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Quality of life and psychological distress in community health workers*

Qualidade de vida e sofrimento psíquico em agentes comunitárias de saúde

Calidad de vida y sufrimiento psíquico en agentes comunitarias de salud

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This research aims to investigate the perception of community health workers about their quality of life and the activities they perform. The participants were thirteen community health workers from two family health units in the interior of the state Minas Gerais. The nature of the study was exploratory, developed with qualitative and quantitative methodology, carried out between 2017 and 2018. The instruments used were a scale for assessment of quality of life, a sociodemographic questionnaire and a semi-structured interview. From the analysis of the reports, two categories emerged: *Activities developed and their relationship with quality of life* and *Psychological distress caused by work and their relationship with quality of life*. The domains related to Social Relations and the Environment presented worse quality of life, and it was possible to identify through the interviews psychological distress associated with living in the same neighborhood in which they worked, with work overload in times off or holidays. Also, by listening to problems of different orders that need solutions that generally go beyond what the practice allows, the professionals felt incapable, worsening their distress.
Descriptors: Community health agents; Primary health care; Quality of life.

O objetivo desta pesquisa foi investigar a percepção de agentes comunitárias de saúde sobre sua qualidade de vida de vida e as atividades laborativas por elas desenvolvidas. Participaram 13 agentes comunitárias de saúde que atuavam em duas unidades de saúde da família do interior de Minas Gerais. O estudo foi de caráter exploratório, desenvolvido com metodologia quali-quantitativa, realizado entre 2017 a 2018, no qual utilizou-se como instrumentos uma escala para a avaliação da qualidade de vida, questionário sociodemográfico e entrevista semi-estruturada. A partir das análises dos relatos emergiram duas categorias: *Atividades desenvolvidas e sua relação com a qualidade de vida* e *Sofrimento psíquico causado pelo trabalho e sua relação com a qualidade de vida.* Os domínios referentes às Relações Sociais e ao Meio Ambiente apresentaram pior qualidade de vida e identificou-se nas entrevistas sofrimento psíquico associado a residir no mesmo bairro em que atuavam, com sobrecarga de trabalho em momentos de folga ou férias. Também, por escutar problemas de diversas ordens que necessitam de soluções que geralmente vão além do que a prática permite, as profissionais sentiam-se incapazes, agravando seu sofrimento.
Descritores: Agentes comunitários de saúde; Atenção primária à saúde; Qualidade de vida.

El objetivo de este estudio fue investigar la percepción de agentes comunitarias de salud sobre su calidad de vida y las actividades laborales que desarrollan. Participaron trece agentes comunitarias de salud que trabajaban en dos unidades de salud de la familia en el interior del estado de Minas Gerais. El estudio fue de carácter exploratorio, desarrollado con una metodología cuali-cuantitativa, realizado entre 2017 y 2018, en el que se utilizaron como instrumentos una escala de evaluación de la calidad de vida, un cuestionario sociodemográfico y una entrevista semiestructurada. A partir del análisis de los informes surgieron dos categorías: *Actividades desarrolladas y su relación con la calidad de vida* y *Sufrimiento psíquico causado por el trabajo y su relación con la calidad de vida.* Los dominios relacionados con las Relaciones Sociales y el Medio Ambiente presentaron peor calidad de vida y se identificó en las entrevistas el sufrimiento psíquico asociado a vivir en el mismo barrio donde trabajaban, con sobrecarga de trabajo en momentos de ocio o vacaciones. Además, al escuchar problemas de diversa índole que necesitan soluciones que generalmente van más allá de lo que permite la práctica, las profesionales se sintieron incapaces, agravando su sufrimiento.
Descriptores: Agentes comunitarios de salud; Atención primaria de salud; Calidad de vida.

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INTRODUCTION

Community health agents (CHA) are appointed as the professionals of the family health team who play the role of "bridge" between the health unit and the population that resides in the territory. Daily, CHAs carry out home visits for longitudinal monitoring of families, perform educational activities, register and identify health care demands.

