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CARGAS DE TRABALHO DO AGENTE COMUNITÁRIO DE SAÚDE: PESQUISA E ASSISTÊNCIA NA PERSPECTIVA CONVERGENTE-ASSISTENCIAL1

THE WORKLOAD OF THE COMMUNITY HEALTH AGENT: RESEARCH AND ASSISTANCE IN THE PERSPECTIVE OF CONVERGENT-CARE[1]

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ABSTRACT

Objective: to understand the perception of Community Health Agents regarding their workloads and to perform care practices with this group related to workloads.

Method: a qualitative study, based on the Convergent-Care Research, carried out in two primary health care units, with three Family Health Strategy teams, in a municipality in the South of Brazil. The participants were 14 Community Health Agents working in these scenarios. Data were produced through semi-structured interviews, focus groups and convergence groups. The data were analyzed, according to the discourse analysis of the collective subject.

Results: community health agents coexist with intense physical burden (caused by physical exposure in the community, precarious structure in the unit and the risk of violence); cognitive burdens (evidenced by the need to gather information and technical knowledge to orientate the community and changes in the information systems); and mental burdens (resulting from the poor interpersonal relationships within the team, in the excessive workload and frustrations due to the incapabilities of the health system and lack of recognition). The care practice consisted in the mediation of a space for reflection/action/reflection in which the participants could identify strategies that could minimize the burdens.

Conclusion: regarding to the care practice, participants performed a critical reflection, problematizing their work reality, engaging in the challenge of transforming reality through the construction of strategies in order to minimize the burdens they were exposed to.

DESCRIPTORS: Nursing. Worker health. Community health agents. Work load. Work conditions. Qualitative research. Community-based participatory research.

CARGAS DE TRABALHO DO AGENTE COMUNITÁRIO DE SAÚDE: PESQUISA E ASSISTÊNCIA NA PERSPECTIVA CONVERGENTE-ASSISTENCIAL

RESUMO

Objetivo: conhecer a percepção dos Agentes Comunitários de Saúde acerca das cargas de trabalho presentes na sua dinâmica laboral e realizar prática assistencial relacionada às cargas de trabalho junto ao grupo.

Método: estudo qualitativo, fundamentado na Pesquisa Convergente-Assistencial, realizado em duas unidades de atenção primária à saúde, com três equipes de Estratégia de Saúde da Família, em um município ao Sul do Brasil. Os participantes foram 14 Agentes Comunitários de Saúde atuantes nesses cenários. Os dados foram produzidos por meio de entrevistas semiestruturadas, grupos focais e grupos de convergência. Os dados foram analisados, conforme a análise do discurso do sujeito coletivo.

Resultados: os Agentes Comunitários de Saúde convivem com intensa carga física (expressa pela exposição física na comunidade, estrutura precária na unidade e risco de violência); cognitiva (evidenciada pela necessidade de acúmulo de informações e conhecimentos técnicos para a orientação da comunidade e mudanças nos sistemas de informação); e psíquica (manifesta na fragilidade das relações interpessoais na equipe, na sobrecarga de trabalho e frustrações frente à falta de resolutividade do sistema e na falta de reconhecimento). A prática assistencial consistiu na mediação de um espaço de reflexão/ação/reflexão no qual os participantes puderam identificar estratégias para a minimização das cargas.

Conclusão: a partir da prática assistencial os participantes realizaram uma reflexão crítica, problematizando a sua realidade laboral, envolvendo-se no desafio da transformação da realidade através da construção de estratégias para minimizar as cargas a que estavam expostos.

DESCRITORES: Enfermagem. Saúde do trabalhador. Agentes comunitários de saúde. Carga de trabalho. Condições de trabalho. Pesquisa qualitativa. Pesquisa participativa baseada na comunidade.

CARGAS DE TRABAJO DEL AGENTE COMUNITARIO DE SALUD: INVESTIGACIÓN Y ASISTENCIA EN LA PERSPECTIVA CONVERGENTE-ASISTENCIAL

RESUMEN

Objetivo: conocer la percepción de los Agentes Comunitarios de Salud acerca de las cargas de trabajo presentes en su dinámica laboral y realizar práctica asistencial relacionada a las cargas de trabajo junto al grupo.

