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### **Stress in Community Health Agents: a Bioethics Protection Perspective**

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#### **Abstract**

Health care professionals suffer from both regular job stress and caregiver stress that arises from the neglect of their work situation. As principles of bioethics protection, vertical protection ratio, health policies should also target health professionals. So, this paper seeks to understand the issue of stress in relation to mental health professionals, specifically the community health agents of the Federal District in Brazil. **Methods:** This study is an exploratory study that adopts a quantitative approach. Data were obtained by a questionnaire, that measure social, work and stress factors, in 97 community health agents, a different class of health professional. The SPSS 19.0 program was used to measure the results. **Results:** The sociodemographic data of respondents revealed that the majority were women, 40,2% of the group members fall in the age range 30–39 years, 51% of respondents were married and 57.7% were of middle socioeconomic status. All Pearson correlations were significant at the 0.01 level (two-tailed). The results show that all stressors are negatively correlated with the mental health factors. These results showed that mental health deteriorates with increased stress. The mental health indicators are strongly and positively associated, indicating that individuals with better mental health show greater personal,

social and workplace support. **Conclusions:** The results indicate the need for management changes in the public health sector related to Bioethics Protection, which states that populations vulnerable to work exploitation should be protected by guaranteeing minimum working conditions.

**Keywords:** stress; bioethics; working conditions; community health agentes.

### Introduction

The inaugural article on Bioethics Protection began with the following question: “*¿acaso la bioética ha desarrollado las herramientas adecuadas para enfrentar los principales dilemas morales que se dan en programas y prácticas de salud colectiva?*”<sup>1</sup>. To understand the question, it is important to remember that, during the late 20th century and early in the current century, discussion of bioethics tangentially involved public health problems. Sometimes bioethical principles were applied without context, owing to the use of principlist analysis. Meanwhile, sometimes the analysis was limited to analogies related to medical issues – owing to the importance in this context of clinical biomedicine.

Thus, the article by Kottow & Schramm<sup>1</sup> points out that the principle of protection is best-suited to address moral issues related to public health and can generate agreements between health workers and bioethicists.

Discussions on the Bioethics of Protection have now won support, and include such issues as access to drinking water, the guiding principles of the Unified Health System (UHS), quality of life in the context of globalization, the autonomy of the mentally ill, and so on. However, we have found no discussion on the biases of health professionals.

Regarding the clinical biomedical paradigm, some authors recognize factors that support the reductionist analysis of bioethics protection. In this sense, Clinical Biomedicine and Public Health may be considered two small genera within the broad category of Health. Protection Bioethics has thus changed the Doctor / Patient dichotomy into an Institutions / Collective dichotomy. It can be inferred that this new dichotomy preserved a reductionist perspective on analysis of Public Health, and thus led to the neglect of underlying themes, such as health professionals.

Thinking about the Brazilian case, the UHS does not operate dichotomously, but rather through dialogue with its agents, specifically: government (population representatives); service providers (managers of health services); health professionals (multidisciplinary teams); and users (the population). All these agents have voices on Health Councils, which are bodies responsible for social control that permit the creation of effective public health policies, and help ensure dialogue is focused<sup>2</sup>.

We know that some public health policies are ineffective. At this point, the principle of protection can help, because protection is defined as the attitude of safeguarding or providing for essential needs, and providing for other needs and interests only after these essential needs are met<sup>3</sup>.

Health professionals have a responsibility to care for users. However, such care only becomes possible through interaction. Since the subjectivities of both the caregiver and recipient of care determine the means of caring, we can deduce that the way of life or situation of the agents involved will influence the care they provide.

According to Moreno<sup>4</sup>, the study of psychosocial aspects of work acquires public importance when changes in work organization require emotional and cognitive work, which increases the psychological and mental workload. Today both traditional physical and environmental risks coexist, being known as psychosocial risks, and cause worker discomfort as a precursor of mental pathology.

The principle of protection is useful in this context. In a vertical protection relationship, health policies, which involve program implementation to develop a particular area, should also protect healthcare professionals, since these professionals are the frontline implementers of policy<sup>5</sup>. Public resource allocation must meet the needs of professionals and enable their activity to benefit users of health services.

As public health relationships are dialogical, professionals must do not simply wait for resources to be allocated, but should actively request resources. Foucault<sup>6</sup>, in an interview titled “*La ética del cuidado de si como practica de la libertad*”, was asked about the issue of mutual care. He argued: if a person takes care of themselves to the point of understanding his duties as a master of the house, husband, or father, he will gain the respect of his wife and children.

