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MORAL DISTRESS OF COMMUNITY HEALTH WORKERS

Geisa Briese*
Valéria Lerch Lunardi**
Eliana Pinho de Azambuja***
Nalú Pereira da Costa Kerber****

ABSTRACT
Working in the Family Health Strategy (FHS) may have health community agents (HCA) experience the confrontation with different expressions of moral problems that might cause moral distress (MD). We have made a qualitative, exploratory-descriptive study to understand how the work of the multi professional team in the FHS contributes to the experience of moral distress by the agents. We did a discursive textual analysis based on participant observations and semi-structured interviews carried out between June and September 2010 with eleven HCAs from Family Health Units. Three categories were defined: the proximity with the community, work organization, and the ways of life of the community. Many of the situations experienced by the agents involve ethical questions that derive from the way the work is organized and the lack of perception of the resulting moral conflicts, which include values, beliefs, feelings and knowledge. The apparent invisibility, silence and even unawareness of this distress by HCAs and other workers in the team may contribute to the continuity of situations that could and should be avoided, in order to favor the attention to the health care of the community.

Keywords: Nursing. Ethics. Family Health Strategy.

INTRODUCTION

The Family Health Strategy (FHS) is intended to replace the traditional model in primary care by establishing linkages and commitment ties and co-responsibility among health professionals and the population, constituting an important tool for implementation of the Unified Health System (SUS)[1].

The multiprofessional team organized by the FHS has a general practitioner, a nurse, one or two nursing assistants or nursing technicians and four to six health community agents (HCAs). These HCAs are selected from the communities of the areas where FHS actions will be developed so they can also establish links with all the team by the proximity of their work with the families´ way of living, contributing to transform the reality of the community, improving access to health services and contributing to the construction of citizenship[1].

In the FHS, the health professional besides offering assistance care, they need to be suitable for the technical and organizational rules recommended by the Ministry of Health, Health Department of the Municipality and Local Coordination, live with diseases and deaths, functional overload demands, such as supervision, management and assistance from nurses, handle contamination risk situations, coursing kilometers in a defined area in order to exercise health surveillance function[2].

The HCAs assist the residents of each house in health issues: identifying problems, guiding, directing and monitoring the procedures necessary to the protection, promotion, recovery/rehabilitation of people´s health in that community. They are essential for communication between the team and the family, because they work directly with the population[3]; performing home visits (HV), establishing relationships that favor information gathering about the individuals and family health of those they relate in the community, working as a multiplier agent,

[1]This text stems from the Master's dissertation titled: "Family health strategy and experience of moral distress", argued at the Graduate Nursing Program of the Universidade Federal do Rio Grande - FURG.

*Nurse. Master in Nursing. E-mail: geisabriese@yahoo.com.br
**Nurse. PhD in Nursing. Universidade Federal do Rio Grande - FURG. E-mail: vlunardi@terra.com.br
***Nurse. PhD in Nursing. Instituto Federal de Educação, Ciência e Tecnologia do Rio Grande do Sul – Campus Rio Grande . E-mail: gama@vetorial.net
****Nurse. PhD in Nursing. Universidade Federal do Rio Grande - FURG. E-mail: nalu@vetorial.net

integrating scientific discourse to the popular knowledge[4,5].

Among the other team employees, the HCAs accomplish all their responsibilities, successfully answering family, users and institution concerns, despite the lack of necessary conditions for an appropriate assistance[6] with a demand of responsibilities that goes beyond their intervention ability[2,6].

Thus, what is recommended by the Ministry of Health for the FHS may be different from the real situations experienced in many teams, So, professionals working in the FHS may face many ethical dilemmas in the current work situation and the social conditions the assisted families are causing them moral distress (MD) related to decision making about what to do in order to preserve their principles and professional values.

In this way, the work developed in the FHS can trigger the confrontation of different manifestations of moral problems: a) moral uncertainty, when identifying a problem as an improper situation; b) moral dilemma, when recognizing the following two options, however, only one can be selected; c) moral distress[7] (MD) when identifying their responsibility in the conflicts, knowing the following right action,, however, being unable to put it into practice, because of institutional constraints and/or co-workers, recognizing their moral participation as inadequate, which can affect their mind, body and professional relationships[8].

