CHARACTERIZATION OF THE WORK CONTEXT AND QUALITY OF LIFE OF FAMILY HEALTH STRATEGY PROFESSIONALS

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ABSTRACT: The present study aimed to characterize the work contextand quality of life of Family Health Strategy (FHS) professionals.Observational, cross-sectional and qualitative study with 256 Family Health Strategy professionals. The data was collected from September 2013 to January 2014 using the Scale of Assessment of the Work Context and the WHOQOL-BREF tool.Exploratory and bivariate analyses were used for the data. The factor Work Organization showed the highest score, and Socio-professional Relations, the lowest score. In the domains of quality of life, the Social domain obtained the highest score, and the Environmental domain obtained the lowest score. Also, thepoorest work context led to the lowest scores of quality of life.It is essential to understand the work context of health professionals, since it can affect their quality of life and work, with impact on the care delivered.
DESCRIPTORS: Family health strategy; Quality of life; Work conditions.

CARACTERIZAÇÃO DO CONTEXTO DE TRABALHO E QUALIDADE DE VIDA DOS PROFISSIONAIS DE ESTRATÉGIA SAÚDE DA FAMÍLIA

RESUMO: Objetivou-se caracterizar o contexto de trabalho e a qualidade de vida dos profissionais de Estratégia Saúde da Família. Estudo observacional, transversal, quantitativo, realizado com 256 profissionais da Estratégia Saúde da Família. Dados foram coletados entre setembro de 2013 a janeiro de 2014 empregando-se os elo de Contexto de Trabalho e WHOQOL-BREF. Utilizaram-se análises exploratória e bivariada para os dados. Constatou-se que o fator Organização do Trabalho apresentou o maior escore, e as Relações Socioprofissionais, o menor. Nos domínios de qualidade de vida, o domínio Social apresentou o maior escore, e Ambiental, o menor. Evidenciou-se, ainda, que o pior contexto de trabalho resulta em menores escores de qualidade de vida. Compreender o contexto de trabalho dos profissionais se faz fundamental, uma vez que o mesmo pode afetar sua qualidade de vida e a eficácia no seu trabalho, com consequente implicação na assistência prestada.
DESCRITORES: Estratégia saúde da família; Qualidade de vida; Condições de trabalho.

CARACTERIZACIÓN DEL CONTEXTO DE TRABAJO Y CUALIDAD DE VIDA DE LOS PROFESIONALES DE ESTRATEGIA SALUD DE LA FAMILIA

RESUMEN: Estudio cuyo objetivo fue caracterizar el contexto de trabajo y la cualidad de vida de los profesionales de Estrategia Salud de la Familia. Estudio observacional, transversal, cuantitativo, realizado con 256 profesionales de la Estrategia Salud de la Familia. Los datos fueron obtenidos entre septiembre de 2013 y enero de 2014 utilizándose los instrumentos: cuestionario de caracterización sociodemográfica profesional; Escala de Evaluación de Contexto de Trabajo y WHOQOL-BREF. Fueron usados análisis exploratorio y bivariado para los datos. Se constató que el factor Organización del Trabajo presentó el mayor score, y las Relaciones Socioprofesionales, el menor. En las categorías cualidad de vida, el dominio Social presentó el mayor score, y Ambiental, el menor. Se evidenció, todavía, que el peor contexto de trabajo resulta en menores scores de cualidad de vida. Comprender el contexto de trabajo de los profesionales es fundamental, ya que este puede afectar su cualidad de vida y la eficiencia en el trabajo, con consecuente influencia en la asistencia prestada.
DESCRIPTORES: Estrategia salud de la familia; Cualidad de vida; Condiciones de trabajo.

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INTRODUCTION

Today's world is marked by strong competition and increasing demand in the workplace. Several factors indicate that relationships in the workplace are driven by multiple motivations, and labor relationships impose precarious working conditions. Thus, few individualsregard work as a pleasurable activity[1-3]. This process interferes directly in the quality of life of these workers.

Work as a mode of interaction in society and essential in human life can generate stress and trigger the health-disease process, depending on how it is performed, because life and work are inseparable[4-5].

According to the World Health Organization (WHO), "quality of life (QOL) is an individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns"[6:1405]. QOL also depends on the characteristics of the society in which the individual lives and works[7].

Quality of Life at Work (QLW) is related with satisfaction and involvement in work, organizational commitment, safe environment, stress, independence, respect by the management and adequate remuneration[8-9]. QLW can be affected by the worker's involvement with such aspects, with direct impact on the service provided[10].

QLWis also related to the process of humanization of work and social responsibility of the employing institution, involving the valuation of the worker, the understanding of the individual's needs and aspirations. It is also associated to the redesign of positions and new ways of organization, to create teams with greater job autonomy and a positive work context, promoting the balance of work and other domains of life[4,11].

