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ANALYSIS OF THE SOCIODEMOGRAPHIC, WORK PROFILE AND OCCUPATIONAL RISKS OF COMMUNITY HEALTH AGENTS

Análise do perfil sociodemográfico, laboral e dos riscos ocupacionais de agentes comunitários de saúde

Análisis del perfil sociodemográfico, laboral y riesgos ocupacionales de los agentes de salud comunitarios

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ABSTRACT

Objective: to outline the sociodemographic and work profile of Community Health Agents as well as to investigate the occupational risks to which they are exposed in a municipality in the Northeast Region. **Method:** conducted by means of a self-administered questionnaire with 64 subjects, consisting of two sections: one related to sociodemographic and work data and the other with questions about occupational risks. **Results:** most of the participants are female, married, with complete high school, took a qualification course, live in the micro area that works and work 40 hours a week. Five variables were listed as occupational risks, namely: contact with infectious people, physical aggression, emotional exhaustion, interpersonal problems and attacks by animals. **Conclusion:** it is imperative that such a professional is recognized for his potential. Furthermore, that he can have his demands met and understood, especially with regard to coping with adversity at work, which makes him so susceptible to illness, as evidenced in this research.

DESCRIPTORS: Community health workers; Working conditions; Occupational risks; Occupational health.

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RESUMO

Objetivo: delinear o perfil sociodemográfico e laboral de Agentes Comunitários de Saúde bem como investigar os riscos ocupacionais aos quais estão expostos em um município da Região Nordeste. **Método:** realizado por meio de um questionário autoaplicado com 64 sujeitos, constituído por duas seções: uma relativa aos dados sociodemográficos e laborais e outra com questões acerca dos riscos ocupacionais. **Resultados:** a maioria dos participantes é do gênero feminino, casada, com o ensino médio completo, fez curso de qualificação, reside na microárea que trabalha e cumpre 40 horas semanais. Elencou-se 5 variáveis como riscos ocupacionais, sendo elas: contato com pessoas infectantes, agressão física, desgaste emocional, problemas interpessoais e ataques de animais. **Conclusão:** é imperativo que tal profissional seja reconhecido pelo seu potencial. Ademais, que possa ter as suas demandas atendidas e compreendidas, especialmente no que concerne ao modo de enfrentamento às adversidades laborais, o que o faz ser tão suscetível ao adoecimento, comprovado nessa pesquisa.

DESCRITORES: Agentes comunitários de saúde; Condições de trabalho; Riscos ocupacionais; Saúde do trabalhador.

RESUMEN

Objetivo: esbozar el perfil sociodemográfico y laboral de los Agentes Comunitarios de Salud así como investigar los riesgos laborales a los que están expuestos. **Método:** realizado mediante un cuestionario autoadministrado con 64 sujetos, que consta de dos apartados: uno relacionado con datos sociodemográficos y laborales y otro con preguntas sobre riesgos laborales. **Resultados:** la mayoría de los participantes son mujeres, casadas, con bachillerato completo, cursaron un curso de calificación, viven en el área micro que trabaja y trabajan 40 horas semanales. Se enumeraron cinco variables como riesgos laborales, a saber: contacto con personas infecciosas, agresión física, agotamiento emocional, problemas interpersonales y ataques de animales. **Conclusión:** es imperativo que dicho profesional sea reconocido por su potencial. Además, que sus demandas sean atendidas y comprendidas, especialmente en lo que respecta al afrontamiento de las adversidades laborales, que lo hacen tan susceptible a la enfermedad, como se evidencia en esta investigación.

DESCRIPTORES: Agentes comunitarios de salud; Condiciones de trabajo; Riesgos laborales; Salud laboral.