Health care professionals suffer from both regular job stress and caregiver stress that arises from the neglect of their work situation. This second situation puts health care professionals in the violation condition, demanding not only their protection but also – consistent with Foucault's ideas – the transformation of that protection from action into reality.

This reality is also observed in a group of professionals that was instituted in Brazil, more specifically in the state of Ceará, working with the issue of patient care, but where they live. These workers are called Community Health Agents, and differ from other health professional, such as nurses, because they perform their work within their own communities, visiting patients in their homes, and only then, leading to the diagnoses within the hospitals.

For these professionals exposure to stress at work is even more alarming, since many times, besides the involvement that can occur with patients in hospitals, can also be seen in many homes that they need to visit daily. So the bioethics of protection is an important tool in improving the quality of life of such professional as it can act in the public sphere both inside and outside hospitals.

### **Psychiatric Reform and Protection of Worker Mental Health**

Law 10.216/2001, known in Brazil as the Psychiatric Reform Law, sought to institute new mental health practices to deinstitutionalise users of health services, as below<sup>7</sup>:

Article 3. The State is responsible for the development of mental health policy, as well as for the assistance and the promotion of health actions that target mental disorders, with due participation from society and the family, which can be provided in a mental health facility, as well as in specific institutions or units that provide health care to patients with mental disorders.

Article 4. Admission in any of its forms will only be indicated when outpatient resources prove insufficient.

Article 5. Patients hospitalized for a long time or characterized with serious institutional dependence, due to their clinical condition or lack of social support, will receive specific highly planned and assisted psychosocial rehabilitation, overseen by the competent health and supervisory authorities indicated by the Executive, and will be assured of continuity of care when needed.

However, the law does not address the deinstitutionalization of healthcare, understood here as the removal of that which is already established. In other words, we do not find in the law any precepts on the withdrawal of mental health workers from old practices.

Deinstitutionalization forms part of the dialogical relationship between caregiver and patient, as do protective measures for workers responsible for the implementation of public health policies. In this regard, Moreno<sup>4</sup> pondered the decreased importance of Brazil's states in the protection and regulation of labor relations, the decline in the bargaining power of workers, the primacy of the market as an articulator of social relations and a system of work organization that reproduces existing social inequalities, combined with increase part-time work, underemployment and unemployment, erode job security and promote the casualization of working conditions. As work is destabilized and the employment relationship becomes more precarious, health care and related risks are transferred to workers.

The allocation of public resources, which is largely determined by the bioethics of protection, must be discussed on boards of health. Also, since the work of these boards is to realize public policy, they must consider the protection of health professionals.

### **Instrument designed to measure work stress.**

In the 1990s, Brazil conducted the SWS (stress, work, social) Survey, a questionnaire dealing with stress, mental health and work. Earlier studies on stress at work had already examined the following<sup>8</sup>:

- The search for the cause-effect relationship between stress and disease (low correlations were found);
- Differentiation of independent and dependent variables (interaction between them was occasionally found);
- The role of moderator variables using more sophisticated measures, which can be detected via statistical analysis, as well as curvilinear and linear relationships;
- The prospects of using longitudinal studies and multidisciplinary research to overcome the complexity of work stress. (p. 154).

The discussions that preceded the establishment of this survey initially focused on treating the physiological symptoms generated by stress. After this phase, psychological studies found that personal variables, situational and psychological stress could either cause or alleviate stress.

Thus, an operational change has occurred in relation to this issue that involves a shift from the physiological field (treatment of symptoms) to the psychological field (identification of causes). This change resulted in a redefinition of work stress itself, and recognition that mental health at work was not exclusively the result of work demands, but also involves other subjective issues spanning the workplace.

Regarding the evaluation of the stress model, according to Guimaraes and Grubits<sup>8</sup>, the questionnaire considers:

1. What support factors can nullify the effects of stressor factors;
2. Separate identification of variables related to three dimensions for diagnostic differentiation;
3. Validation based on the criteria of mental health and life achievements;
4. Distinction between healthy and unhealthy stresses rather than normative comparison (p. 156).

Thus, the questionnaire was a tool that does more than merely diagnose stress and mental illness, and contributes to prevention through early detection of factors, such as lack of support, that may negatively impact the individual. In this sense, this paper seeks to understand the issue of stress in relation to mental health professionals, specifically the community health agents of the Federal District in Brazil.