Upon returning to the unit, the CHAs report what they found in the visits to the responsible nurse and the cases must be discussed in a team to build care. CHAs would be responsible for a "touch of strangeness"[1] that takes some teams from a more biological focus of action, expanding the spectrum of health needs of the population, and bringing the discussion of health closer to the notion of social determinants, that is, the look not directed at the sick and the disease, but at the person as a whole, with the retrieval of data on the family's history and life condition. The CHAs' sensitivity to non-biological aspects and their proximity to families - considering that they also reside in the neighborhood in which they operate - can be of great value for the construction of truly unique therapeutic projects in the work of health teams[2,3].

The dual role played by CHAs - being part of the health team and living in the area covered by the service - however, can generate stressful and painful situations for these professionals[2]. The routine of a CHA can generate a high level of stress due to the high demand at work, as they are constantly under demand for the performance of numerous tasks and the achievement of productivity goals, which adds to the scarcity of resources to carry out their work, situations of great poverty and illness at various levels with which they have contact during visits[4].

CHAs can carry out extensive walks on their daily journey, carrying backpacks with working materials such as index cards and clipboards, sitting in inappropriate positions during their stay at home, including suggesting ergonomic risks at work[5]. The work of CHAs is also compromised by inadequate salaries, population resistance to the guidelines given by them, in addition to the lack of limits between workplace and place of residence, which causes great mental and physical stress, due to the absence of separation from personal and work life[6].

The presence of musculoskeletal symptoms (pain in the neck, shoulders, wrists and lower back) and negative indicators for mental health and emotional aspects related to the quality of life of community health agents[7] may imply the need for health care. Feelings of low self-esteem, tension, and problems with body image contribute to a negative appreciation of one's own health[3].

In addition, performing a highly demanding job and having little social support can contribute to the establishment of impairment in personal and professional relationships of those who perform the CHA function[3]. Thus, it can be said that suffering is established when the professional realizes that even though they are considered agents of transformation, they do not have the necessary instruments, knowledge and also not all the property of change that the theory brings about their role. Thus, their performance puts them in a delicate position in which they see the reality of the place where they live and what can actually be done to improve the situation[4].

The quality of life that these professionals have, directly influences the quality of care of the service they provide[3]. According to the World Health Organization[8], quality of life (QoL) refers to a person's perception of their life position within the context of the culture and value system in which they are inserted and in relation to the goals, concerns, expectations and standards that have. QoL is a concept that can be seen as subjective and multidimensional, as it covers positive and negative aspects of assessment, such as pain, sleep, mobility, self-esteem, social support, financial resources, personal health, activities of daily living, work capacity, among others.

A condition of mental health in productive contexts considered adequate is given, among other factors, by the well-being of the worker, resulting from the balance of professional expectations of this subject and their respective achievements, which would contribute to the

improvement of their quality of life[9]. To achieve this satisfaction, this subject has several conditions, such as employment, quality housing, affection, self-esteem and support and social recognition.

One study pointed out that the CHA's assessment of QoL in their psychological domain (such as low self-esteem and negative feelings) is related to the negative assessment of their health status[3]. Studies point out that there may be an idealization regarding the CHA[1,2,5,6] for being the professional who resides in the community where he also works it would be easier to establish a bond with users6 and to carry out interventions, when compared to the rest of the team. Difficulties in gaining access to homes in their coverage area[5] and being less valued when compared to other team professionals6 are situations pointed out by CHAs. In this context, it is relevant to understand whether the constant exposure of CHAs to the realities of families would affect their quality of life or if their quality of life would affect the work they perform.

Thus, this study aims to investigate the perception of community health agents about their quality of life and the work activities they develop.

METHOD

This is an exploratory research, developed with qualitative and quantitative methodology. Community Health Agents (CHA) linked to two Basic Family Health Units (BFHU) operating in a medium-sized municipality in the state of Minas Gerais, located in the same health district, were invited to participate. Inclusion criteria were: to act as CHA for at least three months and to be interested in participating in the study.

A meeting was scheduled at each health unit to present the study and organize the date for data collection, which was divided into two phases. In Phase 1, it took place in the health units on the day that there was a team meeting, before the start of the meeting. All community agents from each team were invited, and only one did not participate, declaring not to be interested (unit 1).