Método: estudio cualitativo, fundamentado en la Investigación Convergente-Asistencial, realizado en dos unidades de atención primaria a la salud, con tres equipos de Estrategia de Salud de la Familia, en un municipio al sur de Brasil. Los participantes fueron 14 Agentes Comunitarios de Salud actuantes en esos escenarios. Los datos fueron producidos por medio de entrevistas semiestructuradas, grupos focales y grupos de convergencia. Los datos fueron analizados, según el análisis del discurso del sujeto colectivo.

Resultados: los agentes comunitarios de salud conviven con intensa carga física (expresada por la exposición física en la comunidad, estructura precaria en la unidad y riesgo de violencia); cognitiva (evidenciada por la necesidad de acumulación de informaciones y conocimientos técnicos para la orientación de la comunidad y cambios en los sistemas de información); y psíquica (manifiesta en la fragilidad de las relaciones interpersonales en el equipo, en la sobrecarga de trabajo y frustraciones frente a la falta de resolutividad del sistema y en la falta de reconocimiento). La práctica asistencial consistió en la mediación de un espacio de reflexión/acción/reflexión en el cual los participantes pudieron identificar estrategias para la minimización de las cargas.

Conclusión: a partir de la práctica asistencial los participantes realizaron una reflexión crítica, problematizando su realidad laboral, involucrándose en el desafío de la transformación de la realidad a través de la construcción de estrategias para minimizar las cargas a las que estaban expuestos.

DESCRIPTORES: Enfermería. Salud del trabajador. Agentes comunitarios de salud. Carga de trabajo. Condiciones de trabajo. Investigación cualitativa. Investigación participativa basada en la comunidad.

INTRODUCTION

In Brazil, the Community Health Agent (CHA) is an exclusive and obligatory member of the Family Health Strategy Team (FHS)strategy considered as one of the main entry points into the Brazilian public health system, known as the Unified Health System (SUS). The CHA is a worker whose main responsibilities include: register and accompany the families assigned to their micro area through the home visits and guiding them regarding the use of health services; develop actions that aim to integrate the FHS and the community; develop health promotion activities, disease prevention, health surveillance, through home visits and individual and collective educational actions.[1] Thus, it has been said that, in Brazil, the CHA represents the link between the FHS and the community and plays an important role in the consolidation of SUS.

However, studies have evidenced risks and harms present in the work of the CHA. Brazilian research demonstrated that these professionals are exposed to community violence, poor sanitary conditions within the micro area, time constraints and infectious diseases, culminating in injuries of the musculoskeletal system, as well as dermatological, psychological and allergic complaints.[2] Other studies demonstrated a high prevalence of depression and stress in this population,[3] in addition to skin lesions associated with daily sun exposure.[4]

It is evident that the work process of the CHA has had harmful effects on their health. These effects result from their workloads, which are involved in the wear and tear processes. A recent study confirmed the presence of mechanical, biological, physical, physiological and mental loads, causing injuries of the musculoskeletal and connective systems of these workers.[5] Therefore, workloads are elements present in the day-to-day lives of workers which have an impact on their physical and psychological health.

In this context, it is important to discuss the workloads to which these workers are exposed to, as well as strategies to minimize them. In this study, workloads are approached from the perspective of work psychodynamics, a French strand that focuses on the analysis of mental health at work.[6] Workloads are defined as "the set of efforts developed to meet the demands of tasks. This concept encompasses physical, cognitive, and psycho-affective (emotional) efforts".[7:58] Physical loads result from the relationship between the work and the physical body of the worker; the cognitive ones are concerned with the cognitive processes present during the work activity; the mental ones are triggered by the onset or aggravation of psychological suffering due to the organization of work. These loads are interdependent, connected, and are potentiated in work organization.[6-7]

These loads are related to the work conditions to which the workers are subjected[8] to and, therefore, are related to an important concept in the relationship between work and health. Therefore, participatory studies aiming to know how the CHA can understand the workloads they are subjected

to and also to carry out educational actions with them, can support nurses to better understand the experience of this worker as well as develop possible strategies to positively influence this experience.

Thus, the objective of the present study is: to understand the perception of the CHH regarding the workloads present in their work dynamics and to perform health care practices related to workloads with this group.

