Descriptores: Agentes Comunitarios de Salud; Autoevaluación; Salud Pública.

INTRODUCTION

Community Health Agents (CHAs) play a fundamental role in the public sector, working in primary care and interacting directly with Brazilian communities.[1] Professional regulation of this category began in 1991 with the creation of the National Community Agents Program (PNAC), which was later replaced by the National Community Agents Program (PACS), focused on preventive actions, especially aimed at reducing maternal and infant mortality.[2] However, it was only in 1997, after the incorporation of the PACS into the Family Health Strategy Program (PSF), that these professionals obtained specific responsibilities and currently, they are part of the minimum composition of the Family Health Strategy (ESF) care model.[1]

According to data from the Ministry of Health in 2020, more than 257,000 CHAs were fully active in the country, with approximately 11% of this contingent remaining concentrated in the southern

region.[3] The responsibilities of these workers are comprehensive, involving health promotion and surveillance through a complete diagnosis of the territory, conducting health education processes, conducting home visits, enrolling and monitoring individuals and families, in addition to encouraging the social participation of the population.[4]

However, with the implementation of Ordinance No. 2,356/2017, which reduced the minimum number of ACS from four to one per Family Health team (eSF), along with the increase in responsibilities for these workers, there is a risk of compromising the care model focused on health promotion, prevention and education, as well as the health status of these employees.[5]

The World Health Organization highlights the importance of investigating social determinants, highlighting self-assessment as a valuable resource for monitoring individuals' health conditions.[6] This analysis, usually carried out through a comprehensive question, subjectively reflects the multidimensionality of an individual's health and contributes to the planning of actions that will influence the reduction of the disparities found.[7]

Given the above and considering the importance of these employees in the Unified Health System (SUS), it is essential to further study the profile of these professionals, as both the health status of these workers and public policies directed at this category can directly impact the Brazilian health situation.

Therefore, the objective of this study was to evaluate the sociodemographic, occupational and self-rated health profile of CHAs in a municipality in the southern region of Brazil and to investigate the relationship between these parameters.

METHOD

This is a descriptive, cross-sectional, quantitative research carried out between June and December 2023 with ACS working in the urban area of the municipality of Ponta Grossa, southern Brazil.

During the study period, the municipality had 38 Family Health Units (USF) and 22 Basic Health Units (UBS), 54 of which were urban and 6 rural. They had 84 eSF, 5 Primary Health Care teams (eAP) and 4 Multiprofessional teams (eMulti) registered in the National Registry of Health Establishments (CNES).[8]

This study was approved by the Research Ethics Committee of the State University of Ponta Grossa (UEPG) under CAAE opinion no. 70638323.8.0000.0105, considering all the ethical precepts of the Declaration of Helsinki and Resolution 466/2012 and 510/2016 of the National

Health Council. All participants were instructed on the benefits and risks of the research and signed the FICF prior to data collection.

The study population consisted of 264 CHWs linked to the municipality's Primary Care. The sample size was calculated using a finite population formula with a 95% confidence interval and a 5 percentage point margin of error, totaling 157 professionals. To increase representativeness and reduce sample loss, eight professionals were added, totaling 161 individuals.

The study included professionals who were present at the time of data collection, working as CHWs for at least six months, and who agreed to participate in the study. The sample selection was stratified randomly, following the proposed eligibility criteria. Workers who worked in rural areas of the municipality, did not fully complete the survey instrument, were on sick leave, or were on vacation were excluded.

Participants were recruited at their workplaces at times agreed upon by the USF managers and researchers. Three approaches were attempted in each pre-selected stratum. Data collection began after participants accepted and signed the Informed Consent Form (ICF).

Sociodemographic, occupational and self-rated health data were measured using a self-administered questionnaire structured by the researchers, consisting of an analysis of the following variables: age (in years), gender, color/race, education, marital status, previous position, concomitant occupation with the current one, place of residence, practice of physical exercises, time working as a CHA, professional satisfaction, self-rated health and diseases of the participants.