### **Materials and methods**

This study is an exploratory study that adopts a quantitative approach. The survey was administered to 97 Community Health Agents identified by a matrix as involved in mental health in the district of Riacho Fundo, Brasilia, Brazil. The survey sought to establish relationships between stress, mental health and work for the subjects.

Data collection used the SWS Survey – a questionnaire dealing with stress, mental health and work. The results were collected using SWS questionnaires, with GP shape, and were divided into two sections: Section I described the demographic and socioeconomic profile of participants, while Section II depicted the results observed in the SWS questionnaire. This second section describes the work stress reported by Community Health Agents (CHA), considering the socioeconomic and demographic variables of the sample. The statistical treatment of the data was performed using the statistical package SPSS version 19.

The questionnaire was administered in December 2012, in private rooms on the premises of surveyed health centers. The project was approved by the ethics committee of FEPECS / SES / DF, under No. 643/11, adopted on 15/02/2012. The 97 Community Health Agents who agreed to participate signed an informed consent form that guaranteed their anonymity and the confidentiality of their information. To ensure confidentiality, the names of the family health units surveyed are not disclosed.

### **Results**

#### Section I: Socio-demographic Data:

The sociodemographic data of the 97 Community Health Agents revealed that the majority were women (78.4%). Almost half of the group members fall in the age range 30–39 years (40.2%), 51% of respondents were married and 57.7% were of middle socioeconomic status. The group is divided between those engaged in basic work (55.7%) and those engaged in work of medium complexity (41.2%). In terms of educational level, the largest group among the respondents were those with a high school education (47.4%), followed by those with a college degree (23.7%). The vast majority of agents work 40 hours per week (97.9%) on the morning / afternoon shift (96.9%). Most of these workers had been working in the field for approximately seven years at the time of the survey. Table 1 presents the sociodemographic characteristics of the participants.

**Table 1: Frequency distribution (n) and percentage (%) of Socio-demographic data of 97 Community Health Agents. Brasília, Brazil, 2014**

variables	Nº	%
<b>Gender</b>		
Male	20	20,6
Female	76	78,4
Without information	1	1,0
<b>Idade</b>		
20 – 29	19	19,6
30 – 39	39	40,2
40-49	27	27,8
50-59	5	5,2
+60	1	1,0
Without information	6	6,2
<b>Marital Status</b>		
Single	32	33,1
Married	50	51,5
Divorced	6	6,2
Widower	3	3,1
Free union	3	3,1
Without information	3	3,1
<b>Work</b>		
Basic	54	55,7
Medium	40	41,2
Superior	3	3,1
<b>Education</b>		
Complete elementary school	2	2,1
Incomplete elementary school	1	1,0
Completed secondary school education	46	47,4
Incompleted secondary school education	3	3,1
Higher education completed	23	23,7
Higher education incompleted	17	17,5
Post-graduation	1	1,0
Without information	4	4,1
<b>Dependents</b>		
None	27	27,8
1 a 3	59	60,8
4 a 6	3	3,1
More than 9	1	1,0
Without information	7	7,2
<b>Shift Work</b>		
Rotating shifts	3	3,1
Mornnig/Afternoon	94	96,9
<b>Hours of Work</b>		
40 hours	95	97,9
60 hours	1	1,0
+ 60 hours	1	1,0
<b>Economic Level</b>		
Very low	8	8,2
Low	33	34,0
Average	56	57,5

**Section II: Mental Health and Psychosocial Risk Factors**

The score for each factor of the SWS survey was calculated based only on the “yes” answers that participants indicated for each question. Responses were grouped by watching the screen correction SWS survey, in GP form (Brazilian SWS), with adaptation and translation into Portuguese carried out by Guimarães and MacFadden (1995). According to the riddle, the number of questions per factor is as follows: Psychosocial Risk Factors (PRF) = 19, Mental Health (MH) = 27, Stress at Work (SW) = 26, Work Support (WSp) = 25, Social Stress (SS) = 20, Social Support (SSp) = 23, Personal Stress (PS) = 21, Support Staff (SSt) = 22.

**Correlation Between Mental Health and Stress Factors**

The data presented in Table 2 show the bivariate correlations between rates of SWS. All Pearson correlations were significant at the 0.01 level (two-tailed). The results show that all stressors (PRF, SW, SS, PS) are negatively correlated with the mental health factors (MH, WSp, SS, SSt). These results showed that mental health deteriorates with increased stress. The average of these correlations was 0.58 (SD = 0.06) suggesting a moderate association between stress levels and mental health.