METHOD

The present study is characterized as a qualitative research, anchored in the methodological reference of the Convergent-Care Research (CCR). CCR advocates the sharing of the physical/temporal space of the investigative and scientific action with the health care practice, aiming to provoke changes that improve the care provided. In CCR, research actions are carried out in concomitance with care movements, so that knowledge is produced in convergence with improvements in the health care scenario.[9]

The research was carried out in two primary health care units, where three FHS teams work in a municipality in the South of Brazil. The inclusion criteria for this study were: to be an active CHA in these scenarios for at least one year, considered sufficient time for contact with all the different types of work experiences. The study population consisted of 18 CHA, four of whom were excluded because they were on leave from work. Therefore, 14 participants composed the research sample, which took place between October and December 2016. Contact with the participants and an invitation to participate in the research occurred in person by the principal researcher in their places of work. Fourteen CHSs accepted to participate in the study.

In the context of CCR, the research process was divided into the investigative and care phases. These phases were triggered by the triangulation of instruments,[10] semi-structured interviews, focus groups and convergence groups, all conducted by the main author of this study.

In the investigative phase, individual semi-structured interviews were carried out with the help of a semi-structured script that investigated the workers' perceptions about the organization of work, conditions and loads that are present in their day-to-day work lives. The participants were randomly selected for interviews. According to the criterion of data saturation, six interviews was considered sufficient.[11] The interviews lasted an average

of one hour and were performed in the health units where each CHA worked. In order to guide the discussion in the large group, the data that emerged was summarized using Microsoft PowerPoint® 2013.

Subsequently, four focal group meetings were held on two consecutive days, with an average duration of three hours each with the participation of the 14 CHAs. The debates were mediated using topics that emerged from the interviews: workloads and their relationships with work organization and technical, ethical and political competencies of the CHA. The action plan involved the creation of a dynamic presentation using the Microsoft Power Point® 2013 program, which included the concepts and types of workloads, as well as the elaboration of a poster containing the CHA´s perception regarding the loads that exist in their day-to-day work life. It must be emphasized that conducting the research involved the researcher´s gradual immersion into the day-to-day work of the CHA, and each step provided support for new reflections, establishing reflection/action/reflection movements.

Next, the assistance phase was conducted by the convergence group (CG) technique, which includes a group technique specific to the CCR that aims to carry out investigative actions in concomitance with the practice of health care, with a focus on health education.[12] As it was a CCR, the data production phase also included nursing care for the respondents' health,[9] giving rise to data production, the critical-reflexive process, the experimentation of proposals for change and the collective evaluation of the results of the experiment. The pedagogical/care intentionality was developed based on health education, in which the CHA were invited to critically reflect on their workloads and construct strategies that interfered in the pleasure/suffering dynamic of their work.

Taking into account the singularity of the local reality and the referenced UBS, two groups were formed. G1 contained six CHA belonging to one FHS team, and the G2 contained eight CHA members from two teams. Each group participated in six biweekly meetings, with each meeting lasting an average of three and a half hours. In order to encourage the participation of the CHAs, the meetings were held in places close to the UBS. All G2 CHAs participated in every meeting; three CHAs from G1 missed a meeting due to professional and/or personal motive.

It is important to add that during the conduction of the meetings the researcher mediated the reflections on the existing loads in the day-to-day

work, instigating the problematization and the elaboration of strategies in order to minimize the effect of the loads on the workers. At the end of each meeting, the researcher evaluated the subjects' reports and highlighted the aspects that needed to be worked on in the next meeting, thus elaborating new strategies to be used with the group. The dynamic nature of this process led the researcher to use various resources to stimulate the dialog, the spirit of cooperation and autonomy between the CHSs. The legislation that guides the professional exercise was widely discussed, as well as the recovery of the identity of the CHS and the social responsibility to act in the prevention of diseases and health promotion in the community.

The participants gave their permission for the meetings to be recorded, and the Informed Consent Form was signed. Subsequently, the statements were transcribed using a text editor, which composed the corpus of the research. The analysis was performed by using the discourse method of the collective subject,[13] which in this study followed the following steps: reading each report; extracting the key expressions from each report; grouping homogeneous key expressions; extracting the central idea from each grouping of key expressions; composing the collective subject discourses corresponding to each central idea, including: the perception of the CHA regarding the workloads existing in their day-to-day work, the identification of the influence of these workloads on their experiences of pleasure/suffering and the construction of strategies to minimize these effects in all workers. The data were grouped according to the theme, forming the following categories: reflecting on the workloads of the CHA; and, developing strategies: nursing action through the convergent-care method.

