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Original Article

The quality of life of community health agents and possible contributions of occupational therapy

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Abstract: Introduction: Community Health Agents (CHAs) are a link between the health team and the community. Their work may cause suffering and illness, harming their Quality of Life which is understood as the individual's perception of their life position in cultural context, and value system in which they live. The occupational therapist contributes to the worker's quality of life. Objective: To describe the profile, job specificities and quality of life of CHAs, contextualizing possible contributions of Occupational Therapy. Method: A descriptive study conducted with health network CHAs Recife/PE. We assessed quality of life using sociodemographic questionnaire, with information on health/life habits and occupational conditions and the WHOQOL-Bref. Results: Seventy-one, most of them women, young, non-smokers and practicing physical activity participated. They work in a regular access area (71.84%), in complete teams (47.89%) and accompanying over 750 people (46.48%). The quality of life has in the social domain achieved greater satisfaction, where the facets personal relationships and social support were better scored. The environment domain obtained lower score, with the facets freedom, physical safety and security, financial resources, transport and physical environment having greater dissatisfaction levels. The occupational therapist can use group activities, expressive tasks and orientations in order to improve the agent's health by using techniques for safety, team work, self-care and relaxation. Conclusion: The community health agents lack the general definition of quality of life, with domains of satisfaction and dissatisfaction. The occupational therapist acts to reduce the sources of illness and suffering in these professionals' work.

Keywords: *Occupational Therapy, Community Health Agents, Quality of Life, Worker Health.*

A qualidade de vida do agente comunitário de saúde e possíveis contribuições da terapia ocupacional

Resumo: Introdução: O Agente Comunitário de Saúde (ACS) configura-se num elo entre a equipe de saúde e a comunidade. Seu trabalho pode gerar adoecimento e sofrimento, prejudicando sua Qualidade de Vida, compreendida como a percepção de sua posição na vida, no contexto da cultura e do sistema de valores que vive. O terapeuta ocupacional atua de forma a contribuir para a qualidade de vida do trabalhador. Objetivo: Caracterizar o perfil, as especificidades do trabalho e a qualidade de vida do ACS, contextualizando possíveis contribuições da terapia ocupacional. Método: Estudo descritivo com dados coletados usando um questionário sociodemográfico sobre hábitos de saúde/vida e especificidade do trabalho, e aplicação do WHOQOL-Bref para avaliar qualidade de vida. Resultados: Participaram 71 ACS, a maioria mulher, jovem, não fumantes e praticantes de atividades físicas. Trabalham em área de acesso regular (71,84%), em equipes completas (47,89%) e acompanhando acima de 750 pessoas (46,48%). A Qualidade de Vida tem, no domínio social, maior satisfação, com melhor pontuação nas facetas Relações Pessoais, Suporte e Apoio Social. O domínio Meio ambiente tem maior insatisfação e menor

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escore nas facetas Segurança Física e Proteção, Recursos Financeiros, Transporte e Ambiente Físico. O terapeuta ocupacional pode utilizar atividades grupais, expressivas e de matriciamento, abordando técnicas para segurança, trabalho em equipe, autocuidado e relaxamento, visando à saúde do ACS. Conclusão: A qualidade de vida geral apresenta indefinição, com ACS de muito satisfeitos a insatisfeitos. O terapeuta ocupacional atua com o objetivo de minimizar as fontes de adoecimento e sofrimento no trabalho dos ACS.

Palavras-chave: *Terapia Ocupacional, Agentes Comunitários de Saúde, Qualidade de Vida, Saúde do Trabalhador.*

1 Introduction

In the Primary Health Care (PHC), the Community Health Agent (CHA) is a promoter and vigilant of health conditions and one of his functions is the integration between health services and the community. This expected integration is possible because, by being part of the community and knowing "the daily ways of living, of meaning life and of behaving in local families" (OLIVEIRA et al., 2010, p. 31), the CHA has the potential of collaborating in the communication of these families with the health team, and of facilitating the creation of bond and trust (MASCARENHAS; PRADO; FERNANDES, 2013; JESUS et al., 2014).

In this direct contact with the community and the experience in the territory, the CHA identifies the difficulties, and in most cases, he is the facilitator with the PHC teams and the community, for the transformation of problem situations which are affecting the health and quality of life of the residents (BRASIL, 2009; GUANAES-LORENZI; PINHEIRO, 2016). For Malfitano and Lopes (2003, p. 114):

> The CHA is seen by his 'neighbor' as someone who can help him, as he is inserted in a public service, facilitating the communication and the presentation of his demands at that moment, demands that may or may not be related to basic health actions, but in most cases, are basic social actions.