When the employees achieve a balance between their personal lives and social interactions at work they are more satisfied with their jobs, but sometimes desires and frustrations prevail in the workplace and generate stress resulting from the distance between what is envisioned and what is experienced. This canaffecteven strong ties already established, with an adverse impact on the quality of work[3].

Regarding the health care area, researchers have focused mainly on issues related to work and its impact on the lives of professionals, especially those in the tertiary sector of health care. The motivation for studies on the QOL of workers attached to hospitals results from the particularities of the work context, frequently associated to excessive workload, night shifts, double shifts and direct contact with illness and death[3,12].

There are few studies on this topic in primary health care. However, the fact that they are in direct contact with the patients' families and the community increases the vulnerability of these professionals, leading to stressful situations both for the health teams and the users[4]. The increase of these ties exposes health professionals to situations of poverty and violence experienced by the community, generating a great emotional tension[7].

The present study can be justified by the need to gain insight on the work context of these professionals in order to propose actions aimed to minimize the factors that cause organizational stress, and thereby support the planning of strategies for the promotion of the quality of life of FHS professionals.

In view of the aforementioned, the present study aimed to characterize the work context and the quality of life of Family Health Strategy professionals.

METHOD

Observational, cross-sectional and qualitative study. The participants were Family Health Strategy (FHS) professionals of the city of Uberaba/MG, as follows: nurses, nursing technicians and assistants, physicians, community health workers, dentists and dental assistants, distributed in the 50 Family Health Teams (FHT),of which 46 were located in the urban zone and four in the rural zone.

According to the records of the personnel sector of the Municipal Health Department, 531 professionals were attached to the FHS. Because it is part of a larger project, this study used the same sample obtained by calculation based on a multiple linear regression model that resulted in 228. Considering a loss of sampling of 20% (refusals to participate), the maximum number of attempts that resulted in interviews was 285, selected by simple random sampling grid, containing the list of participants that represent the target population.

The professionals who performed their

activities in Basic Health Units not attached to the FHS, were excluded from the study, even when they pertained to the occupations studied; the professionals on vacation, on sick leave and who refused to participate were also excluded.

A total of 256 FHS professionals participated in the study. Data collection was performed in previously scheduled meetings with the managers of the healthcare units, by a group of researchers, from September 2013 to January 2014.

For data collection, a socio-demographic and professional questionnaire, the Scale of Assessment of the Work Context (EACT) and Whoqol-Brefwere used. The first tool aimed to characterize the study population and included the following items: date of the interview, initials of the professionals, gender, birth date, marital status, education, function, date of admission, number of employment relationships, period of time under the same management and how did the employment relationship start. Brazil's Socio-economic Classification Criteria of the Brazilian Association of Survey Companies was used in the assessment of economic status.

The second tool, already validated, assesses the views of FHS professionals on their work context. It is composed of three factors: Work Organization (WO), which expresses the division of tasks, standards, control and pace (composed by 11 items); Work conditions (WC), which concerns the quality of the physical environment, equipment and materials available for performing the activities (composed by 10 items); Socio-professional Relationships (SPR), which expresses the types of management, communication and professional interaction (composed by 10 items) [12]. It consists in a Likert scale with the following response options: never (1), rarely (2), sometimes (3), often (4) and always (5). EACT analysis considered the mean of each factor.

Finally, the World Health Organization's Whoqol-Bref, validated and translated into Portuguese[13]. This tool assesses quality of life and contains 26 questions: the first two questions are general and the other 24 questions represent the aspects of the original tool that assess four domains: Physical (pain and discomfort, energy and fatigue, sleep and rest, mobility, daily life activities, dependence on medication or treatments and working capacity); Psychological (positive feelings, thinking, learning, memory and concentration, self-esteem, body image and appearance, negative feelings, spirituality, religion and personal beliefs); Social Relationships (personal relationships, social support and sexual activity) and Environment (physical safety, home environment, financial resources, social and health care: availability and quality, opportunity to obtain new information and skills, participation/ opportunities for recreation/leisure, physical environment: pollution, noise, traffic, climate and transport).The responses are obtained using a 5 point Likert scale in such a way that the higher the score, the better the professional feels about their QOL. WHOQOL-BREF syntax was used for obtaining the scores of each domain.

The project was approved by the Ethics Committee for research involving humans of Universidade Federal do Triângulo Mineiro, under protocol no. 2244.

For data analysis, double data entry was used, with further validation, using the Statistical Package for the Social Science (SPSS), version 1. The data were initially subjected to exploratory analysis using single frequencies, position (median and mean)and variability (amplitude and standard deviation) measurements. In bivariate analysis, Pearson's correlation was usedto measure the relationships between the quantitative variables.