The research obtained was approved by the Committee of Ethics in Local Research under (CAAE) 58331416.1.0000.5324 and complied with Resolution 466/12 of the National Health Council.

RESULTS

This study made it possible for the workers to perform a critical identification/reflection on the workloads existing in their work routine, identify how they influence their health, formulate collective strategies that can influence their work reality, and minimize the negative effects on their health. The CHA used the research to reflect and modify some aspects of their day-to-day work actions that were causing suffering by using the reflection/action process.

Reflecting on workloads

Firstly, the participants reported a set of elements related to the physical load in the socio-environmental context of the community they work in, exemplified mainly by physical exposure in the community, the precarious structure of the health unit, and also the risk of being exposed to violence present in the community:

At work I spend all the day walking, I have to carry a heavy backpack. It has hard to reach some areas, there are hills, cobbled streets, barbed wire fence, flooded areas. I suffer more in the summer, the sun and the heat are unbearable. I often feel unwell, I have dizziness, pains in my legs, in my back and head. At the end of the day, tiredness sometimes takes over and I cannot sleep because of it.

The physical loads do not stop there, I have to do some things in the health center where there are almost no windows, it is stuffy, the noise is intense, there is no sink to wash my hands. I have to put up with it because I need to type up my work on the computer there.

I also consider the use weapons, knives and stones in the community as a physical load. In reality, the fights happen in the streets and in the houses. I often find myself in the middle of a gunfight. Once a man ran after me with a gun. I feel that I run the risk of being attacked.

In addition, the cognitive load was highlighted by the participants related to the need to gather information and technical knowledge for the benefit of the community. The participants referred to the need to "know everything" in order to account for the multiplicity of activities that the work imposes:

My role is to guide the population about health and serve as a link between the team and users. Therefore, I need to be prepared to accompany diabetics, people with hypertension, child growth and development. I have to know about immunizations, healthy eating, prenatal care, women's, adolescent, and man's health. The community is poor, so I also had to inform myself about the social benefits such as work permits, all the types of social welfare payment, unemployment benefits. I have to know "everything", from public health policies to social programs.

In addition, the CHAs emphasize that, in their day-to-day work routine, they need to know the activities of the unit and the organization of the team in order to be able to carry out their work, indicating that there are failures in communication:

In addition to the whole structure of the health service of the municipality, I have to know the whole organization of the unit. The schedules, the professionals who are working in the unit, the care that each one performs and the health campaigns that are being developed. It is

difficult, sometimes I am not informed about the progress of work or changes in the schedule of the unit. I'm always under pressure, the changes are constant and I have to memorize "everything again".

The CHAs also highlighted recent changes in the information system of the FHS teams. This fact led to changes in the way CHA work information was generated and transmitted. The CHAs considered the adaptation to the new work tool difficult and the participants reported increased cognitive load as a result:

It changed a lot, now everything is done on the computer, online. I need to put all my reports on the system. I had difficulty with the computer, it took me a long time to learn. I had to do all the registrations again. Sometimes I do all the typing, come to the end and do not record. Despite the help of my colleagues, I still have difficulty; I have not been able to do all the registrations yet.

The change also caused the CHA to feel insecure because they did not have the record of their work on the subscription form, which was signed by the user. As a result, they chose to duplicate the records, increasing the cognitive load of the work:

I no longer have the record of home visits, my work is sent directly to the computer. This has made me insecure, I cannot prove that I did the job, the user can simply say that I did not visit. In order to protect myself, I decided to keep a printed version of the record in "problematic" cases, especially when it involves specific social cases, accompanying guardianship advisers and justice representatives.

Finally, regarding the psychological load, the CHA identified that the interpersonal relations established with the team often result in suffering for these workers:

Previously, I worked for the EACS [Community Health Agents Strategy], the nurse helped with the work, like a partner. She went on vacation and put another person from the FSH [Family Health Strategy], I was disgusted, I did not accept the way she worked. Before everything was discussed, we made it happen; now everything stopped. We are always in conflict. I'm going through a difficult situation [crying], but no one on the team gave me any support. It was my birthday and no one remembered. I feel lonely.