In this way, the CHA establishes social relationships with the community as a health worker and, because he belongs to the community, he is a friend, counselor, and supporter, as well as establishes relationships with the health team in which he performs his function. In the work of the CHA, there is a technical dimension, direct action to the health of the population, as mediator, promoter and articulator of care, and another political dimension, in which solidarity and responsibility for community organization and transformation are evidenced (VASCONCELLOS; COSTA-VAL, 2008; JARDIM; LANCMAN, 2009; GUANAES-LORENZI; PINHEIRO, 2016).

Silva and Dias (2012) affirm that working is important in people´s lives, because through it, the people have access to income, especially to satisfy basic needs such as food, leisure, housing, education, among others. However, its importance is not only for income and access to resources for well-being, but also for the sense of utility, recognition and social participation, and the work is integral to the identity of the person.

Like other workers, the CHA seeks recognition for his work, either by the technical aspect of direct action in health or by the solidarity role of articulator of relationships. For the CHA, these aspects both lead to the recognition as the existence of tensions, problems, and difficulties in the performance of the function and in the health of the professional (VASCONCELLOS; COSTA-VAL, 2008; JARDIM; LANCMAN, 2009; GALAVOTE et al., 2013; GUANAES-LORENZI; PINHEIRO, 2016).

Several authors point out that health is not independent of work situations. Although it is fundamental for the construction of the subjectivity of the individual and his experiences, the conditions the workers are exposed and how they perform their function can cause suffering and illness (OLIVEIRA, 2001; SILVA; DIAS, 2012; BORSOI, 2007).

In this sense, this study considered the working conditions contextualized in the PHC, focusing some of the specificities of this process, in which physical, social, administrative and normative determinations such as the number of people assisted, the composition of the teams or the programmatic actions pressure on the worker and the functioning of the services (BRACARENSE et al., 2015; ASSUNÇÃO, 2011; URSINE et al., 2010). Thus, the adopted approach is distanced from the ergonomic analysis of occupational health and seeks to deal with aspects related to the organization and specificity of the CHA work.

The version of the Brazilian National Policy of Primary Health Care (PNAB) published in 2011 established in the specificities of the Family Health Teams (FHT) that 100% of the territory should be covered by CHAs and the number of people registered per agent should not exceed 750 people. It also stressed the need to respect equity criteria

when defining each territory and population ascribed. It is recommended that the number of people per CHA consider the vulnerability of the families of that territory, so where there is greater vulnerability, the smaller the number of people per agent and team should be (BRASIL, 2012). However, in the PNAB in force from 2017, this universal coverage becomes only a recommendation, that is, the new version relativizes the population coverage and does not define parameters necessary to guarantee the quality of access to the population and the work process of the professionals of the FHT (BRASIL, 2017; MOROSINI; FONSECA; LIMA, 2018).

The specifics about the work of the CHAs are essential for the maintenance of adequate working conditions, since they are not limited to carrying out the work, but also they are related to everything that is around the work, implying directly on the quality health, satisfaction and attachment to work, as well as occupational diseases and the income of these professionals (SILVA; DIAS, 2012).

Regarding the work as CHAs, Martines and Chaves (2007) and Guanaes-Lorenzi and Pinheiro (2016) showed that the task can provoke depressive experiences, disappointment due to the lack of recognition of their work by the community, reflecting on devaluation, apprehension, pain in the body, physical and emotional fatigue, as well as stress and feeling of powerlessness in the community difficulties, which triggers the failure of the care process for the micro area that this agent is responsible.

Other factors such as the structure of the Family Health Unit (FHU), the insecurity of the community, the lack of support from local management and public authorities, weak relationships between professionals in the unit, and long walks on streets with inadequate sanitation may create risks to the health and well-being of the CHA (MARTINES; CHAVES, 2007; OLIVEIRA et al., 2010; MASCARENHAS; PRADO; FERNANDES, 2013). According to Martines and Chaves (2007), the occupational health conditions such as in CHAs do not only compromise their performance at work but interfere in the Quality of Life of these professionals.

According to Mascarenhas (2011, p. 77), "the quality of care provided by these professionals to the community can be influenced by their Quality of Life". This Quality of Life is generated through the values of the organization, respect for the human being and his health, his moral, physical and psychological integrity (CARVALHO, 2014). Thus, to ensure the well-being of the CHAs as a professional results in a higher quality of life, affecting the satisfactory performance of the work (MORETTI, 2005).

For this study, the understanding of Quality of Life was adopted as

> [...] the individual´s perception of his position in life, in the context of the culture and value system in which he lives and in his goals, expectations, standards, and concerns (WORLD..., 1998, p. 8).