In this sense, it is believed that the roles assumed by HCAs in the multidisciplinary team, as well as their proximity to the families they assist, can favor the experience of situations that may cause MD. Thus, from the research question: how does the work performed by the professional team in the Family Health Strategy contribute to the experience of moral distress by the Health Community Agents?, has established as objective: to understand how the work performed by the multiprofessional team in the Family Health Strategy contributes to the experience of moral distress by the Health Community Agents.

METHODOLOGY

This is a qualitative, descriptive and exploratory research trying to work with the universe of meanings, motives, aspirations, beliefs, values and attitudes in order to further investigate the issue and provide greater familiarity with the problem[9].

The study was conducted in the city of Rio Grande (RS), in two Basic Family Health Units (BFHU), with eleven community agents, from June to September 2010. Data collection was performed by using two techniques participant observation of the performance of 05 HCAs of one of the Basic Family Health Unit (BFHU) during home visit (HV) to fifteen families and semi-structured interviews, recorded, with the eleven HCA.

Observations focused on how the HCA behaved with the information of users, questions manifestations, domestic violence situations, drug use, BFHU assistance, among others. As the observations implemented of home visits to fifteen families helped the identification of many situations that were useful data for its analysis as to complement and enrich the script provided for the interview, it was considered that the observations made in only one of BFHU have proven enough for the data collection process.

The observed events were daily recorded and in field notes, information, the synthesis and data understanding were pointed out. Elements identified in participant observation, recognized as moral problems (issues of domestic violence and drug use) were rescued and explored during the interview, and possibly other issues related to moral problems and MD experienced in the workplace. The average duration of each interview was approximately 40 minutes.

The data were submitted to discursive textual analysis, which has three main elements: the unitarization process to examine the records of the observations and the transcripts of the interviews in detail, fragmenting them, towards achieving constituent units, with statements relating to the studied phenomena. Then, the categorization process, which involved building relationships between themes, combining them and

classifying them to form groups that gathered near elements, resulting in a category system. Then, the metatext, representing an effort to explain the understanding of the elements identified as the product of a new combination of elements built over the previous steps and the self-organizing process which emerged new understandings[10]. Thus, three categories were built: proximity to the community; work organization and people´s ways of living.

After the Ethics and Research Committee on Health - CEPAS (Opinion 30/2010) approved the project, data collection began. Participants (HCAs) were asked to sign the free and informed consent. Their identification were the initial of the profession of the community agents in capital letter (A) followed by the corresponding number (1, 2, 3 ...).

RESULTS AND DISCUSSION

The eleven HCAs presented the following socio-demographic data: predominantly female, aged between 22-48 years old; most with a high school level of education and fewer with higher education and graduate; and the operating time on the team was from one year and eleven months to 5 years, with an average of 2 years.

From the data analysis, it was found that the MD of HCAs is related to their proximity to the community, the work organization of BFHU and FHS; and the ways of living of the community, as in the following addressed categories.

Proximity to the community - the MD experiences of the HCAs are strongly related to their proximity to the community, due to the knowledge of their health-disease process, problems and situations of social vulnerability, the referrals in addition to solving the demands of the community:

> [...] we identify the problem, we notify it and when it comes to solving problems, the team often does not give the right value; in this way, we are pressed by the community (A9).

In this way, HCAs work going beyond their abilities and resolution possibilities. As many times, their work does not meet the multiple demands of the population, they may not recognize the quality of the HCAs´ actions, nor their efforts to perform them, regardless of the results achieved by requiring these professionals a more effective and resolute action. This pressure is strengthened by the constant contact that community residents have with the agent, attending the same social spaces and have access to their homes, considering them as a neighbor, even before a HCA[11]. Acting as mediator between the community and the BHU, the HCA suffers from lack of adequate answers to the population[6], which causes him MD when identifying the needs in the community and the perceived lack of resoluteness.

Even this lack of resoluteness can cause him additional distress, due to their close, and continuous contact and the entire relationship with the community, which makes them feel responsible for their customers, as well as witness and share the consequences of inaction in the health problems and the suffering of family members[11].