They also emphasized the excessive workload and frustration regarding the health systems incapabilities as a factor, which caused suffering, and, therefore, psychological load:

Users complain about the service, they ask for help about their problems. I think they have the right; I fight for them, but it doesn't matter. The health system isn't capable of providing everything they need. There is a two-year waiting list for a consultation with specialists everything is very difficult.

They create teams and they don´t have the correct working conditions, the structure of the unit is bad, the professionals are not organized. To do a good job, I need the support of the team, but I have difficulties scheduling home visits with nurses and doctors, sometimes, they schedule and don´t go. I have too many families to attend, I feel powerless and angry. It is bad not to be able to do things for the user, but the worst is somebody who can do something but doesn´t do anything, it is very frustrating.

The frustrations were also related to the fact that they were not properly appreciated by the team, management and government offices:

I feel overwhelmed, because in addition to the work of CHA, I do many other things. They give me all the bad tasks. They ask me to work outside my area; light referrals [specialty care]; do collections; accompany students, guardianship council and judicial officer; help the PIM staff [Better Early Childhood Program] and help in the reception of the clinic. I do every type of work. I worry because I can´t do my actual job. At the moment, I have only been making visits to families that have some priority, I worry about the situation of the other families. I feel physically tired and mentally stressed out. I want to give up everything.

For many years, I organized and led the coexistence group, but the nurse thought I didn´t have the competence and decided that she would coordinate the group. Now I only invite the community to participate. During the meetings, I sit in a corner and just watch... I can see that the group is getting smaller. I feel sad because the bond is fading and all my work was for nothing.

Talking about my relationship with the health department is depressing, I feel like I don´t exist. They do not know about my work. Besides my work not being very appreciated, I earn very little. There is a law about the types of wages. Do you think they pay us!? The union has had a case in court for some time. It seems that the city has appealed but, I haven´t seen any difference.

Reflecting and developing strategies for the minimization of workloads: nursing care practice

The data obtained from the CHAs showed their perception in relation to the existing loads in their day-to-day work routine. The reflection on these loads allowed the discussion and elaboration of the groups regarding collective strategies that can minimize the loads. Thus, during the meetings, the CHAs were invited to critically reflect on their

work process and to create group strategies that could reduce the effects of the loads on themselves and the movement towards a healthier and more pleasant work environment.

The researcher mediated the discussions by problematizing the day-to-day work routine of the CHA, instigating the formation of a group unit that promoted the construction of strategies to improve

the quality of life in the work environment. Thus, in a continuous process of looking at each other, involving the established human relationships established with the peers, team and community, the CHA elaborated the following strategies for the minimization of the workloads and actions for the accomplishment of these strategies, shown in Table 1:

Table 1 - List of strategies for the minimization of workloads and actions for the implementation of the strategies. Rio Grande do Sul, Brazil, 2017.

Strategies	Action for the implementation of strategies
Work Reorganization	- Give priority to home care, register and visit all families in my micro area; organizing them by street sequence, avoiding unnecessary displacements. - Expand the collective service, organizing health-education group meetings in a place close to the user's residence, improving the health prevention/promotion service and recuperating the relationship with the user. - Stop working outside the micro-area, using work hours to perform my duties.
Work according to CHS legal attributions	- Orient the community on my limits, so that they understand that I cannot carry out activities outside my attributions. - Increase the dialogue with the other team professionals and managers, talking about the problems that I have had because the deviations in my work activities, with the intention of building joint strategies in order to avoid them. -Assist in solving the environmental problems of the community, approaching the other secretariats, demanding improvements in the infrastructure and basic sanitation.
Strengthen the collaboration and cooperation between the management and the FHS team	- Inform staff about the occurrence of harassment and violence at work, negotiating support and follow-up visits. - Document and communicate to the nurse about the impossibility of making visits, explaining the reasons, such as: families that do not accept the visit, homes closed during my working hours and those with only minors at the time of the visit. - Improve the relationship with the team by talking more about what each one is doing, the schedule of the activities of the unit, the health campaigns, making me available to help. - Recuperate communication with the managers, together with the other members of the team, requesting improvements regarding working conditions; - Follow the progress of the judicial process regarding enforcing the salary law for each work category.
Mental health care	- Encourage dialogue in the group. - Carry out social meetings, such as birthdays, Christmas, Easter and others. - Request, together with the Nucleus of Permanent Education in Health, care assistance in the area of health of the worker, especially in the area of mental health.