Being a broad term in its conceptualization and addressing several domains, Quality of Life is the target of study of professionals from different areas. When these studies are usually linked to health, they aim to analyze how the Quality of Life presents for a given grouping and how to intervene in its conditions to prevent or cure the problems that generate the wear and tear (GESSNER, 2006).

Among occupational health professionals, understanding work as an occupation area of the subject, contributing to the constitution of social identity, and having knowledge of the influence that work exerts on Quality of Life and on the integral health of the worker, the occupational therapist is one addressing this area in his practice, recognizing that work can be both a health promoter and a generator of illness for the worker (DALDON; LANCMAN, 2012; SANTOS; RODRIGUES; PANTOJA, 2015).

In this context, the occupational therapist aims at competence and satisfaction in the roles of life chosen by individuals, as well as in the activities of his roles, improving his occupational performance. Besides to being focused on the doing of the individual, he also covers work situations in the organizational sphere in which it is performed (LANCMAN; GHIRARDI, 2002; FASOLI, 2013).

For the occupational therapist, it is necessary to know what can interfere negatively in the quality of life and work, to restore this condition once it is impaired (ANJOS; CASSAPIAN, 2011). Thus, the objective of the study is to characterize the profile, work specificity and quality of life of the CHA, contextualizing possible contributions of Occupational Therapy.

2 Methodology

This is a descriptive study to identify the way in which the quality of life of the CHA of the health network of Recife-PE is expressed from January to March 2017. The study area corresponded to 20 Family Health Units (FHU) of the Sanitary

District IV (DS IV) of the municipal network, with 40 Family Health Teams (FHT).

The study area was intentionally chosen because of the ease of access to health services, defined by municipal management as a field of practice and reference territory for students training at the university to which the research team is linked.

This study was authorized by the municipal administration and received approval from the Ethics and Research Committee (CEP), having complied with the procedures required for human being research (CAAE 61642216.3.0000.5208). It was decided to study all the CHAs who were regularly working in one of the teams of the chosen Sanitary District. The population was estimated in 240 professionals eligible for the study, following the parameters on average of six CHAs per team, according to information provided by Sanitary District managers.

For the data collection, a visit from the principal researcher was scheduled, by phone and/or in person, on the day of the meeting of each team, as this was the most attended presence of CHAs in FHUs. The CHAs present were invited to participate, forming a non-probabilistic sample with the professionals who were able to access the data collection period. The CHA who accepted to participate received the Free and Informed Consent Form and the research forms to be answered at that moment, in each participant´s choice space. The researcher waited at the FHU reception to complete the forms.

The research was performed in 14 (70%) of the 20 FHUs and, for limitations of study time, each FHU was visited only once. A total of 74 participants in the study were treated with only three refusals.

Two instruments were used to collect data. A questionnaire was prepared by the research team to collect sociodemographic information, containing questions about life habits and some aspects of the specificity of CHAs work, and another WHOQOL-Bref of the World Health Organization, in its version translated and validated for Brazil to evaluate Quality of Life (SALES; FERREIRA, 2011).

The questionnaire elaborated by the researchers was divided into three sessions, one with personal data such as age, gender, education level, and marital status; another one with habits of life and health, focusing on smoking and alcohol consumption, physical activity, type, and frequency; and the third session had information on the specificity of the work, characteristics of the territory, access, composition of the team and the number of people monitored. Some questions had one option and all contained a space to freely add information.

The WHOQOL-Bref is a multidimensional, self-administered instrument with 26 questions. The first two questions deal with Quality of Life and satisfaction with own health in general, and the others deal with four domains: Physical, Psychological, Social Relationships and Environment (FLECK et al., 2000). Each question is scored from 1 to 5, according to the level of satisfaction, ranging from “nothing satisfied” to “very satisfied” (GOMES; HAMANNI; GUTIERREZ, 2014).

For data storage, the Microsoft Office Excel program was used through the link provided by Pedroso et al. (2010), with a database specifically designed for WHOQOL-Bref data entry. For the analysis, the simple frequency for population and work characterization was used, and descriptive statistics were calculated using mean, standard deviation and confidence interval (95%) for quality of life analysis, using free software R.

The WHOQOL-Bref scores were converted to a scale from zero (0) to 100 and the mean of each domain was extracted; these averages were categorized from the scale adapted by Gomes, Hamanni and Gutierrez (2014). This scale quantifies the Quality of Life in three ranges, in which from zero (0) to 40 points means INSATISFACTION; 41 to 69 points means INDEFINITION, and more than 70 points means SATISFACTION.