RESULTS

According to the results, 231(90.2%) participants were female, in average 39.59years old, with a standard deviation of 11.33, minimum age of 21 and maximum age of 79 years. Regarding marital status, 164 (64.1%) were married or in a stable relationship and 92 (35.9%) of the participants did not live with a partner. There was a predominance of classes D and E (83.6%). Regarding education, nine (3.5%) completed elementary school, 161 (62.9%) ocompleted secondary school and 86 (33.6%) completed high education. 58 (22.7%) participants had a specialization and four (1.6%) had completed a master's degree. 181 (70.7%) studied in a public institution and 75 (29.3%) in a private institution. Regarding the profession and the number of employment relationships, most participants were community health workers: 144 (56.3%), and the least common occupation was dental assistant: 16(6.3%) participants. Most participants had only one employment relationship: 228 (89.1%).

In the scale of assessment of work context, the factor Work Organization showed the highest mean score, while Socio-professional relationships showed the lowest mean score. Regarding the quality of life domains,the Social domain showed the highest mean score, followed

by the Physical and Psychological domains. The domain with the lowest mean score was the Environmental domain. Regarding the assessment of internal consistency of the tools, assessed by Cronbach's α coefficient, good internal consistency was observed, with values ranging from 0.64 to 0.89 (Table 1).

Regarding the bivariate relationship between Work Context and Quality of Life there were statistically significant negative correlations between the factor Working Conditions and all quality of life domains, demonstrating that the higher the scores in this factor, the worse the quality of life of the subjects. The factor Work Organization had statistically significant negative correlations with the Physical, Psychological and Social domains. This result indicates that the lower the work organization, the worse the quality of life. Regarding the factor Socio-professional relationships, there was a significant correlation in all the domains, indicating decline in the quality of life of the professionals. It should be stressed that higher scores in the factors of work context indicate worse work context, which, in turn, results in lower scores in quality of life (Table 2).

Table 1 – Minimum and maximum values, mean score, standard deviation and Cronbach's α coefficient of the factors of the "Scale of assessment of work context" and of the Quality of life domains of FHS professionals of an inland municipality of Minas Gerais, Brazil, 2014 (n = 256).

	Minimum	Maximum	Mean	Median	Standard deviation	α
EACT						
Working conditions	1.00	5.00	2.93	2.90	0.87	0,89
Work organization	1.11	5.00	3.24	3.22	0.63	0,76
Socio-professional relationships	1.00	4.60	2.52	2.60	0.71	0,84
QOL						
Physical Domain	25.00	100.00	65.77	67.86	15.88	0,82
Psychological Domain	29.17	95.83	65.55	66.66	13.32	0,74
Social Domain	25.00	100.00	69.17	75.00	16.03	0,64
Environmental Domain	9.38	96.88	55.90	56.25	13.75	0,8

Table 2 – Pearson's Correlation between the factors of the Scale of assessment of work context and the Quality of Life domains of FHS professional of an inland municipality of Minas Gerais, Brazil, 2014 (n = 265)

Predictors	Physical Domain		Psychological Domain		Social Domain		Environmental Domain	
	R	P	R	P	R	P	R	P
Work conditions	-0.24	<0.001	-0.24	<0.001	-0.27	<0.001	-0.30	<0.001
Work organization	-0.22	<0.001	-0.15	<0.001	-0.13	0.04	-0.09	0.17
Socio-professional relationships	-0.25	<0.001	-0.29	<0.001	-0.27	<0.001	-0.31	<0.001

DISCUSSION

In the present study, sociodemographic characterization indicated that most FHS workers were women, which is consistent with other studies that reported the greater female presence in the health care area, as well as among FHS professionals[10,14]. Analysis of census data on the health workforce in Brazil shows a significant increase in the number of working women, indicating a trend in this context[15].

Regarding marital status, most professionals were married or had a stable relationship; This finding corroborates another study with FHS professionals in an inland municipality of São Paulo[16].

Regarding the professional activity, it was observed that the FHS teams were composed of workers of different professions, with expertise in different areas. This aspect favors a better interpretation of the context of social, technical and operational relationships associated to the production and complexity of interactions among the various workers involved[17].

Concerning the number of employment

relationships, 89.1% of these workers had only one employment relationship. Precarious or multiple contracts are common in this field; however, this finding is consistent with the results obtained in another study with nurses who worked in Family Health teams[10].

In this regard, Ordinance no 2.027/2011 stipulates a workload of eight hours per day for FHS professionals, but allows different workloads for medical professionals (20 to 30 hours a week). This change may interfere in the activities performed by these professionals, since it favors multiple employment relationships[18].