At this moment, the collective application of: (a) a questionnaire about the participants' sociodemographic aspects (such as gender, age, if they have children) occurred; (b) a questionnaire about the activities performed in daily life as CHA (activities developed, perception of the work performed and the role of CHA); (c) the instrument on quality of life "WHOQOL-bref", from the World Health Organization, whose abbreviated version in Portuguese was studied in Brazil[11], composed of 26 questions that investigate quality of life in the four domains: physical (such as: pain, fatigue, sleep, work ability), psychological (memory, concentration, self-esteem, body image, spirituality and others), social relationships (eg. personal relationships, social support, sexual activity) and the environment (physical security, financial resources, home environment, health care, leisure, pollution, transportation, climate). After applying the instruments, the CHAs interested in the interview left a contact phone for scheduling on the preferred day and time.

In Phase 2, individual interviews recorded on a digital device took place, using a semi-structured script that investigated the understanding of the work of the CHA; activities developed daily; building the relationship/bond with users; perception of the relationship between their work and quality of life; identification of critical situations accompanied by the CHA and that can generate psychological distress. The interview took place on the day and time agreed with each participant, always at the end of the day, to carry out the interviews, in a reserved room, on the day and time indicated by the interviewees. The interviews lasted an average of 18 minutes and were transcribed in full. Data collection took place from October of 2017 to February of 2018.

This research respects CNS Resolution 466/2012 and used the Free and Informed Consent Term in two copies, having been approved by the Ethics Committee on Research with Human Beings (Opinion 2.096.04 - CAAE: 67275917.7.0000.5152). All participants were duly informed about their free participation and guarantee of anonymity. After reading and signing

the Informed Consent Form (in two copies), data collection began. To protect the participants, it was decided not to disclose the name of the municipality in which the research was carried out and numbers were adopted to designate each unit.

The responses to the questionnaire and the assessment instrument on quality of life were typed into an Excel spreadsheet by one researcher and checked by the second researcher, to eliminate errors in this step. The correction of the WHOQOL-bref instrument was performed using the model available online[12] in an Excel spreadsheet. The questionnaire with the activities developed by the CHA was analyzed with the support of an Excel spreadsheet and descriptive statistics.

The transcribed interviews were literally analyzed based on Bardin's thematic content analysis[13]. In the next moment, the material was read in full to identify themes and then these themes were grouped according to the meanings presented. The highlighted excerpts were again read by the researchers, independently to refine the grouping of themes, and discussed again, until reaching consensus.

RESULTS

The participants were 13 women between 24 and 58 years of age and their professional experience as CHA varied from 1 to 5 years in the municipal network (Table 1) whose activities are described in Table 2.

Table 1. Participants by health unit. Minas Gerais, Brazil, 2017/2018.

Participants characteristics	Unit 1	Unit 2
Age	22–58 years (mean=34.28)	36-58 years (mean=51.4) No information 1
Gender Female	7 (100%)	6 (100%)
Marital status		
Partner	3	1
No partner	3	2
(Single/Separated/Widow)	1	2
No information	0	1
Amount of children		
None	2	1
One	3	2
Two	2	2
No information	0	1
Religion		
Catholic	3	2
Evangelical	2	3
Christian	1	0
Jewish	0	1
No information	1	0
Family income		
Up to R$ 1500,00	3	2
R$ 2000 to 3000,00	2	0
Over R$ 10.000,00	0	1
No information	2	3
Time working at the unit (years)		
1 to 2	1	1
2 to 3	6	1
3 to 4	0	3
4 to 5	0	1

Table 2. Activities and CHA. Minas Gerais, Brazil, 2017/2018.