The moral problems and the resulting MD faced by HCAs also seem to be associated with their difficulty in establishing limits to users, as they are often asked to provide guidance and information on health and health resources of the BFHU service, regardless of time and place of the community where they are:

> [...] We are community agents Saturday and Sunday too, because sometimes they seek us out of time, out of day; but there are people who live within the micro area that does not have right to Sunday, they ask things [...] (A7).

Due to their proximity to the community, HCAs are part of the health care team in BFHU being a reference to families and the first keeper of the community dissatisfactions[12]. At the same time being resident of the area and institutional worker, they are source of information on the process of organization of health services. However, they have problems to impose limits on the enrolled population. They are commonly sought regardless of their working hours, replacing their simple role of a neighbor to take the be a permanent health worker[6], being

uncomfortable, generating anxiety and distress, despite the recognition of their social role[13].

As part of the community, the HCA can experience many of the situations that are referred to and reported by the users, feeling identified with their living conditions and health, which favors their understanding of the values and needs of that community[6], but on the other hand, it can make it even worsen the limitations on this permanent demand.

Recognizing they are close to the community, and despite identifying their needs, the HCAs need to be preserved, needing to take care of themselves and not to allow the work absorbing the time of their lives, being provided by the FHS, as their workload is forty hours per week, distributed in eight hours[14], limits to be imposed by the HCA, in a respectful relationship with the community, explaining both their duties as their rights.

Work organization - negative experiences related to BFHU work organization as exchange of medical appointment scheduling, without user availability of the consultation; delay in treatment by specialists; suspension of service for provided procedures such as vaccines; no assistance of the request by the HCA and HV to users who require medical evaluation and/or nursing may cause MD in HCA:

> [...] Lack of agility, in the schedule because sometimes there are consultations that you let them know, you go after it. Then there comes the patient and the consultation has changed, it has changed the day and time, it has changed everything: "Oh! She called and changed my consultation", it is very disorganized, there are experts who take years [...] (A3).

As also observed in this study, the health professionals involved in FHS are exposed to the reality of the enrolled community with scarce resources to assist the complex demands and also to network outages of health care that are reflected in the work and solving actions[15,16].

Even the HCAs perform monthly HV, identifying problems, carrying out guidance and referrals, according to the established routine in the team. Thus, users seek to solve their problems with the BFHU team, often by guidelines of the HCAs, not finding, however, the desired and necessary care, such as when:

> One user with heavy bleeding attended the health center, in need of care and the receptionist said that there would be no service at that time, because there was a training in the unit (A1).

The community people first seek the HCAs, to make complaints, to get information or resolution of a more serious problem, requiring answers in a constant relationship of demands and requirements not always quiet. For this reason, it was also evidenced in this work, the MD of the HCAs is very much based on the amount and intensity of motivation to which they are submitted and the many features that they are required in order to implement the Health Surveillance of the territory under responsibility[17].

Thus, the established bond by the HCAs with the community through interaction facilitates adherence of the community to the FHS and the team approach. However, paradoxically, feelings of helplessness and frustration are evidenced by limitation of HCAs participation in solving problems in the community by demanding interventions outside their resolving power, with the involvement of the system and other sectors, with the intersectoral practice and the integration of actions in the health promotion and disease prevention[3,16,18].

The MD that HCAs face in daily work occurs mainly by the conflict of interests, values and beliefs of the team and situations involving the health of users with the lack of commitment and responsibility to obtain the solving for the quality of care and community life due to insufficient commitment of some professionals working in the FHS and the organization of the proposed work.

The HCAs recognize that the way the work is organized can cause them a moral dilemma, because they feel unsure about how to tackle the problems of these users. Sensitive and confidential information related to drug use, domestic violence, crime, among others, reported to the HCAs by the users in a "trust relationship" may be a dilemma object and

MD for the worker, needing to communicate such data to the other members of the multidisciplinary team, especially, to other HCAs belonging to the same community:

> We must protect the privacy of families who rely on their secrets and diseases, unless such secret endangers their health; we must try to help them as best as possible, seeking their approval to seek guidance and help (A8).