To analyze the health assessment, a questionnaire with five answer options was used.divided into two groups: one group that indicated a negative perception, composed of the responses "terrible," "bad," and "moderate," and another group that indicated a positive perception, composed of the responses "good" and "excellent." The results of the self-assessment of health were correlated with the following factors: physical exercise, time working as a CHW, residence in the coverage area, diagnosis of systemic arterial hypertension (hypertension), diabetes mellitus (DM) and depression.

The data were tabulated in Microsoft Excel 2013® software and the analyses were conducted in SPSS® (Statistical Package for the Social Sciences) 21 statistical software. To investigate the self-rated health variables, the chi-square test was used, using Pearson's correlation coefficient. The p-value was considered≤0.05 to assume the hypothesis

that there was an association and correlation between the variables studied.

Data collection began after theoretical discussion and prior training of the research team to ensure clarity of objectives and avoid confounding factors. The questionnaire was administered in a standardized manner, and after being invited to participate in the study, all workers were informed that their participation was voluntary and the data collected would be treated confidentially. Finally, they were asked to attribute their responses to the context at the time of the study.

RESULTS

This study revealed a predominance of women in the sample, with a mean age of 46, white ethnicity, married, and with a high school diploma or equivalent. A minority of the sample studied did not live in the coverage area, performed other work activities, and had less than 5 years of professional experience. The most common illnesses were depression, hypertension, and diabetes. The statistics related to the study are presented in Table 1.

Table 1- Characteristics of CHAs, according to sociodemographic, work and lifestyle variables, 2023 (n=161).

Variables	Categories	N (%)	Mean (standard deviation)
Age (in years)			46 (±8.42)
Gender	Feminine	161(100)	
	Masculine	0(0)	
Skin color	White	127(78.88)	
	Brown	27(16.77)	
	Black	7(4.35)	
Educational level	Complete elementary education	4(2.49)	
	Incomplete high school	5(3,11)	
	Complete high school	102(63.25)	
	Incomplete higher education	27(16.77)	

	Complete higher education	21(13.04)
	Specialization	2(1.24)
Marital status	Single	31(19,25)
	Married	80(49.69)
	Living as a married couple	21(13.04)
	Divorced	23(14.29)
	Widower	6(3.73)
Practice of physical exercises	Yes	55(34.16)
	No	106(65.84)
Reside in the coverage area	Yes	134(83.23)
	No	27(16.77)
Have another job	Yes	29(18.01)
	No	132(81.99)
Time working as an ACS	Less than 1 year	0(0)
	Between 1 and 2 years	0(0)
	Between 2 and 3 years	0(0)
	Between 3 and 5 years	1(0.62)
	Between 5 and 10 years	70(43.48)
	Between 10 and 15 years	49(30,43)
	Over 15 years old	41(25,47)
Hypertensive	Yes	53(32.92)
	No	108(67.08)
Diabetic	Yes	14(8.7)
	No	147(91.3)
Depression	Yes	54(33.54)
	No	107(66.46)

Source: Own authorship.

Regarding self-rated health, a relationship was found between the following variables: diabetes mellitus, hypertension and depression, as shown in Table 2.

Table 2: Correlation of self-rated health with the variables analyzed.

Variables	p-value
DM	0.001*
HAS	0.001*
Depression	0.017**
Practice of physical exercises	0.857
Time working as an ACS	0.408
Housing in the coverage area	0.648

*p≤ 0.01. **p≤ 0.05 (Pearson's Chi-square test).
Source: Own authorship.

DISCUSSION

The professionals covered in this study were predominantly female, which reinforces previously found statistics. Female immersion in the healthcare labor market has been analyzed for some years, emphasizing the importance of this population in the workplace.[9] The eventual feminization became a majority in the economic sector during the 1970s, with the significant participation of women in the labor market, reflecting to the present day.10

There were particularities in the profile of this population, such as the entry of women into the healthcare job market, with an average age of 46, married women, and women who assume a double workload, consisting of balancing their professional careers with domestic work and family care. The sample examined the practice by some professionals of holding a second job in addition to their role as CHWs, aiming to supplement their monthly family income.