Activities as CHA	Unit 1		Unit 2	
	N	(%)	N	(%)
(1) Field work developing activities aimed at families	7	(100)	6	(100)
(2) Field work developing activities aimed at the general community	7	(100)	6	(100)
(3) Continuous training activities on topics related to the care practices performed by the team	6	(85)	4	(66.66)
(4) Home visit	7	(100)	6	(100)
(5) Team meeting	7	(100)	3	(50)
(6) Registration update	7	(100)	6	(100)
(7) Identification of families at risk	7	(100)	5	(83.33)
(8) Active search for priority groups	7	(100)	6	(100)
(9) Monitoring child growth and development	7	(100)	6	(100)
(10) Monitoring pregnant patients	7	(100)	6	(100)
(11) STI/AIDS prevention	7	(100)	6	(100)
(12) Dengue prevention	7	(100)	6	(100)
(13) Information on child immunization	6	(85)	6	(100)
(14) Information on oral rehydration (homemade saline)	6	(85)	2	(33.33)
(15) Incentive for breatfeeding	7	(100)	6	(100)
(16) Information on family planning	7	(100)	4	(66.66)
(17) Information on healthy eating	7	(100	5	(83.33)
(18) Cervical cancer prevention	7	(100	5	(83.33)
(19) Hypertension, diabetes, tuberculosis or leprosy control	6	(85)	5	(83.33)
(20) Elderly care	6	(85)	6	(100)
(21) Monitoring of nurses and doctors during home visits	7	(100)	6	(100)
(22) Necessary schedules and referrals	6	(85)	6	(100)
(23) Survey of the health problems of the population of its micro-area	7	(100)	6	(100)
(24) Filling out information forms for the Primary Care Information System (*Sistema de Informação da Atenção Básica* - SIAB)	4	(57)	4	(66.66)
(25) Coordination/supervision meetings	6	(85)	4	(66.66)
(26) Use of an intelligent map of the area of activity in which the micro areas of responsibility of the CHA are listed	7	(100)	4	(66.66)
(27) Diagnosis of the population's health situation, identifying the most frequent problems	6	(85)	4	(66.66)

The Quality of Life (Table 3) of the participants in Unit 1 scored higher in the physical domain, followed closely by the psychological domain, and then by the social relations and environment domains. The physical domain, according to the instrument used, evaluates aspects related to: Pain and discomfort; Energy and fatigue; Sleep and rest; Mobility; Activities of daily life; Dependence on medication or treatments; Work capacity.

The psychological domain involves positive feelings; Think, learn, memory and concentration; Self esteem; Body image and appearance; Negative feelings; Spirituality/religion/personal beliefs. Thus, the aspects that were least well evaluated in terms of quality of life were Social Relationships (Personal Relationships; Support/Social Support; Sexual Activity) and the Environment (Physical Security and Protection; Home Environment; Financial Resources; Health Care and social: availability and quality; Opportunities to acquire new information and skills; Participation in/and opportunities for recreation/leisure; Physical environment such as pollution/noise/traffic/climate; Transport). Among the participants in

Unit 2, the domain with the highest quality of life is the psychological domain, followed by the physical domain, social relationships and the environment (Table 3).

Table 3. Quality of life of CHA by Health Unit. Minas Gerais, Brazil, 2017/2018.

Area	Unit 1			Unit 2		
	Mean	Minimum – maximum	Standard Deviation	Mean	Minimum – maximum	Standard Deviation
Physical	13.96	11.43-16.00	1.61	12.67	11.43-14.29	0.98
Psychological	13.43	10.67-16.00	1.70	13.00	10.00-16.00	2.14
Social relations	11.24	9.33- 14.67	1.86	12.44	8.00-16.00	2.88
Environment	11.36	7.5- 13.50	1.99	11.25	9.50-14.50	1.89
Self-evaluation QoL	15.43	14.00- 18.00	1.51	12.00	10.00-18.00	3.35
TOTAL	**12.84**	**10.46 – 13.85**	**1.11**	**12.23**	**11.08-14.31**	**1.32**

From the analysis of the reports, two categories emerged: *Activities developed and their relationship with quality of life* and *Psychological distress caused by work and their relationship with quality of life*.