The FHS is focusedon the establishment of bonds between the team and the community. The FHS professional participates in the fight against diseases and actions aimed to improve the quality of life of the individuals, in agiven territory. In this setting, the working conditionsare influenced by organizational arrangements where the services are arranged[19].

In the assessment of the FHS professionals that participated in this study, the factors related to work conditions and organization shown in the EACT< defined as the division and the content of tasks, standards, controls and paces of work, indicated a limit-situation because of the high mean scores, which can enhance discomfort at work, with a risk of sickening. This aspect requires immediate action in the short and medium terms, as these negative effects impact the work context[19].

Within the context of the FHS, the reorientation of the care model indicates the rupture of conventional and hegemonic practices and the adoption of new work technologies; the main goal of this strategy is to transform the current health care model into a primary care based model[15].

A study with FHS professionals identified patterns of commitment using organizational and work variables, and found that the committed individuals demonstrated satisfaction with both variables, demonstrating the concern of these professionals with the working conditions, a factor that contributes to the consolidation of this care model[19].

The present study showed that poor socio-professional relationships have a negative impact on QOL. According to the EACT, these relationships are defined as ways of work management, communication and professional interaction. In the FHS, the effectiveness of team work depends on the interaction of individuals with different competencies and skills. This relationships between professionals establish the differences between regulations and actual work; these relationships become complex between individuals, between the work object and the results of work activities[20-21].

Studies on socio-professional relationships in FHS teams describe sensitive situations in the work context, related to the communication between management and subordinates. There is lack of integration in the workplace, communication between coordinators and collaborators is often unsatisfactory at various levels of the hierarchical structure, preventing integration and cooperation among individuals and teams, both in sharing resources and expertise and in identifying problems and looking for solutions[22].

In this context, both the types of relationships and the elaboration of standards, regulations and codes limit the work conditions within the FHS. It should be stressed that this process may require strategies and defense mechanisms to deal with management and communication problems, which can be harmful to the worker's health, as well as to the quality and effectiveness of the service provided to the population[22].

In the FHSsvarious situations related to the quality of life of workers were observed. The FHS units are the main access to Brazil's Unified Health System (SUS), and tensions between health teams and users are frequent in these environments[4].

The results of the WHOQOL-BREF tool regarding the physical, social relations, psychological and environmental domains in the work context are consistent with those obtained in a study with community health workers, which related the quality of life of workers to improvement in work dynamics, demonstrating a positive assessment of this dynamics especially in the physical, social and psychological domains, and a negative assessment for the environmental domain[23].

In the present study, the relationships between Work Context and Quality of Life were negative and statistically significant between the factor Work Conditions and all quality of life domains. These findings are similar to those from a study with nursing professionals that also obtained negative correlations and found that the greater the vulnerability to stress, particularly regarding the workplace structure and the relationship between collaborators and their superiors, the lower the quality of life of the professionals[24].

In view of the above, the negative rationale of the assessed constructs was expected, since the conditions were opposing, indicating that work context interferes directly on the quality of life of health professionals.

Regarding the factor Work Organization, this study showed significant correlations between the Physical and Psychological domains, excluding the Social and Environmental domains, demonstrating that the lower the Work Organization scores, the poorer the quality of life. According to studies on these topics, the quality of life in the workplace is aimed to improve work conditions in all its aspects, regardless of the type of working activity, in order to promote humanization between the productive sectors and, consequently, benefit the workers[22-24]. These studies concern the satisfaction of workers with their professional activities.

Socio-professional relationships were statistically significant in all the domains, indicating a poorer quality of life of the workers,because they were identified as the most serious situation in the work context[22-23]. This finding corroborates studies involving health professional in different work contexts[4,19,21-24].Quality of life at work is a social issuewhere worker satisfaction is associated to work relationships and conditions[4].

Insufficient or inadequate work means hinder, or even prevent the fulfillment of the purposes of Family Health care, such as comprehensive health promotion. Thus, there is a directly proportional relation between work conditions and QOL.

CONCLUSION

The results of the present study suggest that the work context in FHS is focused on increased productivity, represented by division of tasks, standards, control and pace, which is demonstrated in the mean scores obtained in the factors Work Conditions and Organization. The quality of life of FHS professionals is characterized by higher scores in social relations. Also, work context had a negative impact on the quality of life of Family Health Strategy professionals.

The work context and the quality of life of primary health care professional require greater attention, since the critical condition of work context may affect the quality of life of these professionals and their work, with implications on the quality of the care delivered.

Knowing the factors that influence the work context, to a lesser or greater extent, is important for planning global and specific actions in the workplace. Forums for discussion of this topic may contribute to the improvement of work conditions, as well as to the quality of life of this population. Insight into the topic is necessary for the identification of solutions to the problems encountered.

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