INTRODUCTION

Reflecting on the health of workers in Primary Health Care (PHC), one realizes that professionals in the Family Health Strategy (FHS) are exposed to several occupational risks. Among them, the activities performed by Community Health Agents (CHAs), who are the link between the health team and the community, are emphasized. Most of them live in their own community, and therefore have a potential demand that goes beyond the scope of their work, often overloading them, even outside working hours.[1-13]

The work of the CHAs in the FHS is based on the constant improvement of Continuing Education in Health (EPS), which is strengthened by the physical and mental confrontation faced by the professionals due to the realities to which they are exposed in their daily work and micro area. Their role requires posture and ethics, inside or outside the FHS, so that their work can be reliable and committed to social welfare, because the population that depends on the FHS sees the CHA as a link between the community and the Basic Health Unit (BHU), thus making it possible to strengthen the care bond.[2]

From this perspective, Primary Care (Atenção Básica – AB) professionals are exposed to occupational risks that, in addition to contributing to the worker's health problems, interfere in the assistance provided by them, making it essential to notify accidents. It is also important to provide information about the self-assessment of health, generated by public health services, in order to contribute to the prognostic analysis, preparation of services in prevention and follow-up[3].

A review article exposed a series of difficulties related to the work developed by CHAs. Among the findings, the following stand out: broad attributions of actions, often being taken to incorporate activities that are not their responsibility; poor working conditions, including low pay, excessive work hours, unhealthy environments, and devaluation; weak relations with the community, such as exposure to conflict and violence, etc.[4]

It is also noteworthy that the lack of specific training can trigger problems that affect the physical and mental integrity of the professional, making this public one of the most vulnerable among the members of the FHS. At this juncture, the CHAs face a range of factors that can induce work stress, such as frequent team meetings, the high number of families assisted daily, and even the relationship with managers and the community.[5]

As a protagonist of the Primary Care setting, the CHAs, in their daily activities, reveal a diversity of situations that are fields of exposure to occupational risks. In a broader sense, it shows the complex interaction work-worker and what is produced in this relationship, in different spheres of effects.[6]

In this context, the work practice of CHAs is highlighted in this study, due to the important role of this professional as a determinant element of the health-disease process, both individual and collective, in view of the social, economic, environmental, cultural, physical, and psychological impacts resulting from the production of work in contemporary capitalist society.[7]

Thus, it becomes necessary to reflect on the practices performed by CHAs. For their work process to be truly understood and, especially, valued, it is essential to remember that they are also health professionals and play the role of close contact with community members. Thus, the objective of this study was to delineate the sociodemographic and labor profile of Community Health Workers, as well as to investigate the occupational risks to which they are exposed.

METHOD

A cross-sectional, quantitative field research developed in Family Health Units (FHU) located in a Health District of a capital city in the Northeast of Brazil. This district was selected because it is the one that meets the greatest local demand, since its network of services offered to the population includes 50 units of the Family Health Strategy (FHS), 18 Family Health Units (FHUs), 1 Comprehensive Health Care Center (CAIS), 1 Center for Dental Specialties (CEO), 1 Center for Integrative and Complementary Health Practices (PICS), 1 Emergency Care Unit (UPA) and 2 hospitals.

The target population consisted of the CHAs who work in the FHU of this district. Although the sample size was expected to be 200 professionals, many of them were on vacation and some refused to participate. Moreover, it is important to clarify that in March 2020, the performance of any non-emergency activity in the Health Units was suspended, after the declaration of the new coronavirus pandemic by the World Health Organization (WHO). For this reason, data collection, which started in the month of December 2019, was interrupted in the second half of March.

The eligibility of participants, as an inclusion criterion, occurred from the minimum time of five years of professional performance as a CHA. As exclusion criteria, those who were on vacation or on some kind of leave at the time of data collection were not included in the sample. Thus, the study had a total of 64 respondents.

The collection was carried out through a self-administered questionnaire, containing 25 variables as response options that vary from multiple choice, dichotomous and Likert scale, consisting of two sections: the first concerning the characterization of the sample as sociodemographic and labor data (11 variables); the second concerning the proposed objectives, containing questions about occupational risks (14 variables).

The SPSS 20.0 software was used to systematize the data, which were statistically analyzed using absolute and relative frequencies and the chi-square test, to verify the association between the sociodemographic factors and occupational risks, considering a significance of 5%.