Activities developed and their relationship with quality of life

In this category, the statements that indicate the impact of work activities on the quality of life of the CHA were grouped. The main characteristics that the interviewees highlighted about the CHA function were helping, guiding and assisting users of the service. When performing the assignments as CHA, the interviewees felt useful:

I like to help, I like to feel useful, and in this service I feel useful, I feel that I can do something for someone else. (E2U1)

Scheduling appointments and delivering exams are very common actions in the interviewees' daily work, when they realize the need to support elderly users or those with mobility problems to the health unit. The recognition by the users makes them feel valued and recognized:

Sometimes elderly people, I make an appointment, I take it to the person, I take the exam here and I take it, when it is ready I take it, for those who are elderly, who I see who need, I have it like this, I do it [...] *but when you are an elderly woman, a person who needs it, then yes, I book, I take it, I call, what we do is like this.* (E4U1)

Home visits proved to be an important tool for professionals to relate to users in their micro-areas, as interaction allows for the creation of bonds with users:

[...] *in many houses they are like that, there is a house that I go to, that has a lady of eighty-nine years old* [...], *her visit has to be the last one, because if I arrive at her house I I don't do any more views in the morning, you get there, have cake, have coffee, no, you have to see what it's like at her house, have some visits which is very good.* (E5U1)

The appreciation of the self for the care exercised and the possibility of strengthening bonds are components of the quality of life in its psychological aspect and are present in the statements of the interviewees when they report the actions under their responsibilities in the CHA function. The work of the CHA, by allowing them to get to know users better, expands the bonds between professionals and users, which enables the development of new skills and new knowledge, obtained from exchanging with others, which includes greater knowledge of agent itself:

I really like dealing with people, talking, having that contact, you know, because it's as good for the agent as it is for the person, you know, we also learn and teach, it's very good, very rewarding [...]. *Ah, I think an exchange of knowledge, right, it's very good, it's very rewarding.* (E5U2)

[...] *because I was very closed, I didn't talk to anyone, then I expressed everything I felt in drawing or in artistic things, like that related to the arts, then after I got loose, then with the service as a community agent like that, it's the same as I said before, he added me a lot more with people ..., it made me feel like a better person.* (E6U2)

The creation of bonds with the population was very present in the speeches of the interviewed CHA. The proximity created between professional and user allows to identify problems that would not be taken spontaneously to the health service:

[...] *at the patient's house, we see the reality there, you know, how people live..., and we go over all this here* [...]. (E5U2)

Through the establishment of bonds, CHAs, feel perceived, valued and understand that their role is of paramount importance for the functioning of the care network:

They are grateful, especially when we are able to help them, we see that the love they feel for us is not a false thing, it is not a matter of interest, it is that they really fought hard to try to get it and were not getting it and through us they got to where they needed to be. (E2U2)

Why do you think with me, if there is no community agent, who does not enter the house, who does not know the patient's life, does not talk to the patient, how would it work? The patient was going to come and sit in front of the doctor and was going to say ah, I have this, this, this and this so what? Not now, we, with us, have this bond, this closeness to the patient, we can already reach the doctor, already say something to the doctor [...]. (E6U2)

Psychological distress caused by work and their relationship with quality of life

In this category, the CHA's reports on their performance were grouped, which were related to psychological suffering. Unlike the previous category, where the appreciation of the CHA was evidenced, the reports in this second category highlight that the daily care of the CHA is involved in situations that generate suffering, which the interviewees often do not know how to deal with.

The participants reported that the population has difficulties in separating the moments when they are at the service of the health unit, and the moments when they are outside working hours, since they live in the same neighborhood in which they work. Sometimes, being CHAs in the neighborhood in which they live implies attending, listening and welcoming patients on weekends, outside office hours, and even in their homes, when they are contacted directly by the local population or by telephone. These situations generated suffering in these professionals since they remain connected to work all the time, failing to enjoy the moments of leisure and leisure in a peaceful way, a fact that negatively impacts their quality of life:

It's complicated. You know why? [...] *you don't have a weekend, see?! You went out on the street, you are at the market, you are in the queue, you are on the bus, or let me ask you from the post then your time, if you don't stop, you live post it thirty days a month, because on the weekend the patient sees you at the door, or I have something to ask you* [...] *it's tiring, you don't hang up on the weekend, what you do during the week.* (E2U2)

It is difficult, because there are people who come to your house on Saturday, on Sunday, you go to the supermarket, you go to the market on the weekend and if you are in the center or if you take the bus, you don't have more peace, it's over. Then you will tell the patients, they think it is bad, what kind, how do you do it? It's no use, there's no separation, they think it's like a normal day, there's no rest. (E1U1)