At the end of the meetings, the research was evaluated with the participants. It was observed that the participation in this research benefited the CHA, shown by the union of the group, in the sense of learning to share their sufferings and their pleasures and the positive influence on mental health. The feelings of the CHAs are illustrated by the report of one CHA who said: *this research came at a time when we had locks over our mouths, and someone threw the key away. You came with the keys. This is how I feel about this study, we were oppressed, under a lot of pressure, gave us things that were not our responsibility. Then you came with the keys to open the locks and we are glad. We learned to speak and position ourselves. What I*

can say is that we have to continue with our positive and constructive attitudes.

DISCUSSION

The data obtained in this study point to the occurrence of physical, cognitive and psychic loads in the day-to-day work routine of the CHA. When excessive, workloads can cause exhaustion and psychological suffering. Studies have highlighted conditions considered painful by the CHA, such as: the exposure to infectious and parasitic diseases; exposure to solar radiation; risk of animal bites, traffic accidents and falls; long daily walks, fast work

pace, lack of water intake and inadequate diet; risk of psychological aggression and predisposition to psychic illness.[5]

An integrative review study showed that CHAs coexist with unfavorable working conditions related to inadequate physical structure, unsuitable resources to perform tasks, exposure to physical, chemical, biological and ergonomic risks. All these elements can culminate in physical and psychological exhaustion, or even lead the CHA to physical, psychological, spiritual or social illness.[15] These data are in line with this study; and therefore, he implication that the physical burden represents for the risk of illness of these subjects should be considered.

Participants also highlight that they constantly use memory to account for the various roles they play and to keep up-to-date; an example of this is the overlapping of accumulated papers. Although little explored, the cognitive loads of CHAs involve the incorporation of multifunctionality into professional practice, involving work flexibility and overlapping activities, where they assume more and more responsibilities, often outside their job description.[16]

Cognitive loads can emerge as a result of the worker's difficulty in responding to the demands of tasks when they are greater than their ability to perform them. The imbalance between the demands and the cognitive capacities of the worker causes increased mental fatigue, causing the worker to become exhausted.[17]

It is also emphasized that the cognitive burden is conditioned by a set of elements that include the characteristics of the task itself (such as the degree of concentration, memory and attention needed), individual variables (such as previous worker experiences) and external variables to the situation (for example, the availability or lack of technology for the execution of the tasks).[18] This may explain the complaints of the workers regarding changes in the home visit registration system as a factor that increases their psychological load, demonstrating that in addition to the amount and work intensity, there are secondary elements that influence/hinder the work and the completion of the tasks.

In this context, it is emphasized that the CHA requires specific knowledge regarding the health area, therefore continuous education is necessary in the work context of the CHA , in order to give meaning, value and effectiveness to the acquired knowledge. Despite the necessity, studies have warned about the insufficiency and/or lack of continuing education for this group, in particular regarding the area of humanistic knowledge.[19]

The psychological load was related to the mismatch between the work of the agent and the other professionals of the team, which was identified in another Brazilian study carried out with these workers.[20] Thus, it is emphasized that the psychological load comes mainly from the interpersonal relationships established with the team and the community, with the conflicts causing an additional loads to the workers, resulting in suffering at work.[21]

Among these mismatches, the incapabilities of the health system was identified as an important element in the moral suffering of CHAs. In this same study, the reports of suffering also involve the lack of recognition for their work and the excessive work targets. Workers reported feeling devalued, frustrated, and powerless in the face of community problems, which are similar to those found in this study.[22] In addition, the established link with the community can make them more vulnerable to suffering as they become more deeply involved with the problems of the community.[2]

Evidence regarding the psychological load and the work of CHAs appears in a qualitative study where the workers report the overlapping of tasks, bureaucratization and the performing tasks beyond their area of work. They also highlight systematic pressure related to attending the user, including working overtime, weekends and holidays. The participants report the negative effects on the psychological burden, manifesting into depression.[2]

Another study carried out with Canadian public health workers showed a substantial increase in the workload due to a lack of structure and adequate working conditions, where the lack of human resources entails the need to take on external roles.[23] The data from this study reveals that the precariousness of the work culminates in the increase of the psychological load.