The high number of agents starting a family, considering the sample was entirely female, can be interpreted as greater pressure on them, as they also carry out family activities in addition to their work activities. Regarding marital status, there were similarities with other studies11, where a large proportion of the interviewees reported being married.

In addition to what is stated regarding marital status, it is possible to observe the predominance of ACS professionals who declare themselves to be white, corroborating another study[12], this data reflects in the national index where there is little representation of the black population in terms of health, in addition to the historical factor of colonization of European origin predominant in the southern region of the country, making up a natural historical consequence.

In the education question, the largest percentage of participants had completed high school. Based on this data, a study pointed to the predominance of a maximum education level of high school, emphasizing the provisions of Law 13,595/2018 as a

minimum requirement for exercising the professional activity.[10] While a small portion of the sample had completed elementary school, this education was based on the provisions of Law 11,340/2006 before its amendment, which stated that having completed elementary school was the minimum requirement for practicing the profession.

After implementing an ESF[13], an introductory course should be made available to professionals working in the healthcare facility, with practices based on SUS guidelines and principles, strengthening teamwork and sociocultural elements. Ongoing training of CHWs in the humanities is essential.

When analyzing self-rated health related to chronic noncommunicable diseases such as DM and hypertension, followed by the affective disorder characterized as depression, we observed a worse assessment of their health status, with responses pointing to a diagnosis of these diseases. Chronic diseases are the main causes of illness and morbidity and mortality in the population, followed by depression, which is prevalent in women and may be associated with chronic conditions, and may present a high risk for developing cardiovascular diseases.[14] The prevalence of depression in this professional group can generate harm and impact public health, in addition to reducing the progress of Primary Health Care (PHC) programs, not to mention the negative impact on quality of life.[15]

The practice of physical exercises analogous to self-assessment of health, when asked to the interviewees, did not show a significant correlation, as for those who do not practice any physical exercise in relation to those who reported practicing at least one exercise per week, contrary to another study, where it can be observed that the practice of physical exercise is linked to a better self-assessment of health status.[16]

Working as a CHW for more than a decade can have negative effects when analyzing functional capacity and their emotional and physical limitations. Therefore, it is suggested that these professionals face unfavorable working conditions, including challenging goals, which can lead to physical and emotional impairment. Above all, the relationship between longer tenure as a health agent and poor performance is reflected in self-rated health when associated with the group that has worked as a CHW for more than 10 years, being predominantly negative. It is noteworthy that there was no statistically significant correlation in this approach.[17]

Self-rated health in relation to housing in the coverage area did not show a significant statistical correlation, given the

work routine, which requires facilitating elements, such as developing bonds and communication with families. Being located in the same territory, residing in the coverage area, allows professionals to better understand cultural conditions, behaviors, and beliefs. However, this close connection can lead to emotional exhaustion, as they are often asked by the population to travel beyond their workplace and working hours.[18]

CONCLUSION

The profile of the CHA professionals covered in the study was predominantly female, self-identified as White, with a high school diploma, married, and living within the coverage area of their primary care units (PHCs). They had been working in the profession for between 5 and 10 years and did not have a second job as a source of income. The study included 264 professionals working in PHC in the urban area of the municipality.

The research demonstrates relevance for the search for improvements in work environments and better focus on the health needs of these professionals. However, there is a limitation in the study, due to the methodology chosen for statistical sampling, which observes the lack of opportunity for monitoring for a longer period, which would allow observing the evolution of the health condition of the CHAs, which may be observed in later work.

This study may highlight future improvements, such as the implementation of new strategies focused on the living and working conditions of CHWs. It also provides statistical support for public health analysis. It may also influence further research in the area, focusing on new data collection models and new methodologies.

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