The correlations also show that stress levels are positively associated with one another. That is, as an indicator of stress increases, so too do other indicators in the same category. The average of these correlations was 0.71 (SD = 0.07) indicating a strong association between the various indices.

The mental health indicators are also strongly and positively associated with one another (mean = 0.71, SD = 0.04), indicating that individuals with better mental health show greater personal, social and workplace support.

**Table 2: Pearson Correlation matrix for mental health and stress levels. Brasília, Brazil, 2014**

	PRF	WS	SS	PS	MH	WSp	SSp	PSt
PRF	1,00							
WS	0,61	1,00						
SS	0,73	0,77	1,00					
PS	0,77	0,63	0,66	1,00				
MH	-0,60	-0,64	-0,53	-0,64	1,00			
WSp	-0,48	-0,70	-0,52	-0,47	0,68	1,00		
SSp	-0,58	-0,66	-0,62	-0,59	0,76	0,68	1,00	
PSt	-0,60	-0,59	-0,54	-0,54	0,75	0,68	0,72	1,00

Legend: PRF = Psychosocial Risk Factors, WS = Work Stress, SS = Social Stress, PS= Personal Stress, MH = Mental Health, WSp = Work Support, SSp = Social Support, PSt = Personal Staff.

**SWS factors depend on socioeconomic and demographic factors**

It was impossible to verify significant differences between indicators of mental health and stress in relation to socioeconomic and demographic factors. However, comparing the SWS factors in terms of socioeconomic and demographic factors revealed some interesting answers, as follows:

**SWS factors and sex:**

Table 3 indicates that most indicators of mental health and stress are slightly higher for women. However, comparisons across multiple chi-squares for each of the indices revealed no significant differences due to participant sex.

**Table 3: Distribution of mental health outcomes and stress by gender. Brasília, Brazil, 2014**

	Gender	PRF	WS	SS	PS	MH	WSp	SSp	PSt
Average	Male	5,6	10,5	5,5	7,4	18,1	14,6	15,6	16,3
SD	Male	3,9	5,8	3,4	4,6	5,3	6,2	4,5	3,5
Average	Female	6,5	10,2	6,01	7,6	19,3	15,2	16,7	16,3
SD	Female	4,1	5,2	3,9	4,3	4,8	5,0	4,3	3,3

Legend: PRF = Psychosocial Risk Factors, WS = Work Stress, SS = Social Stress, PS= Personal Stress, MH = Mental Health, WSp = Work Support, SSp = Social Support, PSt = Personal Staff, SD = Standard Deviation.

#### SWS factors and marital status:

Regarding marital status, divorced (n = 6), widowed (n = 3), and free (n = 3) participants were excluded from marriage because the small number of cases in each category is insufficient to produce reliable descriptors. Comparisons across multiple chi-squares for each of the indices revealed no significant differences with participant status.

#### SWS factors and socioeconomic status:

Comparisons across multiple chi-square for each of the indices revealed no significant differences with socioeconomic level.

### **Discussion**

Based on the socio-demographic data obtained in this study, we found that most Community Health Agents (CHA) were women aged 30–39 years old. Most CHA were married, of middle socioeconomic status, had finished high school, worked for 40 hours a week and had about 7 years of service experience. Similar responses were found by Lopes<sup>9</sup> in a study conducted in two health districts within the Federal District, focussed on model teams implementing the Family Health Strategy in adherence to the National Program for Improving Access and Quality of Primary Care (PMAQ-AB), into which CHA were inserted. The author also noted that most of the teams participating were women (86%). Additionally, respondents were in the 28–56-year-old age group. Regarding length of professional experience, 59.4% of professionals had less than 5 years of experience of the Family Health Strategy.

Corroborating the present work, Ferreira & Parreira<sup>10</sup> conducted a study on gender differences and satisfaction and stress that surveyed cardiology hospital nursing staff, and noted that of the 61 nurses who participated, 65.6% were female and 34.4% were male. Most respondents were aged in or near their 30s and were married (64%). Of the 132 users, 78% were male while the remainder were female, which at times caused embarrassment for the beneficiaries.

In a study of workers from 14 Community Health or Family Health Teams in Paranoá, in the Federal District of Brazil, Lopes<sup>9</sup> noted that the majority of respondents were female and aged between 25 and 42 years old, and that 80% had completed high school. Of the 14 respondents, only three CHA had participated in a training course in mental health.