3 Results

The study population was 71 CHAs, corresponding to less than 30% of the estimated population. The reasons for this population were the small participation of CHAs in the team meetings in the shifts where the FHU were visited, the time limitation of the survey, which did not enable to return to other meetings, and the large number of incomplete teams in the Sanitary District, which was only detected during fieldwork.

The study population (Table 1) is characterized by 91.50% of female subjects and age between 20 and 69 years old, with an average of 41 years old, corresponding to the range of young adults. The most frequent marital situation was married or consensual union (52.12%) and most of the CHAs (60.57%) reported having completed High School and Higher Education (29.57%). When verified the habits of life, 88.73% of the CHAs do not smoke and 63.38% do not consume alcoholic beverage, and most of them (59.15%) perform some type

of physical activity. Among the physical activity practiced, 60.9% were aerobic practitioners, and walking was the most cited modality. Among those who practice anaerobic activities, bodybuilding predominates. As to the frequency, they practice physical activity, more than 48% of respondents perform between 3 and 4 times a week, and 36.58%, more than 5 times a week.

Regarding the specificities of the work of the CHAs interviewed (Table 2), 71.84% reported working in a regular access area, while 26.76% of CHAs work in an area considered difficult to access. As reported by 47.89% of the participants, these work in complete FHT, and 45.07% in incomplete team.

When verified the number of people accompanied by a professional, 46.48% take care of 751 to 1000 people and 42.25% of CHAs report to accompany up to 750 people. Just over 80% of those surveyed work exclusively as CHA. Among the 16.91% who perform another function, nursing technician was the most cited.

Table 3 presents the Quality of Life of the study participants, evaluated in each WHOQOL-bref domain. Considering the Self-Assessment of Quality of Life, the average reached is 60 to 79, which indicates an evaluation in the category of indefinition by the CHA, as proposed by Gomes, Hamanni and Gutierrez (2014). Based on the scale proposed by these authors, it was verified that no domain was evaluated in the category of dissatisfaction. The Social domain reached the highest average (71.70), the only one corresponding to the satisfaction category (70 and more) between the CHAs, and the Environment domain (47.27) was in the lowest area in the region of undefinition (41-69).

The participation of facets in the assessment of Quality of Life is presented in Figure 1. The Personal Relationships and Support and Social Support facets were the most well-scored by the CHAs, as shown

Table 1. Sociodemographic characterization and life habits of the CHAs interviewed between January and March/2017 of the Sanitary District IV, Recife-PE.

Variables	N (71)	%
GENDER		
Female	65	**91.50**
Male	6	**8.50**
AGE GROUP (years old)		
20 to 29	5	**7.04**
30 to 39	13	**18.30**
40 to 49	31	**43.70**
50 to 59	16	**22.52**
60 to 69	2	**2.81**
Not informed	4	**5.63**
MARITAL STATUS		
Single	16	**22.52**
Married/Consensual union	37	**52.12**
Separated/Divorced	15	**21.13**
Widow	3	**4.23**
EDUCATION LEVEL		
Complete High School	43	**60.57**
Complete Higher Education	21	**29.57**
Postgraduation	3	**4.23**
Incomplete Higher Education	1	**1.40**
Not informed	3	**4.23**
LIFE HABITS		
Smoking		
Yes	3	**4.23**
No	68	**95.77**
Alcohol consumption		
Yes	26	**36.62**
No	45	**63.38**
Practice Physical Activity		
Yes	41	**59.15**
No	30	**40.85**
Type of Physical Activities (n41)		
Aerobic activities	25	**60.97**
Anaerobic activities	16	**39.03**
Frequency Physical Activities (n41)		
Less than 3 times a week	6	**14.64**
3 to 4 times a week	20	**48.78**
More than 5 times a week	15	**36.58**

Table 2. Characterization of the specifics of the work of the CHAs interviewed between January and March/2017 of the Sanitary District IV, Recife-PE.

Variable	N 71	%
SPECIFICITIES OF THE WORK		
Hard to reach area		
Yes	19	26.76
No	51	71.84
Did not answer	1	1.40
Team Composition		
Complete Team	34	47.89
Incomplete team	32	45.07
Did not answer	5	7.04
N.º accompanied people		
Up to 750 people	30	42.25
751 to 1,000 people	33	46.48
Up to 1,000 people	5	7.04
Did not answer	3	4.23
Other occupations		
Yes	12	16.91
No	57	80.28
Did not answer	2	2.81

Table 3. Domains and Self-assessment of Quality of Life (QOL), according to WHOQOL-bref, of the CHAs interviewed between January and March/2017 of the Sanitary District IV, Recife-PE.