As the contact of the CHA is more frequent than other professionals, such as doctor and nurse, they end up being intensely involved with certain cases and being more affected with the users' questions. It is the CHA who hear and see the problems, afflictions and difficulties of the users and suffer continuously because of this, since they do not have a training that allows them to accept this suffering and within the actions applicable to the CHA, they reveal that they can do little to change the scenario. Listening to the reports and not being able to stop this suffering identified in the users/patients does not allow them to be excluded from work. They feel all the time unable to help users with everything they need, which affects their quality of life:

There are days when we get very tired, because we end up suffering a little because of the problems of our patients, even though we didn't want to get emotionally involved, you know? (E2U2)

Ah, there are times when I freak out, [...] *there are times when I talk a lot to my husband, I charge myself a lot, so if I can help, if I help, I get sick, so I end up ... there are times when I leave myself aside* [...]. (E2U1)

In addition to these issues, the CHA still revealed to live with the feeling of uselessness and frustration on a daily basis, since they often receive requests from patients who, most of the time, are unable to attend because they need interventions that go beyond can be accomplished by their function. Exposed to this, again, professionals are affected and end up suffering from situations generated at work:

There are those things that we can solve and what we cannot solve, so, every day we have that satisfaction of helping, but we also have the feeling of defeat for not being able to help. (E2U1)

[...] *it is not my role, but we go there, we suffer together with them, we know that they are in need and we cannot do anything* [...]. (E3U1)

According to the CHAs, overwork and the respective charges for doing it, in the shortest possible time, mark their day-to-day. They are faced with an extensive routine of activities to be done, such as home visits, filling out forms and some training. This whole situation ends up generating tension in the professionals, who once again feel charged and helpless, directly affecting the quality of life in a negative way:

Oh, I was much more stressed today, so I am tired, more tired, but I was much more stressed, I already took leave [...] *so I was away for a while today* [...] *I get more mentally tired, stressed, these things* [...]. (E3U1)
[...] *you are doing one thing, you have to leave that one, to start another, you will not come back, and if you come back people have even demotivated you about why you should come back. So they are delegating many things for us to be doing and I don't see anything being completed.* (E2U2)

A few months before the interviews, the CHA started to add the function of controlling zoonoses, before the responsibility of the agents linked to another department of the Municipal Health Department, a fact that also caused suffering for the professionals. The result was assessed as a greater number of tasks and the resulting charges on their performance:
Ah, my daughter, that's complicated! Let me tell you why, because today the CHA does not only perform the CHA function, she is also doing zoonoses. And then, what happens, it ends up being complicated by the following fact: a lot of the function was delegated to us. Overloads. (E2U2)
It was very hard for us [because of dengue control], because what happens, now you can't go to the home of a patient who needs you more often, since you have control of zoonosis. Today you enter a house, you take much longer, than you look at the yard. (E1U2)

Despite playing a role that is of paramount importance for the functioning of the health network, the professionals feel a lack of recognition for the work performed, a fact that generates suffering in the interviewees. Thus, the current scenario in which these professionals find themselves directly affects negatively the perception of the importance of them and their work for users and the health service:
I don't know, before I had a health agent here, the staff also lived, normal, I don't even know if they have such a need, to have it. (E4U1)
We lack recognition of our profession, you know? !! I think. We still have a lot to do, we do it, we have an important role in the life of the individual, the family, the person you visit and do not have much professional recognition. That's what I think. (E6U1)

The CHA work requires a significant physical effort from the professional, since it is necessary that he walks on foot during most of the working hours, being exposed to the sun or rain daily, having to deal with the excessive heat or, more rarely in the municipality in question, the cold. Linked to this, these professionals are faced with an excess of physical tiredness, caused by work, a situation that directly interferes with the quality of life of the participants:
Sometimes people are very exposed to risks, they walk a lot, their feet hurt, their legs hurt. (E6U1)
What is bad is only when the sun is hot. It is stressful, tiring, those hot days, then you spend that way in that hot sun. (E4U1)

The quantitative data that incorporate the physical domain of quality of life, go against what is reported by them in the interviews, since the numbers referring to the physical domains are high, when compared to other domains, however it is notorious in the speech of the agents, how much physical wear caused by work harms them.