Thus, it is important to note that the work environment of the CHA is permeated by workloads related to the characteristics of the work environment, to the training process, the work practice, to the organization of the work and to the differentiated emotional involvement with the community. It must also be noted that workloads are dynamic and interact with each other, increasing potential, which can culminate in workers becoming exhausted and/or ill.[24]

A noteworthy study with CHAs evidenced a high incidence of musculoskeletal symptoms. In terms of quality of life, participants received critical evaluation regarding pain, vitality, social aspects,

mental health, general health status, emotional aspects, physical aspects and functional capacity.[25]

Another recent study evidenced a high number of individuals with symptoms of burnout syndrome or in the process of developing burnout.[26]

A cross-sectional study revealed statistically significant relationships between stress and quality of life of CHAs, it discussed the relevance of the humanization of relations and valuing the CHA.[27]

Another study measured a broad set of physical, psychological and emotional exhaustion processes related to CHA, fundamentally related to workloads.[21] Therefore, the relevance of considering and discussing the implications of workloads on the physical and psychic health of these subjects is reaffirmed.

It is known that work acts as a determinant agent in the processes of illness, and that it is necessary to pay adequate attention to the health of workers who transcends the uni causal relation to the genesis of the injuries to which workers are exposed.[21] In this context, knowledge regarding workloads emerges as an important tool for workers in order to create or reclaim better working conditions, as well as to prevent illness.[24]

A recent study indicates that issues with management, problems in the relationships with the team/users and the poor working conditions, have significantly influenced the manifestations of dissatisfaction in the FHS health professionals.[28] Therefore, it is necessary to reevaluate the work processes and organization of the CHA in order to improve the working conditions of these individuals.[3] In this context, the actions carried out with the participants during the group meetings aimed at promoting and mediating a collective process of the resignification of suffering, aiming to develop strategies that can minimize these loads and, consequently, enable these improvements in the working conditions.

It is noteworthy that the CHA experienced a process of action/reflection/action during the study which involved their work process and the loads present in the day-to-day work routine. They were able to identify the situations that interfered with their health, and considered the technical, ethical and political competences necessary for the development of humanized work, as well as the development of strategic thinking as a way to improve the work.

From the perspective of a dialogical process, the CHA created a group capable of recuperating

their professional identity, self-esteem, the spirit of cooperation and autonomy, as well as the social importance of their work and their responsibility to act in the promotion of community health. Thus, in an ongoing process of looking at each other, involving the established human relationships with peers, staff, and community, they devised strategies that could minimize the effects of these loads.

Thus, the importance of nursing care for workers' health and the responsibility to promote care actions that increase their access to health care are highlighted. In the FHS team, it is up to the nurses to monitor/manage the work of the nursing team and the CHA, and therefore, nurses must focus on creating healthy workplaces.

As a limitation of this study, we can mention the fact that the study was only carried out with CHA from three FHS teams, which refers to the need to value the results in their singularity, as well as the need for new investigations on the CHA in both the municipality and other regions of the country. It must be noted that the results of this study promote nursing actions in the area of worker health, as well as other scenarios, and can be used to propose alternatives that rethink the human factor of organizations, as well as the need for quality of life in the working environment.

CONCLUSION

This study evidenced a set of elements that highlight the high workloads which CHAs are exposed to. The data indicate that CHAs experience intense physical loads (expressed by physical exposure in the community, precarious structure in the health units and risk of violence); cognitive loads (evidenced by the need to gather information and technical knowledge to orientate the community, and changes in information systems); and psychological loads (manifested in the poor interpersonal relationships in the team, in the excessive workload and frustrations due to the incapabilities of the health system and lack of recognition). These data corroborate the intensity of elements that culminate in the physical, cognitive and psychological loads of these workers, and evidenced the need to develop actions that benefit the health of these subjects.

Thus, the use of the CCR methodological framework made it possible to bring the researcher (nurse) closer to the care context and to rescue the social function of the researcher, by presenting a concrete possibility both for the construction of nursing knowledge and for care actions for the

participants. Thus, the CHA critically reflected and problematized their work reality by involving themselves in the transformation of a reality through the development of strategies that can minimize the loads they encounter in their day-today work routine.

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