Domains	Mean (CI 95%)	Standard Deviation	Coefficient of variation	Minimum	Maximum	Amplitude
Physicist	57.75	9.20	15.93	55.52	59.97	4.45
Psychological	62.30	12.81	20.56	59.20	65.41	6.21
Social	71.70	16.68	23.26	67.64	75.77	8.13
Environment	47.27	12.84	27.16	44.17	50.38	6.21
Self-assessment QOL	60.79	16.69	27.18	57.36	65.44	8.08

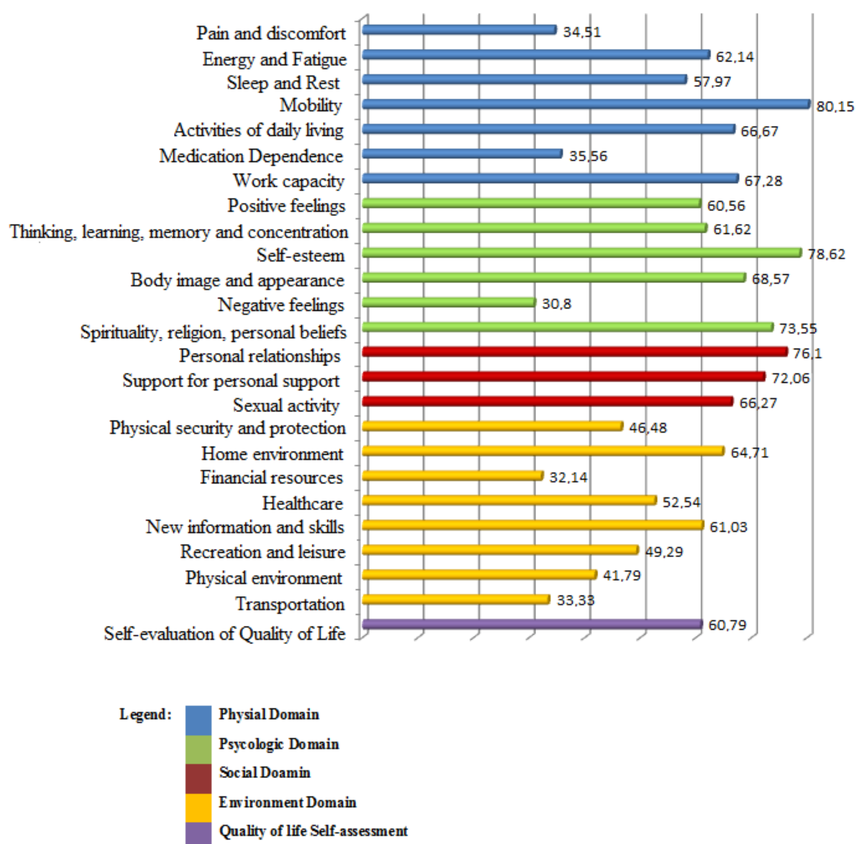

Figure 1. Factors evaluation by Quality of Life Domain (WHOQOL-bref) of CHAs interviewed between January and March/2017 of Health District IV, Recife-PE.

in Figure 1, contributing significantly to the average satisfaction of this domain. The low satisfaction in the Environment domain for the study participants deserves attention and, the coefficient of variation also indicates a variability of answers in the CHAs. The Factors that contributed the most to this result and which have the worst WHOQOL-bref evaluations are Financial Resources (32.14), Transportation (33.33%), Physical Environment, being pointed to pollution, noise, traffic and climate (41.79), and Physical Security and Protection (46.48).

The dissatisfaction of the CHA regarding Financial Resources and Transportation, which are part of the Environmental Domain, are in the region of dissatisfaction. Analyzing the average of the Physical domain (57.75), it was verified that the level of satisfaction is in the category of indefinition. The lower coefficient of variation of this domain

indicates a greater homogeneity in the answers, showing that the commitments regarding the physical aspects reach most of the CHAs. The pain and discomfort able to prevent the accomplishment of what they need to do and the dependence on medication or treatment were the facets showed by the CHAs surveyed with indices of dissatisfaction, obtaining the means 34.51 and 35.56, respectively.

Among the facets of the Physical domain, Mobility (80.15), Work capacity (67.28) and Ability to perform day-to-day activities (66.67) contribute to better satisfaction averages. The Psychological domain encompasses the facets Positive feelings; Thinking, learning, memory and concentration; Self-esteem, Body image and appearance; Negative feelings, and Spirituality/religion/personal beliefs. The Negative feelings facet corresponds to the highest dissatisfaction of the CHAs of the study, with a mean of 30.80, and Self-esteem assumes the highest average in this domain (78.62).