In addition to all the wear and tear caused by work, the CHA still face other obstacles that appear during their performance. One of them is the fact that many users do not want to receive them in their homes even if they are at home, because they have health plans or because they prefer to be seen in other units:
Because people have a certain resistance to welcoming us into homes. (E6U2)

Another obstacle is the fact that many users are not at home when they try to carry out home visits, which often creates the feeling of work being in vain and directly affects the fulfillment of their "goals" (pre-established number of houses/families) to be visited in one day), and consequently in the perception that these professionals capture from their work, reinforcing once again the feeling of frustration and lack of recognition:
Just like I did yesterday, I made a street there, the street has it, do you want to see it? There are, there are about ten houses, out of ten I must have done two, two, three at most. (E4U1)

DISCUSSION

All participants in this study, in the two units surveyed were women, which corroborates other studies and points to the growing feminization observed in the health field in Brazil. The average age of the professionals who participated in the research is also similar to the findings of other studies[14-16]. Unlike what was found in two other studies[5,16], in which the majority of

CHA were married, here most CHA declared themselves without a partner. The high turnover, pointed out in a study in which the CHA had been in the job for approximately two and a half years[15], is consistent in this study.

Carrying out and updating registration of families in their micro-areas, detecting risk situations, offering guidance on the services offered by the network, scheduling consultations and delivering exams, conducting home visits, informing other team members about the conditions of the families the coverage area and promoting health promotion and disease prevention actions were carried out by the interviewees, in dialogue with what is signaled by the Ministry of Health and other research[17-20].

Other studies[4,6,18,19] highlighted, in the same way as identified in the present study, that the CHA is one who provides services to the community in order to help them within the limits of their practice, being seen as someone who assists the community, insofar as it manages to offer resources that promote the improvement of their respective states, at the same time that it seeks to guide them towards achieving an improvement in the quality of life.

Listening to users is done by the interviewed CHA, in view of the proximity with these people, being then responsible for listening to patients 'complaints in order to take them to the health team so that an evaluation of the users' questions is carried out[6]. Often, this listening occurs through home visits, one of the main activities developed by the CHA, in line with the National Primary Care Policy[20].

Administrative tasks are also part of everyday life (filling out information forms for the Primary Care Information System [SIAB], carrying out and updating the records of subjects residing in their micro areas) and constitute[14] as the second most frequently performed task by CHA, being more cited, the activities of assistance nature. In this research, all thirteen surveyed claimed to update their records, as it is in line with what is presented in another study[14].

Several situations and work characteristics that lead to psychic suffering were highlighted. The CHA perceived many difficulties in finding agile and punctual responses to the situations of the families they refer to other professionals and also to the other services in the network, which generated great discouragement for the performance of their functions, since in many of them, they they end up being barred by other instances and can do little to change this reality, as corroborated by other research[21].

The fact of living in the same place where they worked can be taken as an indicator of suffering for the interviewees[22]. Due to personal involvement with users, CHAs had difficulties in separating the professional from the private. This identification between CHA and the community makes the professional extremely observed, causing the most diverse impressions and opinions, something that should be considered as an important variable of the success of her work.

In addition, the personal life of the CHA continues in that same place after office hours, and the separation between the resident and the health unit professional is lost in the midst of this, exceeding the duties assigned to him, since he is obliged to dealing with users and their issues, on weekends, holidays, and holidays, which was also observed in other studies[6,23].

The interviewees also reported that they perceive and affect themselves daily with the most diverse forms of suffering of the users. This leads, according to the testimonies, to the development of some symptoms of stress by the CHA, more significant than the rest of the team, since they are the ones who have the greatest bond with the community and do not receive adequate training and support from the multidisciplinary team to face and discuss the difficulties perceived in the relationship with users. Thus, the feeling of helplessness and guilt in relation to the problems suffered by families prevails in these professionals, as also noted by other studies[22,23]. The CHA are the professionals of the primary health care network who are more propitious and vulnerable to presenting manifestations of stress, due to their extreme proximity to the population served and, consequently, to the creation of a bond with the subjects who reside in the community[4,15].