The organization of work in the FHS exposes workers to violence, sometimes invisible, the lack of boundaries between professional and personal aspects, the intense contact with situations of domestic and social violence, fear of exposure risk, feeling of moral and physical integrity threatened and reprisal fear[19], intensified by regular contact with situations of violence that cause them suffering, fear and feelings of vulnerability, which can sometimes hinder the HCAs attempts to impose limits on the community they live in, with regard to their professional relationship.

The difficulty of the HCAs to organize their working time, together with the demands on their monthly productivity can also cause them MD:

> [...] Productivity could be different, lack of humanization; productivity is well outdated because there are things that we do, no one says anything and, to us, it is much more important [...]. There is a person with AIDS who does not enter into any statistics. AIDS does not enter the productivity and we always visit them; when sick, when they feel alone, when they are depressed, they seek you, and I do not need to visit them. Of course, as a number, will not, but as a person and human being, I think she needs more of another person; all need, really, because everyone needs a visit, but I think the person who has AIDS would have to enter in productivity, because they are a very troubled person, very needy ... and others too, other caresses that it does not enter as productivity (A5).

The organization of the FHS provides service priorities, especially to the elderly, hypertensive, diabetic, pregnant women and children under three years old, and the HCS is the professional who performs the monthly HV to these user groups. Thus, without their quality being evaluated, they are asked for the productivity understood as quantity of care in order to meet certain goals to ensure the transfer of funds for the expansion and maintenance of the FHS. However, the HCAs can identify different priorities in their micro area, to carry out the HV, as users diagnosed with AIDS, with manifestations of depression, struggling to manage, autonomously, their working time, which also can give them MD.

The invisibility, silence and even ignorance of that distress by the HCAs and other team workers, have an important ethical dimension and may be contributing to the continuity of situations that could and should be avoided, to favor the health care of the community. Many of these situations are related to the way the work is organized and the apparent lack of awareness of everyday conflicts, which involve values, beliefs, feelings and knowledge[19].

People's ways of living - the way of living of some community members, living with domestic violence, violence against the elderly and children, drug use in the home environment by adolescents and their parents seem to be practices sometimes recognized as normal, confronting cultural and moral values. Coping difficulties in these situations, caused questions, the different attempts at resolution and the resulting threats of reprisal for HCAs´ aggressors can cause them MD:

> [...] drug users, every one house, there is a drug den; that area is dangerous; the difficulty is because you never know who will find in the house, you never find the owner, just people, friends who use drugs (A8).

> [...] a drug user raped a pregnant adolescent in the street and the HCA was threatened by the user to not go through that road (A9).

The population´s living conditions followed by the HCAs working in BFHU are characterized by poverty, lack of food, unhealthy living conditions, unemployment, lack of resources, factors to consider in planning of health actions at the local level and issues that agents feel powerless to deal with[15], especially those related to violence experienced by users and the possible

consequences of their intervention in these situations.

Commonly, they can be in situations of violence, either in domestic or not, causing them moral dilemmas as to what action they take and how to do it, because they both recognize the need to intervene, as their vulnerability, as well as their own families, before the aggressors[19], which favors their manifestations of MD, as identified in this study.

Given the various witnessed situations of violence, there was confirmed an apparent naturalization of such violence by the HCAs, who choose to omit and prove indifferent, and may also understand this attitude as ethical. This reconfiguration of what is right and wrong can be adopted, so they can continue acting as HCAs, protecting their employment[6], which it is possibly an important cause of MD.

Another source of MD is related more specifically to the situation of users who choose not to change their way of living and add their care, either as patients with chronic diseases, either as drug addicts. The feelings expressed related to the situations experienced in the professional performance of HCAs are quite negative:

> [...] unhappiness, frustration [...] (A1)

> Helpless, bad for help, defend the family (A2).

To express such feelings, HCAs also seem to show a sense of responsibility for the necessary membership of community practices perceived as healthy and desirable, seemingly beyond their role and in such situations, their limits in the professional relationship with the community. However, these feelings can be associated with responsibility for errors and weaknesses identified in the unit, demanded by the other team members, even if they are not fulfilling their duties. It is also highlighted that despite HCAs be liable for inconsistencies in the unit, they do not take the leading roles and even participate in decisions that could contribute to the improvement of the service[20].