4 Discussion

The prevalence of female and young adult CHAs (between 18 and 45 years old) is similar to other studies (HENRIQUES et al., 2015; PAPALIA et al., 2006; VASCONCELLOS; COSTA-VAL, 2008). The greater number of women working as CHAs can be explained because even if they expand their participation in other professions in the labor market, women are still perceived socially as caregivers, adapting to the CHA profile (MASCARENHAS et al., 2012). Another aspect to be highlighted is the community's resistance to the male CHA, or because of the male´s difficulties to perform some tasks, to establish ties, to enter a household where the woman lives alone and to guide the health care of the woman and the child, through constraints in revealing certain particularities to a man (WAI, 2007; BAPTISTINI; FIGUEIREDO, 2014).

The education level of the CHAs is beyond the prerequisite established by Law 11.350/2006, confirming other studies (KLUTHCOVSKY et al., 2007; VASCONCELLOS; COSTA-VAL, 2008). Higher education level, although not an exclusive factor, can influence the capacity for care, since a higher educational level expands the condition of the CHA to incorporate new concepts and use them in their practice, for the benefit of the users (URSINE; TRELHA; NUNES, 2010; LOURENÇÃO et al., 2012; MASCARENHAS et al., 2012; DENTI; TOZZO; MENDEZ, 2014; FREITAS et al., 2015).

The participants' lifestyles are also similar to the study by Mascarenhas, Prado e Fernandes (2013), so the health work developed by the CHA can help them to have a critical assessment of habits, with lower smoking and alcohol consumption. The practice of physical activity among CHAs is similar to the findings of Ursine, Trelha e Nunes (2010). The execution of these activities is one of the fundamentals for the improvement of the physical capacity and the control of diseases, particularly for the CHAs, since the own work activity demands long walks and the capacity of improved physical performance (URSINE; TRELHA; NUNES, 2010; CAMELO; GALON; MARZIALE, 2012).

When the labor specificities are appreciated, the difficulty of access in their work area reported by some CHAs, can be related to environmental aspects, typical of the periphery of large cities, such as the locality under study, geographical distance and difficulties physical characteristics of the territory (stairways, slopes and slopes), and logistic aspects in the work organization of the FHU, which aims to offer services to the most vulnerable population. Studies also highlight closed homes in working hours, not wanting to receive the CHA at home, the attack of domestic animals and the action of drug trafficking groups that establish areas of restricted circulation as factors of constraints of the CHA in their professional practice (BAPTISTINI; FIGUEIREDO, 2014; FERRI, 2014; LIMA et al., 2015; NASCIMENTO et al., 2017).

When the composition of the Family Health team is incomplete, it fails to develop some essential services to the community, in addition to the risk of neglecting care, due to the weak team-community linkage, so even if the users have a need, they do not seek the unit for service. Also, the overload of work for other professionals of the unit is important, depriving the users of an adequate assistance, since the work in incomplete teams and the instability of the professionals regarding the permanence in the FHU, as well as the discontinued relationships between the members of the FHT are difficulties that the CHAs can experience during their work (SPERONI, 2016).

It is worth highlighting the hierarchical relationship with higher level professionals, leading to a lower participation of CHAs in work organization spaces, such as team meetings. The CHA, because they feel devalued and because they have no room for opinion, are now absent from the planning spaces for actions at work (CARDOSO; NASCIMENTO, 2010; GUANAES-LORENZI; PINHEIRO, 2016; SPERONI, 2016).

Among the specificities related to work, the number of people followed by CHAs exceeds the recommendation by PNAB (BRASIL, 2012) for almost half of the professionals in this study. The number of people monitored can generate an excess of demands, extrapolating the ability to respond and resolve, and hamper the work process of the professional, compromising the quality of care provided. This larger number of registered families/people can be a source of illness for the CHA and to reaching the team (WAI; CARVALHO, 2009; DENTI; TOZZO; MENDEZ, 2014). It is worth mentioning that the new PNAB (BRASIL, 2017) leaves the number of CHA undefined by teams and flexibility the coverage parameters, causing probable losses to the work overload assistance. According to the new PNAB, an FHT can be composed of only one CHA, compromising the link between community and team, which is facilitated by this professional (MOROSINI; FONSECA; LIMA, 2018).

In the accumulation of activities of the CHA and another health profession, this was also found in the study of Ursine, Trelha and Nunes (2010), identifying most of the CHAs with a technical course in the nursing area. Marzari (2007) explains that the CHA with technical course justified this other formation by necessity of qualification, adding the experiential knowledge as CHA to a theoretical reference. Also, the search for other opportunities to enter the labor market as complementary income, considering that the exclusive remuneration as CHA is not enough to meet the basic needs of these professionals, make them seek other occupations. However, the performance of several roles generates overload and may have negative health effects (WAI; CARVALHO, 2009; LOURENÇÃO et al., 2012; FREITAS et al., 2015; ALMEIDA; BAPTISTA; SILVA, 2016).