In a study to estimate the prevalence of burnout and common mental disorders in community health agents, in identifying associated factors, Silva & Menezes<sup>11</sup> found that participants had a mean age of 38.9 years, and predominantly belonged to the 31–40-year-old age group (33.3%). Most were women (92.2%), had completed elementary or high school (73%), and were in a stable relationship (55.4%). Participants had worked as CHAs for an average of 40.9 months, and 92.9% reported having completed a training course.

Barcellos et al.<sup>12</sup> assessed the profile of community health agents of Vitória, Espírito Santo, Brazil. Their results showed that 275 (90.76%) were women, 272 (89.76%) were aged between 21 and 49 years old and 201 (66.34%) had a high school education.

This work, and those mentioned above, identified a trend toward increasing numbers of women working in health in Brazil. This trend was first observed long ago by Machado<sup>13</sup>, whose work identified the feminization of the health workforce in Brazil. Flores<sup>14</sup> highlighted this trend and emphasized that behind it lay factors such as gender issues, and the historical linking of care to women's roles. Furthermore, the trend was strengthened by the conscious recruitment of women

as CHAs, as occurred in Ceará, Brazil to improve women's living conditions, and the closeness between health professionals and nursing staff.

In this sense, Gomes et al.<sup>15</sup> reported that the first experience of CHA in Brazil as a comprehensive public health strategy structure, occurred in Ceará in 1987, and aimed to create jobs for women in an area of drought and contribute to reducing infant mortality. It confirms the issue of the feminization of CHA.

According to Bezerra et al.<sup>16</sup>, in a study of ideas and practices related to community workers providing health care for older people, CHA themselves prefer that such staff be entirely female because of community resistance to male agents. This stance can be partially justified by the collective acceptance of a woman stripping naked in front of a health professional, whether a doctor or a nurse, as necessary given life history and context. However, the same acceptance does not exist in connection to CHA since such work touches on our own daily experiences, including occurring in similar geographic spaces to those we inhabit daily. Thus, male CHAs face a higher risk of involvement in situations that cause embarrassment, which limits their access to certain assisted housing inhabited by older people.

Regarding mental health and psychosocial risk factors, we found that mental health indices decrease with increasing stress levels. We saw similar results in the research of Panizzon et al.<sup>17</sup>, who investigated stress among nursing staff in an emergency clinic, and observed that, based on analysis of the Chi-square and Spearman correlation tests, the stress level of the analyzed population is high, and that workload is the main stressor. All sources of work pressure were significantly and positively correlated with level of stress, with predictors of stress being workload, difficulties related to clients and processes, and organizational structure.

Regarding organizational structure, CHA, who participated in the current research, report that security is improved when work is performed as part of a team, as in the Family Health Strategy Programme (FHS). This may be related to lower stress, in relation to organizational structure, among Community Health Agents.

According to Ramminger<sup>18</sup>, theories of stress, though based on physiology, resulted in more complex models that incorporated social perspective and subjectivity.

Furthermore, in the present study, the Pearson correlation indicated a positive association with stress levels. In this sense, when one index of stress increases, so too do other indicators. Mental health indicators also exhibited this same behavior, indicating that individuals with better mental health show greater personal, social and workplace support. These associations are important because they reveal that stress levels and mental health vary with related indexes.

In a pioneering work on SWS, Areias<sup>19</sup> found a positive and strong correlation between the Mental Health and Social Support variables. In the present study, social support was the variable with the greatest impact on mental health among all classes of health workers. In this sense, the importance of such support was observed, including the insertion of community and family support to improve quality of life for health professionals, especially in relation to stress.

Areias and Guimarães<sup>20</sup> observed in a study on stress factors in workers that psychosocial risk factors are positively correlated with stressor factors and negatively correlated with support factors. However, mental health was negatively correlated with stressor factors and positively correlated with support factors. These results corroborate the findings of this work, which observed problems with psychosocial factors to be accompanied by increased stressors and decreased levels of mental health.

Taking into account the results suggesting a dependence of SWS factors on socioeconomic and demographic factors, it was observed that most indicators of mental health and stress are slightly higher for women.

These results were corroborated by a survey conducted by Areias and Guimarães<sup>20</sup> that sought to identify by gender, rates of mental health and psychosocial risk factors among workers at a public university. The results of this research found significant associations between mental health and gender, and between psychosocial risk factors and gender. The female subjects showed higher rates of psychosocial risk factors, work stress, and social stress than males, and had poorer mental health.

These higher levels of stress in females may relate to the fact that many women face a double workload. Specifically, women simultaneously engage in both paid service work outside the home

and service within the home. This situation is true in most Brazilian homes and also throughout the world.