FINAL CONSIDERATIONS

The study revealed that it is necessary and urgent to uncover and enhance the moral problems of the HCAs work routine and the construction of strategies to ease their MD. The analysis and discussion in an organized and systematic multidisciplinary team of situations involving ethical issues and values in the workplace, with the appreciation of the experiences and knowledge of HCAs, towards a better resolution, both for users and for the workers, seems fundamental.

In the same way, enhancing skills, with the use of transformative educational proposals for the qualification of all the team through the questioning of experiences and the different conflicts of daily work, strengthening the knowledge of the moral dimension in the different actions and omissions, as well as the multiple decision-making, seems to be a reviewed and implemented strategy.

Considering the relevance of MD theme and HCAs for the performance of the FHS, and that the results of this exploratory study refer to a specific reality, it is suggested further investigations to expand the understanding of the thematic and its implications for the users´ care..

SOFRIMENTO MORAL DOS AGENTES COMUNITÁRIOS DE SAÚDE

RESUMO

O trabalho desenvolvido na Estratégia da Saúde da Família (ESF) pode desencadear nos agentes comunitários de saúde (ACS) o enfrentamento de distintas manifestações de problemas morais que lhes podem provocar sofrimento moral (SM). Com o objetivo de compreender como o trabalho desempenhado pela equipe multiprofissional na ESF contribui para a vivência de SM pelos ACS, realizou-se um estudo qualitativo descritivo - exploratório. A partir da observação participante e de entrevistas semiestruturadas realizadas no período de junho a setembro de 2010, com onze ACS de Unidades de Saúde da Família do município do Rio Grande (RS), realizou-se análise textual discursiva dos dados, definindo-se três categorias: proximidade com a comunidade; organização do trabalho; modos de viver da comunidade. Muitas dessas situações vivenciadas pelos ACS envolvem questões éticas que decorrem do modo como o trabalho se organiza e da falta de percepção dos conflitos morais decorrentes, os quais envolvem valores,

crenças, sentimentos e conhecimentos. A aparente invisibilidade, silêncio e, até, desconhecimento deste sofrimento por parte dos ACS e dos demais trabalhadores da equipe pode estar contribuindo para a continuidade de situações que poderiam e deveriam ser evitadas, de modo a favorecer a atenção à saúde da comunidade.

Palavras-chave: Enfermagem. Ética. Estratégia Saúde da Família.

SUFRIMIENTO MORAL DE LOS AGENTES COMUNITARIOS DE SALUD

RESUMEN

El trabajo desarrollado en la Estrategia Salud de la Familia (ESF) puede desencadenar a los agentes comunitarios de salud (ACS) el enfrentamiento de distintas manifestaciones de problemas morales que pueden provocarles el sufrimiento moral (SM). Se ha realizado un estudio cualitativo, descriptivo-exploratorio con el objetivo de comprender cómo el trabajo desarrollado por el equipo multiprofesional en la ESF contribuye con la vivencia del SM por los ACS. A partir de la observación participante y de entrevistas semiestructuradas realizadas en el periodo de junio a septiembre de 2010, con once ACS de Unidades de Salud de la Familia de la ciudad de Rio Grande (RS), se realizó un análisis textual discursivo de los datos, definiéndose tres categorías: proximidad a la comunidad; organización del trabajo; modos de vivir de la comunidad. Muchas de estas situaciones vividas por los ACS involucran cuestiones éticas que resultan del modo cómo el trabajo se organiza y de la falta de percepción de los conflictos morales existentes, los cuales envuelven valores, creencias, sentimientos y conocimientos. La aparente invisibilidad, silencio y, aún, el desconocimiento de este sufrimiento por parte de los ACS y de los demás trabajadores del equipo puede estar contribuyendo con la continuidad de situaciones que podrían y deberían ser evitadas, a fin de favorecer la atención a la salud de la comunidad.

Palabras clave: Enfermería. Ética. Salud Familiar. Estrategia.

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Corresponding author: Valéria Lerch Lunardi. Rua Gal Osório s/n, CEP-96200-201, Centro- Rio Grande, RS. E-mail: vlunardi@terra.com.br.

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