Primary care is a vast field of activity in the health sector and requires, in addition to the minimum family health team, the support of the so-called NASF-AB (Núcleos Ampliados de Saúde da Família), formed by specialists in different areas who are in charge of both the development of care actions for the population served, as well as the training of professionals from the minimum team to deal with problems detected in the community, developing permanent education with the family health units[23]. The various accounts of the CHA interviewed in this study point to the feeling of helplessness and isolation for which work strengthened by case discussions, action planning to meet community demand and articulation with other points of care to be done by NASF-AB could reduce the suffering of these agents by expanding the offer of shares.

Work overload, exposure to sunlight and exacerbated heat are responsible for hindering the work of CHA[24], standing out as a great cause of suffering and responsible for interfering in the interviewees' quality of life. These factors interfere with the operationalization of work in different dimensions and limit the actions of professionals in carrying out comprehensive care, causing great concern, due to the possibility of negative consequences for themselves.

Another study[6] calls attention to the factors that cause suffering and illness and that are not noticeable at first, since they are intertwined with some values and beliefs that are accepted and normalized by society. The risks to which CHAs are exposed every day can cause long-term effects, even if they are not immediately noticeable[6].

One can understand as risk factors the direct contact with the users' issues, being exposed to the situation of suffering of different orders daily, living in the same place where they work, lack of appreciation of work. The psychological domain present in the quality of life scale obtained the highest score in Unit 01, and is among the highest scores in Unit 02. This fact draws attention, since the qualitative analysis of the interviews' speeches showed that there was a high level of suffering caused by the situations that the CHA are exposed to at work, as well as in another study[6]. Professionals have difficulties in perceiving the wear and tear caused by work.

It was noticed in this study, in agreement with others[24,25], that the overload of tasks and the devaluation of the CHA's work cause demotivation in relation to the work performed and the consequent feeling of devaluation, facts that influence professional satisfaction and contribute in a way negative for the professional's immersion in suffering and possibility of illness. The findings of this research corroborate with investigation6 as to the existence of psychological suffering that the CHA faces when he perceives himself as a driver of changes for which he does not have the instruments, knowledge and attributes necessary to propel.

Thus, acting in the space in which he resides, places him in a position divided between what can really be done based on his actions and what needs to be done, generating in him the feeling of helplessness and incapacity, since the needs of community go beyond what can be done by these professionals.

Regarding the data representing the quality of life domains, it was noticed in this study that the environment domain obtained the lowest score in one unit and the second lowest score in the other health unit. The environment, on the scale employed, represents physical security and protection, home environment, financial resources, health and social care: availability and quality, opportunities to acquire new information and skills, participation in/and opportunities for recreation/leisure, environment physical[11].

These findings are in line with the data identified in another study[15], in which the lowest values between domains was represented by the environment. This points out a weakness of the research participants to carry out their activities in the health unit.

Unlike studies[11,25], the domain that represents social relationships (social support/sexual activity), in this research did not obtain the highest score in any of the units, even reaching the lowest value among the domains in Unit 01. The reasons for what the value

of this domain obtained so low scores may be related to the speech of the agents, who complain of devaluation, lack of recognition and support at work.

CONCLUSION

This study evaluated the perception of community health agents about their quality of life and the work activities they perform. Living in the same neighborhood where they work as health professionals can bring them closer to the territory and the community they serve, but they generate suffering due to easy access, blurring the boundary between work and private life, interrupting moments of rest and leisure.

Listening during home visits generates suffering, as they do not have tools to act, finding ways to provide welcome and care to users. The support of staff from the Extended Family Health Center in the analysis of the demands and provision of care can alleviate suffering, also reducing the perception that they are powerless.

As limits of this study, the reduced number of participants, the access to only two family health units and the fact that both are located in the same health district of a medium-sized municipality stand out, reasons that make it difficult to generalize the results. Therefore, studies that investigate the quality of life of these professionals and the existence of work support in other locations are suggested.

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Bárbara Aline Bezerra de Miranda participated in the collection, analysis and interpretation of data and writing. **Renata Fabiana Pegoraro** contributed to the conception, design, analysis and interpretation of data, writing and review.

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