However, several investigations indicate that employed women report fewer physiological symptoms, anxiety, depressive symptoms, and psychosomatic symptoms than do women who are not employed<sup>21</sup>. In this sense working may be beneficial to women's welfare, depending on working conditions, the quality of the organization of daily activities and subjective individual perceptions. Thus, some studies identify the need for reorganization, such as sharing of household responsibilities, as well as active public policy to facilitate family tasks, to reduce gender inequalities in health attributable to unequal distribution of family demands.

Regarding SWS factors as a function of marital status, comparisons across multiple chi-square tests for each index revealed no significant differences related to marital status of participants. However, we often observe in everyday CHA activities, and in other workers, that married life interferes with daily work practices.

According to Areias and Guimarães<sup>20</sup>, studies show that the beneficial effects of paid work on mental health and the performance of multiple roles exceed the adverse effects. However, these beneficial effects can be reversed when negative attitudes of men towards their wives are observed in relation to paid employment, causing marital conflicts, which can increase stress factors and hamper individuals' personal and professional lives. This fact related to marital problems affects both males and females, and represents a major influence on increased stress and decreased quality of life.

Even the present study could not find significant differences in SWS that correlated with socioeconomic level. However, social level strongly influences various aspects of workers' lives. According to Cooper<sup>22</sup>, stressors in the work environment can be categorized into six groups. One such group comprises factors intrinsic to a job, such as inadequate working conditions, work shift, working hours, payment, travel, risks, new technologies and work volume. Since wages are closely related to social level, stressor levels are higher among the working class.

As said before, health professionals have an obligation to care for users of health systems. We must remember that interaction is vital to providing care. Subjectivities also exist around the caregiver and the recipient of their care, and we can infer that the ways of life or situations of agents may interfere with care. Here we add the nature of work as described by Moreno<sup>4</sup>, which states that the study of psychosocial aspects of work acquires public importance when changes in work organization demand emotional and cognitive work that increases the so-called psychological and mental workload. The continued coexistence of workers with traditional physical-environmental risks has highlighted certain psychosocial issues and made labor discomfort a precursor of mental pathology.

The principle of protection is useful. In the vertical relationship of protection, health policies, which implement programs for the development of a particular area, should also protect healthcare professionals since these professionals comprise the front line in healthcare provision. The allocation of public resources must meet the needs of professionals such that policy actions actually reach health service users.

## Conclusions

Analysis of the effect of demographic variables, based on comparing the average frequencies associated with Psychosocial Risk Factors and Mental Health, found no significant effects of sex, age, education, socioeconomic status, employment, number of dependents, or marital status. However, correlational analysis revealed significant associations between factors. Mental health is negatively associated with stress factors — i.e., higher stress is associated with worse mental health. Stressors are also significantly associated with each other, as are mental health factors. That is, the magnitude of a given stress factor is similar to that of the other stress factors, and the level of mental health revealed by a given mental health factor resembles that revealed by any other mental health factor.

The results indicate the need for management changes in the public health sector related to Bioethics Protection, which states that populations vulnerable to work exploitation should be protected by guaranteeing minimum working conditions and thus reducing their stress.

The principle of mutual responsibility of care, i.e. caring for oneself and for others, generates considerable psychological distress in community health agents, and interferes with the quality of

care these workers provide. In this sense, worker stress levels increase, and the quality of the care they provide decreases. The quality of life of these workers also changes owing to the impacts of professional relationships, along with personal and social relationships. Thus, public subsidies are needed for new policies aimed at improving the organization and working conditions of these professionals.

Developed mainly in the twentieth-century, bioethics has become a legitimate and efficient tool for critically analyzing the morality of public health policies. According to Schramm & Kottow<sup>1</sup>, in public health the principle of protection meets the requirements of ethics and allows the moral justification and analysis of public policies, by requiring clear identification of the objectives and authors involved in the implementation as well as the specification of appropriate execution methods. In this sense, according to Schramm<sup>23</sup>, the bioethics of protection is seen as applying to moral conflicts involved in human practices, which may have significant irreversible effects on living organisms, particularly human populations, considered in their etiological and sociocultural contexts. Thus the bioethics of protection applications facing health professionals, such as Community Health Agents, can ensure better professional development inside and outside the work environment.

Since measures to support health professionals, related to both bioethics and bioethics of protection, will benefit both professionals and society, the relationship between these two groups is systemic and cyclical – i.e., each individual belonging to these groups is dependent on others.

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