Analyzing the average evaluation of the general health status and Quality of Life of the CHAs, Kluthcovsky and colleagues in their studies (KLUTHCOVSKY et al., 2007), Bernardes (2008) and Santana (2015) found higher means, showing a higher level of satisfaction than the CHAs of this study. It can be verified that the general health and quality of life status reported by the interviewed CHAs is the domain with the highest coefficient of variation (27.18%), indicating that the answers were more dispersed. That is, there seems to be no consensus regarding this evaluation among the population studied.

Sensitive to the complexity of factors of the work experience, the occupational therapist considers the specificity of the work, stimulating the worker to reflect on the changes in this relation, if the occupation is harmful to him (JARDIM; LANCMAN, 2009; DALDON; LANCMAN, 2012; SANTOS; RODRIGUES; PANTOJA, 2015). Therefore, the issues that most influence the Quality of Life of the CHAs in this study and from the literature, possible contributions of occupational therapy to minimize the possibility of illness due to work are highlighted.

The indefinition in the evaluation of the Physical domain and greater homogeneity of the CHAs with less satisfaction attributed to the facets Pain and Discomfort, and Dependence of Medication are issues that seem to require care. The work routine as a CHA requires long walks, with backpacks weighed of the scale to weigh children, and notebooks besides the postures assumed during the work, which can represent biomechanical risks and for musculoskeletal disorders, constituting a potential source of discomfort (MASCARENHAS; PRADO; FERNANDES, 2013).

The actions to prevent suffering, promotion of well-being and proposals of physical conditioning that protect the worker can positively influence their health (KING; OLSON, 2011). In this way, the occupational therapist can guide the CHA regarding the correct transportation of work equipment, the maintenance of good posture during the tasks to be performed, stretching and self-massage, and physical exercises, among other care to cope pain and discomfort, cooperating to improve the health conditions of the CHAs (WAI; CARVALHO, 2009; TOLDRÁ et al., 2010).

As for the Psychological domain, the negative feeling reached the lowest score and contributed to dissatisfaction with the quality of life. Besides to the potential for stress due to the unfavorable dimensioning of the number of people, among other reasons of frustration and impotence of real expectations and those idealized in CHA´s work, it can create and feed a complex conflict, impacting on the professional´s physical condition, affecting the quality of life (MARTINES; CHAVES, 2007; CAMELO; GALON; MARZIALE, 2012).

Studies have also identified that the devaluation of the work of the CHAs, with pressure from the community, team, and management, leads to sufferings due to the conflict between the idealized and the expectations regarding their competence. On the other hand, if the health system does not respond to the needs of the population immediately, the community collects actions that run away from the governance of the CHAs, overloading them (SOUZA; FREITAS, 2011; CAMELO; GALON; MARZIALE, 2012; ALMEIDA; BAPTISTA;

SILVA, 2016). The CHA is a professional who takes care but also needs to be cared, so the situations inherent to his work are not reason for illness and worse quality of life for this worker (JARDIM; LANCMAN, 2009).

The occupational therapist can intervene so the actions are directed to the transformations of the work organization, to the reduction of the mismatch between actual and prescribed work, from changes in the relation of people to their work (TOLDRÁ et al., 2010; OLIVEIRA, 2004; LANCMAN, 2004).

The occupational therapist should understand the reflection that the work exerts on Quality of Life and on the health of the worker, to intervene in situations that generate health damages and reinforce positive situations. This understanding captured by the listening, in a moment of matrix-based strategies or reflection with the workers in group work, so these meetings allow the subject to readjust or transform the understanding of their work, promoting changes necessary for this coexistence to become healthier (LANCMAN, 2004).

It should be noted that the Self-Esteem facet was the one that reached the highest average in the Psychological domain, demonstrating that the CHAs of this study are satisfied with themselves. Also, the positive results achieved in the Spirituality/religion/personal Beliefs and Body Image facets are similar to those of Vasconcellos and Costa-Val (2008), Mascarenhas (2011) and Bernardes (2008). We infer that the occupational therapist can use corporal and self-expression activities in a group approach, such as art therapy and self-care workshops, reinforcing in these professionals the ability to appreciate and value their own feelings, and personal and professional self-confidence in addition to eliminating possible attitudes detrimental to themselves, reinforcing these positive dimensions for their health (KUBOTA et al., 2013).