We respected the guidelines contained in Resolution No. 466/12 and its complements, of the National Health Council (CNS), which regulates research with human beings.[8] Thus, the larger project in which this manuscript is derived, entitled ANALYSIS OF OCCUPATIONAL EXPOSURE AND POSSIBLE IMPACTS ON THE VOCAL QUALITY OF COMMUNITY HEALTH AGENTS, was sent to the Research Ethics Committee of the Health Sciences Center of the Federal University of Paraíba, being approved on May 29, 2019 under opinion no. 3,354,081 and CAAE 12874019.7.0000.5188.

RESULTS

The results of Table 1 show that in the gender variable there is a predominance of females, with 55 (85.9%) women interviewed. As for marital status, there was an emphasis on married people, with a total of 25 (39.1%) CHAs. With regard to education, 33 (51.6%) interviewees had completed high school. Regarding the ACS training course, 54 (84.4%) of the ACS had taken it. Of the 64 participants, 47 (73.4%) live in the micro area where they work, all 64 (100%) working 40 hours a week.

Table 2 shows the distribution of results according to the intersection of sociodemographic data and occupational risk of the research participants. Of the 58 CHWs who indicated that contact with infectious people is an occupational risk, 100% are married or divorced and 80% are single, presenting a statistically significant association. It is noteworthy that 100% of the sample has a stable union and considers physical aggression as an occupational risk, followed by the married ones, with 92% of this part of the participants agreeing with the risk.

Table 1 – Distribution of research participants according to sociodemographic and work characterization. João Pessoa-PB, 2020.

Variable	N	%
Gender		
Female	55	85,9
Male	9	14,1
Marital Status		
Single	15	23,4
Married	25	39,1
Stable Union	5	7,8
Divorced	16	25,0
Widower	3	4,7
Schooling[a]		
Elementary School Complete.	4	6,3
Incomplete High School	1	1,6
Complete High School	33	51,6
Higher Education	26	40,6
Resides in the micro-area		
Yes	47	73,4
No	17	26,6
Training Course		
Yes	54	84,4
No	10	15,6
Workload 40h	64	100,0

Table 2 – Distribution of the survey results according to the intersection of sociodemographic data and occupational risk. João Pessoa-PB, 2020.

SOCIODEMOGRAPHIC DATA										
	Marital Status						Income			
RO[a]	SINGLE[b] N(%)	MARIEDA N(%)	SU[c] N(%)	DIVORCED[d] N(%)	WIDOW N(%)	sig*	-1SM[e] N(%)	1-2SM N(%)	+3SM N(%)	sig*
V1										
Yes	12 (80%)	25 (100%)	3 (60%)	16 (100%)	2 (67%)	0,008	6 (75%)	36 (92%)	16 (94%)	0,000
No	3 (20%)	0 (0%)	2 (40%)	0 (0%)	1 (33%)		2 (25%)	3 (8%)	1 (6%)	
V2										
Yes	10 (67%)	23 (92%)	5 (100%)	14 (87,5%)	1 (33%)	0,030	5 (62%)	33 (85%)	15 (88%)	-
No	5 (33%)	2 (8%)	0 (0%)	2 (12,5%)	2 (67%)		3 (38%)	6 (15%)	2 (12%)	
V3										
Yes	14 (93%)	25 (100%)	5 (100%)	16 (100%)	2 (67%)	0,025	6 (75%)	39 (100%)	17 (100%)	0,001
No	1 (7%)	0 (0%)	0 (0%)	0 (0%)	1 (33%)		2 (25%)	0 (0%)	0 (0%)	
V4										
Yes	13 (87%)	23 (92%)	4 (80%)	15 (94%)	0 (0%)	0,001	5 (63%)	34 (87%)	16 (94%)	-
No	2 (13%)	2 (8%)	1 (20%)	1 (6%)	3 (100%)		3 (37%)	5 (13%)	1 (6%)	
V5										
Yes	14 (93%)	25 (100%)	5 (100%)	15 (94%)	2 (67%)	-	6 (75%)	38 (97%)	17 (100%)	0,001
No	1 (7%)	0 (0%)	0 (0%)	1 (6%)	1 (33%)		2 (25%)	1 (3%)	0 (0%)	

a. RO = occupational hazard; b. SOLT = single; c. UE = stable union; d. DIVORC = divorced; e. SM = minimum wage; *sig = statistical significance
V1 = Contact with infectious people; V2 = Physical aggression; V3 = Emotional distress; V4 = Interpersonal problems; V5 = Animal attacks