Regarding the spiritual dimension, the document Structure of the Occupational Therapy practice: domain & process, produced by the American Occupational Therapy Association (ASSOCIAÇÃO..., 2015), places beliefs and spirituality as client factors that have the capacity to influence and motivate the performance of the subject´s occupations. Thus, they can favor these CHAs and allow them to cope in situations of suffering and challenges often experienced by these workers (URSINE; TRELHA; NUNES, 2010).

Positive evaluation in social relationships was also present in the studies by Vasconcellos and Costa-Val (2008) and Bernardes (2008). The essence of work as a CHA is the relationships and bonds established with the team and with the community, so if this occurs harmoniously, a better professional performance and an increase in personal satisfaction are conceived (MASCARENHAS et al., 2012; NASCIMENTO et al., 2017).

The occupational therapist at the Family Health Support Center (NASF), through the matrix support, has the role of collaborating and facilitating in the activities with the CHAs for bonds with the community and also for the care of the worker´s condition. The bond is facilitated by the fact that CHA lives where he works and, upon being trained, the work process flows with less wear and tear (SPERONI, 2016; CAMPOS; DOMINITTI, 2007). The action of the occupational therapist through matrix-based strategies, in this case, is not directed only to the bond with the community, but to the performance in the FHT, which requires the development of technical skills and social sufficiently harmonious for teamwork.

Thus, through group dynamics with reflexive, expressive, playful and recreational approaches, the occupational therapist seeks to promote the strengthening of the bond and integration with the other professionals of the Unit. It can also raise awareness about the importance of teamwork, allowing the empowerment of CHAs to express their opinions, constituting more horizontal relationships in the team (SANTOS; RODRIGUES; PANTOJA, 2015; NASCIMENTO et al., 2017).

For Mascarenhas (2011), the social and environmental context the person is exposed is an important health influencer, so living in an area with little pollution, pleasant climate, safety and adequate infrastructure results in a longer life expectancy. On the other hand, inadequate urbanism creates unsustainable situations, such as housing, work, transportation, and leisure deficits, generating endemic forms of urban evils.

When considering the social determinants of health, it is understood that the condition and social support, the organization of work and the physical environment, and health practices, among others, are directly associated with the health of the population and the worker (LETTS, 2011). The insufficiency of the provision of quality social policies, such as security, housing, transportation, education, salary, health, among other conditions, affects the population and also the CHAs. This worker is doubly affected because he provides services to the community and is a victim of lack of assistance, and because he is also a community and target of the same problem (JARDIM; LANCMAN, 2009; CAMELO; GALON; MARZIALE, 2012).

The occupational therapist, guided by the principle of territorial responsibility in care, is constituted as a political and social actor, outlining possibilities for transformation and social emancipation along with the CHA. Besides to recognizing health risk conditions, stimulating strategies to manage stress and fatigue at work, these professionals can work together with other citizens in search of better living conditions. Thus, it is not only the public power, but also professionals and the community as a whole, to promote actions aimed at health promotion and quality of life (BARROS; GHIRARDI; LOPES, 2002; PÁDUA; MAGALHÃES, 2008; LANCMAN et al., 2009; CAMELO; GALON; MARZIALE, 2012).

5 Conclusion

This study allowed analyzing the profile, the specificities of the work and the aspects of the Quality of Life of the CHAs of the Sanitary District IV, in the city of Recife-PE. The professionals who participated in the study are mostly female, young adults, have high school level and some are college graduates, do not take alcohol or smoke, and practice physical activities. Approximately 50% integrate incomplete teams and report covering more than 750 people, which is excessive.

Regarding the results obtained by the WHOQOL-bref, the General Self-Assessment of the Quality of Life of the CHA was classified as undefined and had a variation in the responses with very satisfied to unsatisfied CHA. In the Social, Psychological and Physical domains, the facets of Self-esteem, Support and Social support, and Mobility are the best evaluated by the CHAs researched. In the domain of Environment, the Facets Financial Resources, Transportation, Environment and Physical Security are evaluated in the category of Dissatisfaction.

The specificity of the work of CHAs can harm their health and interfere with their Quality of Life. Understanding work as an area of occupation of the subject and understanding the existence of the relationship between health-disease work, the occupational therapist acts for the well-being of these professionals through collective strategies, to address sources of illness and suffering at work, through reflections and experiences that problematize the issues of scopes that surround the day to day of the CHAs. It is also important to show the incentive to achieve social public policies that benefit the health of the community and, consequently, the health of the CHAs.

Other studies on the performance of occupational therapy in the health and quality of life of the CHA worker, and the incentives for the occupational therapist are suggested, being part of the NASF, to develop care actions in the health of the worker from the matrix-based strategies both for these professionals as for the other FHT members.

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Author’s Contributions

All the authors contributed equally in the conception of the article and approved the final version of the text.