The results show that 100% of the study population who are married, in a stable union and divorced, totaling 46 interviewees, ensure that emotional distress is an occupational risk to which the CHAs are exposed. And yet, 56 of them have a salary income above 1 minimum wage (MW), with 39 (100%) of the interviewees with income between 1 and 2 MW and 17 of the interviewees (100%) with more than 3 MW.

A lack of dialogue and empathy towards their work was verified, corroborating the results of the research: 94% of the divorced and 92% of the married ensure that interpersonal problems are configured as occupational risk. It is worth pointing out that in the present research, 38 (97%) of the CHAs affirm that animal attacks are an occupational risk, have a wage income of 1-2 SM, and 17 (100%) have a wage income of +3 MW, with significant statistical relevance in this association.

DISCUSSION

When the female gender was in the majority, it was immediately thought that this factor is justified because the figure of the woman is historically recognized in society as synonymous with affection and care. The CHA

In the case of CHAs, their femininity is continuous, of which their social nature succeeds in the daily care and their maternity is replaced in the educational for the community, becoming the one who takes care of everyone.[9] An investigation conducted in 107 Basic Health Units in the Northeast of Brazil10 demonstrated that of the 535 CHAs interviewed, 76.5% were women, corroborating the predominance of the female presence found in the present study.

As previously mentioned, most of the CHAs have completed high school, and although they did not have a degree, they repor-

ted participating in courses offered by the municipal government for qualification purposes. Basic qualification for CHAs, besides being a requirement for professional practice, is also a method that teaches them to perform actions of health promotion, disease prevention, and home and/or community interventions, individual and/or collective.[10]

Authors add that the qualification of CHAs for such a complex and diverse field as health care in Brazil implies in establishing the important objective of consolidating primary care policies in the Unified Health System (SUS).[11]

The fact that they live in the same community they work in allows CHAs to create unique bonds with users, because besides knowing the health demand, the professional gets to know intimate aspects, the socioeconomic reality, and family issues. On the other hand, for the same reason, many of them usually have their privacy invaded and may be constantly embarrassed by users, who insist on approaching them in public places and at any time of the day to talk about health care issues.[12-13] Moreover, the permanence of professionals working full time in BHU is considered a risk for disease, since they are exposed to the community's problems all day long.[14]

In the Paraíba municipality in question, the Municipal Health Secretariat (SMS) reached an agreement with the Union of Community Health Workers of Paraíba (SINDASC-PB), determining, since August 1, 2018, a new workload for all CHAs, with the entrance hours at 07:00 and departure at 13:00. Even in this new work schedule, the CHAs report that users routinely approach them outside of the proposed working hours in order to seek information regarding care, make complaints, or even charge for the delivery of exams.

Moreover, many CHAs expose factors that complicate the performance of their functions, favoring the process of becoming ill. This is due to the high demand for care, the inability to meet all the requests of the community, the lack of resolution of the users' problems, and the continuous contact with diseases.[15]

It is common for these professionals, besides the constant contact with diseases, as mentioned above, to be surprised by occupational accidents (OA), which can occur in different ways. Exposure to inanimate mechanical forces is the cause of many AT and some examples can be given: a CHA wearing sandals during a visit to the user's home had his body perforated by a foreign object, exposing him to tetanus; another agent was perforated by a hypodermic needle when a nurse was collecting blood from the user in the same room where the CHA was signing in.16 This last episode shows how the structure of the BHUs, in general, needs to be improved in order to minimize incidences of this type.

It is a fact that the use of Personal Protection Equipment (PPE) is essential for all professionals, since it helps and protects against possible risks of accidents and/or illnesses resulting from work practice.[17] Therefore, we emphasize some essential PPE for the use of CHAs, such as disposable masks, latex gloves, boots, and caps, regardless of whether the CHA will be in the field or assisting in the units.[17]

It is also necessary to rethink the posture and organization of the FHS management so that it can effectively facilitate the notification of accidents in the workplace. A study[18] shows that among 30 CHAs, 27 agree that having contact with infectious people is an occupational risk, exposing that it is almost inevitable not to be contaminated. This statement raises the issue that this professional, as well as the members of the FHS, cannot deny assistance to users, whether they are in any condition of disease or vulnerability.

Regarding aggression, it is quite common the presence of physical and/or verbal aggression in the CHAs' practice, especially at the moment of the reception. Moreover, violence is not restricted only to the physical dependencies of the units, but extends indirectly to the communities where they work, and it is routine to see police confrontations with some users.[19] An example of this is given in a survey when statements from CHAs about violence experienced in their daily lives are revealed. One of these statements mentions that during the implementation of the FHS in the community, CHAs were threatened by drug dealers for suspecting them of being spies for the drug trade.[20]

As for the emotional/affective involvement and the resulting stress, scholars argue that this strong involvement between the user and the CHA can make the professional feel sad and cause suffering or sickness, since he/she is always in contact with disease situations. It should not be forgotten that the exercise of this profession requires the professional to be well with his own health, so that a positive message can be transmitted about what he promotes, and so that he can perform a good job in the community.[15] Thus, it is also important that the CHAs collaborate and organize their time better, so that they can create healthy habits and behaviors, which will certainly result in an improvement in their disposition to work.[21]

In addition to a feeling of devaluation and injustice in their work, the participants of this research refer the suffering of working together with the other professionals of the FHS. In team meetings there is a lack of dialogue, which is configured as a barrier to solving relational problems. It is also explained that the health care provided by the CHAs takes second place in the discussions and they end up not having any space to speak. Hierarchically, in front of their teammates, they are usually seen as subordinates.[13,22]

In some moments during data collection, it was observed the dissatisfaction of CHAs with the BHU manager, a fact that occurred in more than one facility visited. There were several reports about the lack of assistance to CHAs in the units, as well as the lack of professional empathy from managers and the lack of listening to solve professional problems. For this reason, it is essential to value and cultivate a good relationship among professionals, promoting harmony, understanding, and the satisfaction of all involved in the work environment.[21]

However, there is something external to the units that hinders the work of the CHAs and that cannot be left unemphasized: the presence of domestic animals in the users' homes. It is common

for the agents to be chased, sometimes even bitten, and, most of the time, this occurs in the presence of the owner. One of the strategies used is to create a bond of friendship with the animal in order to protect themselves and get to the house for the home visit.[15-16].

CONCLUDING REMARKS

Given the results, we can encourage the creation of spaces and discussions about the occupational risks that the CHAclass is exposed. As a gap, we point out the scarcity in the literature of research that correlates the profile of CHAs and occupational risks, and it is important that new studies are directed to such reflections and updating of the theme.

A limitation of the study is the small number of participants, justified by the fact that the collection was carried out in months that are naturally festive and vacation months. Moreover, the current scenario resulting from the pandemic made it impossible to complete the study. It is also noteworthy that the findings refer to only one Health District of the investigated city, being restricted to the peculiarities of this area, not covering other realities.

Therefore, there is a need to value CHAs as professionals who need to be recognized for their potential both as mediators and caregivers. They need to have their demands met and understood, especially regarding the way they face work adversities, which makes them as susceptible to illness as the other components that make up the FHS. It is then an invitation to the union of convergent thoughts to improve the health of this worker who represents and is present, literally, in the lives of the communities that seek the services of the Unified Health System (SUS).

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